

DID Screening Inventory

Symptoms of Dissociative Identity Disorder

(Multiple Personality Disorder)

Note: This lecture and questionnaire are intended for educational purposes only and should not be taken as providing a clinical diagnosis. Results need to be confirmed by professionals qualified to do so in your state.

For each “yes” answer, put the indicated number in parenthesis on the line to the left. The clinical title of each section can be found on the last page with fuller descriptions in the full lecture notes entitled “Diagnostic Symptoms of DID.”

A. _____

- ____ 1. (14) **Do you have difficulties with insomnia, sleepwalking, traumatic nightmares, and/or night terrors?**
- ____ 2. (14) **Are you constantly concerned about your safety? Do you find yourself almost always in a heightened state of alertness and fear? Do you startle easily?**
- ____ 3. (14) **Do you have intrusive thoughts or imagery of traumatic events repeatedly coming into your mind while you are awake?**
- ____ 4. (14) **Do you tend to have either extremely strong or extremely weak emotional reactions? Do you often respond to emotional events by going into a numbed out state?**
- ____ 5. (14) **Do you have difficulty knowing what you need and devising a plan to meet that need? Do you have difficulty staying focused on a task? Do you have difficulty holding a thought in your mind without immediately acting on it? Are you impulsive?**
- ____ 6. (14) **Do you have an unusual number of physical symptoms which lack a known cause?**
- ____ 7. (14) **Do you repeatedly find yourself in abusive relationships or engaging in behavior that is harmful to yourself or others?**

____ **Total for A**

B. _____

- ____ 1. (14) **Has there been a prolonged period of time in your life during which you were under the strong domination or control of another person or group of persons?**
- ____ 2. (14) **Do you often feel unable to regulate your emotions, resulting in any of the following:**
- Persistent unpleasant or sad feelings,
 - Chronic suicidal preoccupation,
 - Self-injury,
 - Explosive or extremely inhibited anger (may alternate),
 - Compulsive or extremely inhibited sexuality (may alternate)?

- ___3. (14) **Do you find your state of consciousness sometimes being altered, such as having:**
- Periods of amnesia or gaps in consciousness and/or memory,
 - Times of unusually vivid recall of traumatic events,
 - Episodes of trance-like states,
 - Episodes in which you feel unreal or world around you feels unreal,
 - Vivid, intrusive flashbacks of past traumatic events or a preoccupation with mentally rehearsing such events?
- ___4. (14) **Does your sense of self sometimes alternate, having times of feeling any of the following:**
- Totally helpless or paralyzed in being able to take any initiative,
 - Intense shame, guilt, and self-blame,
 - Sense of being defiled or bearing a negative stigma,
 - Rationalizing the acts of a perpetrator,
 - Completely different from others, either positively or negatively, or even non-human,
 - Utterly alone or unable to be understood by anyone?
- ___5. (14) **Does the way you view your perpetrator (if identified) alternate to include any of the following:**
- Preoccupation with the relationship or with a desire for revenge,
 - *Unrealistic* attribution of total power to perpetrator? (Caution: victim's assessment of power realities may be more realistic than clinician's.)
 - Idealization or sense of gratitude,
 - Sense of special or supernatural relationship,
 - Rationalization or acceptance of his/her belief system?
- ___6. (14) **Do you have problems relating to others that include:**
- Isolation and withdrawal,
 - Avoidance of, or inability to maintain, intimate relationships,
 - Repeated search for a rescuer,
 - Persistent distrust,
 - Repeated failures of self-protection?
- ___7. (14) **Do you have alterations in your worldview or major belief systems, such as:**
- Your faith in God?
 - Your sense of hope?
 - Your purpose in life?
 - Your view of the world?

___ **Total for B**

C. _____

- ___1. (15) **Do you have little or no memory of the events of your childhood, large gaps in your memory as an adult, significant events in your life which you cannot recall, or other times of amnesia, such as:**
- Not being able to remember important personal information about yourself or the time of day or year that it is,
 - Suddenly realizing that you have no conscious recall of what has happened in the previous minutes, hours, or days (time loss),
 - Being told that you were acting very abnormally although you have no recall of such behavior,
 - Finding items in your possession that you don't remember acquiring or finding things missing that only you had access to, or finding things done that you don't remember doing,
 - Being accused of doing things you strongly believe you didn't do or would *never* do,

- Having people act like or claim they know you when you have no recollection of ever meeting them,
- Find yourself unable to do a task or skill that you usually do with great ease,
- Find yourself performing artistically in an obviously different style than you normally do,
- Losing touch with who you are, what your history is, or what you usually do in a certain circumstance?

___2. (15) **Do you have intermittent or sustained times when parts of your body do not function normally?**

___3. (15) **Do you hear voices or “loud thoughts” in your head that may be critical of you or give a running account of your performance or carry on arguments or discussions internally after they have ended externally?**

___4. (15) **Do you have times of feeling detached from your body, your emotions, or your actions? Do you ever have distorted perceptions of your body or times when you do not recognize yourself in the mirror?**

___5. (15) **Do you find yourself frequently experiencing any of the following:**

- Staring off into space or losing yourself in deep thought so that you are unaware of your surroundings and passing time,
- Having a “wandering mind” when trying to listen to something,
- Losing the train of thought in a conversation?

___6. (15) **Have others ever observed or reported an abrupt or subtle shift in the way that you act or perceive yourself, others, or your environment or a change in your perspective, feelings, logic, or habits over a period of time? Have you ever observed a change in your handwriting or handedness?**

___7. (15) **Do you ever have times of feeling detached from your environment or that what is happening is not real? Do familiar people or places ever seem unfamiliar?**

___8. (15) **Do you ever feel like you have several identities or refer to yourself as “we” or “us”?**

___9. (15) **Do you have times of feeling uncertain or in conflict about who you are or how you would describe yourself?**

___10. (15) **Do you ever experience involuntary flashes or sensations of past events intruding into your daily life?**

___11. (15) **Have you every had times when you felt or feared you were going crazy or losing touch with reality?**

___12. (15) **Have you ever heard sounds that you knew were not coming from the environment around you?**

___13. (15) **Have you ever seen things that you knew were not part of your physical environment while not under the influence of drugs or alcohol (other than spiritual visions or images)?**

___ **Total for C**

D. _____

- ____ 1. (18) **Have you ever experienced a seemingly different part of you present itself to your prayer minister, therapist, or another person while you were totally aware of it?**
- ____ 2. (18) **Do you sometimes hear child thoughts or voices inside your head?**
- ____ 3. (18) **Are you ever aware of a totally different perspective within yourself, perhaps arguing with you or trying to persuade you to alter your plans concerning something?**
- ____ 4. (18) **Are you sometimes aware of internal voices directing or criticizing you?**
- ____ 5. (18) **Do words sometimes come out of your mouth that you do not feel you originated or that do not reflect your thoughts?**
- ____ 6. (18) **Do you ever have thoughts come into your mind that do not seem to be your own or are very different from your own, or does something you are about to say ever get suddenly lost out of your mind?**
- ____ 7. (18) **Do you sometimes sense emotions inside you that do not reflect what you are feeling at the moment, such as laughing or crying?**
- ____ 8. (18) **Do you sometimes have impulsive urges, seemingly coming out of nowhere, to do something that is contrary to what you would usually do in a given situation?**
- ____ 9. (18) **Do you sometimes find yourself doing things that are very uncharacteristic for you or feel as if you are watching yourself do something that you did not direct or feel unable to control?**
- ____ 10. (18) **Do you ever experience times when you manifest characteristics that are very unusual for you (e.g., bravery, sexuality, etc.) or perceive your body in a way that does not match reality (e.g., different age, gender, build, etc.)?**
- ____ 11. (18) **Do you ever feel puzzled about why you sometimes seem to be different from your normal state, wondering what is wrong?**

_____ **Total for D.**

E. _____

- ____ 1. (16) **Do you experience depression at least intermittently?**
- ____ 2. (16) **Do you experience explosive anger or times when your anger seems much greater than the situation warrants?**
- ____ 3. (16) **Do you have unusual, exaggerated, or irrational fears or anxieties?**
- ____ 4. (16) **Do you have extreme mood swings that occur suddenly or without apparent reason?**
- ____ 5. (16) **Do you sometimes display emotions that are exaggerated or opposite to what is appropriate in a given situation, such as laughing at a funeral when sadness is the normal cultural response?**
- ____ 6. (16) **Does your self-esteem fluctuate greatly from one extreme to the other?**

_____ **Total for E**

F. _____

- ____ 1. (25) **Do you have frequent headaches?**
- ____ 2. (25) **Do you have pain or other physical symptoms for which no medical cause has been found?**
- ____ 3. (25) **Do you have medical symptoms that fluctuate for no apparent reason, such as:**
- Eyesight, need for glasses
 - Allergies
 - Blood sugar, need for insulin
- ____ 4. (25) **Have you ever had bruises, welts, scratches, burns, pain, or sensations of touch or pressure occur that cannot be explained by current experience?**

_____ **Total for F**

G. _____

- ____ 1. (16) **Do you sometimes manifest aggressive, inappropriate, or risky behavior that is uncharacteristic of you?**
- ____ 2. (16) **Have you ever injured yourself on purpose, tried to commit suicide, or struggled with ongoing thoughts of suicide or self-harm?**
- ____ 3. (16) **Have you ever had an eating disorder or severe disruption in normal eating habits, such as:**
- Refusing to eat normal amounts of food
 - Consistent overeating
 - Binging
 - Purposely inducing vomiting
 - Taking inordinate amounts of laxatives?
- ____ 4. (16) **Have you struggled with confusing, intermittent addictive behaviors, such as:**
- Alcohol,
 - Drugs
 - Sex
 - Food
 - Gambling
 - Work?
- ____ 5. (16) **Have you suffered repeated failures in school, jobs, and relationships that are not due to lack of capability, or do you at times feel “unable to pull life together”?**
- ____ 6. (16) **Has your ability to function decreased seemingly without cause?**

_____ **Total for G**

Add Totals:
A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____

_____ **Total**

A score of 45-60 out of a possible 126 points may be a potential indicator of DID. A score of 60 or more in most of the 7 areas indicates a strong possibility of DID. A score below 45 generally indicates either a lack of DID or a case of undiagnosed DID in which the Primary Presenter is carrying strong denial. In any case, **any official diagnosis must be made by a qualified professional.**

Total _____ $\div 7 =$ _____ **SCORE**
(Total divided by 7 = Score)

The type of symptoms being evaluated in each section is found in the list below. Further descriptions of them are found in the “Diagnostic Symptoms” lecture notes, which, if not included, can be requested (without charge) from rcm@rcm-usa.org.

- A. Post-traumatic Stress Disorder
- B. Complex Post-traumatic Stress Disorder
- C. Dissociative Symptoms
- D. Partially Dissociated Intrusions
- E. Affective Symptoms
- F. Somatic Symptoms
- G. Behavior Symptoms

Please note that the questions asked on this screening sheet reflect a composite understanding of the dissociative disorders based on available DID literature, but the scoring system has not undergone rigorous testing and validation. I have basically allotted scores to each question so that the total adds up to approximately 100 in each of the seven areas with double weight being given to the questions in sections C and D, which most directly reflect dissociative symptoms. Having used a variation of these questions since 1995, I have found the results to be helpful to both clients and people I have trained to work with this population.

When using this screening sheet, I recommend that you not give the category names (A-G) until after a person has answered the questions for each category. If you are giving the screening sheet to someone to fill out on his/her own, just withhold page 6 with this information. In this case, I recommend that you still ask the questions again verbally while you are together so you can evaluate whether the person truly understands what each question is asking.

Because of the fragmented nature of memory in DID, it is often helpful to have another person present who knows the individual well and will be able to jog his/her memory about various things that might otherwise be overlooked or forgotten. The main purpose of these questions is to get a person thinking and beginning to give a narrative about themselves in relation to these key areas that most commonly reflect a dissociative disorder.

Please remember that only a qualified professional can make a diagnosis.