How Do Stigma and Culture Affect the Clinical Validity of Dissociative Identity Disorder?

Caroline Lu

Abstract

Dissociative identity disorder (DID) is defined in the DSM-5-TR as a dissociative disorder characterized by a disruption of identity, consciousness, and behavior involving two or more distinct personality states. This includes experiences in which an individual feels that an outside force has taken control, accompanied with recurrent gaps in recall. DID may affect up to 1 in 100 people, and has limited treatment options. It is a complex disorder that has been called a "fad" and confused with borderline personality disorder. Myths around the disorder impede the research needed for treatment. The process of diagnosing DID is highly complex. The presentation may be highly varied patient to patient, which hinders rapid diagnosis. DID has been found across many cultural backgrounds, but socio-cultural influences impact how individuals present their symptoms and what treatment is sought. Confronting patients with trauma is not always productive. Due to the complexity of treatment, combined with the stigma surrounding DID, many researchers avoid studying this intricate disorder. Broadly, DID has been described historically as well as in modern case studies, and research has focused primarily on diagnostic predictors of the disorder. This paper will cover the challenges that come with diagnosing DID, the socio-cultural impact on the disorder, and why DID is a valid construct. Awareness and education about DID is critical, as the stigma and myths surrounding the disorder have resulted in little targeted research and no specifically targeted treatments. By shedding light on dissociative identity disorder, we are allowing for more treatment options, less stigma, and fewer myths surrounding DID.

Background

For years, dissociative identity disorder (DID) has been mischaracterized and portrayed in a negative light by popular culture and the media. Although DID had been recognized for well over a century, clinicians—and even the general public—still question its validity. Back when Bleuler had first introduced schizophrenia as a term in 1910, the original definition included having multiple personalities. This historical relationship between schizophrenia and DID complicates the diagnoses of cases which involve multiple personalities, with some cases potentially being mischaracterized as schizophrenia.[1] Still, it is not uncommon for professionals to diagnose DID as another disorder, even in cases where patients do not fit criteria for the other, more accepted, disorder. DID may affect up to 1 in 100 people. Yet to this day, many questions surrounding DID remain unresolved—and there is no medication specifically approved to treat DID. The stigma surrounding DID hinders research and access to appropriate treatment, highlighting the importance of accurate understanding and continued research for DID patients who have suffered for years.

The earliest reports of the disorder trace back by centuries, with the first documented case likely being in 1584. Her name was Jeanne Fery, and she recorded her symptoms (previously thought to be demonic possession) in specific detail, allowing historians to apply a retrospective diagnosis aligning with DID symptoms observed in modern psychiatry.[2]

In spite of the long existence of the disorder, DID was only added to the DSM-III in 1980, under the name *Multiple Personality Disorder*. The name was later changed to emphasize the fragmentation of self instead of trivializing the true severity of the disorder to just be "personalities." The use of the word "multiple identities" can oversimplify adverse symptoms and overshadow the developmental trauma associated with DID. This change emphasizes the disturbance in identity and consciousness rather than incorrectly implicating that multiple individuals coexist in one body.[3]

Living with Dissociative Identity Disorder

DID has been conceptualized within trauma-based models as a coping mechanism to create protection from severe trauma experienced during childhood. This disorder has been characterized as a posttraumatic developmental disorder,[4] which addresses the effect of long-term abuse and neglect during an individual's developmental years. Patients with this disorder may lack a cohesive sense of self as they experience disruptions in their conscious awareness. Each "identity state" retains a collection of memories, actions, and affect based on past experiences. Experts describe this as having one identity state becoming an observer while another identity state takes control of mind and behavior.[5]

Living a normal life can be extremely difficult for individuals with DID. Patients often report recurrent gaps in their autobiographical memory, known as *dissociative amnesia*, a diagnostic criterion of the disorder. Research compares amnesia in DID to operate in a similar metacognitive way as cardinal symptoms from other disorders; just as perceived catastrophe in panic disorder doesn't equate to actual danger, and perceived fatness in anorexia doesn't always align with their actual physique.[6] Correspondingly, perceived amnesia may not directly reflect an inability to recall personal information or experiences while another identity state was dominant. A systematic review using objective memory testing found mixed evidence of inter-identity transfer from 19 empirical and four case studies.[7] This suggests that some memories may remain accessible even when amnesia is reported by patients. Rather than undermining the disorder's validity, this evidence indicates that dissociative amnesia reflects a disruption in the retrieval of stored memories instead of complete loss of information. This phenomenon, in which an individual with DID in one identity state may not always be able to retrieve memories encoded by another identity state, is termed inter-identity amnesia (IIA). Consistent with this, awareness in DID is a spectrum: it is possible that identities may have mutual awareness of one another, one-sided (asymmetric) amnesia, or mutual (symmetric) amnesia.[7]

Dissociative amnesia may occur during *switching*, a change in which dominance shifts from one identity state to another; however, the degree of amnesia can vary between each individual. Switching is a psychophysiological process[8] that could be observable when elicited by an event in the individual's environment, or it could be an internal process occurring in the mind. An example of an observable switch is demonstrated in the case of Rosalie, a 21-year-old woman diagnosed with dissociative identity disorder and post traumatic stress disorder (PTSD). During dialectical behavior therapy (DBT), Rosalie was observed to have brief, 15-20-second periods where she spoke in a different voice and assumed a different posture. She reported no lapse in time when asked to come back and continued her sentence without realizing the switch in identity states that occurred.[9]

There are many possible triggers for switching, some of which remain unknown. However, reported triggers for switching include stress, strong emotions, memories, substance use, or sensory stimuli. For example, a patient who experienced abuse in early childhood may be brought back to that memory from a certain smell or sight, therefore potentially triggering a switch in identity dominance.

Furthermore, many patients with DID struggle to cope adaptively with stress, leading to a substantial proportion turning to maladaptive coping mechanisms. Clinical research has found that self-harm and substance abuse affect a significant majority of patients diagnosed with DID, with prevalence rates greater than 50%[6,10]. Additionally, the DSM-5-TR found that over 70% of psychiatric outpatients with dissociative identity disorder attempted suicide at least once, with multiple attempts being prevalent.[3] These self-destructive behaviors can cooccur with other existing disorders, leading to further distress and mental deterioration.

Diagnostic Challenges

The prevalence of dissociative identity disorder among outpatient psychiatric patients in Egypt was found to be 4.8% using the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D), and 6.8% using the Dissociative Disorders Interview Schedule (DDIS)[11] The lack of data on DID from large-scale community-based epidemiological research makes this prevalence difficult to determine. This is partially due to the absence of dissociative disorder (DD) modules in diagnostic assessments. Furthermore, variation of DID prevalence could be attributed to methodological differences across settings, research using SCID-D reports lower rates of DID compared to the fully-structured DDIS. Despite the reported high prevalence in psychiatric outpatients, DID is not considered a research priority in the medical field. It is necessary to first examine the issues that come along with identifying and treating DID.

One barrier to improving and standardizing DID diagnosis and treatment is the widespread distrust of the diagnosis itself. Critics consider the entire condition to be a fad, using three models to support their claim. One is the Iatrogenic Model (IM), declaring the disorder came from highly “suggestible” patients—often with borderline personality disorder (BPD), to have experienced hypnosis by clinicians and leading to “false” memories. In return, the memories generate a striking and vivid inner world where patients confuse their reality from this created fiction. On the other hand, the Fantasy Model (FM) considers dissociation as a gateway to these false memories of trauma. The Sociocultural Model (SCM) of DID considers that culture is involved in developing a false belief of having multiple identity states. An example of this would be North American media, which emphasizes childhood sexual abuse, repressed memories, and multiple personalities, prompting highly susceptible people to believe they have this disorder.[4] This blends with cultural issues in identifying and diagnosing DID.

While DID is characterized as having two or more distinct self-states, the very concept of self varies across cultures. The definitions of self in Western and Eastern philosophy are considered “diametrically opposed”[12]. In the West, the idea of personal identity, self, and consciousness overlap, with the exception of a few specific differences. Dissociation is typically perceived as having separate “personalities,” when viewed from a more Western perspective. However, some Eastern philosophical traditions conceptualize the self as more fluid. In some cultural contexts, identity disruption can easily be depicted as “possession” or spiritual intervention. This may contribute to misdiagnoses when clinicians rely on Western-centric

diagnostic criteria, as non-Western presentations can be mistaken for psychosis rather than dissociation.

Due to the complicated nature and widespread myths surrounding DID, it lacks the medical attention and research it deserves. Researchers consider the condition to be one of the most controversial and heavily-debated diagnoses in psychology and psychiatry. The Trauma Model proposes that chronic abuse or neglect may lead a child to utilize profound dissociation to mentally detach from overwhelming trauma. According to trauma-based models, this process isolates the traumatic memories to preserve overall psychological functioning as identity undergoes fragmentation rather than cohesion, preventing the development of a single unified self.

Dissociative identity disorder is highly co-morbid with borderline personality disorder, which may co-occur in 50%-66% of cases[6]. While critics use this in the IM as an argument, borderline personality disorder is already established as being linked to early life trauma[4] and is the personality disorder most likely to have a secondary DSM diagnosis associated with it[13]. Therefore, the high comorbidity between BPD and DID could be explained by their shared traumatic etiology, rather than DID being a subset of "suggestible" BPD patients. The overlap says little about the validity of DID since the existence of one disorder does not disprove the existence of another.

Furthermore, it is highly difficult to get funding for long-term treatment and research needed to study treatment outcomes for DID patients. The National Institutes of Health (NIH) funds projects relating to the neurobiology of traumatic dissociation and studies on dissociative phenotypes. However, studies primarily focused on dissociative identity disorder yield no results in the NIH RePORTER[14].

Validity

The validity of DID requires a consistent clinical presentation and evidence that distinguishes it from other disorders. The traditional standard for psychiatric diagnostic validity is the Robins and Guze[15] criteria, which include a clinical description, lab studies and follow up studies, including family study, and the delimitation of other disorders. Dissociative identity disorder satisfies several of these criteria. The clinical description is well established with core symptoms of identity alteration and identity confusion paired with amnesia in DID patients. Although derealization and depersonalization are common symptoms, they are not required for a diagnosis.[3] This presentation is reflected consistently across multiple methods of assessment, including clinical interviews, clinician diagnoses, and DID patient self-reports, as demonstrated by the SCID-D-R (Structured Clinical Interview for DSM-IV Dissociative Disorders—Revised). Delimitation from other disorders is supported by the fact that DID can be accurately differentiated from other psychiatric disorders that share overlapping symptoms, with core symptoms of identity alteration and amnesia being the distinguishing features.

Skeptics use the previously mentioned sociocognitive model to propose that DID symptoms are induced or intensified by clinicians' beliefs, media influence, or improper therapies that were not aligned with professional standards. However, empirical testing for the disorder's validity[4] does not support these claims.

Neurological studies demonstrate accurate differentiation of DID patients from DID simulators, even those high in suggestibility, based on measurable, physiological responses. These include heart rate, blood pressure, emotional arousal, and cerebral blood flow patterns.

Different dissociative identity states, including those fully aware of trauma experiences, displayed unique physiological profiles when exposed to autobiographical trauma scripts, compared to dissociative identities amnesic to previous trauma.[6]

Available Treatment Approaches

Treatment for DID primarily focuses on psychotherapy rather than specific medications. DID patients rely on medication for co-existing disorders such as depression, anxiety, and PTSD as a result of this. Because the research field focusing on diagnosing and treating DID is relatively small, most evidence stems from clinical observations and systematic reviews instead of large-scale randomized controlled trials.

Long-term relational psychotherapy is often considered as a main approach by the International Society for the Study of Trauma and Dissociation (ISSTD). This type of therapy focuses on addressing deep trauma through a mutual process between a therapist and a patient. To manage and reduce symptoms from worsening, patients need stability within a long-term therapeutic relationship. Therapists treating DID may require specialized training to understand the clinical aspects of dissociative disorders. They also require knowledge of appropriate interventions for psychotic episodes or co-morbid disorders that may hinder the treatment process.

Before starting treatment, clinicians assess the condition of a patient, evaluating who can be safely treated in an outpatient setting, or if an inpatient stay is needed.[16]

Outpatient Therapy

Outpatient-based individual psychotherapy is often the preferred treatment route due to the easier arrangement plans and cheaper therapy. However, outpatient therapy is susceptible to liabilities. External factors such as relational sway or stressors can disrupt the treatment during the initial stages of treatment, possibly influencing threat of harm to self or others. When clinicians use treatment in an outpatient setting, it is important to consider these factors.[16]

Inpatient Therapy

If a DID patient fills the following criteria: having high risk of danger to oneself or others, persistent suicidal ideation, staggering dissociative episodes, unresponsive to outpatient treatment, or worsening behavior, they are considered by medical professionals for inpatient therapy.[16]

Patients with complex dissociative disorders can require an entire, multidisciplinary treatment team. These teams consist of clinicians, specialists, case managers, and various therapists (e.g., somatic, primary, and family therapists). To yield the best results, team members work in a coordinated and appropriate manner with demarcation of responsibility.[16]

Phase-Oriented Psychotherapy is a widely used clinical approach for DID. This type of therapy is intended to safely treat complex dissociative phenotypes without destabilizing the patient, and may be performed inpatient, outpatient, or in combined settings:

Phase One: Stabilization

Prior to initiation of treatment, therapists focus on creating a secure environment to stabilize the patient while addressing their risk status. Because emotional dysregulation is common in DID, patients are taught how to identify, manage, and evaluate emotional responses.

Phase Two: Trauma Processing

Once the patient is stable, therapists gradually process past and current traumas while keeping within the patients' window of tolerance. This phase can also include short-term interventions for PTSD, including cognitive processing therapy or eye movement desensitization, and reprocessing therapy. However, trauma-focused treatments may be difficult to implement long-term. Addressing traumatic experiences too quickly may cause severe destabilization.[16]

Phase Three: Rehabilitation

The third phase focuses on improving the patient's overall functioning and reconnecting with different aspects of self by using healthy and effective coping mechanisms. This phase requires time for adaptation and the main goal is for the patient to recognize that their different identity states are parts of the same person. [5]

Conclusion

Despite the historical marginalization of dissociative identity disorder, a growing body of evidence supports that DID is a *valid*, complex, under-researched disorder. Following its official introduction to the DSM in 1980, medical professionals spent decades debating over the diagnostic validity of DID instead of advancing the research needed for the severity of this disorder. This continued controversy has accompanied a comparatively limited research literature.

Today, DID still isn't considered a high-level priority in the psychiatric field. Funding to DID-specific clinical trials is extremely rare, cultural variation of DID is under-researched, and an exact number for the prevalence for DID does not exist. Most importantly, decades of heavy stigmatization appear to have impeded the development of target treatments. Despite this, treatment options have emerged, although no DID-specific medication has yet to be developed. While therapies have been adapted from other disorders and may provide relief, it is not yet clear what is most effective in alleviating the distress or disability associated with DID.

It is a priority to work through the cultural, conceptual, and cost issues that interfere with long-term studies of DID. Addressing and recognizing these obstacles is critical to promote improved, targeted treatment and improve the quality of life for people with DID.

References

1. Rosenbaum, M. The role of the term schizophrenia in the decline of diagnoses of multiple personality. *Arch. Gen. Psychiatry* **37**, 1383–1385 (1980).
2. van der Hart, O., Lierens, R., & Goodwin, J. (1996). Jeanne Fery: A sixteenth-century case of dissociative identity disorder. *The Journal of Psychohistory, 24*(1), 18–35.
3. American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.; DSM-5-TR). American Psychiatric Association Publishing.
4. Brand, B. L. *et al.* Separating Fact from Fiction: An Empirical Examination of Six Myths About Dissociative Identity Disorder. *Harv. Rev. Psychiatry* **24**, 257–270 (2016).
5. Purcell, J. B. *et al.* Treatment of Dissociative Identity Disorder: leveraging neurobiology to optimize success. *Expert Rev. Neurother.* **24**, 273–289 (2024).

6. Dorahy, M. J. *et al.* Dissociative identity disorder: An empirical overview. *Aust. N. Z. J. Psychiatry* **48**, 402–417 (2014).
7. Beker, J. C., Dorahy, M. J., Moir, J. & Cording, J. Inter-identity amnesia and memory transfer in dissociative identity disorder: A systematic review with a meta-analysis. *Clin. Psychol. Rev.* **114**, 102514 (2024).
8. Reinders, A. A. T. S. *et al.* The Psychobiology of Authentic and Simulated Dissociative Personality States: The Full Monty. *J. Nerv. Ment. Dis.* **204**, 445–457 (2016).
9. Biswas, J., Chu, J. A., Perez, D. L., & Gutheil, T. G. (2013). From the neuropsychiatric to the analytic: Three perspectives on dissociative identity disorder. *Harvard Review of Psychiatry*, *21*(1), 41–51. https://doi.org/10.1097/HRP.0b013e31827fd7c8
10. Nester, M. S., Boi, C., Brand, B. L. & Schielke, H. J. The reasons dissociative disorder patients self-injure. *Eur. J. Psychotraumatology* **13**, 2026738.
11. Abdellah, M. M., Ragheb, K. M., Elshafie, T. M. & Hamed, R. A. Prevalence of dissociative identity disorder among psychiatric outpatients in different cultural groups. *Middle East Curr. Psychiatry* **32**, 54 (2025).
12. Dimkov, P. R. The concept of self in Eastern and Western philosophy. in *5th International e-Conference on Studies in Humanities and Social Sciences: Conference Proceedings* 197–204 (Center for Open Access in Science, Belgrade, 2020). doi:10.32591/coas.e-conf.05.17197d.
13. Leichsenring, F. *et al.* Borderline personality disorder: a comprehensive review of diagnosis and clinical presentation, etiology, treatment, and current controversies. *World Psychiatry* **23**, 4–25 (2024).
14. RePORT ⟩ RePORTER. Accessed August 18, 2026
15. Aboraya, A., France, C., Young, J., Curci, K. & LePage, J. The Validity of Psychiatric Diagnosis Revisited. *Psychiatry Edgmont* **2**, 48–55 (2005).
16. Subramanyam, A. A. *et al.* Psychological Interventions for Dissociative disorders. *Indian J. Psychiatry* **62**, S280–S289 (2020).