MENTAL HEALTH · DISSOCIATIVE DISORDERS · NCLEX 2026

Dissociative Identity *Disorder*

A trauma-based disorder where the self fragments into 2+ distinct identity states with memory gaps — formerly called Multiple Personality Disorder. Highest suicide risk among dissociative disorders.

DSM-5-TR · 300.14 / F44.81 | Psychosocial Integrity | Safety & Infection Control | Reduction of Risk Potential

1 Definition & Overview

YELLOW · DEFINITION

- **DID is a severe dissociative disorder** defined by the presence of **2 or more distinct personality states** (alters) that recurrently take control of behavior, with **gaps in memory beyond ordinary forgetfulness**.
- **Why it matters:** DID is a survival adaptation to overwhelming early-childhood trauma — **not psychosis**. Patients carry the **highest suicide and self-harm risk** in the dissociative spectrum and require long-term, safety-focused care.
- **Core features:** identity disruption · amnesia · depersonalization · derealization · functional impairment not better explained by religion, culture, or substance use.

2 How DID Develops

RED · PATHOPHYSIOLOGY

STEP 1 Severe, repetitive childhood trauma (typically before age 6–9) →

STEP 2 Developing brain unable to integrate experiences →

STEP 3 Dissociation = protective defense mechanism →

STEP 4 Identity fragments into separate "alters" holding trauma →

STEP 5 Triggers cause switching + amnesia between alters

Key point: Each alter may have its own name, age, voice, gestures, handwriting, and even allergies or eyeglass prescription. The host (primary identity) often has **amnesia** for what other alters do — this is why patients find unfamiliar clothes, drawings, or hear they were "called a different name."

3 Signs & Symptoms

ORANGE · CLINICAL PICTURE

Core / Classic Features

- **≥2 distinct identity states** (alters) — different names, voice, posture, gender, age
- **Dissociative amnesia** — gaps in personal history, daily events, or trauma
- **Depersonalization** — "watching myself from outside my body"
- **Derealization** — "the world feels foggy / dreamlike / unreal"

Frequent Co-occurring

- PTSD (very common — flashbacks, nightmares)
- Major depression, anxiety disorders
- Substance use (numbing the trauma)
- Self-harm (cutting, burning) — often during switches
- Somatic complaints (headache, GI, conversion sx)

- Time loss, "blackouts," finding unfamiliar items
- Internal voices arguing or commenting (alters talking)
- Sleep disturbance, eating disturbance

Mild / Early Presentation

- Brief "spacing out" episodes
- Mild depersonalization under stress
- Forgetting recent conversations
- Feeling "not myself" intermittently

Severe / RED-FLAG Presentation

- **Active suicidal ideation or attempt** — HIGHEST risk dissociative dx
- **Self-harm during dissociative episode** — no memory of injury
- **Command voices** from an alter to hurt self/others
- **Dissociative fugue** — wandering away from home, identity loss

GREEN · PRIORITY ACTIONS

4 Priority Nursing Interventions

SAFETY FIRST (Always Priority)

- **Assess** for SI/HI and self-harm every shift
- **Initiate** 1:1 observation or safety contract per protocol
- **Remove** potential means of self-harm from environment
- **Monitor** closely during/after switches — amnesia raises injury risk
- **Provide** safe, structured, low-stimulation environment

Therapeutic Relationship

- **Establish trust** through consistency, predictability, calm tone
- **Acknowledge all alters** with equal respect — never dismiss or favor one
- Use neutral language: "the part of you that…" not "your other personality"
- Avoid confronting or arguing about whether alters are "real"
- Maintain professional boundaries — same nurse when possible

Grounding & Stabilization

- Teach **5-4-3-2-1 grounding** (5 see, 4 hear, 3 touch, 2 smell, 1 taste)
- Use cold water, ice, or textured object for sensory anchor
- Speak the patient's name calmly, orient to date/place/situation
- Help identify **triggers** that precipitate switching
- Encourage **journaling** for memory continuity across alters

Long-Term & Collaborative

- Refer to **trauma-focused psychotherapy** (integration is the therapist's role, not the nurse's)
- Coordinate with psychiatrist for co-morbid symptom management
- Encourage support groups; involve trusted family only if safe
- **Do NOT** push trauma recall — can re-traumatize
- Reinforce coping skills used between dissociative episodes

PURPLE · PHARMACOLOGY

5 Medications (Symptom-Targeted)

No FDA-approved medication treats DID itself. Pharmacology targets **co-occurring symptoms** (depression, PTSD, anxiety, nightmares). Psychotherapy is the primary treatment.

SSRIs

sertraline · fluoxetine · paroxetine

MOA: ↑ serotonin in synapse · **Use:** depression, anxiety, PTSD symptoms
S/E: GI upset, sexual dysfunction, ↑ suicidal thoughts (esp. first 2–4 wk)

Prazosin

α_1-blocker · trauma-related nightmares

MOA: Blocks α_1-adrenergic receptors → reduces nightmare adrenergic drive

Nursing: 4–6 wk for full effect · monitor for serotonin syndrome · suicide watch early in tx

S/E: **1st-dose orthostatic hypotension**, dizziness, syncope
Nursing: First dose at bedtime · BP sitting/standing · rise slowly · fall precautions

Atypical Antipsychotics (low-dose)

off-label · severe dissociation / intrusive sx

MOA: D_2/5–HT_2A antagonism · **Use:** only if severe sx + failed first-line
S/E: sedation, metabolic syndrome, EPS, weight gain
Nursing: Monitor glucose/lipids/weight · AIMS for EPS · NMS warning

Mood Stabilizers / Anticonvulsants

lamotrigine · valproate (off-label)

MOA: Stabilize neuronal firing · **Use:** affective lability between alters
S/E: Lamotrigine → **Stevens-Johnson rash** · valproate → hepatotoxicity, thrombocytopenia
Nursing: Teach rash reporting · LFTs · CBC · titrate slowly

⛔ AVOID: Benzodiazepines

lorazepam · alprazolam · diazepam

Why avoid: Can **worsen dissociation**, impair memory further, and carry **high abuse/dependence risk** in trauma-survivor population. Reserve only for acute panic if absolutely needed, short-term.

⚠️ Adherence Caveat

Unique to DID

One alter may **refuse** medication another alter accepted. Switches can disrupt dosing. **Nursing:** Observe administration, use pillbox + journal, involve trusted alter in plan, never coerce.

BROWN · EXAM PITFALLS

6 NCLEX Test Traps ⚠️

THE TRAP DID alters = psychotic hallucinations, treat with antipsychotics	*vs*	THE TRUTH Internal voices = alters communicating. **Not** schizophrenia. No external voices.
THE TRAP Priority is to "integrate" the alters or confront the patient about them	*vs*	THE TRUTH Priority is **SAFETY** first. Integration is a long-term therapist goal, not nursing role.
THE TRAP Memory gaps = patient is lying, malingering, or "attention seeking"	*vs*	THE TRUTH Amnesia is a genuine protective response to trauma. Validate, never accuse.
THE TRAP Encourage patient to "remember the trauma" to heal faster	*vs*	THE TRUTH Forced recall can **re-traumatize**. Stabilize first; trauma work comes later, with a therapist.
THE TRAP Give a benzo for the agitated dissociating patient	*vs*	THE TRUTH Benzos **worsen** dissociation. Use grounding techniques first.
THE TRAP Use language like "your other personalities" or "the real you"	*vs*	THE TRUTH Use neutral phrasing: "the part of you that…" All alters are valid parts of one person.

TEAL · PATIENT EDUCATION

7 Patient & Family Teaching

- **DID is a response to trauma** — not weakness, "craziness," or possession. You survived something extraordinary.
- **Treatment is long-term** (often years). Goal is stabilization, functioning, and gradual integration.
- **Identify your triggers** (sounds, smells, places, anniversaries) and build a coping plan for each.
- **Practice grounding daily** — 5–4–3–2–1, cold water, ice cube, breath counting. Use BEFORE crisis.
- **Keep a journal** with date, time, mood, who was "fronting." This builds memory continuity across alters.
- **Avoid alcohol and recreational drugs** — they intensify dissociation and reduce safety.

- **Keep a safety / crisis plan visible** — 988 Suicide & Crisis Lifeline, therapist line, trusted contact.
- **Sleep hygiene matters** — fatigue lowers the threshold for dissociation and switches.
- **Attend every therapy session.** Consistency with one trauma-informed therapist is the most important factor.
- **Family teaching:** don't argue with alters, don't ridicule, learn grounding cues, encourage continuity.

GOLD · MNEMONICS & PATTERNS

8 Memory Boosters

🧠 Mnemonic: *DISSOCIATE*

D Distinct identities (2 or more alters)	**I** Identity disruption + internal voices
S Suicide risk is HIGH — top priority	**S** Severe childhood trauma is the root
O Often comorbid: PTSD, depression, SUD	**C** Consistency in caregiver = builds trust
I Internal voices ≠ schizophrenia	**A** Amnesia + gaps in personal history
T Triggers cause switching — identify them	**E** Establish safety FIRST · ground · journal

🛟 Bedside: *SAFE*

- **S**afety first — assess SI, remove means
- **A**cknowledge all alters with respect
- **F**oster trust through consistency
- **E**ncourage grounding + journaling

🎯 Pattern Recognition

- **Trauma + memory gaps + alters** → think DID, not schizophrenia
- **Internal** voices = alters · **External** voices = psychosis
- Always pick the **SAFETY answer** first on NCLEX
- Never the answer that **confronts, forces recall, or favors one alter**
- Grounding > medication for acute dissociation