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Dissociative Identity Disorder: A Comprehensive Review of Etiology, Diagnosis, Neurobiology, and Treatment

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Abstract

Dissociative Identity Disorder (DID) is a complex and often misunderstood psychiatric condition characterized by the presence of two or more distinct identity states, memory disruptions, and episodes of dissociation. This review presents an overview of DID, focusing on its definition, symptoms, etiology, neurobiological underpinnings, diagnosis, treatment, and ongoing controversies. Current research highlights early childhood trauma as a key etiological factor, with emerging neuroimaging studies supporting the disorder's distinct biological profile. Despite its prevalence, DID remains underdiagnosed and frequently misidentified as other psychiatric conditions, particularly borderline personality disorder or schizophrenia. The review also explores sociocultural influences, including the impact of social media on public awareness and self-diagnosis. Diagnostic challenges persist, though

structured clinical interviews such as SCID-D-R offer reliable tools. Treatment is primarily based on long-term, phase-oriented psychotherapy, supported by adjunctive pharmacological strategies targeting comorbid symptoms. While debates surrounding the validity and origin of DID continue—particularly regarding the trauma model—empirical findings increasingly affirm the disorder's legitimacy. Simulation of DID remains a concern, especially in forensic contexts, yet validated psychological and physiological assessments can aid in differential diagnosis. This review underscores the importance of continued research and clinical awareness to improve diagnosis, treatment outcomes, and public understanding of DID.

Material and Methods

This paper is a narrative literature review based on scientific articles retrieved primarily from the PubMed database. Relevant peer-reviewed publications in English were selected using keywords such as "Dissociative Identity Disorder," "dissociation," "childhood trauma," "Phase-Oriented Psychotherapy," and "Dissociative Disorders." The selection included both recent research and foundational works to provide a comprehensive overview of DID. Priority was given to studies published within the last two decades, although earlier key studies were also included when historically or clinically significant. No formal inclusion or exclusion criteria were applied, as the goal was to provide a broad and integrated understanding of the disorder across various perspectives.

Keywords: Dissociative Identity Disorder, Dissociation, Dissociative Disorders, Childhood Trauma, Phase-Oriented Psychotherapy

Dissociative identity disorder (DID), formerly known as multiple personality disorder, represents a complex condition that lies at the intersection of psychiatry and psychology. It involves the coexistence of two or more distinct personality states (dissociative identities), each exhibiting unique behaviours, memories, and preferences. These separate identities are capable of independently perceiving both the self and the external world [1].

Epidemiology

Dissociative identity disorder affects an estimated 1.5% of the global population [2]. The diagnosis of dissociative identity disorder is often delayed, with patients sometimes spending 5 to 12.5 years in therapy beforehand [3]. Despite having prevalence rates comparable to

schizophrenia, dissociative identity disorder remains under-researched [4]. Individuals diagnosed with DID frequently seek emergency care, often due to self-harming actions or issues related to substance abuse [5].

Symptoms

Main symptoms of DID involve memory loss, episodes of dissociation, and the alternation between distinct identity states with unique characteristics. Individuals may experience amnesia, encounter unfamiliar objects without recollection, feel detached from themselves (depersonalization) or from reality (derealization), undergo sudden emotional shifts, report unexplained physical sensations, and describe experiences such as hearing internal voices. The intensity and combination of these symptoms differ from person to person [6].

Individuals with dissociative identity disorder typically lack awareness of their alternate identities and have limited or no access to the memories held by those other identity states. At any given moment, usually only one identity is active. Shifts between identities often happen abruptly and are triggered by specific stimuli, often linked to past traumatic experiences. In such moments, a particular identity temporarily assumes control over the person's actions [1].

This review article discusses the history, psychopathology, mechanisms, diagnosis, and treatment of DID.

Historical Background

At the start of the 19th century, the first cases of what would later be known as Dissociative Identity Disorder began to surface, typically involving people who displayed two clearly different personalities. While the exact origins of these early accounts remain uncertain, this era saw a growing interest and increasing number of such descriptions [7]. In 1924, Janet was the first to introduce the concept of dissociation, describing it as a psychological condition in which parts of an individual’s personality become split off and unreachable [8]. Some years later, in 1954, psychiatrists Thigpen and Cleckley published a book about a patient named Eve, who was notable for presenting three separate personalities [9]. Between 1970 and 1979, only 39 papers were published on this subject, but that number rose significantly to 212 during the following decade, from 1980 to 1989. The peak came in 1996, when as many as 176 papers were released in just one year [10]. A similar upward trend was observed in the number of reported cases: while only 76 cases had been documented over a period of 128 years, by 1984 that figure had jumped to over 1,000 in the United States, and then reached 4,000 just five years later [7]. In the midst of this so-called "epidemic" phase, there was a rise not only in the number of publications and diagnosed cases, but also in the number of personalities

individuals reported. At the beginning, when the disorder was first identified, most people exhibited just two distinct personalities. However, by 1989, the average number had increased to thirteen, and by the following year, it had climbed to twenty-five. These alternate personalities, or "alters," were often given specific names and roles by the individuals, such as protective figures, child-like personas, or even persecutory identities [11].

In DSM-III, the disorder was linked to childhood trauma, while DSM-III-R connected it directly to sexual abuse. This led to a wave of controversial accusations, often based on recovered memories through suggestive techniques like hypnosis. False memories, wrongful convictions, and sensational claims of satanic abuse became widespread. As skepticism grew, the False Memory Foundation was formed. Many psychiatrists stopped diagnosing DID, opting instead for PTSD, which was less controversial and more accepted by insurers. By the late 1980s, DID had largely disappeared from mainstream psychiatry in North America [7].

In recent years, interest in Dissociative Identity Disorder has grown once again, with an increasing number of research articles and media appearances featuring people who identify as having the condition. As a result, DID has returned to the spotlight. This renewed attention extends beyond media, as psychiatric clinics have reported a rise in individuals questioning whether they might have the disorder. Some of these individuals were already in treatment for other issues and now suspect DID, while others are seeking help specifically for this diagnosis [12]. The current trend shows parallels to the DID surge in the U.S. during the 1980s—particularly its higher occurrence among women—though today's landscape is shaped by the influence of social media. These platforms allow people globally to connect and share experiences, contributing to the spread of DID awareness far beyond the United States [7].

Etiology

The development of dissociative identity disorder (DID) involves multiple contributing factors. On the psychosocial side, developmental trauma and sociocognitive influences play a significant role, while biologically, the condition is linked to neurobiological responses triggered by trauma. In addition, innate biological traits and epigenetic processes are thought to contribute [13]. Although no studies have yet directly investigated the genetic basis of DID, a genetic component is considered likely especially in light of established genetic associations with dissociation and early-life adversity [14, 15].

Dissociative Identity Disorder (DID) is presently conceptualized as a long-term, complex developmental condition rooted in trauma, often beginning in early childhood. It emerges when a child is unable to integrate a cohesive sense of self across different behavioural and emotional states [16, 17]. The shifts in identity seen in DID can be viewed as a more intricate

manifestation of trauma-related intrusions and avoidance mechanisms, similar to those observed in post-traumatic stress disorder (PTSD) [18]. However, unlike PTSD, DID involves distinct identity states, each with its own subjective sense of self (“I”), as well as disruptions in consciousness between these identities [19].

Early-onset and more severe forms of childhood abuse appear to be a key distinguishing factor between DID and other psychiatric conditions [20, 21]. According to findings by Krüger and Fletcher, among various types of abuse and relational dynamics, individuals who reported experiencing emotional neglect from their biological parents or siblings during childhood were the most likely to be diagnosed with a dissociative disorder (including DID) later in life within psychiatric populations [22]. Research and theoretical perspectives indicate that a disorganized attachment style could play a foundational role in the emergence of dissociative identity disorder [23]. Experiences of abuse or neglect in early childhood, particularly when perpetrated by a caregiver, are closely linked to the development of disorganized attachment—and this attachment pattern may, in turn, increase vulnerability to further maltreatment. As such, disorganized attachment may serve as a contributing factor in the formation of DID [24]. Individuals with dissociative identity disorder frequently struggle with intense feelings of loneliness and isolation, often perceiving themselves as uniquely different from everyone else and lacking a clear understanding of their own identity. These experiences are commonly accompanied by symptoms of depersonalization and derealization, which may have their roots in early childhood [25].

Debates and Controversies Surrounding the Trauma Model

Critics often regard dissociative disorders as a pseudoscientific trend that gained popularity in the 1980s [10]. To support this perspective, they refer to three interconnected theoretical models.

The Iatrogenic Model (IM) suggests that DID may be unintentionally induced by therapists in individuals who are highly hypnotizable, imaginative, and easily influenced—traits often associated with patients diagnosed with Borderline Personality Disorder (BPD). According to this model, clinicians who endorse the concepts of repressed memories and multiple personalities may inadvertently encourage false memories through techniques such as hypnosis and recovered memory therapy, which are considered by some as potentially harmful [3, 10]. The term 'fantasy-prone' originates from cognitive and hypnosis research and refers to individuals, typically not diagnosed with mental illness, who have an exceptionally vivid inner fantasy life and often struggle to distinguish between internal and external reality

[26]. From this viewpoint, the rise in dissociative symptoms is attributed to Freudian-inspired notions of trauma being completely repressed and later retrieved under hypnosis [10].

The Sociocognitive Model (SCM) argues that formal therapy is not required for dissociative disorders to emerge. Instead, cultural influences—particularly in North America—such as media portrayals of childhood sexual abuse, repressed memories, and multiple personality narratives, are thought to shape the beliefs of suggestible individuals, leading them to assume they have dissociative conditions [27].

Lastly, the Fantasy Model (FM) frames dissociation as a cognitive predisposition that promotes the creation or distortion of traumatic experiences through imagination or confabulation [28].

The influence of social media

Interest in Dissociative Identity Disorder (DID) has surged on social media, with hashtags like “DID” and “DIDsystem” accumulating hundreds of millions of views. Influencers focusing on this topic have gained massive followings, reflecting the platform's fascination with the disorder. At the same time, mental health professionals report a growing number of DID-related consultations—a sharp contrast to the condition’s relative obscurity since the 1980s [7].

Content about DID on platforms like TikTok tends to follow similar patterns. Popular videos often include themes like "meet the system" or "catching a switch," where different alters are portrayed with distinct clothing and behaviours. Many creators introduce numerous personalities within their system, frequently adopting naming conventions influenced by other users [7]. Giedinghagen suggests that the rapid increase in DID-related content on platforms like TikTok may be understood as a form of Mass Social Media-Induced Illness [12]. In this context, algorithms amplify exposure to similar videos once a user begins engaging with them. For individuals who are uncertain about their identity or seeking a diagnosis, this content can serve as an informal guide to DID symptoms, which they may later report as their own [29].

Sharing emotionally charged videos on this topic often leads to increased engagement and positive feedback from online communities. Research by Ostendorf and colleagues shows that posting about mental health can boost social interaction and a sense of satisfaction, though it may also risk long-term exposure of private experiences [30].

On the other hand, some experts argue that not all cases are unintentional. They propose that certain individuals might deliberately feign symptoms for attention or other rewards. This aligns with the concept of “Munchausen’s by internet,” coined by Feldman, which refers to fabricating illness online for personal gain [31].

The Neuroscience of DID

Research into the neurobiology of Dissociative Identity Disorder is still at an early stage. So far, studies have primarily explored two areas: the variations between different identities within individuals diagnosed with DID, and the contrasts between those with DID and control groups (which include both healthy individuals and those with other psychiatric conditions). Neuroimaging studies have revealed both structural and functional brain differences when comparing DID patients to non-clinical populations [13].

Some brain imaging research suggests the potential to identify biomarkers associated with Dissociative Identity Disorder. In one study, pattern recognition algorithms successfully differentiated individuals with DID from healthy participants, achieving 72% sensitivity and 74% specificity based on brain structure alone. These results support the idea that there may be biological indicators that help distinguish those with DID from non-affected individuals [32].

Another study reveals distinct abnormalities in cortical thickness (CT) and surface area (SA), with reduced CT observed in in the anterior cingulate, insula, and parietal regions, and decreased cortical SA in the temporal and orbitofrontal cortices. These alterations occur in largely separate brain areas, indicating that CT and SA may be shaped by different neurobiological and developmental mechanisms. Additionally, reductions in SA and cortical volume (CV) were significantly associated with dissociative symptoms and early childhood trauma, particularly in the first three years of life [33].

Reduced hippocampal volumes have been observed in individuals with DID, particularly in regions such as the bilateral global hippocampus, CA1, CA4, GC-ML-DG, and the left presubiculum. Notably, only dissociative amnesia showed a significant correlation with decreased volumes in the bilateral CA1 subfield. Among trauma-related factors, emotional neglect was the only one linked to volume reductions across multiple hippocampal regions. These findings suggest that reduced CA1 volume may serve as a potential biomarker for dissociative amnesia and highlight a possible connection between emotional neglect and structural changes in the hippocampus [34]. Supporting this, another MRI study found that women diagnosed with DID showed not only significantly reduced hippocampal volumes but also smaller amygdalar volumes compared to healthy individuals [35].

Functional neuroimaging studies in DID have revealed alterations mainly in the limbic system, especially during tasks involving emotional processing. Based on the Theory of Structural Dissociation, different identity states show distinct neural responses. Emotional Parts (EP)

display hyperactivation in the right parahippocampal gyrus when exposed to emotional facial expressions, reflecting their link to traumatic memory recall. In contrast, Apparently Normal Parts (ANP) show globally reduced brain activity [36].

Additional findings include insula hyperactivation during trauma-related recall and preserved egocentric learning abilities, often accompanied by increased activity in the cingulate gyrus and precuneus. This suggests that some cognitive functions may remain intact or even enhanced in DID [37].

Individuals with DID exhibited increased activity in the prefrontal cortex—especially in the dorsomedial region—as well as in other parts of the default mode network (DMN) during rest, when compared to healthy controls [38].

A recent DTI study found distinct white matter differences in individuals with DID, including reduced fractional anisotropy (FA) in midbrain, bilateral pallidum, and pontocerebellar white matter compared to healthy controls, as well as increased FA in right temporal areas and right internal capsule compared to PTSD patients. FA alterations were linked to dissociative symptoms and trauma exposure, highlighting the role of white matter integrity in the neurobiology of DID [39].

Neuroimaging isn't typically used as a routine method for differential diagnosis, mainly because of its high cost. However, it can be helpful in especially unclear or challenging cases [1].

Diagnosis

Diagnosing dissociative identity disorder typically requires a thorough clinical history obtained by both psychiatrists and trained psychologists. Misdiagnosis is common, with DID frequently being confused with other personality disorders—especially borderline personality disorder—due to overlapping features such as dissociation and memory gaps. Accurate diagnosis often depends on long-term observation and in-depth assessments, with information collected from various sources to ensure a comprehensive understanding of the patient's history [40].

Dissociative Identity Disorder is recognized as a distinct condition in the American DSM-5. In contrast, the European ICD-10 does not use the term DID; instead, it refers to the condition as "multiple personality". This discrepancy in terminology was acknowledged by the creators of ICD-11, who updated the classification by adopting terminology consistent with that of the DSM-5 [1].

The diagnosis of DID requires ruling out organic causes and the influence of alcohol or psychoactive substances [1].

A hallmark of this disorder is early, repeated exposure to severe stress or trauma, such as physical abuse or sexual violence, typically during childhood. As a result, DID is categorized among trauma-related disorders. The onset of identity fragmentation often coincides with the timing of traumatic experiences, as the mind employs dissociative defense mechanisms—such as blocking memories and emotional responses—to cope with overwhelming distress [1]. Over time, these mechanisms may disrupt autobiographical memory, leading individuals to perceive memories from other identity states as unfamiliar or disconnected from the self [41].

Dissociative disorders have also been associated with genetic factors, as indicated by research involving several hundred pairs of identical and fraternal twins [42]. A potential connection between DID and specific gene variants involved in neurotransmitter regulation has also been explored. Particular attention has been given to the rs25531 polymorphism in the promoter region of the serotonin transporter gene (5-HTTLPR) [43] and the Val158Met variant in the catechol-O-methyltransferase (COMT) gene [44].

Detecting subtle dissociative symptoms is essential for accurate diagnosis, yet many clinicians overlook or fail to inquire about dissociative experiences during assessment. Proper screening that includes targeted questions about dissociative symptoms is crucial for obtaining a complete clinical picture and avoiding misdiagnosis. Given the concealed nature of identity shifts in DID, especially when symptoms are subtle, clinicians without specific experience may struggle to recognize the condition if it is not initially considered in the diagnostic process [1].

Different types of assessment tools, from basic to more advanced, have been utilized to diagnose DID. The SCID-D-R is currently regarded as the most practical and reliable method, frequently described as the gold standard for identifying dissociative disorders. In recent years, researchers have evaluated a newly developed diagnostic instrument called the Trauma and Dissociation Symptoms Interview (TADS-I). This semi-structured interview aims to detect dissociative disorders using diagnostic guidelines outlined in both the DSM-5 and ICD-11 [1].

The problem of DID simulation

Dissociative symptoms can sometimes be deliberately fabricated or exaggerated to adopt the sick role, obtain financial gain, or avoid legal consequences, particularly in forensic or institutional settings. The "fantasy model" of trauma may also contribute to the amplification of genuine symptoms. Concerns have been raised that highly suggestible individuals might find psychological comfort in identifying with the sick role, which can complicate the diagnostic process. Studies indicate that malingering occurs in up to 17% of forensic cases and around 7% in psychiatric institutions [45].

A review of the literature indicates a consistent reluctance on the part of courts to accept Dissociative Identity Disorder (DID) as a basis for a not guilty by reason of insanity (NGRI) defence. This tendency is largely attributed to concerns over the scientific reliability of DID diagnoses, the potential for individuals to feign symptoms convincingly enough to receive a favourable diagnosis from certain professionals, and the societal backlash that may follow a successful NGRI-DID defence. Additionally, questions arise regarding legal responsibility when an alternate identity—who may be mentally competent—is in control during the offense. Practical examples suggest that individuals found not guilty due to DID may still pose a risk of reoffending, which contributes to prosecutors' preference for pursuing criminal responsibility, informed by previous research and legal experience with DID [46]. Despite these concerns, some empirical findings offer compelling support for the validity of Dissociative Identity Disorder, particularly in relation to its origins in early trauma. A notable study investigated a group of twelve individuals diagnosed with DID, all of whom had committed homicide. Drawing on a wide range of sources, the researchers were able to independently confirm dissociative symptoms in all cases. Additionally, objective evidence of severe and prolonged childhood abuse was found in eleven of the twelve individuals. Interestingly, most of the subjects exhibited significant amnesia for their traumatic experiences and tended to underreport them. The study also documented notable changes in handwriting or signatures in the majority of cases, further indicating the presence of distinct identity states. These findings reinforce the strong link between early abuse and the development of DID, and suggest that when thoroughly and professionally assessed, the disorder can be reliably distinguished from malingering and other psychiatric conditions [47].
Recent controlled research has demonstrated that individuals attempting to simulate DID can be consistently differentiated from genuine DID patients using a range of established psychological assessments (such as the MMPI-2), forensic evaluation tools (like the SIRS-2), and neurophysiological indicators, including brain imaging as well as measurements of heart rate and blood pressure [48]. Using the MMPI-2 questionnaire, researchers were able to correctly identify 86% of genuine DID cases and 83% of individuals attempting to simulate the disorder, even though the simulators had been trained in the typical symptoms and behaviours associated with DID. This suggests that feigning the condition in a way that fully avoids detection is highly challenging. Even well-prepared individuals could not replicate the full complexity of DID, often missing subtler symptoms or signs of comorbid conditions such as depression, PTSD, or sexual dysfunction. Additionally, they struggled to convincingly portray the distinct characteristics of separate personality states [1].

Differential diagnosis

Borderline personality disorder is one of the most frequently considered alternatives in the differential diagnosis of DID. This condition is also linked to significant trauma and may involve dissociative features and brief psychotic-like episodes. Since individuals with DID commonly exhibit dissociation and memory loss—symptoms that also occur in borderline personality disorder—misdiagnosis is possible [40]. One study found that 43.3% of individuals diagnosed with borderline personality disorder experienced dissociative symptoms of varying intensity. In the most severe cases, these symptoms involved distinct identity states, each characterized by its own emotions, memories, and behavioural patterns [45]. Although symptom overlap exists, recent studies indicate that DID and BPD are separate diagnoses. While both disorders may involve emotional instability, identity disturbance, and dissociation, the nature and severity of dissociative symptoms differ. In DID, amnesia, identity alteration, and a fragmented sense of self are typically more pronounced and enduring. In contrast, dissociation in BPD tends to be transient and stress-related. Structured clinical interviews and psychological assessments, such as the Rorschach test, have helped distinguish the two conditions. Individuals with DID often demonstrate greater introspective capacity, emotional regulation, and cognitive complexity compared to those with BPD, supporting the view that these are clinically and diagnostically distinct disorders [48].

DID is sometimes misdiagnosed as schizophrenia, and the two can co-occur. Studies report varying rates of overlap, but dissociative symptoms are frequently observed in individuals diagnosed with schizophrenia spectrum disorders. One study noted that patients with both conditions exhibited more intense psychotic symptoms compared to those without dissociative features. These findings, along with other research, suggest that dissociative and psychotic disorders are often difficult to differentiate. Overlapping symptoms, such as Schneiderian first-rank symptoms, contribute to diagnostic confusion. However, the absence of negative symptoms and the clinician's expertise can aid in distinguishing between the two [49].

Since trauma plays a central role, PTSD is another condition that should be considered during differential diagnosis [40].

Treatment

DID is considered a treatable condition, with expert consensus supporting long-term, phase-based relational psychotherapy as the most effective approach. Since DID typically arises

from early trauma and disrupted attachment, treatment focuses on rebuilding trust and restoring a sense of self through a stable therapeutic relationship.

Therapy is structured into three overlapping phases. **Phase 1**, "safety and stabilization," aims to establish emotional safety, build coping skills, and help the individual understand and manage dissociation. Psychoeducation, grounding, and containment techniques are central here. One structured program for this phase, *Finding Solid Ground*, uses guided exercises to strengthen emotion regulation and distinguish past trauma from present experience.

Phase 2 involves careful and gradual processing of trauma-related memories. However, high levels of dissociation can hinder this work, so stabilization in Phase 1 is essential. Manualized PTSD treatments may be adapted, but require flexibility due to the complexity of DID. Techniques like self-hypnosis may also support affect regulation and integration of dissociated self-states.

Phase 3, focused on reconnection, supports individuals in integrating their experiences and developing new, healthier ways of relating to themselves and others. The ultimate goal is to reduce reliance on dissociation and foster a coherent sense of identity and agency in daily life [50].

Cognitive Behavioral Therapy (CBT) is commonly used to address co-occurring conditions such as anxiety and depression in individuals with Dissociative Identity Disorder (DID), by targeting unhelpful thought patterns and behaviors [6].

In one study, a patient diagnosed with both PTSD and DID received an intensive two-week CBT-based treatment, which led to a significant reduction in symptoms, maintained at three- and six-month follow-ups. The intervention was based on the idea that dissociative symptoms function as maladaptive coping mechanisms in response to trauma-related distress and are maintained by distorted beliefs. Since PTSD frequently coexists with DID, directly treating trauma symptoms also diminished dissociation.

This approach differed from traditional DID protocols by omitting a stabilization phase, not using grounding techniques, and avoiding efforts to foster communication or integration between identities. A farewell ritual was included to help the patient emotionally detach from long-held identity states.

Although the results are promising and align with findings from other brief CBT treatments for trauma-related conditions, the study has limitations. It involved only one patient, who was open to the treatment and able to engage with her identities—a factor that may not generalize to all DID cases. Furthermore, the diagnosis was not confirmed using gold-standard

diagnostic tools. Therefore, while the findings suggest potential, further research on a larger scale is necessary to evaluate the broader applicability of this method [51].

Hypnosis has been explored as a therapeutic tool for DID, with research indicating that individuals with this disorder tend to be more responsive to hypnotic techniques compared to other clinical groups. Specific methods include using hypnosis to access dissociative identities that may not emerge during standard therapy sessions, allowing for more comprehensive engagement with all identity states relevant to treatment [40].

While there is no medication specifically designed to treat DID itself, associated symptoms such as depression and anxiety can be addressed pharmacologically. Psychiatrists may prescribe antidepressants—including SSRIs, SNRIs, or TCAs—to help regulate mood by increasing certain neurotransmitter levels. In cases of significant anxiety, anxiolytics like benzodiazepines may be used, as they enhance the calming effect of the neurotransmitter GABA [6]. Additional pharmacological options proposed for managing symptoms associated with DID include prazosin for alleviating nightmares, carbamazepine to help manage aggressive behaviour, and naltrexone to reduce repeated self-harming actions [52]. Using psychiatric medication in DID can be challenging, as different identity states may express varying symptoms and levels of cooperation. While some may follow the treatment plan, others might resist or reject it [40].

Although some critics claim that DID treatment may be harmful, research does not support this view. In fact, evidence shows that trauma-focused, phase-based psychotherapy—aligned with expert guidelines—leads to significant reductions in dissociation, PTSD symptoms, depression, and self-harm, while improving overall functioning. Studies demonstrate positive outcomes, particularly when treatment directly addresses dissociated self-states. While some limitations exist in the research, such as lack of control groups, the claim that DID therapy is harmful is largely based on non-scientific sources. Overall, properly conducted treatment appears to be both safe and effective [48].

Conclusions

Dissociative Identity Disorder remains one of the most complex and debated diagnoses in modern psychiatry. Although often misunderstood, DID is a severe trauma-related condition characterized by disruptions in identity, memory, and consciousness. Research into its etiology highlights the critical role of early childhood trauma, while neurobiological findings increasingly support its validity as a distinct disorder. Despite ongoing controversies and diagnostic challenges, structured clinical interviews and a careful differential process can aid in accurate identification. Current treatment models emphasize long-term, phase-based

psychotherapy, often supported by adjunctive pharmacological interventions targeting comorbid symptoms. As awareness and empirical understanding continue to grow, it is essential to approach DID with both scientific rigor and clinical sensitivity. Further research is needed to refine diagnostic tools, develop targeted interventions, and challenge lingering misconceptions that continue to surround this condition.

Disclosure

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