

Dissociative identity disorder

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Dissociative Identity Disorder (DID)

Primary Disciplinary Field(s): Psychiatry, Clinical Psychology, Traumatology

1. Core Definition

Dissociative Identity Disorder (DID), historically known as **Multiple Personality Disorder (MPD)**, is a complex, chronic psychiatric condition characterized by a profound disruption of the unified sense of self and agency. As defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, Text Revision (DSM-5-TR), DID is marked by the presence of two or more distinct **identity states** or self-states (often referred to as alters or parts), accompanied by significant, recurrent gaps in memory. This condition represents a severe failure of the personality structure to integrate, a process that typically completes during early childhood.

The core pathology of DID lies in the lack of a cohesive sense of identity that persists across time and context, resulting in a profound disconnect from aspects of one's own consciousness, memory, and personal history. It is understood by the prevailing consensus as a **trauma-related dissociative disorder**--the most severe condition on the dissociative spectrum--which results from overwhelming, inescapable developmental trauma occurring when the foundational structures of personality are still forming. These symptoms cause clinically significant distress and substantial impairment in major areas of life functioning, requiring specialized, long-term therapeutic intervention.

2. Etymology and Historical Development

The conceptual journey of DID spans centuries, evolving from ancient interpretations of identity alteration, often framed through the lens of **demonic possession** or spiritual phenomena, to modern psychological and neurobiological models. Early accounts in the 16th and 17th centuries, while lacking formal diagnostic language, described individuals exhibiting distinct identities coupled with histories of childhood trauma. The late 19th century brought a medical shift, greatly influenced by the work of Pierre Janet, who introduced the term "**dissociation**" (**désagréation**) to describe the splitting off of mental processes--thoughts, feelings, and memories--from conscious awareness in response to overwhelming traumatic experiences.

The disorder gained widespread, albeit sensationalized, public attention in the mid-20th century, particularly following the highly influential media portrayals in books and films like "**The Three Faces of Eve**" (1954) and "**Sybil**" (1973). This popularization coincided with the formal inclusion of **Multiple Personality Disorder (MPD)** in the DSM-III in 1980. The subsequent rapid increase in diagnoses led to significant controversy, pitting the **trauma model** against the **sociocognitive model (SCM)**, which argued that the disorder was an iatrogenic artifact created by suggestive

therapeutic techniques.

In 1994, the diagnosis was officially renamed Dissociative Identity Disorder (DID) in the DSM-IV to reflect a more accurate understanding of the condition as a "**disruption of identity**" characterized by distinct states, emphasizing the failure of integration rather than the proliferation of separate personalities. Current scientific consensus, backed by cross-cultural studies and mounting neurobiological evidence, firmly validates the trauma model, cementing DID's classification as a severe consequence of chronic developmental adversity.

3. Key Diagnostic Characteristics (DSM-5-TR Criteria)

The diagnosis of DID hinges upon five required criteria, establishing the pathological disruption of identity and associated amnesia.

Identity Disruption (Criterion A): The presence of two or more distinct personality states or experiences of possession, which involve a marked discontinuity in the sense of self and agency. These states, often referred to as alters, possess unique and enduring patterns related to affect, behavior, consciousness, memory, perception, cognition, and sensory-motor functioning. The shifts between these states can be either overtly observable or covertly experienced as internal struggles, intrusive thoughts, or emotional discontinuities.

Dissociative Amnesia (Criterion B): Recurrent, clinically significant gaps in the recall of everyday events, important personal information, and/or traumatic experiences that cannot be explained by ordinary forgetfulness. This amnesia is often asymmetrical, meaning the identity state presenting for treatment (the host) frequently lacks memory for the actions or experiences of other alters. Amnesic episodes can include finding evidence of unremembered actions (e.g., discovering writings or purchases) or experiencing fugue-like episodes.

Distress and Impairment (Criterion C): The symptoms must cause clinically significant distress or result in impairment across crucial areas of functioning, such as social relationships, occupational performance, or academic pursuits.

Exclusion of Cultural/Religious Practice (Criterion D): The disturbance must not be a normal part of a broadly accepted cultural or religious practice. This criterion differentiates pathological, involuntary, distressing possession experiences from culturally sanctioned rituals. In children, symptoms must exceed normative fantasy play.

Exclusion of Substance/Medical Cause (Criterion E): The symptoms must not be attributable to the direct physiological effects of a substance (e.g., alcohol blackouts) or another medical condition (e.g., complex partial seizures).

4. Etiological Mechanism: Structural Dissociation

The trauma model views DID as a highly complex adaptation to survival, elucidated by the Theory of Structural Dissociation of the Personality (TSDP). TSDP posits that humans are born with proto-systems for survival--attachment, defense, exploration--which normally integrate into a unified personality. When a child faces overwhelming, inescapable, and chronic relational trauma, particularly before the age of six, this integration fails, leading to a fundamental structural division within the personality.

This division separates the personality into two primary types of dissociative subsystems: the **Apparently Normal Part(s) of the Personality (ANP)**, oriented toward managing daily life functions, attachment, and avoiding trauma reminders; and the **Emotional Part(s) of the Personality (EP)**, fixated on the traumatic experience and holding the raw emotions, sensory memories, and defensive responses (fight, flight, freeze).

DID is the defining characteristic of **Tertiary Structural Dissociation**, the most complex level, characterized by the presence of **multiple ANPs and multiple EPs**. In this configuration, the demands of non-traumatic daily life are partitioned among various ANPs (e.g., a work part, a social part), while the traumatic material is held across several EPs, each potentially holding different aspects or different events of the trauma history. This complex compartmentalization creates the necessary amnesic barriers between parts (the dissociation) that allow the individual to survive unbearable childhood conditions, but at the immense cost of a fragmented sense of self.

5. Neurobiological Correlates

Neurobiological research provides converging evidence that the psychological fragmentation in DID is reflected by distinct alterations in brain structure and function, particularly in areas responsible for self-awareness, memory, and emotional processing. These findings underscore the biological embedding of chronic trauma.

Structural Brain Differences: Studies using MRI have consistently reported volumetric reductions in key limbic structures, including the **hippocampus** (implicated in memory fragmentation) and the **amygdala** (involved in threat processing), similar to findings in PTSD. Furthermore, abnormalities, such as reduced volume or cortical thinning, have been observed in regions of the **Prefrontal Cortex (PFC)**, particularly the medial and orbitofrontal areas, which are critical for executive function, cognitive control, and the integration of experience necessary for a unified sense of self.

Functional Brain Differences: Functional neuroimaging reveals distinct patterns of brain activity corresponding to different identity states. Emotional Parts (EPs) often show **heightened limbic system reactivity** (hyperarousal) when exposed to trauma cues. Conversely, Apparently Normal Parts (ANPs) may exhibit simultaneous **increased activity in inhibitory PFC regions** alongside

decreased amygdala activity, reflecting the active, suppressive emotional detachment central to dissociation. Crucially, functional connectivity studies show altered communication within large-scale networks, most notably the Default Mode Network (DMN), suggesting that the experience of "switching" between alters involves rapid, profound shifts in network interactions that govern self-representation and cognitive control.

6. Treatment Approaches

Effective treatment for DID requires specialized, long-term psychotherapy within a phase-oriented framework, prioritizing stabilization over early trauma confrontation. The overarching goal is **integration**--the achievement of greater communication, cooperation, and co-consciousness among parts, leading to a more unified sense of self.

Phase 1: Stabilization and Safety. The longest and most critical phase focuses on establishing a strong therapeutic alliance, providing **psychoeducation**, reducing immediate risks (such as self-harm and suicidality), and developing essential coping skills (e.g., emotional regulation, grounding techniques). A key task is **mapping the internal system** and facilitating gentle communication and cooperation between identity states to reduce internal conflict and functional impairment.

Phase 2: Trauma Processing. Once stabilization is sufficient, this phase addresses the core traumatic memories held by the Emotional Parts (EPs). Trauma processing techniques, such as adapted forms of Eye Movement Desensitization and Reprocessing (EMDR) or Sensorimotor Psychotherapy, are used carefully and gradually. The goal is the integration of traumatic affect, sensation, and cognition into a coherent narrative, thereby reducing the need for dissociative compartmentalization.

Phase 3: Integration and Rehabilitation. The final phase focuses on consolidating therapeutic gains, addressing remaining relational issues, and facilitating the integration of the personality (either full fusion or functional co-consciousness). Emphasis is placed on developing a stable, unified sense of self that is not defined by trauma and improving overall functional capacity in life. Pharmacotherapy is used only adjunctively to manage severe comorbid symptoms (e.g., depression, anxiety) but does not treat the core dissociative pathology.

7. Debates and Criticisms

Despite decades of research validating DID as a trauma-related disorder, it continues to face controversies, primarily fueled by the historical **sociocognitive model (SCM)**. Critics of the trauma model argue that DID is an iatrogenic (therapist-induced) artifact, suggesting that highly suggestible patients learn to enact the role of having multiple personalities, often influenced by media portrayals or suggestive therapeutic techniques (like uncritical use of hypnosis to "recover" alters).

However, empirical research has largely dismantled the core claims of the SCM, demonstrating the consistency of the trauma link, the existence of DID in diverse cultures worldwide, the presence of subtle symptoms pre-dating diagnosis, and distinct neurobiological markers. A related criticism stems from public and media misconceptions, which often sensationalize the disorder, depicting dangerous or overtly dramatic alters, thereby contributing to significant **stigma**. Clinically, DID is differentiated from conditions like **Schizophrenia** by the nature of the voices (internal, conversational pseudo-hallucinations related to alters versus external, bizarre psychotic hallucinations) and the absence of formal thought disorder. It is also differentiated from **Borderline Personality Disorder (BPD)** by the fundamental difference in identity disturbance and the presence of recurrent amnesia.

Further Reading (Authoritative Sources)

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