

# Dissociative Identity Disorder: An Integrative Study from the Perspectives of Mind, Brain, Body, Memory and Language

## Dissosiyatif Kimlik Bozukluğu: Zihin, Beyin, Beden, Bellek ve Dil Perspektifinden Bütüncül Bir İnceleme

Hasan Belli<sup>1</sup>, Selin Laçın<sup>2</sup>

<sup>1</sup>Istanbul Atlas University Faculty of Medicine, Department of Psychiatry, İstanbul, Turkey

<sup>2</sup>University of Health Sciences Turkey, İstanbul Bağcılar Training and Research Hospital, Department of Psychiatry, İstanbul, Turkey

### Abstract

The nature of dissociative identity disorder (DID) can be viewed holistically from developmental, neurobiological, psychophysiological, cognitive, and linguistic perspectives. DID is described as a defense and adaptive mechanism that arises in response to chronic and overwhelming trauma in childhood. It is characterized by identity changes, dissociative amnesia, and fragmented self-states. DID is not only a clinical diagnostic category but can also be understood as a developmental adaptation to traumatic environmental conditions. The concept of ego-states is in direct agreement with modern cognitive theories and represents different forms of subjective experience. In DID, discontinuities and shifts in subjectivity between these states are evident, while the ego-state approach explains these experiences as an emotional and behavioral organizational pattern emerging from early life experiences. Neuroimaging studies have demonstrated significant differences in brain activity between ego-states, particularly highlighting functional and structural alterations in regions such as the hippocampus, amygdala and parahippocampal gyrus. Furthermore, it is crucial to emphasize the physical dimension of DID. Differences in peripheral psychophysiological parameters such as heart rate, skin conductance, and muscle activity have been observed across different ego-states. The functioning of memory lies at the heart of the disorder: discontinuities in autobiographical memory, the fragmented storage of traumatic memories, and the phenomenon of “state-dependent memory” are described as key

### Öz

Dissosiyatif kimlik bozukluğunun (DKB) doğası gelişimsel, nörobiyolojik, psikofizyolojik, bilişsel ve dilsel boyutlarıyla bütüncül bir şekilde ele alınabilir. DKB, çocuklukta maruz kalınan kronik ve ezici travmalara karşı geliştirilen bir savunma ve uyum mekanizması olarak tanımlanmakta, kimlik değişimleri, dissosiyatif amnezi ve parçalanmış benlik-durumları ile karakterize edilmektedir. DKB yalnızca klinik bir tanı kategorisi değildir; aynı zamanda travmatik çevresel koşullara karşı gelişimsel bir adaptasyon biçimi olarak anlaşılabilir. Benlik-durumları kavramı, modern bilişsel kuramlarla doğrudan uyumlu olup, bireyin öznel deneyimlerinin farklı biçimlerini temsil eder. DKB’de bu durumlar arasında süreksizlik ve öznellik kaymaları gözlenirken, ego-state yaklaşımı bu deneyimlerin erken yaşantılardan kaynaklanan duygusal ve davranışsal örgütlenmeler olduğunu açıklar. Nörogörüntüleme çalışmaları, benlik-durumları arasında belirgin beyin aktivite farklılıklarını ortaya koymuş, özellikle hipokampus, amigdala ve parahippokampal girus gibi yapılarla ilişkili işlevsel ve yapısal değişikliklere dikkat çekmiştir. Ayrıca, DKB’nin bedensel boyutunu vurgulamak çok önemlidir. Farklı benlik-durumlarında kalp atış hızı, deri iletkenliği ve kas aktivitesi gibi periferik psikofizyolojik parametrelerde farklılıklar bulunmuştur. Bellek işleyişi ise bozukluğun merkezinde yer almakta; otobiyografik bellekte süreksizlik, travmatik anıların parçalı depolanması ve “duruma bağlı hafıza” olgusu kimlik sürekliliğini zedeleyen temel mekanizmalar olarak tanımlanmaktadır. Son olarak, dilin rolü hem kavramsallaştırmada hem de öznel deneyimlerin aktarımında merkezi

**Address for Correspondence:** Selin Laçın, MD, University of Health Sciences Turkey, İstanbul Bağcılar Training and Research Hospital, Department of Psychiatry, İstanbul, Turkey

**E-mail:** selin\_demirdogan@hotmail.com **ORCID:** orcid.org/0000-0002-3359-7267

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## Abstract

factors undermining identity continuity. Finally, language plays a central role in both the conceptualization and communication of subjective experiences. The use of the term “ego-states” contributes to reducing stigma, while statements by affected individuals such as “that doesn’t belong to me” reveal the phenomenological dimension of dissociative processes. This multifaceted approach allows us to understand DID not only as a pathological disorder, but as a complex form of adaptation at the intersection of mind, brain, body, memory, and language.

**Keywords:** Brain, dissociative identity disorder, language, memory, mental processes

## Öz

bir öneme sahiptir. “Benlik-durumları” teriminin tercih edilmesi, damgalamayı azaltırken; bireylerin “bana ait değil” gibi ifadeleri dissosiyatif süreçlerin fenomenolojik boyutunu görünür kılmaktadır. Bu çok katmanlı yaklaşım, DKB’nin patolojik bir bozukluk olmanın ötesinde, zihin, beyin, beden, bellek ve dilin keşişiminde yer alan karmaşık bir adaptasyon biçimi olarak anlaşılmasını sağlamaktadır.

**Anahtar kelimeler:** Beyin, dissosiyatif kimlik bozukluğu, zihinsel süreçler, hafıza, dil

## Introduction

Dissociative identity disorder (DID) is understood as a defense and survival mechanism that develops in response to extreme and often repeated traumatic experiences in childhood (1). This disorder is characterized by identity changes, the presence of multiple self-states, and dissociative amnesia (2). As a psychobiological syndrome, DID does not merely represent a psychiatric diagnostic category but can also be understood as an expression of a developmental adaptation to overwhelming traumatic stressors and attachment-related conflicts that massively complicate the need for security in childhood (3).

Therefore, the structure of DID inherently involves a serious level of contradictions. It is undeniable that it significantly impairs the individual’s functioning. It leads to persistent difficulties in the person’s daily life. Nevertheless, it also serves functions such as organizing fragmented childhood experiences, distancing unbearable pain, and maintaining psychological integrity (1,4). This paradoxical dimension necessitates understanding DID not merely as a “complex disorder” but also as a developmental adaptation to traumatic environmental conditions (5,6).

In this context, modern cognitive theories, neuroscientific findings, and body-oriented approaches provide an essential foundation for understanding DID (7). From a cognitive perspective, it is possible to explain how different self-states are formed by independent fragments of memory and perception (8). However, neuroscientific findings point to trauma-related alterations in brain regions such as the hippocampus and amygdala. These remarkable changes in brain regions indicate the biological basis of the disorder (9). Finally, some research has brought body-oriented models to the forefront. This research has shown that dissociative processes emerge not only at the mental level but also at the somatic level. These findings clarify that traumatic

memories are re-experienced through bodily sensations and automatic responses (10).

The aim of this article is to follow this holistic perspective and explain the phenomenology of DID not only through clinical symptoms, but also through the interplay of environmental experiences, brain functions, bodily processes, memory functions, and language use. This will enable a deeper understanding of the complex nature of this disorder and provide a broader theoretical basis for therapeutic approaches (11).

### 1. Mind and Self or Ego-states: Identity Alteration and Cognitive Models

In the psychology literature, some authors frequently use the terms “ego” and “self” interchangeably. In fact, both terms refer to inner experiences; in this context, they may also be regarded as real neurobiological phenomena (12). In its broadest sense, the “self” represents the entirety of self-perception. Nevertheless, it should be noted that the individual perceives their self-concept as an answer to the question “Who am I?” and as the totality of inner experiences (13). This concept includes not only conscious processes but also unconscious perceptions, bodily sensations, feelings of identity, and self-representations transmitted through social relationships (14). In modern psychology and cognitive science, the self is considered a multidimensional and dynamic structure composed of components such as autobiographical memory, identity, body awareness, emotional experiences, and social roles (15).

The “ego”, on the other hand, goes back to Freud’s structural model. Located between the Id, ego, and superego, the ego functions as a regulatory entity that establishes a connection to reality, controls drives, considers social norms, and ensures the individual’s adaptability (16).

Accordingly, the ego does not represent the entire self, but rather its regulatory subsystem, which is responsible for securing reality (17). The self is thus a more comprehensive, phenomenological, and existential concept, while the ego primarily describes a dynamic-psychoanalytic area of functioning (18). Here, we use the terms “ego” and “self” in roughly the same sense. While Western languages allow us to describe such phenomena with different terms, this is quite difficult to achieve in some languages.

The concept of self-states offers a central approach to understanding DID, while the perspective of ego states further enriches this view (19). Self-states are subjective forms of existence that are consistent with modern cognitive theories and are shaped by dynamic learning processes. Every person possesses self-states that represent different facets of the “I am” experience (20). In DID, however, marked shifts between these self-states occur: One state becomes the observer, while another takes control-creating abrupt discontinuities in subjective experience (21). The ego-state approach understands these self-states as “ego states” rooted in early life experiences and embodying specific emotional, cognitive, and behavioral patterns (22). Each ego state thus corresponds to an internal context, role, or experience. In healthy individuals, these states integrate flexibly, whereas in DID the transitions are fragmented, discontinuous, and alienated (23). Therefore, the self-states in DID often appear “ego-alien”; those affected experience them as not belonging to themselves or even as foreign (24).

From this perspective, the dissociative symptoms of DID can also be better understood: Memory lapses, depersonalization, derealization, traumatic flashbacks, somatoform complaints, and amnesia arise from the “unauthorized intrusion” of individual ego states into the conscious realms of others (25). Depersonalization can be interpreted in the ego-state model as an adaptive function that enables the individual to distance themselves from overwhelming emotional states by creating the feeling “that’s not me” (26). Likewise, dissociative amnesia can be understood as a strategy of ego states to compartmentalize conflicting feelings toward abusive caregivers to maintain attachment relationships (27).

Overall, when self-states and ego-state theory are considered together, DID becomes visible not only as a pathological disorder, but also as a complex, paradoxical, and yet adaptive form of regulation of the human mind that arises in response to early traumatic experiences (28). This approach makes it clear that DID is not a mystical or alien phenomenon, but rather an extreme variation of those self-

states that are common to all people and that can develop into radical forms in the context of traumatic experiences (6,7).

## 2. Some Neurobiological Findings in DID

Self or ego-states can be understood as a constellation of perceptions, actions, and internal states that emerge from past experiences and are stored in memory. These structures are supported by a dynamic network of neural activity (6,29). Neuroimaging studies have shown that individuals with DID exhibit distinct neural differences between different self-states, both during experimental tasks and at rest (9). The nature of these differences depends on both the experimental context (e.g., emotionally provocative stimuli, memory tasks) and the imaging techniques used (electroencephalogram, functional magnetic resonance imaging, positron emission tomography) (6,30). Transitions between self-states (switching) have been particularly associated with activity changes in the hippocampus, parahippocampal gyrus, and basal ganglia (31). Furthermore, the integration process that is, when clearly separated self-states no longer occur over an extended period, is associated with structural and functional changes, such as an increase in hippocampal volume (32).

As a disorder within the trauma spectrum, DID shares certain neural underpinnings with posttraumatic stress disorder (PTSD) (33). Symptom provocation studies, for example, have found that depersonalization and derealization are associated with an exaggeration of corticolimbic inhibition (34). When individuals with DID recall or relive traumatic memories, hypervigilant self-states exhibit inadequate corticolimbic inhibition (failed inhibition), similar to that seen in PTSD. In contrast, apathetic or dissociated self-states exhibit excessive corticolimbic inhibition analogous to the dissociative subtype of PTSD (35). Structurally, individuals with DID have been shown to have a smaller and atypically shaped hippocampus; in addition, the amygdala and parahippocampal gyrus may be reduced in size, while the pallidum may be enlarged. These structural abnormalities are usually related to the severity of traumatic childhood experiences (36).

Finally, studies using machine learning methods have shown that the brains of individuals with DID can be reliably distinguished from those of healthy controls. In particular, hyperconnectivity between the default mode network and the frontoparietal control network appears to act as a neurobiological “fingerprint” of DID (6,37). These findings

convincingly support the idea that DID is not merely role-playing or imaginary behavior, but rather a disorder with specific neurobiological foundations. They emphasize that individuals diagnosed with DID should not simply be dismissed as “imaginative narrators”. Clearly, the human brain is an excellent storyteller. To avoid misdiagnosis, careful observation and a thorough understanding of the pathology are of utmost importance.

### **3. The Body and Peripheral Psychophysiology: Somatic Expressions of Self or Ego-states**

Self or ego-states are not only deeply rooted in mental processes but also deeply rooted in bodily experiences, which is crucial for understanding DID (1). When transitioning between different self-states, the affected person experiences not only changes in thoughts and emotions but also significant physical modifications (6,21). For example, in one self-state, breathing may become easier and a feeling of chest expansion may arise, while in another, a sudden adrenaline rush with an accelerated heart rate may be perceived (9). Likewise, experiences such as the feeling that the body is unreal, controlled like a doll, or as if it has shrunk to the size of a child are among the subjective somatic manifestations of these transitions (26). Such sensations illustrate that self-states are not merely mental representations, but integral experiences that emerge from the interaction of body and mind (10).

These observations are supported by scientific findings from peripheral psychophysiological measurements (38). Studies with individuals with DID demonstrate consistent and significant differences between self-states in parameters such as skin conductance, heart rate, blood pressure, and muscle activity, measured by electromyography (35). These differences vary depending on the experimental context and the emotional content of the stimuli used (30). For example, certain self-states react with strong physiological arousal when confronted with trauma-related words or when listening to traumatic scenarios, while others remain indifferent or, conversely, show suppressed reactions (39). These divergent reactions to emotionally provocative stimuli demonstrate that self-states can be differentiated not only by subjective experiences but also by measurable physiological processes (11).

These findings provide strong evidence for understanding DID as a posttraumatic adaptation (23). While neurobiological studies demonstrate differences in brain structure and function in response to trauma, peripheral physiological data show that the body is also actively involved in this adaptive process (34). Hypervigilant self-

states are associated with increased heart rate, elevated blood pressure, and increased skin conductance, consistent with a classic PTSD pattern (40). In contrast, apathetic or dissociated self-states exhibit decreases in heart rate and blood pressure, consistent with the excessive inhibition of the dissociative subtype of PTSD (41). These bodily reactions, which fluctuate between the two extremes, highlight that DID is not a one-dimensional disorder, but rather a complex form of regulation in which different “self- and body-related strategies” are developed in response to trauma (24).

Understanding the bodily dimensions of self-states and their peripheral physiological differences is therefore essential to grasping the clinical nature of DID (42). This perspective demonstrates that the disorder does not merely represent a fragmentation of identity, but rather is an adaptive form of regulation in which traumatic experiences leave complex traces on both the mental and physical levels (43). The fact that the body plays an active role in this process also highlights that therapeutic approaches must focus not only on cognitive and emotional dimensions, but also on the reorganization of physical sensations (44).

### **4. The Relationship Between DID and Memory Functioning**

Individuals diagnosed with DID frequently experience severe memory problems. Forgetting daily events, conversations, or important personal information is a recurrent classic finding. However, this forgetting differs from classical “forgetting” because it is based on a dissociative mechanism. Although the information is stored in memory, it remains inaccessible to a particular self-state (23). To put it another way, memory is fragmented. Experiences obtained from one’s self-state are inaccessible to others. Consequently, affected individuals may not remember activities or conversations from the same day because the self-state that experienced them differs from the self-state that exists later (45).

Discontinuities in autobiographical memory are common in DID. Those affected report fragmented, isolated memories. Some content seems to be completely lost, and others are only accessible to certain self-states (11). This phenomenon is explained by the concept of “state-dependent memory”: Information can only be recalled when the self-state that originally experienced it is active again (26). This principle has a protective effect, protecting against overwhelming traumatic experiences; on the other hand, it impairs the continuity of the life story and weakens the sense of coherence of identity (24).

Understanding memory processes in DID requires special consideration of traumatic memories. Such memories are usually incompletely processed, highly emotionally charged, fragmented, and often stored with physical sensations (1). They occur intrusively in inappropriate contexts and lead to flashbacks. When a self-state accesses a traumatic memory without “consent”, the person experiences the scene as if it were happening again (21). Traumatic memories thus manifest not only as cognitive content but also as physical-emotional re-experiencing processes (10).

Since DID is predominantly the result of severe trauma in childhood, memory processes are also impaired in a developmentally specific manner. In childhood, when memory lacks a coherent structure, traumatic experiences promote fragmented storage (46). These fragments form the basis of different self-states. For example, a child experiencing abuse cannot “forget” the experience but stores it in a separate memory and identity area to protect themselves. In adulthood, these fragments then emerge as independent self-states (25).

The memory impairments in DID directly impair identity continuity. Normally, memory reinforces the feeling of being “the same person”. In DID, however, this sense of continuity is disrupted by the lack of access to memories from other self-states (8). This is not just simple forgetting, but also a fragmentation of the sense of “self”. This often manifests itself in the perception that memories “do not belong to me” or “seem like they were experienced by someone else”, so-called “ego-alien” experiences (47).

Neuroimaging studies show that in DID, the brain regions associated with memory -particularly the hippocampus, amygdala, and parahippocampal gyrus- exhibit functional and structural abnormalities (32). Volume reductions or disturbances in functional connectivity complicate the processing and integration of traumatic memories (9). Furthermore, hippocampal activity differences during state transitions provide evidence for the biological basis of state-dependent memory fragmentation (30).

The relationship between memory processes and DID is a key to understanding the disorder, both clinically and theoretically. Memory functions not only as a repository of traumatic experiences but also as the center of organization of self-states, a site where identity continuity is disrupted, and adaptive mechanisms for dealing with trauma are activated (42). Thus, DID can be understood as a psychopathological expression of a “fragmented memory”,

whose fragments are experienced in the form of self-states (48). Furthermore, autobiographical memory plays a key role in establishing the sense of continuity of identity along the space-time axis. The impact of traumatic experiences creates fragmented memory, which in turn produces scattered and isolated self-states (27).

## 5. DID, A Film and Figurative Language

Numerous productions have emerged in the global film industry, and especially in Hollywood, that address DID (49). Although these films have often contributed to the mystification of DID, some examples nevertheless exhibit remarkable scientific aspects. Among these, the film *Split* occupies a prominent position. Shyamalan’s (50) 2016 production is considered one of the most impressive works depicting DID in its dramatic and psychological dimensions (51). This chapter examines the use of figurative language in screenplays based on Perrine’s classification (51,52) and Leech’s theory of meaning (51,53). At the same time, it discusses how these linguistic devices function functionally in a psychological context.

Figurative language is not only a central element of literary works but is also widely used in everyday life and in audiovisual narrative forms (54). It transcends the literal sense, creates new, context-dependent layers of meaning, and fulfills a central function in the representation of emotions, thoughts, and traumatic experiences. Film, as an art form, deepens these expressive possibilities through its own aesthetics and symbolic language (51,55). In *Split*, the various identities of the main character Kevin are each characterized by specific language styles that reflect different social contexts and psychological states. For example, Dennis uses a harsh, threatening style of expression, while Hedwig speaks a childlike and naive language (50,51). This highlights the central role of language in identity construction and its function in expressing dissociative processes (51).

Based on the aforementioned film, seven different types of figurative language can be identified. These can be characterized as hyperbole, metaphor, paradox, simile, synecdoche, symbolism, and personification (51-53). Hyperboles amplify emotions, thereby intensifying emotional impact. The metaphor of “light” is particularly striking: Light is equated with consciousness, and control over light symbolizes the constant shifting of identities (51,53). Paradoxes, such as the description of death as “beautiful”, demonstrate the characters’ contradictory relationship with reality. Similes are used to render the

“Monster’s” power seemingly superhuman. Synecdoche is employed when a part substitutes for the totality of identities. Symbols such as the sun and chairs acquire central importance: While the sun represents the Monster’s birth and triumph, chairs symbolize the positioning of identities within the self (50,51). Finally, personification is carried out from an anthropomorphic perspective. Human attributes are assigned to inanimate objects to make psychological states metaphorically visible.

Analysis based on Leech’s theory of meaning shows that figurative language is not only an aesthetic stylistic device, but also a multi-layered carrier system of meanings (51,53). Conceptual and connotative meanings are most frequently encountered. The former explains the logical structure of figurative statements, while the latter capture their cultural and emotional dimensions (54). For example, “light” is conceptually equated with consciousness, but connotatively associated with power, control and identity conflicts. The statement “The broken are further developed” reflects the connotative sense that traumatic experiences can strengthen people (51,55). Such expressions are directly related to the psychological backgrounds and inner conflicts of the characters (51).

The results show that figurative language in *Split* not only creates dramatic effects but also represents a functional tool for understanding the psychological nature of DID (49-51). The linguistic images used confirm the reality of fragmented identities and convey to the audience the experience of these parts as independent entities. In particular, the anticipatory announcement of the “beast” through figurative language reinforces the film’s dramatic tension. Furthermore, the analysis opens a new framework for investigating the connection between figurative language and mental disorders (56). Previous studies have already demonstrated that language use is altered in bipolar disorder, depression, and anxiety disorders (57).

Overall, it can be stated that seven types of figurative language can be identified in the film *Split*, which can be linked to Leech’s dimensions of meaning and fulfill multidimensional functions (51,53). Figurative language lends the cinematic representation of DID both aesthetic and conceptual depth by indirectly reflecting psychological states, trauma, and identity splits. It thus proves not to be a mere stylistic device, but a linguistic expression of psychological realities of identity and consciousness (51,54,55). Of course, it should be noted that a film, like any artistic work, represents a significant deviation from real phenomena. Films aim to capture the audience’s attention

through exaggeration and dramatization, while reality is often less colorful and spectacular. At the same time, similar films as with other psychiatric disorders can contribute to the stigmatization of individuals diagnosed with DID. This occurs primarily because cinematic depictions often convey stereotypical, overdramatized, or unrealistic images of those affected. Such representations reinforce social prejudices, impede social integration, and can even hinder access to appropriate treatment. Thus, the medium of film functions not only as a cultural reflection, but also as a potential amplifier of stigmatization processes, which scientifically based education and clinical practice must specifically attempt to correct.

## **6. Making Sense of DID Experience and Language as Communication**

The study of DID highlights that language is central to both the conceptualization and the communication of subjective experiences (2,57). Although language is rarely treated as a separate topic in the literature, its relevance is evident in the choice of terminology: Labeling the phenomena as “self-states” instead of “alter” is not merely a terminological preference, but rather a conscious linguistic strategy. The goal is to make the experiences more understandable within the framework of modern cognitive psychology and neuroscience and, at the same time, to reduce the stigma surrounding the disorder (6,58). Terms shape social perception: While the term “alter” suggests strangeness, mysticism, and an existence independent of the individual, the term “self-state” presents the experiences as differentiations in the natural functioning of the human mind, thus fulfilling a demystifying function (6,59).

Furthermore, language is the central medium through which those affected can communicate their subjective experiences. Expressions such as “That doesn’t belong to me” or “Another self has taken control” linguistically visualize shifts in subjectivity and agency (3,6). Such narratives are indispensable for understanding the inner dimension of DID, as the experiences of those affected cannot be directly observed but can only be conveyed linguistically (60). Language therefore, functions not only as a descriptive tool in scientific discourse but also as a form of expression of the phenomenological experience itself (61).

A further level is revealed in trauma reports, which clarify the connection between language, dissociation, and memory processes. Studies on symptom provocation have shown that listening to one’s own trauma narratives not only fulfills a communicative function, but is also a powerful trigger for the reliving of traumatic memories (62).

Traumatic experiences can be recalled, relived, and even elicit physical reactions through words (1,63). Language thus acts as a bridge that both enables the processing of the trauma and can activate dissociative processes (6).

In summary, language is central to the study of DID on three levels: first, as a means of reducing stigma through the choice of demystifying terminology; second, as a phenomenological bridge for conveying subjective experiences; and third, as a trigger for re-experiencing traumatic content (1,58,60,62). This multidimensional function elevates language beyond its role as a mere means of communication and makes it a crucial factor in the understanding and social perception of the disorder.

## 7. DID and Etiological Background

The etiology of DID cannot be reduced to a single cause. This disorder is a complex and multidimensional process (58). Research indicates that the development of this disorder results from an interaction between genetic predispositions and environmental risk factors (64). According to this view, genetic predisposition increases the sensitivity of the nervous system and vulnerability to stress responses; these biological predispositions are activated by traumatic events in the environment (65). Therefore, DID can be understood as a psychobiological syndrome that emerges from the combination of innate biological vulnerabilities with severe early childhood stressors and adverse environmental factors (6,66).

Among environmental risk factors, severe and chronic childhood trauma is particularly important (60). Physical, sexual, and emotional abuse, as well as emotional neglect, are among the strongest predictive factors for the development of DID (67). Such traumas are usually neither random nor isolated events, but rather continuous, repetitive experiences that permanently destroy the child's fundamental sense of security. They frequently occur in the relational context between the child and their attachment figures (68). This means that the traumatizing person is often the person who should actually act as the central source of security and safety. This paradoxical constellation leads to profound disruptions in the child's psychological development (5).

The effects of such overwhelming childhood traumas are not limited to immediate emotional suffering. They influence the processing of memories, self-concept, and the child's fundamental trust in the world (1). During the trauma, the experienced fear and helplessness lead to the psyche storing unbearable emotional content in a

segmented and split form. These fragmented memories and affects subsequently organize themselves into different self-states (61). In this way, the split representations of traumatic experiences transform into independent identity states that serve to maintain psychological integrity.

A complementary explanatory factor for the development of DID is the insecure attachment style, particularly the disorganized attachment type (69). Children who fail to develop a secure attachment experience their caregivers simultaneously as a source of protection and a potential threat (62). These contradictory attachment experiences create a sense of chronic insecurity and unpredictability that promotes the development of separate self-states (70). To cope with the paradoxical experiences of protection and danger in the same person, the child splits off different cognitive and emotional representations. These function both as a psychological defense mechanism and as an adaptive strategy, but also form the basis for the later development of dissociative identities (71).

Empirical studies demonstrate that the childhood histories of those affected often include severe experiences of abuse and neglect (60,67). Crucial here is not only the intensity of the trauma, but also its embedding in the attachment relationship (68). When the most important source of security simultaneously becomes the source of the trauma, one of the greatest strains on psychological integrity arises (5). In addition, the continuity and unpredictability of the abuse reinforce the fragmentation of the self (1). Children who do not know whether they will receive affection or abuse develop various self-states to regulate this unpredictability (61,62).

In summary, DID can be understood as a disorder resulting from the combination of biological vulnerabilities and traumatic childhood experiences, with relational injuries destroying the child's psychological integrity and disorganized attachment experiences stabilizing the fragmentation of the self (66,70). Genetic factors increase sensitivity to traumatic experiences, while traumatic interactions with attachment figures, in particular, significantly shape the development of the disorder (6,60,71).

## Conclusion

DID has been the subject of intense debate for many years, but recent research demonstrates both the validity of this diagnostic category and the need to understand it as a form of developmental adaptation following severe trauma

(2,64). DID should be viewed not only as a psychiatric disorder but also as a protective and coping mechanism that the individual develops in response to overwhelming childhood trauma (59). This understanding emphasizes that DID is not solely a pathological phenomenon but rather the result of complex interactions between mind, brain, body, and language (3).

The interaction between mind, brain, and body forms a critical foundation for a holistic understanding of DID (6,61). Neuroscientific studies show that different self-states exhibit distinct patterns of neural activity (6,9); psychophysiological measurements demonstrate that these states also elicit divergent responses at the physical level (63). Phenomenological analyses reveal how subjective experiences are articulated through language (72). In this context, memory comes to the fore as a central element (23). Dissociative amnesia arises because certain self-states have no access to the experiences of others; autobiographical memory appears fragmented, context-dependent, and selectively organized (60).

The role of language is also central to understanding DID (59,72). Those affected use language as a primary means of communicating their complex inner world of experience to the outside world. Formulations such as “it does not belong to me” or “another identity has taken control” make the phenomenological dimension of experienced discontinuity visible (62). Such linguistic representations not only describe symptoms but also reveal the effects of dissociative processes on the mind, memory, and body. At the level of conceptualization, the preference for the term “self-states” rather than “alter” contributes to destigmatization and makes the experiences more understandable within the framework of modern cognitive psychology and neuroscience (73).

The connection between memory and language is particularly evident in trauma narratives (23). Symptom provocation studies have shown that listening to one’s own traumatic experiences directly triggers dissociative symptoms. This demonstrates the role of language as a powerful trigger in the reactivation of traumatic memories and the emotional activation of memory (63). Traumatic memories are usually not recalled coherently and orderly, but return fragmented, linked to somatic sensations, and repetitively (60). This fragmentation and its linguistic articulation reveal both the discontinuity of memory and the nature of the dissociative experience.

Future research should deepen this integrative understanding. Genetic and epigenetic studies can uncover

biological mechanisms that increase vulnerability to trauma (64). Direct comparison of DID and PTSD cohorts could reveal both similarities and differences in neurobiological foundations and memory processes (6,61). Longitudinal studies of DID symptoms in childhood would help to better understand the developmental course (3). Furthermore, the analysis of different levels of integration, both in terms of memory organization and clinical course, could provide significant impetus for therapeutic approaches (73).

Finally, the enduring legacy of the historical mind-body dualism warrants explicit attention, as it continues to shape both scientific discourse and clinical intuitions regarding dissociative phenomena. Although this paper has advanced an integrative, non-dualistic framework, the persistence of dualistic thinking still constrains the field by implicitly casting dissociated identities as metaphysical or immaterial constructs rather than as neurobiologically instantiated self-states. This historical residue not only mystifies DID but also marginalizes accumulating evidence on its embodied and developmental foundations, thereby permitting culturally intuitive yet scientifically inadequate interpretations to prevail. Highlighting the limiting effects of this dualistic inheritance strengthens the central argument of the present work: That DID must be conceptualized as an embodied, brain-based adaptive response emerging from the dynamic interaction of neural, psychological, and environmental processes. Only by critically disengaging from the historical dualist paradigm can contemporary science fully account for the coherence and complexity of dissociative self-organization.

## Footnotes

### Authorship Contributions

Concept: H.B., Design: H.B., S.L., Data Collection or Processing: H.B., S.L., Analysis or Interpretation: H.B., Literature Search: H.B., S.L., Writing: H.B., S.L.

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