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Research Paper

Dissociative Identity Disorder: Implications to Nursing (A seminar presentation in the Department of Nursing Science, PAMO University of medical sciences, Port Harcourt- Nigeria)

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In everyday life, we are exposed to stressors and challenging experiences. These stressors and experiences are normal part of life, and the response to these stressors is a survival mechanism which primes us to respond to threats and adjust to new situations. These stressors and experiences can be both positive and negative. Negative stressors and experiences can affect our physical and mental health correspondingly leading to a condition known as dissociative identity disorder (DID). DID is a psychological mechanism unconsciously employed by the victims to assist them manage the stress / protect themselves so asto survive the stressful situations. DIDusually occurs in people who experience overwhelming stress or trauma in childhood and in an effort to survive these overwhelming traumatic experiences, the brain attempts to self protect by “numbing out” or “going away” (dissociating) (Snyder, 2021). The experience of trauma is subjective and individualized, so what one experiences as a traumatic event may not be considered traumatic by another. Similarly, not all traumatic experiences will lead to DID (Snyder, 2021). DID is a survival mechanism and reflects the strength of the basic psyche to survive experiences that would drive some to psychosis (Bowlby& Briggs, 2014).

Dissociative identity disorder (DID), is a condition in which a person experiences disruption of identity characterized by two or more distinct personality states or an experience of possession, which may alternate

within the individual's conscious awareness [American Psychiatric Association (APA), 2013; American Association for Marriage and Family Therapy (AAMFT), 2022]. The different personality states (called Alters, while the real personality is called the Host) usually have distinct names, identities, temperament, and self-image. At least two of these personalities repeatedly assert themselves to control the affected person's behavior and consciousness; causing long lapses in memory that far exceed typical episodes of forgetting (AAMFT, 2022). DID have incorrectly been thought to be rare (Brand et al., 2016; Recovery Village, 2021; Sar, 2011; Howell, 2011). This is because highly dissociative people tend to present poly-symptomatically, and the disorder is so often hidden; in that many highly dissociative people who are aware of their extreme dissociativity work to hide it and many with DID are not aware of this fragmentation, all they know is that their lives are chaotic and difficult to manage. Also, this disorder is often misdiagnosed and requires multiple assessments for an accurate diagnosis (Mitra& Jain, 2021; Recovery village, 2021; Brand et al., 2016; Howell, 2011).

People with DID are often misdiagnosed as schizophrenic, schizoaffective, bipolar, or borderline psychosisas a result the real issue DID, is less likely to be addressed and this has lead to patients receiving treatments they do not need, such as; inappropriate medications and even unnecessary Electroconvulsive Therapy (Recovery Village, 2021; Howell, 2011). Patients may spend up to 5 to 12 years in the mental healthcare system before receiving a correct diagnosis of DID (Mitra& Jain, 2021; Howell, 2011). Also the movie industry and Hollywood's depictions of dissociative identity disorder has further compounded the problemof stigmatization as depictions are always exaggerated, inaccurate and insensitive. The latest example, Split, a movie that portrays a highly stigmatizing, inaccurate version of dissociative identity disorder and plays on the public's worst fears and myths about DID (Peisly, 2017; TeachTrauma, 2022). This further marginalizes those who already struggle on a daily basis with the weight of stigma [International Society for the Study of Trauma and Dissociation (ISSTD), 2017].

The person with DID essentially lives with different personality states or alters which are separated from each other in important ways, such as in memory, behavior, self-image, characteristics, affect, body image and thinking styles. These different personality states/alters have their own sense of separate identity, their own sense of an "I" including a sense of personal autobiographical memory. However, these differentially dissociated parts with separate subjectivities are not separate persons; rather they areall facets/part of one person (Howell, 2011). Individuals with DID may experience their dissociated identities as different persons, even as having separate bodies, it is however important that clinicians while understanding and empathizing with their patients' subjective reality correct this delusional sense of separateness by helping the patient understand that the dissociated identities are all part of who they are (Howell, 2011).

Switching is a phenomenon generally considered most characteristic of DID. Different internal identities can be prone to suddenly taking executive charge, in effect pushing the identity that had previously been in charge, out of charge. This generally results in amnesia on the part of the identity that had been pushed aside for the events that occurred while the other identity was in control. This becomes a problem when people do not remember portions of their activities and thoughts. To compensate for this lack of memory, people with DID will often try to fill in the blanks (i.e. confabulates) with something they think makes sense given the context, especially in social situations. However, because their compensatory version of events may not match what happened, and because their behavior may have been different in different identity states, persons with DID may be accused of lying and may indeed come to feel that they are liars. Amnesia can be worse when people do not know they have amnesia or that they have dissociated identities to them, life is and feels even more chaotic.

Switching can either be full dissociation or partial dissociation and this is not the only problem in DID. There is a larger set of problems that has to do with the influence of dissociative parts who are "beneath the surface" on the part that is in executive control at a given time. Such partial dissociation includes the following phenomena: intrusive visual images; auditory and olfactory hallucinations; unbidden, unsettling, and unexplainable thoughts and emotions; experiences of "made" volitional acts, impulses, and thoughts; and the withdrawal of perceptions, thoughts, and emotions. In cases of made volitional acts, parts of the body, a hand, an arm, or a leg may not be in the person's control and can seem to have a life of its own. For example, a person may feel that her hand, not herself, performed a certain motion (depersonalization and derealisation). In addition to experiences being intruded into consciousness, aspects of experiences may also be withdrawn: Vision, hearing, bodily sensations, emotions, and thoughts may be "taken away" either in part or in whole from the person's experience (or from the experience of the identity that is in executive control). Withdrawn experiences may include "hysterical" symptoms such as functional blindness or can manifest as partial blindness for certain things, as in negative hallucinations (something or someone who is there is not perceived). Such intrusions and withdrawals, especially when constant, can have the potential to make a person's life chaotic indeed(Howell, 2011). There are occasions when intrusions or withdrawals may be visible or known to others as in the case of a paralysis or a reported hallucination but for the most part these experiences remain unknown and contribute to private turmoil or agony.

At present, treatments focuses on fostering communication and cooperation amongst the host(s) and alter(s); understanding and processing the trauma each identity has carried and sometimes, towards the end of therapy there may be integration of the different identities (Ringrose, 2012). People with DID are survivors, their psyche has fractured to allow them to survive physically and not be killed or kill themselves. Living with DID can be confusing and exhausting, likewise supporting people with this condition (Bowlby& Briggs, 2014). It is therefore important that nurses are vigilant in assessing for the possibility of this condition, provide life-saving resources and support to affected individuals and families.

Objectives

The objectives of this seminar are;

1. To raise an awareness in the healthcare community about the causes, signs and symptoms, diagnosis and treatment of dissociative identity disorder.
2. To talk about the reality of living with dissociative identity disorder.
3. To state the nursing implications of dissociative identity disorder.
4. And to suggest the way forward.

Dissociative Identity Disorder

Dissociative identity disorder (DID), formerly referred to as multiple personality disorder, is a condition in which a person experiences disruption of identity characterized by two or more distinct personality states or an experience of possession, which may alternate within the individual's conscious awareness [American Psychiatric Association (APA), 2013; AAMFT, 2022].

Causes of Dissociative Identity Disorder

This disorder usually develops as a way to deal with some type of overwhelming trauma or stress the person experienced during childhood. According to the American Psychiatric Association, 90 percentof people with dissociative identity disorder in the United States, Canada, and Europe have experienced childhood neglect or abuse(physical, sexual, or emotional). Also, some persons have not been abused but have experienced an important early loss (such as death of a parent), serious medical illness, or other overwhelmingly stressful events(Frothingham, 2018; Spiegel, 2021).

Symptoms of Dissociative Identity Disorder

Dissociative identity disorder appears different with individuals, and affected persons can have a range of symptoms which appear at different times (SANE Austrialia, 2021). Symptoms of dissociative identity disorder (also, criteria for diagnosis)based on the criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)includes the following:

1. Two or more distinct identities or personality states are present, each with its own relatively enduring pattern of perceiving, relating to and thinking about the environment and self.
2. Amnesia is a requirement, defined as gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting".
3. An individual must be distressed by the disorder or have an impaired ability to function in one or major areas of life because of the disorder.
4. The disturbance is not part of normal cultural or religious practice. This criterion rules out diagnosis in cultures or situations where multiplicity is appropriate, an example of this is fantasy plays in children.
5. The symptoms are not due to the direct physiological effects of a substance (such as blackouts or chaotic behavior during alcohol intoxication) or a general medical condition (e.g., complex partial seizures) [American Psychiatric Association (APA), 2013]. .

People with DID also commonly have symptoms of other mental health issues, like:

- Depression,
- Suicidal thoughts or self harm,
- Sleep problems,
- Anxiety,
- Obsessive-compulsive symptomsetc. (SANE Australia, 2021; Cleveland Clinic, 2021).

Symptoms in children also include:

- Having distressing dreams and memories,
- Being unresponsive or zoning out (dissociating),
- Mental distress to trauma reminders (triggering),
- Physical reactions to trauma or memories, such as seizures,
- Showing unexpected changes in food and activity preference (Crichton-Stuart, 2018).

Diagnosis of Dissociative Identity Disorder

1. Clinical criteria:

Diagnosis of dissociative identity disorder is clinical, based on presence of the five symptoms recognized in the DSM-5, and is usedby clinicians as an authoritative reference while diagnosing DID.The key element in this diagnosis is the presence of at least two distinct and separate personalities within an individual(Tracy, 2022).

2. Detailed interviews:

Detailed interviews can be used to rule out people unlikely to have a dissociative disorder, and also to give a definitive diagnosis for dissociative identity disorder (or rule them out). Example of these instruments include;The Dissociative Experiences Scale (DES), Dissociative Disorders Interview Schedule (DDIS), Structured Clinical Interview for Dissociative Disorders - Revised (SCID-D)etc (TraumaDissociation, 2022).

Treatment of Dissociative Identity Disorder

While there is no known 'cure' for DID, treatment and support for DID is available. For some persons the goal of treatment may be the integration of separate alters into one single personality state. As such, the DID patient should be viewed as a whole adult person with multiple identities sharing in the responsibilities of life. However, this might not be acceptable for some patients. For these patients cooperation and collaboration between the different personality states, where alters co-exist harmoniously without impacting the person's goals and coping, or the person has a better control over switching is the aim of treatment. Treatment to achieve this centers on psychotherapy (SANE Australia, 2022; Spiegel, 2021).The most successful treatment modality for DID is likely to be individual psychotherapy.A reasonable generalized therapeutic approach would employ a phased treatment strategy, namely:

- Phase 1: Establish safety, stabilization and reduction of symptoms
- Phase 2: Confronting, working through and integration of traumatic memories
- Phase 3: Integration and rehabilitation (ISSTD, 2011).

In addition to psychotherapy, some individuals may also benefit from cognitive therapy, family systems therapy, creative therapy (art and/or music therapy) or clinical hypnosis. Since the basis of DID is not biochemical in nature, it cannot be treated with medication. Nonetheless, if a patient with DID also suffers from depression or anxiety, they could benefit from a psychopharmacologic approach to those disorders (Cleveland Clinic, 2014).While there is no medication that can treat dissociative disorders themselves, medications may be prescribed for associated depression, anxiety or other health issues (SANE Australia, 2021).

Living with Dissociative Identity Disorder

The reality of living with dissociative identity disorder is a far cry from what is portrayed in fiction and movies. For people who cope with dissociative identity disorder every day, their reality of selfhood is different from what the rest of us typically experience. At different points throughout the day, week or the month they see, feel, understand and interact with the world through more than one identity (Nowak, 2019).

People living with DID often refer to themselves as having alters or multiples (Crichton-Stuart, 2018).These various alters have their own unique names, personalities, interests, genders and even ways of dressing. People with DID at some point in their past have experienced overwhelming stress or trauma, that their minds had to adapt by withdrawing and compartmentalizing sensitive parts of itself (dissociation). It was intended as a way to protect the whole person, but this coping mechanism basically ruptured a complete consciousness so that they understand themselves as being a system of various individuals (Nowak, 2019).

DID can have significant impact on the mental health, relationships, and even the person's to work. Living with DID can be frustrating, scary and isolating. Many people with this disorder often get misdiagnosed, and may not be properly diagnosed until they are adults, which means that they get to spend years experiencing frightening symptoms without knowing why (Crichton-Stuart, 2018).

Some persons with DID are aware that they have this disorder and that various versions of themselves take turns living different moments and stretches of their days, while others are unaware. One very important truth is that these alternate personalities are all critical aspects of the original individual (Nowak, 2019).

A person's alternate personality may not always cooperate with each other. When another personality takes control, a person may "wake up" in an unfamiliar place with no memory of how they got there. However, personalities may also work well together and help a person cope with everyday situations. Other persons may find it difficult to notice the shift between personalities, as some people do not display noticeable outward changes. Some people with DID may suffer from social stigmas. Many people are only familiar with DID from what they have read in fiction or seen in movies. People with DID do not inherently have a violent alternate personality, in fact this rare (Crichton-Stuart, 2018).

With treatment and support people with DID have significant improvements in their quality of life and a reduction in other mental health issues and also alters may work together as a cooperative system (Crichton-Stuart, 2018; Nowak, 2019).

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Implications for Nursing

Dissociative identity disorder is complex type of disorder, the complexities in personality of the DID patient poses a difficulty in treatment; however, various treatment methods such as psychotherapy, cognitive behavioral therapy, hypnosis, group and family therapy have been suggested as treatment methods for DID. By the development of an effective long term nursing care plan, and its implementation through the individual, family or group, nursing interventions can play an important role for the treatment of DID patients with differing symptoms (Santosh, 2013). The nursing role in the care of DID is not limited to just the individual with DID but also extends to the family or caregiver of the DID patient and alsoto the nursing staff.

Role of the Nurse to the Individual with Dissociative Identity Disorder

The confines of a hospital setting, with its rules and limits, can be quite threatening to DID patients. It can feel like a re-enactment of the childhood trauma the individual has experienced,with the nursing staff that enforces the rules playing the role of abuser. The patient may subconsciously assign trauma-related roles to staff and will react to them accordingly.Also, certain alter personalities in particular may have a difficult time in the hospital. For example, child alters can be disruptive, limiting settings can bring out the anger of a protector, alters may hide when they feel threatened, and the risk of elopement is high whether volitional or while in a fugue state. An alter may even present as stable enough for discharge in an effort to escape from the demands of a hospital setting.

Primary to the nursing role in working with DID patients is creating an environment that is supportive, accepting, protectivean therapeutic.Building of trust and rapport while dealing with the host and all alter personalities through the use of therapeutic communication skills and trauma informed considerations, such as refraining from touching a patient without permission is an important aspect of the nurse's role(Snyder, 2021). Alters should be encouraged to come out in an environment which feels safe, accepting and empathetic (Nurses learning, 2010).

Nursing responsibilities include:

1. Providing a safe environment, protecting the patient from the self-destructive impulses which arise during therapy and from hostile alter personalities.
2. Providing an environment of acceptance and support.
3. Providing an environment for socialization.
4. Supporting the patient in acceptance of the disorder.
5. Providing consistency in treatment.
6. Assisting patients in learning new coping skills as they interact within the milieu.

It is also important for nursing staff to continually observe and evaluate for potentially self-destructive or violent behavior and to intervene to keep the patient safe. For patients with high risk for self harm and suicide, a careful safety assessment needs to be carried out. The environment of the patient should be assessed and immediate removal of any objects (ligature risks and sharp objects) that poses a safety threat. When patients are in crisis, they should never be left alone, the nurse should stay with patient until the crisis has resolved and imminent safety concerns have passed, or until they can receive a higher level of observation and care (Snyder, 2021;Nurses learning, 2010).

Also, getting the patient to contract for safety may need to be done each shift and with all alters. Staff must insist upon assurance of safety and control from the patient and if the contract is not convincing or does not appear to be an agreement of the entire system, then suicide precautions should be implemented.

Nurses also have an important role in ongoing observation and evaluation. Staff can observe what stressors bring out certain alters and what their functions seem to be. This is a valuable adjunct to the psychotherapy session. Where the therapist has only one hour to observe alter activities, nursing staff has the opportunity to observe around the clock.

As patients begin to break through amnestic barriers related to the childhood trauma they may become more and more dysfunctional. They may feel exhausted and hyper somnolent, or energized and hyperactive. They can also become confused around identity. Nursing staff can help patients to focus on concrete tasks of daily living and problem solving. This helps the patient feel safe, secure and contained at a time when everything seems out of control.Nursing staff can also help the patient become involved in activities such as arts or writing projects which can be used to introduce the different alters to each other, and offer proof to the host of the existence of other personalities. The artwork or writing can help define who the alter is and what his or her purpose is in the system.

When patients show signs of behaviors or somatic symptoms that might suggest the need for medication, nurses should remember that DID patients respond better to psychotherapy than to medications for certain symptoms and behaviors. For example, what may appear to be hallucinations or quasi-psychotic behaviormay in fact be the inner noise of the system; or a severe headache may be due to the conflict of one particular alter. The nurse can call out the alter or alters who are experiencing the problem, encourage them to talk about the conflict and therapy resolve the symptoms.However, if medication does become necessary, it is

wise to ask an adult alter, preferably the host, to come out and take the medication. Staff should monitor the patient's responses to medication, and particularly the different alters responses(Nurses learning, 2010).

Promotion of emotion regulation and helping patients to manage anxiety and agitation is an important aspect of nursing care; this is because DID fundamentally disrupts the mind-body connection. This can be achieved by teaching the patient techniques such as deep breathing, therapeutic journaling, progressive muscle relaxation and also, providing education and resources related to meditation, mindfulness and improve patients interception (perception of sensations inside the body).

Healthy sleeping pattern can also be problematic for patients who experience hyper-vigilance or nightmares, so it is important to address non-pharmocologic methods to promote sleep, such as listening to soothing music, using calming aromatherapy etc (Snyder, 2021).

Managing Dissociative Crisis

Knowing how to manage a dissociative crisis is another important aspect of the nursing role when dealing with DID patients. Switching in DID patients in and of itself is not an indication of a crisis. An alter personality is usually out for a reason, the patient should be reassured of this and also the nursing staff need not to be alarmed by switching behavior. However, rapid switching might be a sign of a great internal struggle and the therapist should be notified in such cases.It is generally not the role of a nurse to uncover alters or to work in-depth with them on issues. When possible, it is appropriate to encourage the patient to delay such work until he or she meets with the primary therapist.However, there may be times when a nurse is confronted with the memory work, and must take measures to assure successful management of such crises in such cases the following should be done;

- Contract with the alter who has the memory to wait for the therapist. Imagery, such as putting the memory in a box and leaving it on a shelf until the next meeting with the therapist is sometimes easily accomplished due to the patient's high degree of suggestibility.
- If patient is unable to delay the emergence of the memory, the nurse can help with the abreaction.The nurse should remain calm and insure patient safety by removing the patient to an area designated for such work (e.g. usually an unfurnished room with pillows and carpeting where the patient can have privacy; often called a quiet room or safe room).
- Notify nursing staff in case assistance is needed as the patient abreacts.
- Call on the alter(s) who need to be present to do this work, while others are asked to go far away. Any physical contact, such as holding the hand or touching a shoulder, should only be done with the patient's approval.
- As the memory unfolds, the nurse should ask the patient to talk. If the patient is unable to talk, ask if it is alright to interpret, and suggest the patient indicate a correct interpretation by the use of hand signals (e.g. index finger for yes, thumb for no).
- At the completion of the memory, summarize the experience as valid and painful, and that the child was not responsible for the experience; it was the sick and dysfunctional adults who were responsible. The child is not to blame and is not bad. Also, reinforce to the patient that the experience took place in the past and although it was terrible, it cannot harm him or her today. Encourage the alter to go to a safe place and recall the host.
- If patient's behavior appears to be threatening to become self-destructive or other-destructive, the nurse must act quickly to control the situation. The out of control alter can be counted down by the nurse into a safe place. The nurse counts out loud 5-4-3-2-1. The system is then asked to call up an alter who can handle the present situation and keep everyone in the system safe. The nurse counts out loud 1-2-3-4-5(Nurses learning, 2010).

These experiences can be unnerving, but after working with a patient consistently the nurse will find it easier to assess when a crisis may occur and how to prepare for it. Staff will also gain an understanding of how a particular patient responds to crisis and to the above techniques(Nurses learning, 2010).

Role of the Nurse to the Family/Caregiver

When a loved one has been diagnosed with DID, the family may feel overwhelmed and it can be both confusing and exhausting while supporting a loved one with this condition (Bowlby& Briggs, 2014; SANE Australia, 2021). It is therefore advisable that the family members are educated as much as possible about DID(SANE Australia, 2021). The nurse should educate family members about DID, and also refer families to resources for education and support, as well as outpatient and inpatient healthcare provider directories(Snyder, 2021).

The nurse should be aware that treatment of DID can involve revisiting traumatic experiences, and this may be upsetting for friends and family. The nurse should encourage family members to look after themselves, and seek help to look after their own mental health. Self-help strategies which could be utilized include:

- Making time to regularly do things they enjoy, either alone or with friends.
- Talking to other people about they feel.
- Focus on the things that they can control, not on the things outside of their control. They cannot control the behavior of a person with DID, but they can manage how they react to the behavior (SANE Australia, 2021).

The Nursing Staff and Treatment Team

Dissociative identity disorder patients can cause anxiety, frustration and anger in nursing staffs for a variety of reasons. Dealing with DID patients can be overwhelming to the extent that it threatens the sense of competence of the staff. The sense of helplessness that the nursing staff may feel can create a negative response toward the patient. This often occurs if the staff has not been adequately educated or prepared in understanding DID and how to work with such patients, and if the hospital has no particular policy or treatment modality for these patients. Staff may become angry with the therapist whom they feel has left them to deal with the overwhelming behavior.

Also, the hospital staffs are often split in their feelings about DID. ThoughDID patients certainly do demonstrate the borderline quality of splitting a staff, staffs however split themselves by their own differing feelings and opinions about the disorder, and this poses a problem in nursing care. This is because DID patients are sensitive to the feelings of others and therefore will necessarily withdraw from anursing staff they feel rejected by and gravitate to those they find accepting. This further adds to the polarized stance of staff members. It is not a necessity for nurses to come to a collective agreement about their feelings of DID, neither is it necessary to convert those who don't believe. Rather it is necessary for the clinician to establish goals of admission, clearly convey them to the nursing staff, and expect that nursing staff will facilitate the achievement of these goals in a professional manner, despite their personal feelings.

The constant dealing with traumatic material from DID patients makes a nursevulnerable to secondary posttraumatic stress disorder. It is therefore necessary that the nursing staff have support groups. Supervision must be provided for nursing staff, with an environment conducive to expressing disbelief, frustration, and anger. Treatment goals and methods should be clearly outlined for all staff to follow (Nurses learning, 2010).

Also, because of the general chaos of the personality system demonstrated by many DID patients, it is necessary to have a treatment plan that is clear to the entire treatment team. This will provide consistency to the patient and cohesiveness among staff.

The following are guidelines for hospital treatment of DID patients:

- Make it clear to the patient that the staff is not expected to recognize each alter. Alters must identify themselves to staff and it is appropriate for staff to ask the patient the name of the alter who is out. Nurses are not expected to change their own behavior according to the alter they are speaking to. Also, nurses should not assume that because they are known to the host or certain other alters, that the entire personality system knows them. Meeting each personality is like meeting a new person, introductions need to be made, trust established, and the treatment regimen explained.
- All alters should be treated with equal respect and the patient should be addressed the way as he or she wishes to be addressed. In this general functioning of the unit the patient should be referred to by the legal name. However, in a more in-depth one-on-one conversation, the patient may be called by the name of the particular presenting alter
- Staff crises are to be expected; therefore the therapist should be available for supervision and problem solving.
- Explain hospital rules and ask all alters to listen and comply. If a problem of compliance arises, respond with firm yet caring limits, punitive measures are to be avoided. Also, too much limiting setting and too much intimacy should be avoided. A professional, caring attitude is appropriate
- Encourage non-verbal groups, such as art, music, or movement.
- Maintain cooperative therapeutic goals among staff. A consistent approach and attitude are extremely important.
- Help the patient to stay focused on the goals of treatment.
- Clarify the various roles of staff members to the patient so that he or she does not become confused or perceive a staff member as uncaring for not working with them as someone else did. For example, the psychotherapist will work with each alter in depth, and may not wish for nursing staff to do the same. Explain to the patient the role of nursing so he or she will not have the same expectations of nursing staff as of the psychotherapist(Nurses learning, 2010).

The Way Forward

Since, dissociative identity disorder develops due to some form of trauma or overwhelming stress experienced usually in childhood. It is therefore our responsibility as a society to ensure that our children are

protected from traumatic situations, and also children who have experienced any form of trauma should be given the resources and support they need to overcome such trauma.
Family life education should be offered to families in order to improve family life and functioning.
Individuals should also be taught on how to adequately manage stress or stressful situations. Individuals should be encouraged to seek help if they feel that they are too overwhelmed or spiraling downwards mentally.
The society should be sensitized about dissociative identity disorder, and the myths surrounding this disorder should be addressed This is to ensure that the society gets the correct knowledge about DID, so that armed with this information they are able to seek proper professional help if either them or a loved one is suspected to or has this disorder. This approach also helps to curb stigmatization which individuals with this disorder face and greatly fear. It also ensures that individuals, especially children are not exposed to harmful traditional practices in bid to cure them from their "bad habits"or "possession", as this can be more triggering for the child and can even lead to more dissociation.
Also, the healthcare team, owe it to themselves and to the society to educate and improve their knowledge of dissociative identity disorder. This works to prevent misdiagnosing of a patient, prolonged hospital stay and financial strain on both the patient and family. And also, to ensure that the affected individual accessthe help that they require promptly.
Also, the healthcare institute should be organized in way that it caters to the need of dissociative identity disorder patient. Such as has having a safe room in a case of a dissociative crisis, a safe, trusting and confidential environment that encourages the affected individuals to be honest with their symptoms, allow them and their alters to speak up about the trauma they experienced etc.

SUMMARY/CONCLUSION

Summary

This seminar paper titled Dissociative Identity Disorder: Nursing implications, focused on what dissociative identity disorder is, its causes, signs and symptoms, diagnosis and treatment, the reality of living with dissociative identity disorder,nursing implications and the way forward.

Conclusion

In conclusion, dissociative identity disorder (DID) is a condition in which a person experiences disruption of identity characterized by two or more distinct personality states or an experience of possession, which may alternate within the individual's conscious awareness. Dissociative identity disorder usually occurs due to an overwhelming stress or trauma, during childhood. Individuals with this disorder, have a range of symptoms which appear at different times. There is however, no known cure for DID, however treatment and support is available which can lead to significant improvements in the quality of life of the affected individual and a reduction in other mental health issues and also encouraging the working together of the alters as a cooperative system. Living with DID can be confusing and exhausting, likewise supporting people with this condition. It is therefore important that nurses are vigilant in assessing for the possibility of this condition, provide life-saving resources and support to affected individuals and families.

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