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Self-Diagnosed Cases of Dissociative Identity Disorder on Social Media: Conceptualization, Assessment, and Treatment

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Abstract: Recent global popularity of social media content about dissociative identity disorder (DID) has coincided with increased self-diagnosis among children and young people who have formed large online communities and presented in clinical settings seeking to affirm their self-diagnoses. We situate this phenomenon within a broader trend toward self-diagnosis due to the widespread visibility and accessibility of mental health content on social media. Social media propelled self-diagnosis raises particular questions for the study and treatment of DID due to long-standing debates over whether the condition is traumagenic, sociogenic, or iatrogenic. This paper draws from the current state of knowledge about psychiatric self-diagnosis, the influence of social media on youth mental health, and the authors' clinical experience to present preliminary conceptualizations of DID self-diagnosis and its significance for clinical practice. Established etiological models for DID acknowledge the role of sociocultural and contextual factors in shaping and reinforcing the elaboration of DID self-states. We hypothesize that multiple forms of online sociality and interaction encourage such elaborations. Social media content regarding DID, however, is routinely unreliable and low quality, often mischaracterizing the condition's symptoms and minimizing associated suffering and disability. This paper considers the likelihood that the self-diagnosing DID cohort includes genuine, genuine but exaggerated, imitative, and malingering cases, and underscores the importance of careful and personalized assessment and diagnosis.

Keywords: diagnosis, dissociation, internet, social media, trauma

INTRODUCTION

In many respects, the rise of the internet and social media has been a boon for public and professional understanding of complex trauma and dissociation. The internet has democratized knowledge about poorly understood conditions, such as dissociative identity disorder (DID), and enabled clinicians, trauma survivors, and mental health consumers to network with one another, provide support, challenge myths, and educate the broader public. An unexpected outcome of expanded awareness about online discussion of DID, however, is an increase in children and young people self-diagnosing the condition. This development is not unique to DID; it has been documented in relation to other psychological conditions, including tic disorders, autism spectrum disorders, attention-deficit hyperactivity disorder (ADHD), borderline personality disorder, and bipolar disorders (BPD).[1,2] DID self-diagnosis based on social media information has been the subject of extensive media commentary,[3-5] but relatively little published clinical writing to date.[6]

The aim of this paper is to review the current state of knowledge about DID self-diagnosis based on social media information, and to explore the implications for clinical assessment and treatment. The phenomenon of psychiatric self-diagnosis appears to have accelerated during the COVID-19 pandemic, which has been associated with increased social isolation and social media use, exacerbation of existing mental health problems, and deterioration in overall community mental health.[1] These developments raise questions and clinical challenges for the study and treatment of DID, long a subject of debate over whether the condition is traumagenic or sociogenic/iatrogenic in nature.

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This paper presents two fictionalized social media self-diagnosis vignettes drawn from clinical and supervision experience of the authors, then presents preliminary conceptualizations of this phenomenon and its significance for clinical practice. There is a clear need for robust empirical research to inform the assessment, diagnosis, and treatment of people who self-diagnose with DID and other psychological conditions based on social media activity.

REVIEW OF DID

DID is described in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (*DSM-5-TR*) as a disruption of identity characterized by two or more distinct personality or identity states associated with interruptions to memory as well as distress or psychosocial dysfunction.[7] A meta-analysis of 98 DID prevalence studies found a 3.7% community prevalence of DID.[8]

There is pronounced media fascination with the identity dimensions of DID.[9] People with DID may present with self-states that claim differences in subjective age, manifest gender, sexual preference, mode of dressing, and so on, while other self-states may be experienced as nonhuman (e.g., demons, animals, aliens). Such variation has provided rich terrain for movie plots, television series, and books.[9] The observable performance of multiple identities is commonly conflated with a DID diagnosis. Such dramatic presentations, however, are not essential for diagnosis or treatment, other than in exploring the possible psychodynamic meanings of these phenomena. Indeed, most DID individuals do not elaborate the presentational role of self-states, and many self-states only manifest intrapsychically. In general, the greater the complexity of subjective elaborations, the longer treatment will take. In fact, such presentations may impede treatment altogether due to narcissistic investment in their complexities.

Since its first formulation in 1980 as multiple personality disorder in the *DSM-III*, DID has undergone protracted debate over whether it is traumagenic (that is, caused by early childhood trauma), sociocognitive (the product of social influence), and/or iatrogenic (caused by therapeutic suggestion or maltreatment). The field of traumatology has generally argued that there is a direct causal relationship between trauma and dissociation. According to this perspective, dissociation acts as a psychobiological defense against the psychologically and emotionally overwhelming nature of acute and/or chronic trauma, often in combination with attachment problems, cultural influences, and autohypnotic capacity.[10,11] In the traumagenic model, the most important function of DID self-states, as they develop, is to mitigate the effects of unpredictable and often sadistic malevolence by parental and/or attachment figures in childhood (e.g, a little girl creates a male self-state with the idea, "If I were a boy, this would not be happening.").[12] Those who contest the trauma model of dissociation argue that suggestible individuals prone to fantasy and/or sociocultural influence experience dissociation and begin to falsely believe they were abused in childhood.[13] According to these theorists, DID is an iatrogenic phenomenon, linked to the "implantation" of false traumatic memories by suggestive therapists, and hence, "dissociation is related to self-reported but not objective trauma."[14]

A series of papers examined the literature to determine whether the traumagenic or sociogenic/iatrogenic model had the stronger evidence base.[14,15] In a review of approximately 1500 studies, including a series of meta-analyses, Dalenberg and colleagues[16] found that the preponderance of research overwhelmingly supported the trauma model of dissociation; objective reports and self-reports of trauma correlated with dissociation. Across multiple suggestibility paradigms, average effect sizes for dissociation accounted for 1–3% of the variance in suggestibility. There are numerous studies showing that dissociative individuals are not, however, prone to developing false memories.[16,17] Effective treatment for DID involves triphased trauma therapy focused on safety and stabilization, trauma reprocessing, and integration, a method that has demonstrated improved clinical outcomes across a number of domains.[18]

While the available evidence does not support the proposition that DID is a sociogenic or iatrogenic disorder, clinical and research literature on DID has long acknowledged the potential for malingered, factitious, or imitative presentations. Malingering is intentionally reporting symptoms for personal gain, such as money or reduced legal sanctions.[7] Factitious disorder requires that illness symptoms are falsely reported yet not solely for external gain—for instance, they also serve psychological needs.[7] Research has consistently found that individuals who feign DID endorse media-based stereotypes of DID, which are easily learned and imitated. Yet, feigners miss the subtle, lesser known manifestations and struggles, such as depression and somatic symptoms.[19,20] Case descriptions report DID individuals who malinger and/or factitiously elaborate the severity of DID symptoms, disability, and trauma history to avoid consequences for criminal or problematic behavior.[21] Studies document high rates of childhood maltreatment and dissociation in individuals diagnosed with factitious disorder, both imposed on self and imposed on another.[22,23]

Boon and Draijer[24] use the term "imitative DID" for individuals who erroneously believe they have a DID diagnosis. Imitative presentations typically lack the disorder's complex comorbidities and avoidance of/ambivalence about dissociation. Instead, such individuals often display a fascination with DID, and enjoy thinking, writing, and talking about different self-states. This sharply contrasts with the disavowal and discomfort that characterizes most individuals with DID.[25,26] Some individuals with imitative DID describe having an unusual degree of awareness of their self-states with little or no conflict among them and/or little or no amnesia. Alternatively, and also atypically, some individuals with imitative DID report total amnesia among self-states.[24]

PRESENTATIONS OF DID ONLINE

No doubt prompted by the controversial nature of the diagnosis, people with DID began self-organizing online almost as soon as the internet was popularized in the mid-1990s.

The website Astreas Web was created in 1995 to champion the rights and needs of people living with DID. The site presents multiple identities as a lifestyle or identity rather than an illness or disorder, but nonetheless fiercely defends the validity of the DID diagnosis from skeptical criticism. The framing of multiplicity or plurality as a preferred identity, but also as a form of severe dissociation produced by early childhood trauma, is evident in online networks across social media platforms such as Twitter, YouTube, and TikTok.[27] Social media users claiming to live with DID are making extremely popular content that is attracting tens of millions of views, creating distinct fandoms, communities, and subcultures. On the video-based social media platform TikTok, videos with the hashtag #DID have been viewed a total of 2.7 billion times and #dissociativeidentitydisorder videos had been viewed 1.5 billion times as of May 2023. (TikTok no longer publishes information on the view count per hashtag.) The largest DID account on TikTok has over 1.1 million subscribers as of February 2021.[28]

Interview research with members of online plurality communities has found that they are typically young, female at birth, and include a mixture of people clinically diagnosed with DID and self-diagnosed, as well as those who identify as multiple or plural but claim to have no trauma history or dissociative symptoms.[29] Within the broad umbrella of the online plural subculture, there is an elaborate vocabulary to describe systems of self-states, their origins, and associated psychological and relational dynamics. (The term "system" is used within online DID subcultures to refer to a collection of self-states within an individual, and sometimes to any individual with DID.) There is sometimes a role-playing aspect as individuals incorporate their favorite fictional characters into their systems of self-states and engage in online interactions among these self-states and other systems. A small body of scholarship has emerged to argue that multiplicity is a valid identity category to describe the experience of multiple selves in a single body, and that the most appropriate therapeutic stance is to always accept, and even celebrate, the multiplicity of the individual.[30] Claims that social media performances of DID represent the authentic voices of people with lived experience, unmediated by professional expertise, should not be dismissed offhand. It is naive, however, to characterize social media platforms as neutral communication systems for self-expression and the distribution of mental health information. Social media content is curated and organized by underlying algorithmic processes that promote the rapid sharing and adoption of emotionally charged and salient content, regardless of veracity.

Ethnographic research on TikTok users who create DID content has found that the predominant focus is on the display of multiple marginalized identities. These identities are not limited to DID self-states, but include a spectrum of LGBTIQ+ and neurodevelopmental, and sometimes nonhuman (vampires, fairies, etc.), identifications within a social media community that has its own complex norms, values, and etiquette.[31] The role of DID identification as a form of self-display, self-expression, and in-group belonging may help explain why the factual content of social media DID material can be low quality or inaccurate. A recent structured assessment of quality and reliability of DID videos on YouTube (60 videos) and TikTok (97 videos), undertaken by four independent reviewers, found that DID content on both sites was both low in quality and reliability.[32] TikTok content was rated significantly worse than YouTube content, commonly presenting misinformation and false claims. Optimistic characterizations of multiplicity on social media consistently underplay the functional impairment and disability evident among people diagnosed with severe trauma-based dissociative disorders.[33]

SOCIAL MEDIA SELF-DIAGNOSIS

The popularity of DID-related content on social media is associated with the relatively new phenomenon of young people self-diagnosing with DID after consuming social media content. Many thereafter seek out DID treatment on this basis. As some mental health experts have pointed out, children and young people often rely on social media for mental health information due to difficulties accessing affordable mental health care.[34] Research suggests that self-diagnoses for common conditions, such as depression, anxiety, and insomnia, are often accurate.[35] At the same time, evidence for the spread of mental disorders within adolescent peer networks suggests that social connection with other teenagers evincing a psychiatric diagnosis increases the likelihood of receiving such a diagnosis.[36] There is ongoing concern about social contagion as various psychiatric conditions receive unprecedented attention among young people on social media.[1]

The public and dramatic portrayals of switching among self-states and other dissociative symptoms recorded and shared online are at odds with commonly reported responses to the DID diagnosis. Confident assertions of DID as a diagnosis and personal identity are also unusual. Clinicians have observed that people with DID typically evince significant "reluctance, ambivalence or shame" about the discussion of dissociative symptoms, such as amnesia or subjective self-division, and may resist or reject the diagnosis.[26] A recent meta-analysis found a consistent correlation between shame and dissociation.[37] Hence, social media presentations of DID as a fun and interesting condition, as well as the assertive claim of a DID identity in the absence of professional assessment or diagnosis, are contrary to clinical experience and research on the phenomenology of the condition.

The literature on self-diagnosed DID through social media exposure is limited. There is, however, a parallel phenomenon that has attracted clinical attention. There was a significant increase in tic-like presentations to Tourette syndrome clinics and professionals during the COVID-19 pandemic of 2020–2021. This increase has been reported internationally, coinciding with the rapid rise in TikTok video views made by individuals claiming to have Tourette syndrome.[38] The recent surge in referrals to Tourette specialists involved an atypical group. The majority of people diagnosed with tic disorders are male, with onset at five to seven years of age.[39] The increase in referrals during

the COVID-19 pandemic, however, was predominantly among adolescent girls with sudden onset of motor and verbal tics, including self-injurious behaviors, object throwing, swearing, and context-specific utterances. These exhibitions are markedly different from the simpler tics that characterize a typical Tourette syndrome presentation.[40] In one retrospective case review of 34 pediatric patients in the UK and Canada presenting with sudden onset of tic-like movements, 77% of patients reported watching social media videos of tics, largely prior to symptom onset.[41]

Clinical examination of tic-related social media videos has identified two important features. First, very popular social media users claiming to have Tourette syndrome display clinically unusual tic patterns.[37] Second, the tic-like symptoms of some patients are remarkably similar to those displayed on social media by other users.[42] Claims that tic-like presentations by girls and young women are evidence of attention-seeking behaviors, however, have been criticized by some Tourette specialists. They note that these patients are likely heterogenous, and that some do have a prior personal or family history of tics.[43] It is likely that increases in such presentations at Tourette syndrome clinics and specialists are driven by multiple factors, including worsening clinical conditions of people with Tourette syndrome during COVID-19[44] and the development of functional tic-like disorders among people exposed to tic content on social media. Heyman and colleagues[39] found that girls and young women presenting with functional tic-like symptoms often had undiagnosed neurodevelopmental impairment, including autism spectrum disorder, learning difficulties, and ADHD. For those experiencing social isolation or social deficits, watching and/or posting tic videos can generate peer support and a feeling of belonging, which may reinforce symptoms.[42] The nature of social media also means that such behaviors may be reinforced by financial incentives and secondary gain.[38]

Increases in DID self-diagnosis may be the result of similar intersecting factors. Young people with backgrounds of adversity were particularly vulnerable to poor mental health during COVID-19.[45] Research indicates that this group uses social media as a coping mechanism at much higher rates than other children.[46] Children and young people self-diagnosing with DID often have a history of adversity and trauma, albeit not necessarily of the magnitude typical among individuals with DID. Underlying vulnerabilities in certain young internet-user cohorts, combined with the reinforcement and elaboration of symptoms via social media dynamics, may provide a useful framework for understanding recent increases in DID self-diagnosis.

CLINICAL VIGNETTES

Experts in dissociation, including the authors of this paper, have seen an increase in clients presenting with self-diagnosed DID. Many of these presentations are inconsistent with the diagnostic criteria and characteristics on reliable and valid screening and diagnostic inventories for DID. Distinguishing whether these cases are genuine, malingered, factitious, or imitative DID, or a combination, is difficult.[47] Their management may be further complicated when some of these individuals respond with anger and defensiveness if clinicians do not agree with their DID self-diagnoses. In late 2022 and early 2023, we presented an online workshop and lecture on social media self-diagnosis of DID that became available on YouTube. These presentations generated significant backlash among social media networks and online communities of people who self-identify as plural, multiple, and/or having DID.[48] Stated concerns included clinical gatekeeping of the DID diagnosis and undermining lived experience and self-understanding. There was significant hostility toward any clinical or academic scrutiny or analysis of social media content distributed for public consumption by people self-diagnosing with DID online.

Based on the authors' clinical and research experiences, we have developed two fictionalized vignettes to illustrate and explore the clinical characteristics of young people presenting for assessment and treatment with self-diagnoses of DID based on social media exposure:

> Courtney, a 19-year-old cashier, brings in a list of "alters in my system" aged 7 to 19 years old. These alters have different qualities that "help [her] with anxiety," particularly in social interactions. Courtney reports that her alters first appeared at age 12, after she learned about DID by watching "people with DID" on YouTube. She has only online friends. Her trauma history includes a car accident as a toddler and peer bullying throughout her schooling. On the Multidimensional Inventory of Dissociation (MID) self-report inventory,[49] she endorsed time loss and "coming to" experiences. Unlike DID individuals, however, she experiences no internal struggle, emotional suffering, flashbacks, or persecutory self-states. Her self-states appear to be internal helpers who assist with difficulties in social situations. They have been developed from her exposure to social media rather than extreme, chronic childhood maltreatment. Although she appears to experience mild depersonalization and derealization, Courtney's alters seem to be largely imitative and a means of comforting herself and fitting in with online groups.
>
> Fiona, a 13-year-old student, describes spending many hours a day since age nine in a complex fantasy world, with imaginary friends based on internet characters. In the last two years, she has noticed that some of these friends are being experienced as "parts of myself." Her list of parts includes imaginary friends, "helpers" (said to assist with productivity and social interactions), and "angry parts." Fiona's trauma history includes intrafamilial emotional and physical abuse, a home-invasion robbery at age eight, and bullying at

school. She spends a lot of time on the internet and has only online friends. On the MID, she over-endorsed all validity scales (except defensiveness) and all dissociative symptoms. Her self-states appear to be a mixture of helpers, imaginary friends, and trauma-based entities. Thus, she seems to have a mixture of trauma-related self-states and possibly social-media influenced imitative self-states.

Like many children and young people adopting social media self-diagnoses, Courtney and Fiona were navigating self-identity formation against a backdrop of varying degrees of childhood adversity, including peer harassment and isolation at school at the time of assessment. Both Courtney and Fiona appear to be experiencing some dissociative symptoms including, for Fiona, persecutory states that are typical in trauma-related dissociative identity formations. Such symptoms are absent in Courtney's case. For both young women, self-identification as a person with DID, including elaboration of a system of alters, is part of the prescriptive norms of their online social networks. Given their experiences of school bullying, their online friend networks are particularly important. Treatment may well explore how belonging to a DID online community might fulfill developmental needs and influence the complexities of identity consolidation in young people, particularly for individuals with a history of trauma and adversity.

Clinical Evaluation of Self-Diagnosed DID

In his etiological framework, Kluft[50] identified four factors that contribute to the development of DID: (1) a genetic capacity to dissociate; (2) interpersonal trauma that overwhelms nondissociative coping; (3) sociocultural and contextual factors that shape and reinforce the subjective elaboration and personification of DID self-states; and (4) a lack of soothing and restorative experiences.

Data on children and adolescents with DID are primarily based on case series. Silberg[51] hypothesizes that, among children with a predisposition (factor 1), DID evolves along a continuum, becoming more rigid and similar to the adult prototype if trauma is unrelenting (factor 2) and there is no treatment or other mitigating factors (factor 4). Younger dissociative individuals tend not to have elaborated dissociative senses of self/identity, and present with what Silberg has termed "transitional self/identities," with some similarities to imaginary friends and subjective helpers.[51] Adolescents with DID have profound difficulties with adolescent experiences (sexuality, separation/individuation, development of more independent self/identities related to their experiences in the world [e.g., school, camp, with peers, etc.]) and coping with past and ongoing intrafamilial trauma. Unfortunately, many children and adolescents with DID suffer from significant victimization outside of their families (for example, bullying at school), increasing trauma burden and complicating important developmental tasks around the self and identity.[51] Thus, during adolescence, individuals with DID often elaborate their subjective self/identity states into adult forms, including into complex self-state systems, frequently in substantial conflict with one another.

Kluft's third factor relates to secondary elaboration of DID through a range of influences that shape and promote the presentation of self-states, often disguising their traumagenic etiology. Research into problematic internet behavior suggests that social media, gaming, and general internet use can have dissociogenic effects, particularly for young people with existing dissociation.[52,53] Children and young people are frequently enjoined online to create new names and identities, and enter into complex fantasy worlds.[52] Recent research into maladaptive daydreaming has highlighted a cohort of young people for whom absorption into online communities and associated role playing constitutes a defensive, possibly dissociative, retreat into an inner world.[54] In such online environments, the ubiquity of DID content, and the fascination that the diagnosis provokes, likely contributes to the process by which some people come to view themselves as having DID. While the influence of social media on mental health and clinical presentation remains poorly understood,[1] there is a large body of literature on sociocultural shaping of psychiatric symptoms and idioms of distress. The *DSM-5-TR* includes a pathological possession form of DID; in some cultures, somatic symptoms are the most common clinical presentation of depression.[14]

The presence, absence, and relative contribution of all four of Kluft's factors can only be assessed through careful clinical evaluation. It may be that social media content has provided useful information to people with DID that facilitates self-diagnosis and seeking help. Likewise, some DID individuals find community and belonging via social media. Simultaneously, social media content is curated and manipulated via algorithmic processes that incentivize novel and engaging forms of self-display, regardless of whether this content is accurate or responsible. Social media offers modes of belonging based on discrete identity categories that users can opt in or out of with relative ease. Not only has this dynamic resulted in misleading DID presentations on social media,[15] but people with other undiagnosed mental health conditions may mislabel themselves as DID. Others may role play DID due to the novelty and utility of the multiple identity concept. These groups appear to intersect on social media under the DID rubric.[8] Additionally, inaccurate or dramatic social media presentations may result in DID individuals incorrectly concluding that they do not have DID.

While DID has attracted social media attention due to the novelty of multiple self-states, underlying the DID diagnosis are specific neurobiological processes not found in individuals who feign the disorder, nor in individuals with trauma-related psychopathology without DID.[55] People with DID endure extreme distress and anguish, as well as a range of psychopathological comorbidities, including high posttraumatic stress disorder (PTSD) rates, severe mood disorder symptoms, substance use and eating disorders, and danger to self; such individuals are also more likely to require

treatment at more restrictive levels of care.[32] These comorbidities are closely linked to early onset and chronic child maltreatment, associated with high-risk behaviors, chronic physical injuries, long-term disabilities, and many medical conditions.[56] DID individuals have very high rates of victimization in intimate partner violence and adult sexual assault, including a subgroup that continues to be sexually abused and psychologically controlled into adulthood by childhood perpetrators.[57,58] These stark realities are glossed over in social media content about DID. A recent article about the phenomenon of social media self-diagnosis noted a tendency by such online movements to amplify the voices of those less affected and experiencing less disability.[59] Such representatives may in turn criticize what they deem pathologizing of their diagnosis, preferring to frame their condition as a beneficial manifestation of human diversity. Similar dynamics are observable in social media portrayals of DID as an enjoyable and fascinating condition, alongside expressions of hostility toward clinicians and organizations supporting severely unwell people with DID.

CONCLUSIONS AND RECOMMENDATIONS

People with DID have complex needs and are vulnerable to retraumatization. On this basis, there is good reason for clinicians and others to be aware of how the DID diagnosis is being incorporated into the range of identity options available to social media users. A potential effect of DID's online popularization is that it may undermine the importance of the diagnosis as a marker and outcome of chronic childhood abuse and ongoing suffering and disability. An additional concern is that, among people with DID, identification with the diagnosis as a basis of self-identity, as well as similar investment in the creation and elaboration of self-states, can impede treatment and recovery. Given that clinicians and researchers focused on DID have exerted considerable effort to defend the validity of the diagnosis, it is ironic that many professionals are now concerned about sociogenically created online DID. This controversy has erupted amid myriad research studies pointing to more sophisticated conceptualization of self, identity, and personality in DID.[36] Relevant developments include research on gene/environment interactions in dissociation; developmental traumatology linking early-life attachment pathology to dissociation; sophisticated neurobiological data on DID; and delineation of a unique DID personality organization. Such developments further distinguish DID from other disorders (e.g., BPD, PTSD, etc.), and prospective outcome data show that the three-phase treatment model for DID leads to significantly positive outcomes in many important clinical dimensions and social functioning.[60]

Much of what is presented about DID on social media relates to the proliferation and elaboration of identities as the distinguishing diagnostic feature, when these identity enactments are not the symptomatic focus of reliable and valid DID screening/diagnostic inventories. Clinicians who are well-informed about accurate DID diagnosis utilize questions about dissociative process symptoms, such as state-shifting and passive-influence experiences, chronic complex dissociative amnesia, and multimodal dissociative hallucinosis.[25] Most experienced DID clinicians primarily work on these more subtle and pervasive processes, rather than on their presentational identity aspects. Personality organization in DID comprises "whole human being" psychological traits for processing and relating to inner and outer reality, and is not subjectively self-divided.[12] Thus, it is predictable that there are difficulties when individuals who conflate their identity systems with DID seek out experienced DID providers. Clinical experience suggests that many are seeking validation for these identity enactments.

Some individuals may require careful diagnostic efforts as dissociation is a transdiagnostic process related to trauma.[61] The *DSM-5-TR* chapter on dissociative disorders includes a detailed description of the complex symptom profile of DID, explicating the diagnostic criteria and differentiating diagnosis from disorders with which DID may be confused (e.g., BPD, schizoaffective disorder, borderline personality disorder, functional neurological disorder, factitious disorder, malingering, etc).[7] Loewenstein[12] has published a comprehensive mental status exam for DID, including many detailed clinical examples that provide a qualitative sense of DID and can assist clinicians in differential diagnosis. In complicated cases in which differential diagnosis is challenging due to atypical features and/or history, clinicians are advised to use validated self-report measures with validity scales, such as the MID and the Semi-Structured Clinical Interview for Dissociative Symptoms and Disorders.[62] These measures have been shown to distinguish DID from other conditions.[63] (Detailed information about assessing dissociation and making the differential diagnosis of dissociative disorders is available.[60])

Accurate DID diagnosis and treatment leads to myriad positive outcomes, including improved mental and physical health, interpersonal safety, and quality of life, as well as decreased health care utilization.[64] A majority of people with dissociative disorders, however, are unable to access dissociation-specific mental health care due to a range of barriers, including a lack of dissociation expertise in the mental health workforce and professional skepticism and disbelief.[65] Sensationalist media presentations of the condition, which have not been counterbalanced by adequate training on complex trauma and dissociation, account for much of the professional skepticism regarding DID. An emerging concern, however, is that inaccurate and misleading social media discourse on DID may provide a new impediment to effective diagnosis and treatment via what Chevalier[66] called the "looping effect" of social media on psychiatric diagnosis. In this effect, lay and inaccurate mental health claims on social media ultimately influence professional discourse and practice; the sheer ubiquity of misleading claims about DID on social media may convince mental health consumers and practitioners alike. At the same time, as discussed regarding Kluft's third factor, psychiatric conditions such as DID do not develop in

isolation from the broader sociocultural environment. Thus, pervasive social media dynamics are likely shaping the development and presentation of dissociative processes. Hence, DID clinicians and researchers must strike a dialectical balance. Evidence-based, scientific conceptualizations of DID should be informed by exploration of how shifts in the sociocultural and technological environment can produce unanticipated but significant changes in psychological processes and presentations.

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