IDENTITY, PERSONALITY AND THEIR DISORDERS IN DSM-V AND ICD-10

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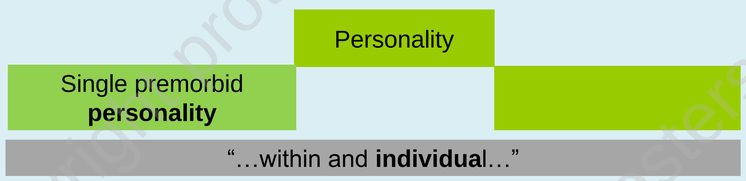
IDENTITY AND PERSONALITY DISSOCIATIVE DISORDERS IN DSM-IV AND ICD-10

Legend { Identity, Personality, Ambiguous terms

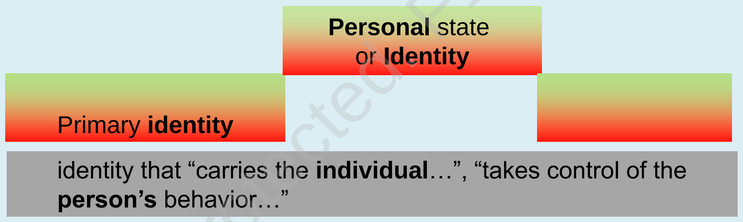
MULTIPLE PERSONALITY DISORDER
(ICD-10: F44.81)

"two or more distinct PERSONALITIES within an individual"



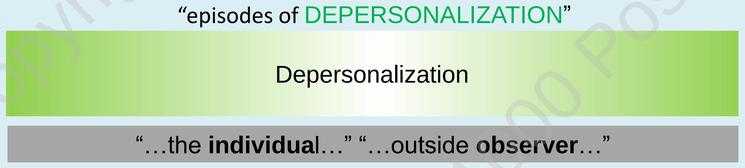
DISSOCIATIVE IDENTITY DISORDER
(DSM- IV-TR: 300.14)

"two or more distinct IDENTITIES or PERSONALITY states"



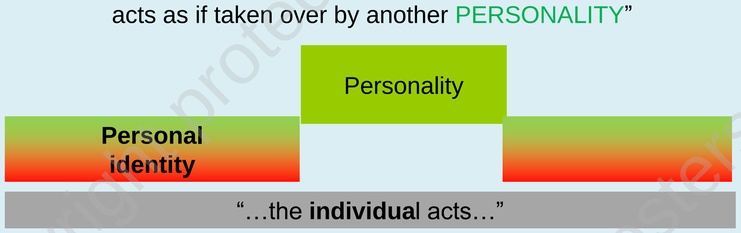
DEPERSONALIZATION DISORDER
(**DSM-IV-TR**: 300.6)

"episodes of DEPERSONALIZATION"



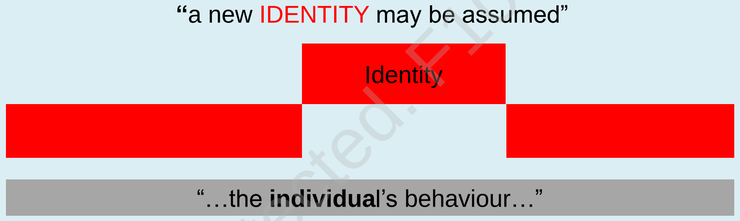
TRANCE AND POSSESSION DISORDERS
(**ICD-10**: F44.3)

"loss of both the sense of PERSONAL IDENTITY" ; "the individual acts as if taken over by another PERSONALITY"



DISSOCIATIVE FUGUE
(**ICD-10**: F44.1)

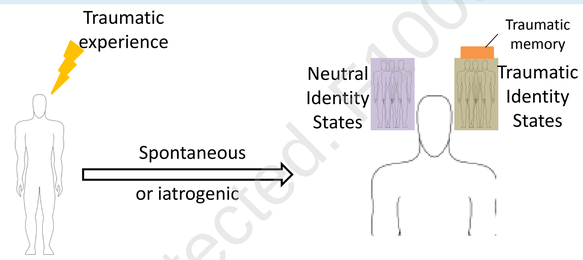
"a new IDENTITY may be assumed"



WHAT IS THE DISSOCIATIVE IDENTITY DISORDER (DID)?

A new proposal for DSM-V by Spiegel et al., 2011

1) Disruption of **identity** characterized by two or more distinct (in terms of cognition, behavior, affect, perception and memory) **personality states.**
2) Amnesia in relation to personal information.
3) Impairment of social functioning.
4) It is not due to the direct effect of substance abuse or general medical condition (f.ex. seizures).



INCONSISTENCIES IN SCIENTIFIC LITERATURE

→ Is the patient a single person?

✓ Yes. "Clinicians must keep in mind that the patient is a single person" (Guidelines for treating DID in adults, Third Revision, 2011)

✗ Some authors ask for experimental consent from each of the patient´s personality states (Reinders et al., 2006)

→ Is there a "host" (dominant) personality?

✓ Yes. There is a dominant personality, equivalent to the premorbid state (f. ex. Barlow, 2011; Spiegel et al., 2011)

✗ However, the Guidelines for treating DID state that "it is countertherapeutic to tell patients to get rid of identities"

→ Does the patient decide to switch identities?

✓ Yes. Patients can even do it during the course of an experiment after clinician request (Reinders et al., 2006)

✗ Only 15% of DID cases show different identities during clinical interview (Dell, 2009). The remaining cases rarely manifest clearly detectable identities (Kluft, 1991; Spiegel et al., 2011)

→ Is there any transfer of information between personality states?

✓ In part, the alter identities seem to know the background of the host identity (Bliss, 1986; Reinders et al., 2006)

✗ By definition, the different personality states of the DID patient must be different "in terms of cognition, behavior, affect, perceptions and memories" (Spiegel et al., 2011)

TERMS THAT SHOULD BE CLARIFIED IN THIS CONTEXT

- What is a person/individual?
- What is identity?
- What is personality?

OUR PROPOSAL

1) Personal identity is the quality of recognizing oneself through certain behavior.
2) Personality is the group of features that make up one's behavior.
3) An individual or person is what remains unchanged even though his/her personality or identity (as a quality) is affected.
4) There is a practice of identity that should be understood as non-pathological. In patients with personality disorders, this would point to the premorbid personality.

In this context, we propose reconsidering the ICD-10 and DSM-V dissociative disorders classification. This will distinguish between two pathological sub-types:

-the first affects Personality: the patient has multiple personalities, and there is some transfer of information between them. The person always has access to his/her premorbid personality (Multiple Personality Disorder).

-the second affects Identity: the patient, when expressing an alter personality, stops identifying with his/her premorbid personality, and identifies with that alter personality. However, the identity as a quality is not dissociated (Aberrant Identity)

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We are indebted to the **Institute for Culture and Society** (ICS) of the University of Navarra (Spain) for backing this study. which is part of the interdisciplinary project *'Mind-brain: biology and subjectivity in contemporary philosophy and Neuroscience'*).
More information about the project and the institute can be found on: http://www.unav.es/centro/cultura-y-sociedad/mente-cerebro