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A REVIEW OF COMPLEXITIES OF DISSOCIATIVE IDENTITY DISORDER

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Abstract:

The complicated mental health disorder known as dissociative identity disorder (DID), originally called Multiple Personality Disorder, is defined by the existence of two or more separate identities or personalitystates within an individual. Every identity has a distinct set of behaviour, recollections, and worldviews.These personalities frequently take charge of a person's behaviour and may or may not be aware of oneanother. Chronic, severe trauma, especially in early childhood, is usually linked to the beginning of DID. Because there is a break in the regular integration of consciousness, memory, and identity, it is classified as a dissociative disorder. Due to DID's covert nature and symptoms that can coincide with those of other mental health issues, diagnosing it can be difficult. mostly for treatment include ongoing psychotherapy with the goal of combining the several identities into a single, coherent sense of self. A key component of treatment is attending to any co-occurring mental health conditions, such as anxiety, depression, or post-traumatic stressdisorder. The fundamental processes and efficacious therapies for DID are still being investigated. Helping people with DID enjoy happy, productive lives requires a thorough and caring approach to treatment. For those impacted by this illness, friends, family, and mental health experts' understanding and support are crucial elements of the recovery process.

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INTRODUCTION:

Dissociative identity disorder, also known as multiple personality disorder in the United States, has been characterized as a complex condition that is challenging to comprehend, diagnose, treat, and have an objective conversation about. The literature on dissociation, hypnosis, memory, cognitive psychology, social psychology, development, trauma, attachment, and other topics that frequently seem far-off and cryptic is consulted in this study.

Situations when a person's typical personality or manner of being is substituted with a different, frequently drastically different personality or method of being, whose actions are not known to the typical personality, were almost universal and frequent before the advent of modern science. A variety of forces, including spirits, angels, devils, gods, or ancestors, were thought to have invaded the possession states.

Judeo-Christian possession states comprised behaviours of the intruding entity and behaviours in which the intruding entity and usual personality knew each other and fought for dominance (lucid and somnambulisticpossession, respectively).

[Mythical creature for psychiatric disorder fig.1]

Treatments and integrations were successful with the use of modern techniques and magnetism, which is a prelude to hypnosis. There was a lot of curiosity in multiple personalities throughout the nineteenth century. Multiple personalities vanished from popular culture within a generation, save for the occasional historical curiosity. Two books that exposed readers in North America to a variety of characters were The Three Faces of Eve and Sybil. The predominance of these people was first noticed by a small but increasing number of North American doctors in the 1970s and 1980s. Because of feminism and the suffering of Vietnam soldiers,they became aware of the effects of violence on women, children, and combat veterans, leading them to diagnose multiple personas as a chronic posttraumatic dissociative disease. Every day, more and more cases were being found. This occurrence has happened overseas, in the Netherlands, among other places.

The 1990s saw highly contentious debates concerning the veracity of patient abuse allegations, which were frequently recalled after years of apparent amnesia, and whether or not these claims were insincere as suggested by leading questions from clinicians or covertly conveyed interests in pushing patients to exhibit multiple personality phenomena.

Whether multiple personality disorder can be caused by iatrogenic factors is still unknown. According to some reports, different intelligence services may have attempted to fabricate situations that resembled several different personalities. Test subjects may display a variety of personality traits when exposed to specific social psychology interventions. Nevertheless, there is no evidence of laboratory experiments or covert agency intervention. Many memories that emerged after a long period of not-being-aware have proven to be trustworthy, even though some persons are more likely than others to produce false memories. Stress, trauma, and abuse are among the many conditions that are thought to trigger multiple personality disorder, a complex psychiatric illness. Stress that a person endured as a child might sometimes trigger multiple personality disorder. In nearly all cases, a person's history of traumas and ongoing, severe, and potentially fatal disruptions from early childhood is connected to multiple personality disorder.

The main distinction between multiple personality disorder and other mental illnesses is that the affected individual displays characteristics of two or more identities, and their personality states totally dictate their behaviour. However, not everybody is an experienced On the other hand, some of them might have assumedother or modified identities regarding their own racial, sexual, or age identities. MPD in a like manner.

Every personality the person has will have a distinct gait, gesture, and manner of speaking.
When someone's behaviour changes, it can be very concerning since they might occasionally act like an animal or become aggressive. Character types can be changed, a process known as switching. It may take a few seconds to many minutes for the character to change. Multiple personality disorder symptoms include headaches, forgetfulness, and out-of-body experiences.

As the psychological states and characters of two or more identities fully dominate the behaviour of the individual [3]. Some people with MPD, however, may have changed or distinct identities related to their own ages, sexes, or races. Not everyone experiences MPD in the same way. Every personality that somebody possesses will have a distinct gait and posture. When a person exhibits altered behaviour, it can sometimes resemble that of an animal or a violent person, which can be extremely frightening. Switching refers to the alteration of a person's character [2]. The character interchange might take place in a matter ofseconds to minutes. A person with multiple personality disorder may experience forgetfulness, migraines, and out-of-body experiences [1].

So, this multiple personality disorder is also called as 'dissociative identity disorder'

Dissociative identity disorder:
Definition: psychiatric disease in which a person experiences the emergence of two or more identities, or personalities, each of which has the capacity to temporarily take control of the person's conscious behaviour.

Dissociative identity disorder is one dissociative syndrome that has significantly increased in prevalence over the last few decades (DID). There were less than 50 documented cases of DID between 1922 and 1972, but by 1990, there were 20,000 cases. To have a deeper understanding of DID, it becomes critical to assess the various concepts related to the disorder.

It is a debilitating and controversial mental condition, with an estimated 1.5% lifetime frequency. It is underdiagnosed even though it is included in the global classification of mental illnesses. Current brain imaging results support the trauma model of DID. Based on data from the DSM-5 criteria, DID is defined as having two or more distinct coexisting personality states, changeable access to autobiographical memory, and variable levels of consciousness a concept that has long been controversial.

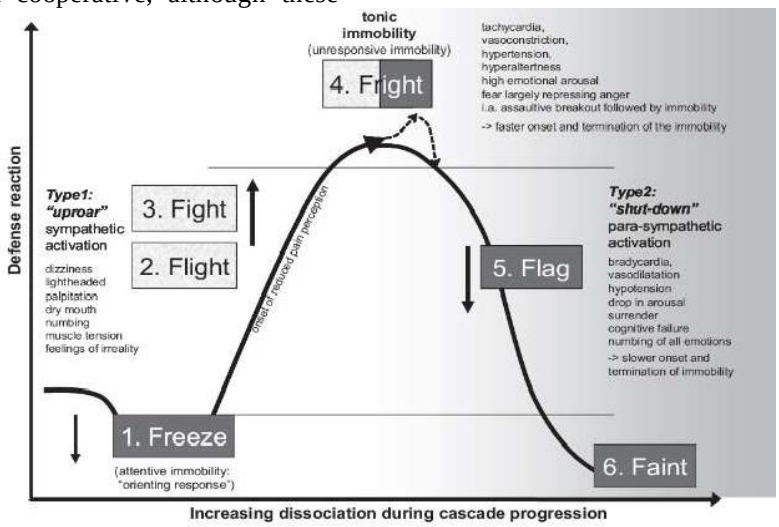
Dissociative identity disorder (fig.2)

Dissociation as an Adaptive Response to Trauma or OverwhelmingCircumstances

In patients with DID, dissociation can be interpreted not just in categorical, psychopathological terms but also in dimensional and adaptive ones. Early dissociation is an adaptive response to unavoidable threat and/or danger, in which the child learns to comfort himself or herself and cannot find other sources of comfort when fighting or fleeing could cause even more harm (Klepht 2001; van der hart et al. 2006). Since there is no other way out of the traumatic events and associated unbearable affective states, the traumatized kid withdraws inward (Klepht and Loewenstein 2007).

Studies show that early childhood dissociation can also be a resiliency factor in DID, in which psychological sequestration of trauma memory appears to allow some aspects of normal development to occur (Brand et al.2009a). compared on psychometric measures with patients with borderline personality and psychotic

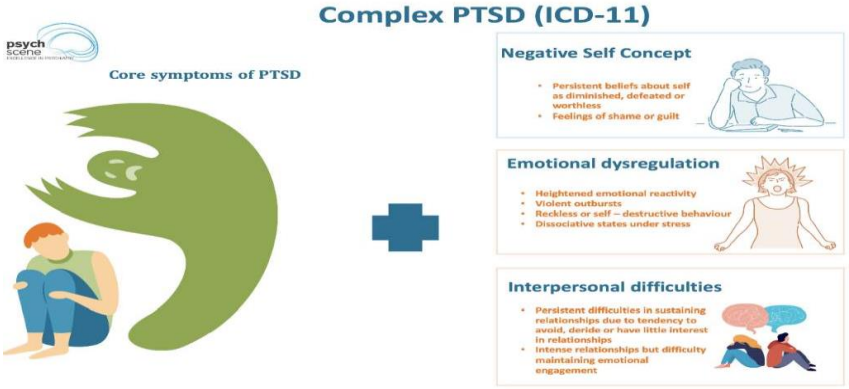
disorders, patients with DID show significantly greater psychological complexity; capacity for insight, reality testing, and logical thinking; and preserved sense of humour, creativity, and hopefulness and even the belief that relationships can be positive and cooperative, although these strengths can be overwhelmed when the person is destabilized or triggered by traumatic material. These capacities may underlie the responsivity of individuals with DID to specialized treatment, despite their symptoms, deficits, and impairments.



[Trauma-related dissociation model by graphically (fig.3)]

Complex Posttraumatic Stress Disorder

The majority of DID sufferers match the criteria for complex posttraumatic stress disorder (CPTSD). The concept of CPTSD is founded on the finding that a series of distinctive deficiencies in various areas offunctioning are caused by recurrent severe traumatic events, mainly interpersonal trauma, during developmental epochs (Courtois and Ford 2009; Herman 1992). The following deficits are present: relationships characterized by intense mistrust coexisting with vulnerability to victimization and exploitation; difficulties with affective regulation; difficulties with regulation of consciousness (i.e., liabilityto dissociation and state changes); difficulties with sense of self and body image (e.g., identity problems, eating disorders, lack of attention to medical needs, and somatization); and deformations in systems of meaning (i.e., the world seen as dangerous and the self-destructiveness (including suicide attempts, self-injury, substance abuse, and risk-taking behaviours).

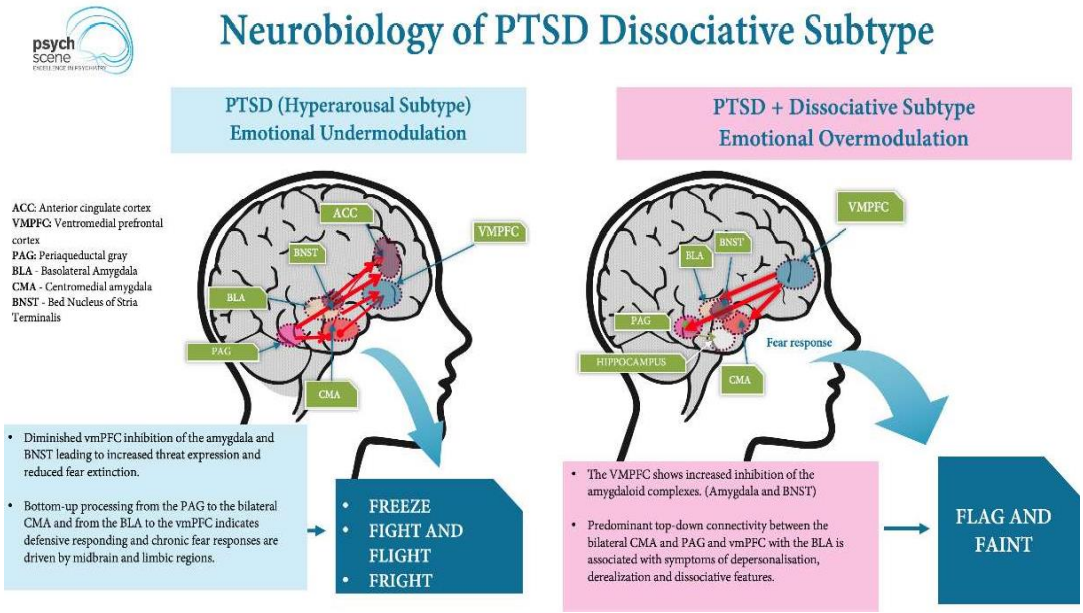


[Complex post traumatic stress disorder(CPTSD) fig.4]

Dissociative Subtype of Posttraumatic Stress Disorder

Dissociative posttraumatic stress disorder (DPTSD) has been defined as a result of related research, and this diagnostic construct is part of the DSM-5 diagnostic criteria for posttraumatic stress disorder (Lanius et al.2010,2012; Stein et al. 2013). This subtype of PTSD will be present in 15% 30% of patients, depending on the study. When compared to non-dissociative PTSD patients, people with DPTSD typically report experiencing several instances of trauma or mistreatment as children. Additionally, DPTSD patients report depersonalization, derealization, and other dissociative symptoms when they hear their own personal trauma scripts. They also frequently exhibit decreased or no change in blood pressure and a neural network characterized by activation of frontal circuits that appear to have a dampening effect on emotional limbic structures like the insula and amygdala.

As a matter of fact, in an imaging study conducted on patients diagnosed with dissociative identity disorder (DID), the trauma script elicited a traumatic identity state that was characterized by fear, activation of the amygdala, insula, and related neural and autonomic systems; a decrease in frontal cortex perfusion; and autonomic activation. On the other hand, in the neutral identity state, autonomic responses were suppressed and frontal systems were activated, causing personal trauma scripts to be experienced as though they were nonautobiographical memories. This also resulted in a dampened limbic emotional state (Reinders et al., 2006).



[The neuroscience of dissociation -clinical application of trauma disorders fig.5]

Classification:

I. Dissociative identity disorder
II. Dissociative amnesia – dissociative fugue
III. Depersonalization / Derealization
IV. Other specified dissociative disorders
1) Dissociative motor disorder
2) Trance and possession disorder
3) Dissociative stupor
4) Dissociative convulsions

Dissociative amnesia:

Amnesia is defined as an unexpected loss of memory for significant personal information that cannot be adequately explained by typical forgetfulness and is not connected to an underlying mental illness (American psychiatry Association, 1980a). The majority of the time, missing personal data relates to the identification of the person and can include name, age, marital status, employment history, and personal lifeevents (Rapaport, 1971).

In stark contrast to organic mental disorders, when personal information is retained until the very end and general information disappears first, an individual's general knowledge base is typically unaltered. Even though they may not recognize their impairment, people with psychogenic amnesia are typically aware thatthey are unable to recollect crucial personal information.

[Dissociation amnesia fig.6]

Based on the disruption in recollection, psychogenic amnesia has been divided into multiple categories. "Localized" or "circumscribed" amnesia refers to the inability to remember all that happened within a specific time frame (Amnesia psychiatric Association 1980a).

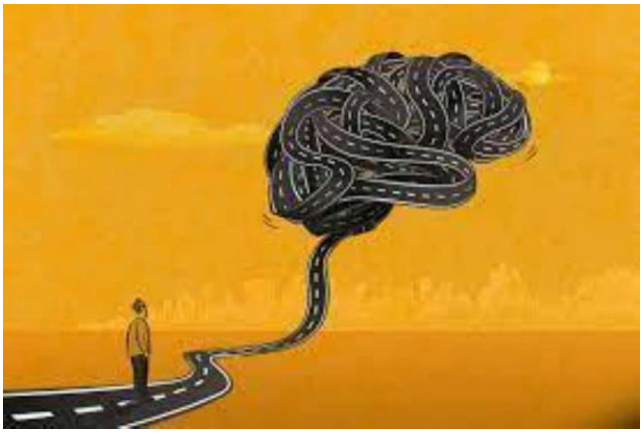
This is the most prevalent type of psychogenic amnesia according to the DSM-III, yet not many of these cases are reported in the literature. The inability to remember some but not all of the events that occurred within a specific time frame is known as "selective" amnesia. "Generalized" amnesia is characterized by a person's inability to recall significant personal details over their whole life. The type that appears in the clinical literature the most frequently is this one. "Continuous" amnesia refers to memory loss that affects a person's ability to recall details of their entire prior life as well as the present.

The occurrence of any of the dissociative disorders is not well-documented. According to Nemiah (1981), the most typical dissociative reaction observed in hospital emergency rooms is psychogenic amnesia.
According to Abeles and Schilder (1935), 0.26% of patients hospitalized to the Bellevue psychiatric department had this occurrence. Psychogenic amnesia is far more common among soldiers engaged in battle; rates during the Pacific and North Africa campaigns of World War II have been recorded as 5% and 8.6%, respectively (Torrie, 1944; Henderson & Moore, 1994).

Psychogenic amnesia usually develops suddenly, right after a painful encounter. The patient may feel depersonalized, have headaches, dizziness, or strange physical sensations. According to the American Psychiatric Association, 1980a; Abeles & Schilder, 1935; Kinzer, 1939; Kennedy & Neville, 1957, the course is usually short and self-limited, lasting hours to days on average. Recovery is often spontaneous. Often, an interview aided by drugs or hypnosis can fill in the blanks and even produce an emotional response to the horrific occurrence. About 25% of the individuals studied by Abeles and Schilder (1935) had at least one prior instance of amnesia.

Dissociative fugue:
In the absence of an intrinsic mental condition, fugue is defined as an abrupt, unexpected departure from one's home or usual place of employment accompanied by an inability to recollect the past (American psychiatry Association, 1980a). The presumption of a new identity occurs frequently.
DSM-III and DSM-III R both indicate that this new Some scholars have noted that this secondary identity is frequently quiet and prosaic, despite the DSM-III and DSM-III R stating that this new identity is typically gregarious and less inhibited than the original identity (Janet, 1890; Nemiah, 1981).

A person in a fugue state may travel in many ways, such as aimlessly meandering, appearing purposeful, and using public transit. The person's behaviour is unlikely to catch the eye of a casual observer as something out of the ordinary. "What is most wonderful about fugues, according to Charcot, is that these people manage not to be stopped by the police at the very beginning of their journey" (cited in Rapaport, 1942, p.201). When characterizing someone experiencing fugue,



[Dissociation fugue fig.7]

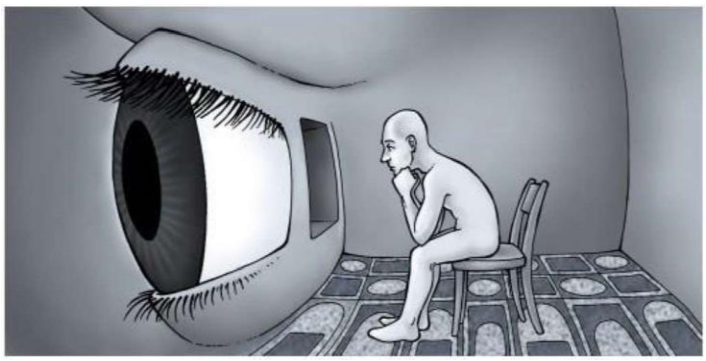
Janet Observed:
Even if they are truly insane individuals experiencing complete delirium, they nonetheless buy train tickets, stay in hotels for meals, and interact with a large number of people. Although we are occasionally informed that they were perceived as a little strange and that they appeared distracted and dreamy, they are ultimately not acknowledged as being insane (cited in Rapaport,1942, p.201).

Fugue victims typically aren't conscious that they've lost their ability to refer to oneself, in contrast to patients with psychogenic amnesia who are aware of their memory loss (Rapaport, 1971). People who are in a fugue state usually don't remember who they are. They frequently experience reciprocal amnesia for the events of the fugue state once they regain their original identity.

Many organic mental illnesses, including temporal lobe epilepsy, as well as toxic or withdrawal conditions, can cause fugue episodes. A comprehensive neurological and medical evaluation is therefore required.

Additionally, fugues are frequently observed in MPD, and this possibility should always be taken into account when making a differential diagnosis. Fugues are thought to occur seldom (Berrington et al., 1956) and frequently by certain experts (Slater & Roth, 1974). The occurrence of fugues is unknown. It is well accepted that during periods of conflict or natural disaster, the incidence significantly rises. Psychogenic fugues typically have an acute traumatic precipitant that happens right before the fugue starts.

Depersonalization Disorder:



[Depersonalization disorder fig.8]

When a person has one or more episodes of depersonalization that significantly impede their ability to function in social or professional contexts or give them great suffering, depersonalization is diagnosed as a condition. When someone experiences depersonalization, their sense of self is altered to the point where theyfeel unreal, as though they are in a dream, like a machine, dead, alienated from themselves, or in some other way drastically different from who they normally are. It is common to feel sensory disturbances including anesthesia, paraesthesia, changes in perception of body parts or size, macroscopic or microscope images, or

the sensation of being outside of one's body and looking down from above or observing oneself from a distance. Additionally, the person can have encountered passive-influence situations, which makes them feelin charge or that a certain function has a "mind of its own" and is not within the individual's control.

[Depersonalization- Derealization disorder fig.9]

It's possible for the person to describe recollections as having a dream-like aspect and occasionally becoming confused with fantasy, leaving them unclear as to whether or not anything truly happened. A person may experience old experiences when they are in a depersonalized condition, or they may comment on the dreamlike characteristic of these memories.

Dissociative Disorder Not Otherwise specified

Dissociative alteration in the typically integrative functions of identity, memory, or consciousness characterizes many dissociative phenomena that do not fall under the traditional DSM-III/DSM-III-R dissociative disorder classification, but are instead lumped into the residual category of dissociative disorder not otherwise specified. This category is known as atypical dissociative disorder in the DSM-III. This category in the DSM-III- includes the Ganser syndrome, a condition typically characterized by symptoms like fugue, amnesia, disorientation, perceptual problems, and conversion reactions.The information suggesting that the Ganser condition is a dissociative disorder was compiled by R. Cocores et al. in 1984.

[Dissociative disorder not otherwise specified fig.10]

Aetiology:
Most people agree that cultural and societal factors have an impact on the underlying processes and mechanisms that underlie psychopathology (Eshun and Gurung, 2009). Cultural differences influence the ways in which people express and convey their symptoms, how those symptoms are understood, and what kind of care is sought after. For instance, evidence points to the influence of culture on the way eating disorders manifest (Anderson - and Becker, 2004). Anxiety disorders (Lewis-Fernandez et al.2010), schizophrenia (Stomp and Friedmann, 2007), depressive disorders (Korman and Molina, 2010), and personality disorders (Mulder, 2012).

Every cultural context has an impact on the phenomenology of DID, which is influenced by both universal and cultural processes. Several cultural and geographical environments, including Turkey, Puerto Rico, Scandinavia, Japan, Canada, Australia, the USA, the Philippines, Ireland, the UK, and Argentina, have documented cases of DID.

Researchers have been looking into potential triggers and pathways that result in suicidal thoughts and behaviors for more than 50 years. Thousands of risk factors have been linked to suicidal thoughts, but no one suicidal ideation risk factor, or combination of risk factors, is a valid, clinically significant predictor of suicide death. The theories in place today argue that complex interactions among biological, psychological, environmental, and cultural elements result in suicidal thoughts and behaviors. This section contains brief descriptions of biological and psychological theories. It is recommended that readers examine the original sources in order to gain a more thorough understanding.

[Multiple Personality disorder fig.11]

Diathesis- stress Models of suicide
According to this concept, only a tiny fraction of people who experience the same stressful circumstances go on to demonstrate suicidal thoughts and behaviours, suggesting that stress alone is not a sufficient explanation for these behaviours. According to the diathesis models, certain people are predisposed to vulnerability due to differences and interactions between biological and/or psychological risk factors. This is known as a diathesis. The combination of distal and present risk factors that result from specific life stressors for predisposed persons can lead to suicidality.
A thorough analysis of 40 years' worth of research studies revealed a link between suicide thoughts and unfavorable life experiences. However, those with serious ideations showed the strongest correlation between SI and unfavorable life events. The majority of the studies in the authors' review had limitations due to unclear terminology and poor design, leading the authors to conclude that improved study designs are required. There was minimal evidence found to support the idea that SI is decreased by positive life events.

[Diathesis stress model fig.12]

Over the past 50 years, more than 3000 constructs and characteristics have been investigated and suggested as potential risk factors for suicidal thoughts and behaviours. According to Franklin et al., a longitudinal research design that looks at the effects of a factor years later is the only reliable method for determining if a construct or factor is a major risk factor. They finished a meta-analysis of all the longitudinal studies carried out during the previous 50 years. While some followed up for as long as ten years, the average follow-up period was four years. Upon examining hundreds of studies, these researchers found that over 80% of the studies examined five major categories of risk variables for suicidal ideation and suicide behaviour. The five categories and examples of factors studied within these categories are summarized below:

Internal psychopathology (e.g., anxiety disorder; mood disorder; hopelessness; emotion dysregulation; sleep disturbance)

Demographic factors (e.g., age; education; employment; ethnicity; gender; marital status; religion;socioeconomic status)

Prior suicidal thoughts and behaviours (e.g., prior deliberate self-harm, non-suicidal self-injury,suicide attempt, suicide ideation)

External psychopathology (e.g., aggressive behaviour; impulsivity; incarceration history; antisocialbehaviours; substance abuse)

Social factors (e.g., abuse history; family problems; isolation; peer problems; stressful life events).

For a meta-analysis employing random effect models, coding the construct/factors that were investigated in the 365 studies produced (n=495) "protective factor" cases and (n=3428) "risk factor" instances. The findings demonstrated that no risk factor, either by itself or in combination with other factors, possesses predictive power significantly superior to random chance. The only two variables that showed up were hopelessness and prior suicide ideation and behaviour, but they weren't very good indicators of suicidality in the future. The researchers came to the conclusion that there is a need to raise the Caliber of research being done and to take into account novel strategies, like identifying combinations of risk factors that are predictive of suicidality using machine learning algorithms. Research over the past 50 years has not produced the empirical knowledge required to detect clinically significant risk factors for suicide ideation and behaviour.

[Mood changes of illustration fig.13]

Epidemiology:

Dissociative identity disorder has been the subject of epidemiological research in the US, Canada, the Netherlands, Germany, Switzerland, Finland, and Turkey. Dissociative identity disorder, the most severe type of DD, has a prevalence of approximately 1% and has been found in 4-14% of psychiatric patients and outpatients, depending on the sample. The most common type of DDNOS, which has been replaced in the Diagnostic and Statistical Manual of Mental Disorder-5, called other specified dissociative disorder (OSDD), is typically found to be the most prevalent DD in clinical studies and the general population [55]. According to estimates, the lifetime prevalence of BPD is 5.9%. It is believed that 7 27% of psychiatric outpatients have BPD, and that BPD accounts for 3.8 life time mental health outpatients and have a role in lifetime mental health hospital admissions.

Regarding presenting symptoms, history, clinical course, and response to treatment for DID here (covered in), the majority of DDNOS/OSDD patients are comparable. According to current theory, DID is a posttraumatic development disorder with a childhood beginning, when a kid experiences severe, ongoing abuse that prevents them from developing a cohesive sense of who they are. This abuse frequently involves a caregiver. Dissociation occurs both during and after the child's repeated maltreatment incidents, which exposes them to physical agony. perhaps leading to changes in the encoding and retrieval of memories. This causes memory to become compartmentalized and fragmented over time, making memory retrieval challenging. Early trauma exposure, which is usually persistent, causes distinct physiological, psychological, and behavioural states to form. These states can last and become more developed later in life, leading to the eventual development of dissociation emotional, behavioural, and memory self-states.

[Schizophrenia behaviour fig.14]

Clinical features:

Diagnosing MPD, a chronic dissociative condition, involves identifying whether an individual exhibits oneor more alter personas. The initial manifestation of an individual's alter personality or alter personas mayhappen on their own initiative or as a result of circumstances that trigger this state (drug-assisted interviewing, hypnosis). The majority of MPD patients have been found to have experienced abuse as children, frequently before the age of five. As a result, it has been noted that the disorder's initial symptoms typically manifest at age six, though theycan manifest as early as three.

Research has shown that people with BPD typically have seven to fifteen personas. Usually, when a personality disorder is diagnosed, only two or three of the personalities exist. During the course of treatment, the others can be identified.

1. People with altered personalities can belong to different communities or families, and they can be of any age or gender. The child alter personality is the most prevalent type of alter personality. Studies have indicated that the prevalence of an alter personality that is different from the patient's gender ranges from 26 to 65%, whilst the prevalence of juvenile alter personalities is 85-96%.
2. In general, the character structures of the alter personalities are different, and sometimes they may oppose to each other. In the same individual, one alters personality may be extroverted, aggressive and sexually seductive, while the other may be withdrawn, depressed and sexually repressed.
3. Alter personalities often have names such as protector, helper, etc. appropriate to their function or position. The transition from one alter personalities are dominant, the patients are usually amnesic about the existence of others and the events that took place.
4. In studies, it has been found that 95-100% of cases experience amnesic periods in some part of their lives. These amnesias occur as gaps related to some time periods in the person`s life. The person may observe objects that they cannot identify among their belongings, writings or shapes that do not belong to them, or find themselves lying in unfamiliar places.
5. Sometimes a personality is not bound by such amnesia and is aware of the existence and functioning of other personalities. This is often observed when the patient is in a personality that at various times takes control, directs and tries to protect the patient against the traumatization he or she has suffered. Relationships between alter personalities may range from friendship to hostility.
6. Conflicts between alter personalities are so high that one alters personality tries to kill the other alter personality tends to be depressed and depressed. Mental and physical examination of the patients may reveal amnesia of varying lengths, hallucinations are the result of conflicts and conversations between alter personalities and are interpreted by the patient as coming from inside the head. headaches may be sign of transition from one personality to another.

Pathophysiology:

The Brain and the dissociative identity disorder

The majority of what we know about the pathophysiology of DID is speculative because there hasn't been much written about it. In this study, we have attempted to compile several relevant studies that discuss a possible pathophysiology for DID. A few interesting research that were discovered are included in this review. We found a few studies discussing the possible links between bipolar disorder and schizophrenia and DID. These studies just raise a possibility rather than making definitive claims.

Co-occurrence with schizophrenia, bipolar disorder and personality disorders

As we can see, a recent study by Ross et al. discovered a strong link between bipolar disorder and DID. Nevertheless, these kinds of research provide only a semblance of a possible connection between the two illnesses, and searches for any anatomical alterations in the brain are not novel. In 1995, Ellason et al. reported that "A significant number of patients with dissociative identity disorder have previously been diagnosed with schizophrenia, due to the presence of positive symptoms of schizophrenia." They looked examined the patterns of positive and negative symptoms in people with and without dissociative identity disorder.

The results showed that the positive indicators and overall The dissociative identity group had higher psychopathology ratings despite the fact that negative symptoms of schizophrenia were significantly worse than the average. The researchers went on to say, "A primary emphasis on positive symptoms may result in false-positive diagnoses of dissociative identity disorder because patients with dissociative identity disorder report more positive symptoms of schizophrenia than do schizophrenics, while schizophrenics report more negative symptoms."

[Bipolar disorder fig.15]

There is enough data to draw the conclusion that almost every brain lobe, including the occipital lobe, is altered in individuals with schizophrenia. Consequently, the co-occurrence of DID and bipolar disorder raises the possibility that future research in this area may reveal additional information and may even reveal some potential alterations in the brains of affected persons. Still, at this point it would be premature to speculate about any such changes in the brain.

[Immune clue to preventing schizophrenia fig.16]

In a manner akin to the manner in which DID has been examined in relation to numerous other personality disorders and varieties. The most common personality disorder is avoidant disorder (76%), which is followed by borderline (53%), self-debating (68%), and passive-aggressive (45%) disorders. It has been discovered that DID and several personality disorders are connected. Our attention was drawn to the personalogic at the core of DID by this work [7]. Furthermore, in a 2011 exploratory study, Ross [8] recommended adding possession experience to DSM V. This implies that scientists have been working to learn more about, understand, and treat DID as a pathophysiological disorder.

Neuroimaging studies and the changes in the brain: Limbic system and thecortex

According to Brunson et al. (2003), one of the main factors influencing the volume of the hippocampal region is stress. This highlights our review's findings that link DID to early stress and alterations in the volumes of brain regions that regulate stress. Numerous research works suggested that the most frequent trigger for DID is childhood trauma. However, does childhood stress tend to alter the hippocampal or amygdala's volume? Many neurological studies in conjunction with radiology must be conducted in order to address the many unsolved questions.

The field of neurosciences was completely transformed with the advent of neuroimaging, particularly structural and functional MRI. The finding allowed for the investigation of other neurological conditions, including DID. Vermetten et al. compared the female brain structure of DID patients with that of healthy people in an MRI research. The study revealed changes in the limbic system, with the DID patients' hippocampal and amygdalae being noticeably smaller (19.2% and 31.6%, respectively). Since the hippocampal formation governs long-term memory and the amygdala regulates emotions, Vermetten's research offers a plausible explanation for the pathophysiology of DID. Nonetheless, a different MRI study showed that PTSD patients had smaller hippocampal and amygdala volumes, but there was little variation between DA/DID patients' and normal subjects' hippocampi and amygdala volumes Vermetten contended that "patients with true dissociative identity disorder without PTSD essentially do not exist" in response to the Weniger et al. study.

Cerebral blood flow and DID

Moreover, according to Sar et al. regional cerebral blood flow (RCBF) in DID patients was reduced in the bilateral orbitofrontal cortex regions (just like attention deficit disorder), and augmented in median and superior frontal regions and occipital areas (bilaterally) considering “decision making’’ and its association with the orbitofrontal cortex, Sar stated that the reduced functioning of the OFC leads in impulsivity and the expression of the new personality in DID could be sign of impulsive behaviour. Cerebral blood flow has also been studied by other scientists. Reinders, et al. calculated RCBF of DID patients in a neutral personality state (NPS) compared with a traumatic personality state (TPS).

The subjects were asked to listen to a memory script. There were no differences between NPS and TPS when listening to the traumatic script, it was observed that a deactivation pattern of brain areas in the NPS exist. The study concluded that on a neurobiological level, the patients with DID possess different autobiographical selves. Furthermore, among the brain areas that were deactivated in the NPS versus the TPS is the medial prefrontal cortex. These kinds of studies point toward an idea about the involvement of orbitofrontal cortex in DID, as OFC is a part of prefrontal cortex (bilaterally). In a previous study by Sar et al. they showed that the regional cerebral blood flow was reduced in the left and right orbitofrontal cortex ofDID Patients and the higher in their left (dominant) lateral temporal some other authors have also discussed the OFC involvement.

In another study by Reinder et al. regional cerebral blood flow data demonstrated different neural networks to be linked with different processing of the neutral trauma related memory script by NIS and TIS. They found that patients with their own access to autobiographical trauma related memory had variation in brain activations in distinct mental states of Self awareness.

Review of Literature:

An overview of the research on dissociative identity disorder is given in this paper. Previously known as multiple personality disorder, this disease is becoming more and more diagnosed, partly because to the availability of more targeted diagnostic methods and partly because more people are seeking help for the long-term effects of early childhood abuse and neglect.

Dissociative identity disorder is addressed in the literature using a range of discourses, all of which offer distinct methods to issue conceptualization and therapy. Psychiatry, psychology, corporeality, feminism, social constructivism, anthropology, and postmodernism are some of the discourses that have been reviewed. The analysis of nursing literature and recommendations for future nursing study into this intricate mental health issue round out the presentation.

Even though it is being diagnosed more frequently, dissociative identity disorder is still a contentious diagnosis. The fact that many of the strange and agonizing DID episodes are concealed from the observer may be one explanation for this. The main characteristics of DID are symptoms rather than indicators. According to Merskey and Piper (1998), these symptoms include migraines, switching, auditory hallucinations, and intrusive memories. Because they may not have obvious behavioral manifestations, they are challenging to evaluate objectively. Opinions differ even among mental health professionals. Some people think that the condition, like the child abuse that came before it, cannot be denied any longer and that too many people are already suffering as a result of their inability to believe (Middleton 1995).

People with DID suffer from a variety of conditions, such as social anxiety and mistrust, loneliness, deep insecurity, loss of a cohesive sense of self, headaches, nightmares, insomnia, flashbacks, loss of time and space, fragmented and missing memories, and emotional instability that can range from intense bouts of rage and terror to numbness and the inability to feel anything at all.
For a brief while, suspending disbelief might allow one to recognize the similarities between DID and other severe mental illnesses that elicit assistance and sympathy despite having symptoms that are not readily apparent. However, some mental health professionals believe that DID symptoms could be the product of overzealous therapists or people with personality issues.
Some people have doubts indeed, cynicism about the notion that suppressed memories can be evoked, recalled, and revealed during treatment (McHugh in Jaroff 1993). Others contend that because case studies rather than empirical investigations have dominated research, the incidence and prevalence of DID are unreliable (Aldridge-Morris 1989).

We will next examine the different discourses related to mental health from which DID has been understood, embraced, and rejected. These discourses include psychiatry, psychology, corporeality, feminism, social constructivism, anthropology, and postmodernism.

Psychiatry
When talking about dissociative identity disorder, psychiatry is the mainstream discourse. The first person to highlight the connection between trauma and the onset of dissociative symptoms then known as hysteria was the French psychiatrist Janet (1889). Due to a number of factors, Janet's theory was quickly superseded by Freud's (1966) sexual theory of hysteria. In this theory, he maintained that dissociative symptoms or conversion were caused by unacceptable fantasies rather than actual trauma, which in turn led to an unconscious defense mechanism known as repression. He maintained that the dissociative symptoms were a result of the suppressed fantasies. For the next fifty years, clinical practice was dominated by psychoanalytic theory, which basically focuses on internal and unconscious affective and psychological processes. Multiple personality disorder, or DID, was viewed as an extreme defence mechanism against internal and unconscious conflict.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) was created in the 1960s in tandem with the global interest in effectiveness and measurement (APA 1994). The DSM had a tendency to see psychopathology as a grouping of symptoms that could be assessed and observed using interview schedules and ratings. Dissociation was viewed as a separate disorder, departing from the psychoanalytic perspective that saw DID as a coping technique in reaction to some internal fear (actual or imagined).

DSM IV lists the criteria for DID as:
The presence of two or more distinct identities or personality states (each with its own relatively enduring **pattern of perceiving, relating to and thinking about the environment and self).**
At least two of these identities or personality states recurrently take control of the persons Behaviour:
Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

The disturbance is not to the direct physiological effect of a substance e.g: ., blackouts or chaotic behaviour during alcohol intoxication) or a general medical condition (e.g., complex partial seizures).

Note: In children, the symptoms are not attributable

to imaginary playmates or other fantasy play. Whilst DSM provides precise descriptions of various symptoms of DID, it does not strongly concern itself with causation. Within the discourse of psychology, theories of aetiology are more commonly found.

Psychology of Multi personality Disorder:

In order to survive, infants may learn to separate their consciousness and memories from the rest of their identity during abusive times, according to object-relations theory (Braun, 1987). The psychological capacity for dissociation and recurrent physical trauma are two risk factors for DID (Braun 1990). Accordingto Bryer et al. (1987), abuse has a profoundly negative impact on a child's psychology because it forces them to cope with intense emotions while simultaneously rejecting their existence. The youngster who has experienced abuse learns to disassociate, or momentarily lose consciousness, which transfers the trauma's memory into the subconscious and eventually manifests as a distinct personality.

Different identities or personalities develop at different times as the child grows and endures recurrent trauma. Every personality is unique, with distinct memories, emotions, and functions (Putnam 1989). Other identities or personalities that live inside the body or "host" are frequently referred to as "alters" or "parts."

These alterations may be beneficial or harmful, and they could be of any age or gender. Dissociating individuals experience disruptions in time, including different types of amnesia and identity disturbances involving fractured or many identities. When a person is unable to cope with stressful, personal, or dangerous situations through other coping techniques, dissociation becomes ineffective. Medically invasive procedures, such as dental or vaginal exams, have the potential to trigger dissociation in patients, according to Bohn & Holz (1996). Indeed, flashbacks can occur in any circumstance that makes one feel exposed, helpless, in control, or invaded.

A person who dissociates may have amnesia and identity dispersal, which may make it difficult for them to interact socially or carry out daily tasks (Bohn & Holz 1996). Being close to someone could result in abuse, which makes the person avoid closeness, unable to trust people, vulnerable to being victimized again, antisocial, and reclusive. A person may be more likely to be unsafe if they have low self-esteem, self-hatred, guilt, a sense of unworthiness, or if they are unable to maintain their own safety and trust their own senses.

Factors of multi personality disorder in psychiatric interview

History of Present Illness

Suicide attempts
Self-mutilation of Self-destruction
" Desperate Depression" or Atypical affective symptoms

Symptoms

- Amnesia
- Auditory hallucinations
- Schneiderian symptoms
- PTSD Symptoms (detachment, avoidance, reexperiencing of trauma, night mares)
- Concurrent somatic and psychiatric symptoms
- " Hysteria "
- Fugue

Psychiatric History

Numerous previous diagnosis and treatment failures Prior or Concurrent Disorder: PTSD (posttraumatic stress disorder)

Borderline personality disordereating disorders
Psychotic disorders unresponsive to medications
Somatoform disorder
Substance or Alcohol abuse Gender identity disorder Transsexualism or Transvestism

Medical History

- Headaches
- Numerous physical com plaints of sexual nature
- Unexplained pain , particularly gyn ecologic or gastrointestinal
- Conversion phenomenon
- Fear of physical exams or rejection of care

Family History

Chaotic family situation

Social and Developmental History

Sexual, psychological and physical abuse, especially repetitive and from an early age

History of neglect

Grossly distorted upbringing and impoverished social network in the absence of psychosisCult involvement as a young child

Ego-dystonic sexual impulses and acting out

Mental Status Exam

- Appearance

- Signs of self -injury

Behaviors
Intra-interview amnesiaSpells
Spontaneous regressionCatatonia
Odd behaviour despite an apparent relatedness to the interviewerThe use of "we"
Spontaneous voice or accent changes Sudden involuntary movements Changes in facial musculature Changes in handedness

Diagnosis:
Psychiatric residency training programs still only give this topic cursory attention, despite an increase in thefrequency of diagnoses of Multiple Personality Disorder (MPD) in recent years. As a result, most psychiatrists lack systematic training in the assessment of dissociative disorders. The best ways to understand MPD are as a complex, persistent dissociative disorder with identity and memory disturbances
(3) and as a post-traumatic disorder that stems from childhood trauma or abuse.

The importance of making the diagnosis of MPD is more than just a n academic exercise. Failure to make the diagnosis results in substantial morbidity and even death. Patients who leave treatment prematurely do not cease ha vin g MPD nor does MPD remit spontaneously. Though the treatment can be arduous, the potential for resolution of symptoms and improvement of functioning is real. It is not un common for patients with MPD to have been previously diagnosed with schizophrenia and treat ed as such with high dose neuroleptics an d adjuvants; occasionally an MPD patient will be detect ed in a chronic ca re facility or even the backwards of a state hospital.

Dissociative states are thought to originate as a defense mechanism against intensely unpleasant stimuli. When presented with tremendous stress, a young, developing child may establish distinct and variable "disconnected" states given a sufficient biological diathesis and the possibility for autohypnosis or dissociation. Maintaining abusive or neglectful relationships contributes to these states, especially when there are no healing experiences with others or a significant other. Initially, the dissociation process assures or raises the probability of the child's survival as a sort of "successful" adaptation. In other areas of the survivor's life, and particularly as an adult, the ability to adapt turns into a handicap that hinders the growthof a consistent sense of self and weakens the establishment of strong interpersonal bonds.

This paper aims to support medical professionals and psychiatrists in identifying the most clinically difficult and dramatic dissociative condition, major depression disorder (MPD), mainly in adults. This paper will highlight areas in a typical initial psychiatric interview that lend themselves to the discovery of MPD in the absence of alter presentation, even though the diagnosis of MPD requires the identification of alternate personalities (alters). Specifically, we will identify the symptoms that make up the polysymptomatic constellation that is frequently associated with MPD.

Diagnostic Criteria:
There aren't many guidelines for diagnosing MPD provided by the DSM-III-R criteria, aside from "the presence of other personalities". The post-traumatic aspect of the illness has not been addressed, and personality change a single dissociative symptom is the only operationalized criterion. The lack of criteria in the DSM-III-R has made it difficult for physicians to distinguish MPD from other syndromes while conducting inquiries.

MPD is a diagnostic that is highly pleiomorphic and comprises of a constellation of non-specific signs and symptoms (polysymptomatology), even though it involves the identification of unique personalities or alters. According to DSM-III-R, each personality state in typical MPD assumes complete control over an individual's behaviour. Less dramatic presentations with less control and distinctness are probably more common than classic MPD. The nuanced gradations have been conceptualized by a number of authors under many names, including atypical variants, ego state modifications, co-presences, isomorphisms, and fragments.

The DSM-IV renames MPD as Dissociative Identity Disorder and does away with the A criterion's need of "full" control. Since 90% of individuals with the illness appear to have amnesia as a symptom, it introduces amnesia as a prerequisite for the diagnosis. It is still debatable, though, whether formal amnesia occurs in MPD patients. "The inability to recall important person-specific information that is too extensive to be explained by ordinary forgetfulness" is a new criterion for the DSM-IV.

Additionally, a fourth condition has been added, which states that "the disturbance is not due to a substance-induced disorder." The DSM is not the

only tool that only vaguely identifies symptoms and indicators that go along with MPD. The updated International Classification of Diseases, or ICD-I O, includes MPD under "other dissociative disorders" rather than officially listing it as a diagnostic item.

Treatment:
Certain treatment modalities for dissociative identity disorder employ fundamental frameworks from their research on personality disorders in a tripartite manner:

establishing symptom alleviation, stability, and safety; addressing, processing, and integrating traumatic experiences Integration of identities and recovery.

Since many DID patients present with suicide ideation and self-injurious behaviour, the first step is to ensuretheir safety. It's critical to reduce that risk. Tolerating, digesting, and integrating prior trauma are all part ofthe second phase's treatment on traumatic memories. This might concentrate on revisiting unpleasant events under various aliases and could facilitate memory sharing. The patient's relationship to the outside world andto themselves as a whole is the main emphasis of the third and final phase of treatment. Trust and a strong therapeutic connection are encouraged during the entire course of treatment.

[Treatment for Dissociative identity disorder Fig.18]

The most popular method uses the above-described psychodynamic psychotherapy procedures. Dialectical behavioural therapy (DBT) and trauma-focused cognitive behavioural therapy (CBT) are two recent techniques. For CBT, there are no regulated clinical studies available. Because borderline personality disorder and DID share some symptoms, the use of DBT skills is essentially secondary. Even with a variety of therapeutic modalities, more education, emotional control, stress management, and day-to-day functioning are some essential components of treatment. Hypnosis as therapy is another form of treatment.

Literature suggests that DID patients are more hypnotizable than other clinical populations. Studies conducted as recently as 2021 have demonstrated the effectiveness of hypnosis as a DID treatment. It is thought that many DID patients are autohypnotic. A approach that can help the emergence of identities vital to the therapeutic process is accessing substitute identities that are not present during the session.

The application of Eye Movement Desensitization and Reprocessing (EMDR) has been another therapeutic approach. Nonetheless, the guidelines support the integration of EMDR within integrative treatment. Only incases where the patient is largely stable and possesses sufficient coping mechanisms is EMDR processing advised. EMDR treatments for ego support, reducing symptoms and containing them, working with different identities, and, when necessary, obtaining consent and creating new identities.

For DID, psychopharmacology is not the main course of treatment. Certain symptoms may be targeted with medications. Medications for mood disorders and PTSD (post-traumatic stress disorder) are among the most often prescribed drugs. The difficulties in administering psychopharmacological drugs persist because various patients may have different symptoms, and some patients may comply while others may not. The examination of the literature reveals that a variety of drugs, including stimulants, mood stabilizers, and antipsychotics, have been used to treat DID; however, no drug has proven to be particularly successful in doing so.
For example;

Antidepressants: These medications are used to treat symptoms of depression and anxiety. They can helpregulate mood and improve overall well-being. Examples include selective serotonin reuptake inhibitors (SSRIs) like fluoxetine (Prozac) or sertraline (Zoloft).

Anti-anxiety Medications: These drugs can help manage symptoms of anxiety and may be prescribedon a short-term basis. Examples include benzodiazepines like diazepam (Valium) or lorazepam (Ativan).

Mood Stabilizers: In some cases, mood

stabilizers may be used to help regulate mood swings or emotional instability. Examples include lithium or certain anticonvulsant medications like valproic acid(Depakote).

Antipsychotic Medications: These may be prescribed if the individual experiences symptoms like psychosis or severe disorientation. They can help stabilize thinking and perception. Examples include risperidone (Risperdal) or olanzapine (Zyprexa).

Beta Blockers: These medications can help manage physical symptoms of anxiety, such as rapid heart rate and trembling. They are not specific to DID but may be used in cases where anxiety symptoms are prominent.

Remember, medication should always be prescribed and monitored by a qualified healthcare professional. It's important to have a thorough assessment and ongoing care to ensure that any prescribed medications areappropriate and effective for the individual's specific situation.

Additionally, it's worth noting that medication alone is not considered a primary treatment for DID. Psychotherapy, particularly approaches like Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) orDialectical Behaviour Therapy (DBT), is the cornerstone of treatment for DID.

CONCLUSION:

The significance of a thorough evaluation by qualified specialists has been emphasized by the evolution of diagnosis criteria and assessment techniques. The neural basis of DID may be better understood because to developments in neuroimaging techniques, while the precise mechanism is still unknown.
With a multimodal approach that includes psychotherapy, medication when needed, and support from an experienced and compassionate therapeutic team, DID treatment has made progress. In particular, integration therapy has drawn interest for its capacity to encourage the fusing of dissociated identities, enabling a more coherent sense of In summary, among psychiatric diseases, dissociative identity disorder(DID) is still a complicated and mysterious syndrome.

This illness calls into question our comprehension of identity, self-awareness, and the complexity of the human mind. The aetiology, diagnosis, and treatment of DID have been clarified over time by research and clinical experience; however, many elements still need to be explored further.

Nonetheless, there are still issues, such as stigma and skepticism about the condition. In order to lessen stigma and guarantee that people with DID receive the right care, it is imperative that the general public and medical professionals receive education. Furthermore, more investigation is required to enhance therapeuticapproaches, improve diagnostic standards, and comprehend the fundamental mechanisms behind the condition.

In conclusion, there is still much to learn even though we have made great progress in understanding and treating DID. Caring and efficient treatment for those impacted by this complex illness requires the continued dedication of researchers, physicians, and society at large.

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