

To: Nancy Borrett  
Subject: RE: I article

# 'Multiple people live within this body - I am only one of them'

Patrick Strudwick  
31 - 39 minutes

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It was after dark when the memories from decades earlier would grip, as if something deeper was taking control. Sam would run into the woods in the middle of the night, in a trance-like state, with no shoes on, darting through trees and foliage to hide in bushes, anywhere that seemed safe.

There in the undergrowth, Sam would black out, only to later regain consciousness unaware of how it all happened – or why. These episodes repeated throughout their twenties.

“I’d wake up in the middle of nowhere. I’d have scratches and bruises,” says Sam. “I had no idea why. It’s absolutely terrifying.”

Psychologists call incidents like this – of amnesia with a lapse in identity, while wandering or running – a “fugue state”. Sometimes, Sam would lose consciousness in the daytime, or be frozen, unable to move for hours. Other times, there would be episodes of shaking, pain, incontinence, or sleep walking. But all form just a fraction of their experiences living with one the most misunderstood and stigmatised mental health conditions: Dissociative Identity Disorder (DID).

DID used to be called Multiple Personality Disorder, but the name was changed in 1994. “Multiple Personality Disorder suggests you have completely different people within you. But it’s one fragmented personality,” says Sam. “One fragmented person.”

Sam sits forward on the sofa, nervously trying to explain. “I have very childlike parts in my brain. I have two very young children and an older child in their early teens. And I have me.” These parts – also known as “alters” or alternate personalities – are separate identities that exist in one person. It was one of Sam’s younger identities that had taken control during their fugue states.

Sam has survived child sexual abuse, and sees these alters as traumatised children.

“My brain had to develop different parts to manage my memories. At some point in my early development, parts of my brain became shut off to cope with very adverse circumstances.”

Some people with DID may have only two alters, others have several, or even dozens. Each can have different ages, genders, characters, behaviours and voices. Some alters may be evident to other people, as they express themselves publicly, other parts are completely internal. But their existence signifies something far deeper: the disorder typically arises out of sustained and severe early childhood abuse.

Sam is in their thirties now, has two degrees, and works in healthcare. It took them 10 years to discover what was happening when they would run out into the night to hide in bushes: “I was doing what I did as a kid.”

But this, among multiple discoveries, was not a spontaneous realisation. It was the result of a decade of specialist psychotherapy — none of which was provided by the NHS.

Today, 30 years after the term DID was coined, the truth about this condition and the silent scandal surrounding it can be unveiled.

Through interviews with patients, psychotherapists, and with exclusive access to the largest DID clinic in Britain, i has uncovered a “postcode lottery” for patients needing help, a chronic lack of treatment for the majority of sufferers, a scarcity of specialist clinics, a lack of awareness of DID among GPs and even psychiatrists, and an absence of any official treatment guidelines.

Despite DID being a recognised psychiatric condition for decades, the [National Institute for Health and Care Excellence \(Nice\)](#) admitted to i it had produced no treatment guidelines – and that they had never been asked to do so by either the Department of Health or the NHS. This can leave patients in a “Catch-22”, according to a leading clinician, with no diagnosis, no treatment, and local services refusing to pay because there are no official treatment guidelines.

[Mind](#), the leading British mental health charity, is today calling for Nice to change this.

“We think having a guideline on how to treat DID would increase awareness and understanding amongst clinicians about how to support people with this diagnosis,” a spokesperson told i . “It’s about access to the right therapeutic approaches, with the right therapist, for the right length of time.”

Studies have estimated higher prevalence of DID in the population than schizophrenia – [1-1.5 per cent](#) compared to 0.5 per cent – yet there are only four clinics dedicated to dissociative conditions, paid for by the NHS, in the whole of the UK. And they are all in England, with none in Scotland, Wales or Northern Ireland. Three of those four clinics are outsourced by the NHS to external clinics such as CDS, with just one within the NHS: the [Trauma and Dissociation Service](#) at the South London and Maudsley NHS Foundation Trust.

Its lead psychiatrist, Dr Nuri Gene-Cos tells i :”This is not enough – by far.” The clinic has to treat people as far away as Gibraltar.

A lack of treatment can have devastating consequences. International studies have shown higher rates of self-harm in DID than in other mental illnesses, with [a US study finding 72 per cent have attempted](#) to take their own life.

Many remain undiagnosed, meanwhile, or at significant risk of harm by others. They include, “patients who are subjected to modern slavery. That might be by gangs or by groups using people for sexual exploitation,” according to Matt Bordonada, deputy clinical director of the [Clinic for Dissociative Studies \(CDS\)](#), one of the specialist clinics.

There is no specific medication for DID. The main dedicated charity, [First Person Plural](#), closed last year. And public recognition of the condition is almost non-existent. People with DID are now resorting to posting videos on social media in an attempt to increase understanding.

With appropriate psychotherapy, however, experts reveal the prognosis can be surprisingly good. And in the 25 years since it was established, not a single patient treated at CDS, Britain's biggest DID facility, has died by suicide.

Sam has only ever discussed their DID diagnosis with their therapist – until today. Even now, they ask for a different name to be used (and for it not to be gendered in keeping with their gender identity).

Their story, which emerges over several hours, offers a rare and extraordinary insight into DID.

We're sitting in a colourful living room on the south coast of England, with Sam's therapist present as support. They are not a patient of CDS nor any NHS clinic, so have to pay for therapy. They want others to find help, and they want people to understand DID – why it occurs, how it manifests, and what happens during the specialist treatment that eludes so many.

## The stigma

First, however, the stigma.

"I'd never heard of DID and I Googled my symptoms for years," says Sam. There have been no government campaigns, no charity adverts, and no public figures disclosing their diagnosis.

Instead, DID is often mistaken for schizophrenia, despite being entirely separate, and fictional depictions have been almost invariably menacing, often criminally so. In the popular imagination, "multiple personalities" are considered a joke – or a threat. To have "split personalities" is to be two-faced, a Jekyll and Hyde figure with a hidden dark side: Norman Bates in *Psycho*, or Tyler Durden in *Fight Club*. The lead character in the [2016 horror film \*Split\*](#), played by James McAvoy, meanwhile, explicitly had DID. He kidnapped and murdered women.



James McAvoy's character in *Split* (left), explicitly had DID. Norman Bates in *Psycho* (centre) and Tyler Durden in *Fight Club* (right) had multiple personalities (Photos: Universal Pictures)

These depictions haven't just distorted the reality; they've concealed it. "The only person I was going to murder was myself," says Sam. Rather than being a threat, people living with DID can often be those who have been most threatened.

"Our patient group have all been traumatised in multiple ways. It can be neglect, torture, sexual abuse, and commonly all three," says Emma Jack, clinical director of the CDS. It's a charity to which the NHS refers patients who may have DID for assessment and treatment.

Jack and I are talking with CDS senior staff in an upstairs treatment room at the centre in Hornsey, north London. From the street it resembles a shop-turned-office with frosted windows and nondescript signage. Inside it conjures any other therapy space: magnolia walls, soft chairs, and coffee tables bearing boxes of tissues.

Matt Bordonada, the deputy clinical director, elaborates further about the typical patient history. "In most cases, the trauma would have been perpetrated by a person close to them, often a family member. Those memories may go back to very early childhood." Sometimes the sexual abuse, he said, occurs when they are pre-verbal, and often before the age of five. "We work with patients who might also have been ritually abused."

Jack explains that people can fracture into different alters or identities in order that abuse or trauma can be stored by one part but not another, enabling the individual to function.

"DID is a defence of the self, so if you pocket away parts of the trauma, then you can continue. The process develops early "in the time in which your personality is forming," adds Jack.

DID is one of several dissociative disorders, and one [of the three listed on the NHS website](#), alongside depersonalisation-depersonalisation disorder and dissociative amnesia. Some conditions contain

symptoms that are more temporary than in DID, but all tend to arise from traumatic events in an attempt to disconnect from what happened, from who you are, or from the world around you.

CEO Mark Linington explains that in DID the different alters may not be aware of each other, or aware of the abuse held by another, but if they are aware, one part may blame others. “There will be an identity that is very critical of another: ‘Why did you put us in that situation where we got abused?’ is a very common thing to come up. ‘You did that, it’s your fault.’”

## **‘I felt like an alien’**

The symptoms that first led Sam to seek help over a decade ago, in their early twenties, were physical: sudden migraines, physical pains, and nosebleeds. Their GP ordered an MRI scan, found nothing, and prescribed medication for migraines, which didn’t work.

But in parallel lay an array of psychological and behavioural issues. “I always felt like I was having an identity crisis, that I wouldn’t know what to say when people asked me to tell them about myself. I had uncontrollable thoughts – intrusions — and I didn’t know where they were coming from. There were self-persecutory thoughts. Saying horrible things to myself all the time.”

Sam looks tense as we talk, with eyes flickering or at times startled as if seeing something horrible. “Normally I’m much more jolly,” they say. “To conceal it.” They are extremely sweet-natured and clever, yet seem to only just bear themselves.

“I felt like an alien,” says Sam, trying to explain what it means to feel fractured from oneself, “like I wasn’t a human, I felt less than human. I had suicidal thoughts and lots of intentional self-injurious behaviour.”

Sam describes a regular process taking place within them, in which a traumatic childhood memory would be provoked, without being aware what it was, which would spark an episode of amnesia and dissociation. Sometimes this would also prompt them to shift into a different alter.

In DID, the alters together form what is known as a “system” — the group of identities within one person. This can form a kind of structure in which some alters speak or “front”, and some do not, and where usually there is a “host”, the most prominent or outward-facing identity.

Some alters can communicate with each other, others may not. But their existence as separate identities functions as a vital defence mechanism against trauma, according to the experts. This does not mean that the distress is removed, however, but compartmentalised.

“I experience the very young parts as being predominantly terrified and in loads of pain: crying, helpless, vulnerable, and very easily coerced,” says Sam. “Then I experience another part as an older child who wants to think he’s tough but probably isn’t.”

In fact, Sam’s adolescent alter could appear most terrified, as the one who would surface to take them into the bushes at night. “He will overreact and think you need to run away.”

We do not discuss details of the abuse Sam experienced. This was one of the conditions of the interview, but afterwards they offer handwritten notes in which they expressed having shame of sexual abuse. As we talk, Sam adds: “People have an aversion to considering the effects of child sexual abuse. There’s a block in people’s brains – people don’t want to see things; they’d rather not believe it.” After a pause, he says: “Same with me.”

“Night times were a big problem. Episodes happened at night. I feared going to bed and to sleep.” Sam would shower in their clothes to help detach from their own body – from themselves.

In public, small incidents could provoke huge distress.

“If someone looked at me wrong, I would think they were going to hurt me. Certain physical traits of men – I’m sure you know what I mean,” they say, suggesting any resemblance to their abuser would provoke an episode. Neglect and violence also seem to re-emerge in their consciousness. “Parts of my brain hadn’t caught up to the present day, so thinks I’m going to be beaten, locked away, or deprived of essentials.”

Other times, there would be daytime blackouts as trauma overwhelmed. “I had an episode where I had a lapse in consciousness, and I woke up and had passed urine. I was sat in a park. Or I’d be lying on the floor unable to move for several hours, or so detached from reality it was like looking at myself through a TV screen. I tried so hard to act normal. I thought I was going mad.”

By then, Sam had visited several GPs in the area, “who dismissed all the symptoms” except one who found an antidepressant that had some effect on their depressive symptoms. But 10 years ago, while studying, Sam found a psychotherapist who began to build trust with them. The therapist became so concerned by some of Sam’s symptoms that he insisted Sam see a psychiatrist too.

To their astonishment, the psychiatrist said Sam couldn’t have a serious psychiatric disorder as they were too intelligent and had two university degrees. “He said: ‘You wouldn’t have got through them if there was something really wrong with you.’”

Having failed to secure any help on the NHS, Sam and their therapist, who was working privately, began to piece together symptoms.

“We started looking at what was happening when I was getting distressed. I started writing a journal to understand and remember everything when it was happening,” says Sam. The more they worked together to examine the evidence – the symptoms – the more it became clear that DID fitted. “I was extremely resistant to it. I didn’t want to believe I had a severe mental illness.”

But it all added up: trauma, dissociation, alienation, amnesia, and different alters. Over the last five years, Sam gradually accepted the diagnosis made by their therapist, who has specialised in DID treatment. The therapy continued with several aims: to build trust, to create more safety, to promote better self-understanding and greater internal communication between their alters. The goal, says their therapist, is not to eliminate the different parts, but to improve relations between them, to understand their functions, to hear them and manage them humanely.

Upstairs in the therapist’s house is the room in which he normally sees patients. To the right as you walk in sits a doll’s house, with three stories and several figures of different ages to help DID patients safely explore elements of their childhood. It’s just one tool in an armoury of techniques to address the trauma and improve collaboration between the alters.

“Now I have internal communication in my brain,” says Sam. “I can tell myself I’m safe. A chunk of work was identifying what was going on – what my parts were trying to express. Now I have some understanding of those parts I can reassure them and make sure their needs are met. I can reassure them that I’m an adult.”

They created with their therapist, for example, a safety plan for when the teenage part surfaces. This involved deciding on places they could go to induce feelings of protection that were not dangerous. It

included wearing shoes, and not self-harming. They even prepare enjoyable activities for their alters, so if they appear at night, terrified, they have already left colouring books or certain snacks out for them. Different alters like different foods.

“I have to be nice to them,” says Sam. “Two years ago I would be like: “Get it out of my brain’.”

Today, Sam functions better and feels that having a psychotherapist with specialist knowledge and training in DID transformed their life. “I was one of the very few people who had a very persistent, compassionate and open-minded therapist,” they say. The nosebleeds and migraines have stopped, the self-injury has stopped, and the different alters remain but in greater harmony.

This has taken 10 years of private psychotherapy.

Working in a healthcare setting, Sam sees other members of the public exhibiting symptoms just like theirs, but most doctors failing to spot it. “There’s a huge lack of understanding among clinicians. Only a couple of colleagues can recognise dissociation.”

“I think we could prevent a lot of deaths by suicide by providing access to long-term therapy,” says Sam. “We could save money and prevent many acute admissions, chronic conditions, and addictions by providing long-term therapy.”

In the hours we spend together, Sam’s alters do not appear. Later, when i meets another person with DID – still awaiting official diagnosis and treatment from a specialist – the opposite happens.

### **What is DID and how do you get help?**

- Dissociative Identity Disorder is a psychological condition typically caused by trauma in early childhood, which is usually repetitive or ongoing.
- Symptoms can include amnesia, dissociation, and having two or more distinct identities.
- Each identity can present with different voices, and have different ages, genders, character traits, and behaviours.
- Previously, DID was called Multiple Personality Disorder, but it is not a personality disorder.
- Successful specialist treatment involves talking therapy that can take several years
- To seek help, contact your GP to discuss your concerns. Either your GP, a therapist, a psychiatrist, or your local community mental health team can refer you for assessment and diagnosis at a specialist DID clinic. If appropriate, you will then be treated by the clinic.

### **‘You dissociate to escape’**

Five years after seeking help, specialist NHS treatment is still not reaching Melody, 30. (Different alters within Melody have different gender identities, but ‘they’ pronouns are common to many of them.) They are sitting in their living room in Aberdeen, surrounded by colourful soft toys, books, and a propped-up guitar when i meets them on a video call.

Melody says they have about 40 different alters. Some do not speak at all, and exist only internally, while some are dormant or have been replaced.

A small proportion of their alters emerge during our conversation. Moth is the one that predominantly speaks to i: “There are multiple people that live within this body, and I am only one of them.”

Melody has not had a job for a while, despite being highly educated, and has also experienced homelessness. Previously, while working in a bar, they would tell people about having DID. The reactions varied from ignorance, confusion, and hilarity, to kind acceptance. They would say: “If you hear me speaking with a different accent or acting in a certain way, know that we’re still trying to get the job done. It just might be someone else is doing it.”

Flashes from their early childhood and adolescence appear over the afternoon we spend talking: abuse and neglect, two older siblings who died, daily bullying at school, grooming and sexual assault as a teenager.

“You dissociate to escape,” says Moth.

Another alter is 17-year-old Xion. “I think of Xion as like a sibling. Xion has suffered significantly and dealt with self-harm issues and suicidality internally.”

When Melody was younger, Xion would speak during school hours and disappear in the evenings.

Later, as we talk, Xion speaks in a quieter, wisper voice. “I see myself as a work in progress. I just want to be OK for me.”

It’s a common phenomenon in DID for some of the alters to be cruel and taunting to the others. This is the role played by Josh, another of Melody’s alters. Josh would tell other parts that they deserved to be hated.

Moth says: “Josh was our primary persecutor for a long time, which basically means that Josh was the dickhead in the system... Josh has a very harsh Fife accent and would come into situations that were bad and make them worse.”

In 2019, Melody sought help, increasingly aware that their experiences were both hard to manage and might indicate DID, after watching a discussion online about it. “It’s very difficult to get a diagnosis in the UK,” says Moth.

Initially, through their university, they were given just 12 sessions with a therapist. Then a second therapist managed to extend 12 sessions to 12 months. Last year, a third therapist began seeing Melody, but despite believing this was DID, she isn’t qualified to make a formal diagnosis using the SCID-D protocol that CDS and other specialist clinics adopt.

“From 2019, when we were first figuring this out, it took until May of 2023 to actually start speaking to someone about DID within the NHS. My therapist is learning about this as we go through it together.”

Nine months later, Melody has no official diagnosis. The therapy continues but without their therapist having specialist training, and with little chance that the six years of therapy that is recommended for DID will be available.



Melody simply wants a therapist who can work with them in the long term, who fully understands DID, and who ideally would be able to make a formal diagnosis. Because if you have better internal communication between your identities, they say, DID “is not a death sentence”.

## Trouble finding treatment

When undiagnosed patients are referred to the Clinic for Dissociative Studies (CDS) by their GP, a psychiatrist, or their local mental health team, the first thing that happens is an assessment.

By this point, however, many have been waiting years for a referral, says Bordonada, the CDS deputy clinical director. “A lot of times NHS [mental health] services are not offering assessments for dissociative conditions because there aren’t enough clinicians who are actually qualified to assess people.”

“There’s a lack of education,” he says. “Most mental health practitioners are not well informed about dissociative conditions. This includes, in my experience, very senior clinical psychologists and psychiatrists who have no understanding about the condition, so they’re not able to identify the main symptoms.”



Matt Bordonada is the deputy clinical director of the Clinic for Dissociative Studies in north London (Photos: Supplied/inews)

Compounding this, he says, is some psychiatrists “don’t believe DID exists”.

This is despite the NHS recognising the condition, despite it using the International Classification of Diseases, which also recognises dissociative disorders, and despite listing the symptoms online, such as “memory gaps about everyday events and personal information” and “having several distinct identities”.

DID has also been “recognised by the DSM [Diagnostic and Statistical Manual of Mental Disorders] for decades,” says Bordonada. The DSM is psychiatry’s glossary of conditions, created by the American Psychiatric Association (APA) but used internationally.

For Dr Gene-Cos, the psychiatrist at the South London and Maudsley’s Trauma and Dissociation Service, the issue is not so much psychiatrists denying the existence of DID (as “dissociative disorders are well accepted,” she says) so much as how few mental health professionals are sufficiently educated to assess and treat it. “It should be part of our training,” she says. “The colleges don’t train about dissociative disorders.”

Instead, Dr Gene-Cos is trying to train more clinicians outside her own clinic, with interest and demand increasing all the time. A symposium she held at the Royal College of Psychiatrists a couple of years ago was attended by over 700 psychiatrists. Three years earlier, a similar event had just 35 delegates.

The barriers to accessing treatment, meanwhile, are “multi-factorial”, she says. “People get the wrong diagnosis, often for a number of years. Difficulties can [include] the waiting list. It could be [geographical] distances.” At the TDS service, for example, clinicians have to travel all the way from London to Scotland to assess patients, while “people from Gibraltar have to come here.”

Once referred, the next stages for patients are assessment and treatment, where further complexities arise. At the CDS clinic, because Nice hasn’t provided treatment, diagnostic, or assessment guidelines, they rely on international advice.

Treatment guidelines come from the [International Society for the Study of Trauma and Dissociation](#), which recommends six years of treatment with a specialist psychotherapist. And the diagnosis is based on a protocol called SCID-D ([Structured Clinical Interview for DSM-V Dissociative Disorders](#)) published by the APA.

The TDS clinic at the South London and Maudsley NHS Trust, however, only uses the SCID-D questionnaire as one of many tools for diagnosis. “We base that on a thorough assessment,” says Dr Gene-Cos, which can take as little as four hours or as much as several months. The complicating factor in diagnosing dissociative conditions, she explains, is the patient’s awareness: before treatment, they can have no idea that they are dissociating so sometimes can’t answer the questions in any questionnaire accurately.

The lack of national guidance, awareness and training among doctors and mental health professionals means DID is “a condition that is often misdiagnosed,” says Bordonada. “So patients will often be provided the wrong treatment.” Certain forms of treatment for trauma, for example, can be “very damaging” for people with DID, because their trauma is stored within a more complex, precarious psychological structure, he adds.

For most patients in England, to be referred to a clinic such as CDS requires an extensive funding application called an IFR (an individualised funding request). This involves a GP, psychiatrist or mental health professional applying to the local NHS body, the ICB (Integrated Care Board).

“The clinician has to be willing to say local services are no longer able to meet this patient’s need,” says Bordonada. For some patients, it ends there, if they have a psychiatrist who denies the existence of DID. “There are some powerful ones, who absolutely block the treatment and all referrals to a service like ours, because they don’t believe in the diagnosis.”

The Royal College of Psychiatrists declined to comment on DID when approached by i .

If the application is made, “which involves a lot of evidence to prove why this patient’s case is exceptional and why they qualify”, he says, it is usually assessed by a panel to decide whether they’re first willing to fund an assessment, and then treatment.

“Sometimes it gets refused,” says Linington. “Sometimes people come for an assessment but they [the ICB] don’t agree with funding treatment.”

The result is extremely patchy. “There’s absolutely a postcode lottery,” says Bordonada. “We have some areas, some NHS funding bodies, who are very willing to refer patients to us and provide treatment and others that have made it clear that they will never fund us. So it really depends where a patient lives.”

Compounding this, according to Bordonada, is the absence of Nice guidelines. “It means that some local services have taken the decision that they don’t need to provide treatment. With no recommended treatment pathway, their view is they don’t need to provide it.”

NICE told i : “Topics are referred to us by the Department of Health and Social Care and NHS England. However, if there is not Nice guidance on a particular topic it does not prevent NHS England from commissioning services or implementing diagnosis and treatment policies.”

But in practice, says Bordonada, the absence of Nice guidelines is being used by ICBs to justify not funding treatment.

A Department of Health and Social Care spokesperson told i : “Topics for the development of Nice guidelines are prioritised through a selection process that takes into account the burden of disease, evidence base and variation in practice. Integrated care boards [ICBs] are responsible for commissioning services for their local populations based on that population’s need.”

Dr Nuri Gene-Cos at TDS, thinks Nice guidelines might help give some clarity but treatment “has to be tailored – centred to each patient at their level of severity”.

But there are other reasons given for treatment being denied, says Bordonada. “We’ve had patients who have been told: ‘Your condition is too complex, we cannot help you. There’s nothing that we can offer.’ It can be a despairing experience for patients. With appropriate treatment, patients can see massive changes and live a quality life.”

With CDS operating at capacity, treating up to 70 patients at any one time, the nationwide picture of four clinics means there will be only a few hundred DID patients at most receiving specialist care through the NHS; a tiny fraction of those who might need it.

There are some positive signs, however. “There are NHS Trusts that are starting to put treatment programmes in place. But we’re really at the very early phases of any kind of change happening on a more national level,” says Bordonada.

An NHS England spokesperson told i : “NHS is expanding access to evidence-based psychological therapies for severe mental health problems including DID.”

But Linington wants to see broader change across the NHS, with more dedicated clinics and greater understanding of this condition among clinicians. “One of the things we want to support is the development in the NHS of services that are much more aware of dissociation, and to support development of specialist services where people can get proper help.”

Treatment is a three-stage process. First, gaining trust with the patient whose only experience of caregivers might be grooming and abuse.

Second, “to gently enable parts to be able to process their own traumatic experiences,” says Bordonada.

Third, improving cooperation between different identities, so they can learn to hear the experiences of the other alters with compassion and empathy. Some patients may have medication for depression and anxiety, but nothing targets DID. And the mix of amnesia, trauma, dissociation, and different identities creates a vast task.

“It’s like having a giant jigsaw puzzle,” says Bordonada. “You don’t know how many pieces are in the puzzle, what pieces are missing, or what the picture is supposed to look like. That’s why the work has to be very slow and very careful.”

For Sam, the work with their private therapist has paid off. A decade into treatment, they can envision a future now. “I want to have meaningful relationships, deep friendships. I’ve never had romantic relationships. I want to feel like I can be close to people and trust people and be myself around people.”

Melody, meanwhile, continues with their therapist while finding support, information and community online alongside many other young people with DID, only some of whom are diagnosed.

Speaking mostly in the alter of Moth, Melody has been posting videos on TikTok about having DID.

“Kids are getting access to it now on platforms like TikTok, which is a fantastic thing,” they say.

There is a downside to this, however. In the last two years, Dr Gene-Cos at the TDS says many people have been seeing videos on social media, believing they have DID, and demanding to be referred to their clinic, when they don’t have it. “We’re getting them almost weekly,” she says. As such, in a landscape of scarce resources, they are “blocking the real patients from being referred”.

But for Melody, the positive impact is undeniable.

“There is a growing body of lived experience discussion from [DID] systems willing to talk about their experience so that other people understand it. And that disseminates outwards. Awareness is growing in the younger generations.”

After we meet, however, Melody emails (signing off as Moth), concerned that they were a little too upbeat about their experience of DID during the interview. “While I think there’s joy still to be found in a life with this disability it’s still very difficult,” they write.

“We do in fact find this disorder absolutely debilitating.”