Literature Review: Dissociative Identity Disorder (DID)

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Abstract. It is critical to have a thorough grasp of the nature of Dissociative Identity Disorder (DID) and how it affects various individuals in order to accurately diagnose patients, successfully treat it, and effectively help those who are in need. The present study is a review that provides a comprehensive summary of DID, containing information on the potential cause of the disorder, its effects on patients and treatments, as well as suggestions for further research. In the section under "Results and Discussion," the present study discusses the biological, psychological, and social variables that contribute to DID. This paper also discusses the effects that it has on people as well as some of the more popular treatment approaches that are available. The ultimate findings included recommendations for more research. Overall, after a thorough discussion, people can gain a better understanding of the causes as well as the treatment of these personality disorders.

Keywords: Dissociative Identity Disorder (DID), Psychopath, Sociopath, Etiology, Treatment.

1. Introduction

Dissociative Identity Disorder (DID) refer to a multifaceted mental disorder defined by the presence of two or more separate identities or personality states inside a single individual.

These identities or "alters" coexist within the same person, each with unique perspectives, memories, emotions, and behaviors. The disorder formerly referred to as Multiple Personality Disorder had a change in nomenclature in 1994, and is now recognized as Dissociative Identity Disorder (DID). DID prevalence is relatively low on behalf affects approximately 1.5% of people worldwide and around 5% in U.S. psychiatric settings [2]. Hence, it is a rare but significant mental health problem. In various cultures, DID has historically been observed and described. However, it has become evident that severe childhood trauma and abuse significantly contribute to the development of DID [2]. Understanding this disorder is crucial due to its impact on individuals' lives. For instance, DID leads to self-injurious behavior, suicide attempts, and other severe psychiatric symptoms. Thus, this underscores the urgency of effective diagnosis and treatment [1,2]. This literature review aims to provide an in-depth exploration of DID. The review provides insights into the etiology, diagnosis, assessment, and treatment approaches for DID By synthesizing and critically analyzing relevant literature from reputable sources. The review also highlights controversy and debate surrounding DID and identifies future research directions, ultimately contributing to a deeper understanding of this complex disorder.

2. Methodology

A systematic and comprehensive approach was adopted to ensure the validity and reliability of this literature review. The primary data collection method involved an extensive review of pertinent literature from reputable sources. Google Scholar was utilized to access a diverse range of research articles and studies addressing various facets of DID, including etiology, diagnosis, treatment, and controversies surrounding the disorder.

3. Results and Discussion

3.1. Etiology and Risk Factors of DID

The etiology of Dissociative Identity Disorder (DID) encompasses a confluence of biological, psychological, and environmental factors:

3.2. Biological factors

3.2.1 Genetic predisposition

While the primary cause of DID is developmental traumatization, some evidence suggests that genetic factors may increase vulnerability to the disorder. High hypnotizability (a non-pathological trait with a genetic basis) has been proposed as a potential diathesis for DID [3]. Hence, individuals with a higher hypnotizability trait might be more susceptible to developing DID when exposed to other necessary factors like severe childhood abuse or neglect. Individuals with chronic refractory post-traumatic illnesses also have a higher level of hypnotizability. Hence, this indicates that it may not be a specific marker for DID but rather a general risk factor for trauma-related conditions.

3.2.2. Neurobiological abnormalities

Neurobiological factors also play a role in the DID etiology. Henning (2013) proposes that individuals with DID may exhibit abnormalities in brain structures and functions related to memory, emotion regulation, and self-identity [4]. These neurobiological changes could contribute to the fragmentation of identity and the presence of distinct personality states [4].

3.3. Childhood trauma and abuse

3.3.1 Role of Severe Early Life Stress

Childhood trauma is a significant contributing factor to DID. Traumatic experiences, typically starting in early childhood, lead to the dissociation of identities as a coping mechanism [3]. The post-traumatic model suggests that DID is mainly caused by physical and sexual abuse in early childhood, which is compartmentalized as a coping mechanism to protect the individual from overwhelming experiences [5].

3.3.2 Types of Trauma Associated with DID

Various types of trauma have been associated with DID development. Millard (2020) highlights that physical and sexual abuses are particularly prevalent in the histories of individuals with DID[5]. Şar et al. (2017) also note that DID patients often report histories of chronic abusive experiences during childhood, including physical and sexual abuse, emotional neglect, and dysfunctional relationship styles/communication among family members [3].

3.4. Psychosocial factors

3.4.1 Attachment disruptions

Disorganized attachment styles may contribute to DID development. The formation of various mental images of self and main caregivers/attachment figures might be attributed to disorganized or insufficient childhood relationships. Wilkinson and DeJong (2021) claim that there exists a correlation between disordered attachment and experiences of childhood neglect and abuse perpetrated by a relational figure [6]. Consequently, this may provide a foundation for DID.

3.4.2 Environmental influences

The family, society, and culture significantly affect the level of DID. According to Şar et al. (2017), dysfunctional family dynamics, denial, boundary violations, and oppressive cultural traditions contribute to an environment conducive to childhood abuse and neglect, which are linked to the development of DID [3]. Prior also highlight that cultural norms and behavioral repertoires can influence the expression of dissociation [7]. Cultural constructions of self and personhood may shape

the presentation and interpretation of DID symptoms, leading to variations in how the disorder is experienced and expressed across different cultures.

3.5. Diagnostic Criteria and Assessment of DID

3.5.1. The diagnostic criteria for DID based on DSM-5

Among dissociative disorders, DID stands out with its specific criteria outlined in the DSM-5. According to Mitra & Jain (2021), the DSM-5 criteria for DID require the presence of at least two or more different personalities within one person [2]. Each personality is characterized by unique behavior patterns, sense of consciousness, memories, and perceptions of the external world. Also, Individuals with DID commonly experience episodes of amnesia, which manifest as significant gaps in their memory and recall of daily life events and traumatic experiences. These amnestic periods are beyond typical forgetfulness and cannot be attributed to the usage of substances or the impact of cultural norms or behaviors [2]. It is essential to emphasize how these symptoms must result in substantial impairment in the individual's daily functioning and overall quality of life.

3.5.2. Challenges and controversies in diagnosing DID

One primary challenge in diagnosing DID involves its resemblance to other psychiatric disorders. DID is often related to other psychological disorders [8]. Hence, this can lead to diagnostic confusion. The overlapping features and symptoms make differentiating these conditions challenging. Consequently, this may lead to underdiagnosis or misdiagnosis. DID diagnosis is also contentious and challenging due to multiple meanings attributed to the term "dissociation." The term defines various concepts, including diagnostic categories like dissociative disorders, psychopathological phenomena like depersonalization or amnesia, and pathogenic processes caused by traumatic experiences [8]. Hence, this ambiguity in the definition can complicate the diagnostic process and make it challenging to identify the exact nature of dissociation in a patient. Moreover, the DID etiology is contentious. For instance, the trauma model proposes that DID arise from chronic/severe childhood trauma. Contrarily, the fantasy model suggests that it is mainly driven by suggestion and enactment facilitated by high suggestibility and fantasy proneness levels [9]. This dichotomy impacts how clinicians approach and understand the disorder. As a result, it potentially affects diagnostic decisions.

3.5.3. Assessment methods and tools for identifying DID

The identification of DID involves a comprehensive assessment using various methods and tools. These tools measure dissociative experiences and physical symptoms related to dissociation, respectively. Clinicians also use the Dissociative Disorder Interview Schedule (DDIS) and the Structured Clinical Interview (SCI) for Dissociative Disorder to conduct structured clinical interviews and observations. Moreover, the DSM-5 criteria for DID are also used [10]. Proper assessment by qualified mental health professionals is crucial for an accurate diagnosis and appropriate treatment of DID.

3.6. Theoretical Perspectives on DID

3.6.1. Psychodynamic Perspective

The psychodynamic perspective posits that DID result from an individual's subconscious defense mechanisms and unconscious processes. Painful memories and emotions related to traumatic events are believed to be repressed and converted into neurological symptoms, protecting the person from overwhelming distress [11]. This theory suggests that individuals with DID develop different identities as a way to escape from their traumatic experiences. By creating separate identities, they can compartmentalize distressing memories and emotions, thereby preserving a sense of self and avoiding psychological pain associated with the trauma.

3.6.2. Cognitive-Behavioral Perspective

The cognitive-behavioral perspective primarily centers on the cognitive processes underlying dissociation in DID. Based on this perspective, memory retrieval deficits are proposed as a possible explanation for dissociative amnesia. Psychological stress and other factors affect the frontal lobes' ability to retrieve autobiographical memories. Bridley & Daffin (2022) cites that neuroimaging studies have shown deficits in prefrontal regions responsible for memory retrieval in individuals with dissociative disorders [11]. Cognitive-behavioral therapy (CBT) is often used as a treatment approach for individuals with DID [2]. It employs grounding exercises, cognitive restructuring, and integrating different identities to manage dissociation and improve memory retrieval.

3.6.3. Neurobiological Perspective

The neurobiological perspective explores the brain's role in the development of DID. According to Manton (2016), neuroimaging studies have identified differences in brain structure and function among DID patients [12]. The orbitofrontal cortex (OFC) functions differently in DID patients. This leads to impulsive behaviors and the switch to alter personalities in response to cognitive and emotional conflicts. Besides, abnormalities in neurochemical pathways related to memory and emotion regulation have also been implicated in DID patients. Bridley & Daffin (2022) also suggest that genetic and environmental factors may contribute to dissociative disorders [11]. Dissociation heritability rates are estimated to be around 50 to 60%. However, a combination of genetic and environmental influences is likely to influence dissociative disorder development.

3.7. Treatment Approaches for DID

3.7.1. Psychotherapy

Psychotherapy is the cornerstone of treating DID, aiming to address this condition's complex traumas and high levels of dissociation characteristics. The treatment plan comprises a three-pronged therapy approach. The initial phase focuses on establishing safety, stabilizing the patient, and reducing symptoms like suicidal ideation and self-injurious behavior [2, 13]. The second phase involves processing and integrating traumatic memories. It mainly utilizes exposure/abreaction techniques in a carefully staged manner. Moreover, the final phase focuses on the patient's relationship with self and the external world, working towards integrating different personality states and achieving a cohesive identity. Recent approaches such as trauma-focused CBT and dialectical behavioral therapy (DBT) have shown promise in managing overlapping symptoms between DID and borderline personality disorder [2, 14]. Notably, successful therapy relies on a strong therapeutic alliance and trust between the patient and the treatment team.

3.7.2. Medication

Medication is not the primary treatment for DID. However, various medications can be used to treat specific DID symptoms. Gentile et al. (2013) emphasize the prescription of antidepressants and anxiolytic drugs for the purpose of managing emotion disorders of post-traumatic stress disorder (PTSD) in individuals diagnosed DID [13]. In addition, it is worth considering the use of atypical antipsychotic medications that inhibit the activity of dopamine (D2) and serotonin (5-HT2A) receptors in the therapy of complicated trauma patients presenting with psychotic symptoms. Pharmacological interventions, such as naltrexone (to address recurrent self-injurious behaviors) and prazosin (for reducing nightmares), are also utilized [2,13]. Healthcare providers should carefully assess and monitor medication use in DID patients due to the potential variability in symptoms across different personality states [2].

3.7.3. Integrative Approaches

Complementary and alternative therapies can play a role in DID treatment. Hypnosis, in particular, has been utilized, as DID patients tend to be more hypnotizable than other clinical populations. Hypnosis can help access alternate identities not present during the session, facilitating the emergence of identities crucial to the therapeutic process. According to Mitra & Jain (2021), Eye Movement

Desensitization and Reprocessing (EMDR) may also be useful. [2] It is mainly recommended for stable patients with adequate coping skills. An essential aspect of managing DID involves coordinating a multidisciplinary treatment team, including psychiatrists, psychologists, social workers, and other healthcare professionals. They collaborate to provide comprehensive care addressing the diverse aspects of the patient's condition [2,13].

3.8. Controversies and Debates Surrounding DID

3.8.1. Validity and skepticism regarding DID as a distinct disorder

The DID validity as a psychiatric disorder has been a subject of ongoing debate within the scientific community. Some researchers and clinicians question whether DID is a legitimate mental health condition or a product of suggestion and fantasy proneness. According to Reinders et al. (2019), skeptics argue that normal healthy individuals can easily simulate dissociative symptoms [15]. They propose models such as the Fantasy Model of DID, which posits that the condition is not primarily caused by childhood trauma but is influenced by multivariant factors [16]. However, proponents of the disorder, such as those supporting the Trauma Model, assert that DID is a severe form of PTSD resulting from chronic/severe childhood traumatization [16, 17]. They highlight the role of psychological trauma, especially early life trauma, in developing distinct alter identities.

3.8.2. The role of suggestion and Iatrogenesis in the development of DID

The role of suggestion and Iatrogenesis in the development of DID have also been a contentious issue. The Iatrogenic Model (IM) proposes that DID can be produced in highly suggestible individuals, often those with BPD, by clinicians who trust in concepts like "repressed memories" and "multiple personalities"[15]. Critics argue that some clinicians might use "risky" treatments potentially leading to the implantation of false memories [17]. The Sociocognitive Model posits that psychotherapy itself may not be necessary for DID patients, attributing the disorder to cultural influences and media portrayals of dissociation [17]. While the debate continues, it is important to differentiate genuine cases of DID from those influenced by suggestion and cognitive processes.

3.8.3. Debates on the concept of altered identities and their origin

DID patients often present two or more distinct personality states, often referred to as "alters." Some critics argue that these alters are merely facets of a single personality rather than distinct identities. The origin and nature of these altered identities remain controversial. Proponents of DID contend that the “alters” arise as a coping mechanism in response to severe trauma, allowing individuals to dissociate from the overwhelming experiences [17]. The Trauma Model posits dissociation is a protective response to traumatic events, sequestering traumatic information from ordinary awareness. On the other hand, skeptics propose that these alters are products of suggestion and cognitive processes and the disorder is not a genuine phenomenon [15].

3.9. Future Directions and Research Needs

3.9.1. Identifying gaps in current knowledge about DID

Research needs to address several key gaps in current knowledge to further our understanding of DID. One essential aspect is determining the accurate prevalence and incidence of DID through comprehensive epidemiological studies across different populations and cultures. The existing estimates may not fully capture the true extent of the disorder. Also, research into the DID underlying causes remains incomplete. There is a need to explore the role of childhood trauma, genetic factors, brain chemistry, and other potential contributors to the disorder. That is essential to ensure early detection and prevention efforts. According to Romanos et al. (2021), differentiating DID from other mental health conditions with overlapping symptoms is another critical challenge that requires improved diagnostic tools and criteria[18]. Moreover, understanding the relationship between DID and other psychiatric disorders like PTSD and BPD is vital for further investigation.

3.9.2. Advancements in neuroimaging and biological markers

Advancements in neuroimaging hold significant promise in advancing our knowledge of DID. For instance, modern neuroimaging techniques can provide a more comprehensive understanding of brain structural and functional differences associated with DID. These techniques comprise diffusion tensor imaging, functional MRI, and PET scans [17]. Identifying specific brain regions or networks involved in dissociation and related symptoms can help researchers gain valuable insights into the underlying neural mechanisms of DID. Moreover, Reinders et al. (2019) note that exploring potential biomarkers, like neurochemical or genetic indicators, may offer valuable diagnostic tools and contribute to more personalized and targeted treatment approaches for DID patients[15].

3.9.3. Promising areas for further research and intervention development

Efforts to improve interventions for DID should focus on developing trauma-informed therapies explicitly tailored for individuals with the disorder. Integrative approaches addressing both the dissociative and post-traumatic aspects of DID are particularly important for comprehensive care. Early intervention strategies targeting childhood trauma may help prevent the deterioration of the condition and mitigate the severity of DID later in life [19]. Additionally, research should prioritize the effective management of comorbidities often accompanying DID and explore the use of technology-assisted interventions, such as virtual reality and smartphone applications, to enhance accessibility and engagement in treatment. Addressing the stigma surrounding DID and understanding cultural perspectives on the disorder are also essential for providing culturally sensitive care [20]. Additionally, investigating the potential role of medication, neurofeedback, and non-invasive brain stimulation techniques may offer novel therapeutic options to complement traditional psychotherapeutic approaches in managing DID symptoms.

4. Conclusion

This comprehensive literature review has provided valuable insights into the complex nature of DID. Exploring its etiology, diagnosis, treatment, and controversies offers a deeper understanding of this rare but significant psychiatric condition. Childhood trauma and severe early-life stress emerged as key factors contributing to the development of distinct identity states, or "alters," within individuals. Diagnosing and treating DID encompass various challenges. Nonetheless, this review highlights the importance of trauma-informed care, integrative approaches, and multidisciplinary treatment teams to ensure improved outcomes. Further research is also needed to address gaps in knowledge, develop effective interventions, and reduce the stigma surrounding DID. Notably, people can support DID patients and work towards enhancing their well-being and quality of life by fostering a compassionate and informed approach.

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