Review Psikiyatride Güncel Yaklaşımlar-Current Approaches in Psychiatry 2025; 17(1):12-29
doi: 10.18863/pgy.1409605

Dissociative Identity Disorder and Its Relationship with Other Diagnoses

Dissosiyatif Kimlik Bozukluğu ve Diğer Tanılar ile İlişkisi

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ABSTRACT

Dissociative identity disorder is the most complex, severe, and chronic condition within the category of dissociative disorders. The core issue in dissociative identity disorder involves significant divisions and discontinuities in an individual's memory, behavior, emotions, consciousness, and identity, which typically function as a cohesive whole. These dissociative experiences lead to impairments in various psychological functions and are often accompanied by other psychological disorders. Compared to other mental health conditions, environmental factors play a more prominent role in the development of dissociative identity disorder. This is primarily because the etiology of dissociative disorders is closely linked to repeated, systematic, and traumatic experiences, particularly during childhood. Historically, dissociative identity disorder has been diagnosed late, and its association with trauma has often been overlooked. The presence of alter identities and the challenges in recognizing dissociative identity disorder have contributed to this oversight, resulting in a delay in exploring the connections between dissociative identity disorder and other diagnoses. This study aims to investigate the history, diagnostic criteria, treatment approaches, and dissociative aspects of dissociative identity disorder, as well as its relationships with other mental health disorders. Notably, dissociative identity disorder has strong associations with conditions such as post-traumatic stress disorder, schizophrenia, borderline personality disorder, somatization, eating disorders, and attention deficit hyperactivity disorder. The interplay between these diagnoses and dissociative identity disorder is examined through the lens of shared symptoms, comorbidity, etiology, and epidemiology. The delayed recognition of the diagnostic and therapeutic protocols for dissociative identity disorder and the consequent neglect of its relationship with other disorders in the literature underscore the significance of this study. By highlighting these connections, we can enhance our understanding and improve the treatment of individuals affected by dissociative identity disorder and its comorbid conditions.
Keywords: Dissociative identity disorder, trauma, alter personality, dissociation, comorbidity

ÖZ

Dissosiyatif kimlik bozukluğu dissosiyatif bozukluklar içerisinde en kapsamlı, ağır ve kronik olan bozukluktur. Dissosiyatif kimlik bozukluğunda temel problem örüntüsü normalde bütün halinde olması gereken kişinin bellek; davranış, duygu, bilinç ve kimliğinde bölünmeler ve süreksizlik olmasıdır. Bu ayrışma ve bölünmelerin görülmesi kişide pek çok alanda psikolojik işlevlerin zarar görmesine ve ek olarak kişide diğer psikolojik bozuklukların görülmesine neden olmaktadır. Dissosiyatif kimlik bozukluğunun oluşmasında diğer tanılara kıyasla çevresel etkenlerin görülme durumu daha sıktır. Bunun nedeni dissosiyatif bozukluğunun etiyolojisinde özellikle çocukluk çağında yaşanılan tekrarlı; sistematik ve yineleyici travmatik deneyimlerin yatmasıdır. Dissosiyatif kimlik bozukluğunun tarihsel akışına bakıldığında tanısal olarak geç farkedildiği, travma ile olan ilişkisinin ihmal edildiği görülmektedir. Alter kimliklerin varlığının ve dissosiyatif kimlik bozukluğunun zor farkedilmesinin bu duruma etki ettiği düşünülürken, bu durum diğer tanılar ile dissosiyatif kimlik bozukluğu ilişkisinin araştırılmasında da gecikmeye neden olmuştur. Bu nedenle bu araştırmada dissosiyatif kimlik bozukluğunun tarihçesi, tanısal kriterleri, tedavisi ve dissosiyasyon gibi kavramların yanı sıra diğer tanılarla ilişkisinin incelenmesi amaçlanmıştır. Travma, travma sonrası stres bozukluğu, şizofreni, sınırda kişilik bozukluğu, somatizasyon, yeme bozukluğu, dikkat eksikliği ve hiperaktivite bozukluğu gibi ele alınan diğer tanılar özellikle dissosiyatif kimlik bozukluğu ile arasında kuvvetli ilişkinin bulunduğu tanılardır. Değerlendirilen bu tanıların dissosiyatif kimlik bozukluğu ile ilişkisi ortak belirtiler; eştanı durumu, etiyoloji, epidemiyoloji gibi bağlamlarla ele alınmıştır. Dissosiyatif kimlik bozukluğunun tanısal ve tedavisel protokollerinin geç tanınması; bu nedenle diğer tanılar ile olan ilişkisinin alanyazında ihmal edilmesi araştırmanın önemini ortaya koymaktadır.
Anahtar sözcükler: Dissosiyatif kimlik bozukluğu, travma, alter kimlik, dissosiyasyon, eştanı

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Received: 27.12.2023 | **Accepted:** 30.04.2024

Introduction

Dissociation refers to a fragmentation and discontinuity in states and phenomena such as perception, identity, body representation, memory, and consciousness that should ideally be integrated in a person (Ayar and Celbiş 2023). It is known that the earliest studies on dissociation were conducted in France in the 19th century by Pierre Janet, who coined the term "desagragation mentale" to describe the concept of dissociation (Şarlak and Öztürk 2018). Janet described dissociation as disruptions in the integrity and coherence of psychological functions, leading to divisions and disturbances in perception (Scalabrini et al. 2020).

Historically, the work of Jean-Martin Charcot on hypnosis and hysteria not only contributed to the development of the concept of dissociation but also influenced notable figures like Sigmund Freud (Loewenstein 2018). Charcot's scientific defense of hypnosis at the French Academy of Sciences helped legitimize hypnosis and contributed to understanding its relationship with hysteria (Walusinski and Bogousslavsky 2020). Inspired by Charcot's work, Freud initially emphasized the necessity of childhood traumas for hysterical symptoms and considered dissociation a fundamental requirement for hysteria. However, he later revised his theory to dismiss trauma, proposing that psychological problems stemmed from childhood fantasies rather than actual events, and suggested that impulses and desires played a role, rather than dissociation (Öztürk and Derin 2020).

Contemporary leading researchers like Nijenhuis and Van der Hart (2011) note that since the 1980s, numerous definitions of dissociation have emerged, but the most accurate remains aligned with the 19th-century understanding. This definition implies a failure to maintain personality integrity, often followed by an unsuccessful integration of two or more personalities. Nijenhuis and colleagues (2002) have termed this phenomenon as structural dissociation of the personality.

Dissociative disorders are divided into positive and negative symptoms. Positive symptoms include recollections of past scenes and sudden interruptions in consciousness by alternate identities. Negative symptoms, on the other hand, represent a lack of normal functioning, such as memory loss and difficulties in maintaining control over certain body parts or personality aspects (Spiegel et al. 2011).

Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder, is the most prominent and persistent condition associated with dissociation (Saxena et al. 2023). Although initially recognized late in psychological literature with its inclusion as a diagnosis in DSM III in 1980, subsequent research on DID has increased significantly (Şar 1998, Tamam et al. 1996). Carlson (1981) mentioned that the earliest cases observed dated back to the 1700s.

In Turkey, the first systematic study on DID was conducted in 1993 at the Department of Psychiatry at Istanbul Medical Faculty, indicating a relatively late recognition of DID in Turkey compared to other countries (Şarlak and Öztürk 2018). Initial epidemiological studies in Turkey showed a higher prevalence of dissociative disorders than expected, with DID prevalence at 5.4% (Tutkun et al. 1998), while Şar and colleagues (2000) highlighted a prevalence of 12% for dissociative disorders and 2% for DID specifically.

Looking at the general epidemiology of DID, it is stated that while the prevalence in the psychiatric world is 1.5%, recent studies suggest an increase to 2-5% among psychiatric patients (Hawayek 2024). DID is more likely to occur in adolescents, emergency psychiatric services, and among brothel workers (Şar 2017). While a higher proportion of women are diagnosed with DID in clinical settings, the gender ratio in the general population is more balanced (Şar 2017).

The diagnostic criteria for DID, the treatment process, and comorbidities are discussed in detail in this review article. The presence of alter identities and a traumatic past complicate the diagnostic process, sometimes leading to misdiagnosis and inappropriate treatment (Pietkiewicz et al. 2021). Understanding the etiology of DID and its relationship with other diagnoses is crucial for preventing misdiagnosis and enhancing treatment effectiveness. This review aims to provide a comprehensive examination of DID's association with trauma, post-traumatic stress disorder, schizophrenia, depression, borderline personality disorder, somatization, eating disorders, and attention deficit and hyperactivity disorder.

Dissociative Identity Disorder's Diagnostic Criteria

Dissociative disorders are classified into simple and complex categories. Simple dissociative disorders include dissociative amnesia, dissociative fugue, and depersonalization disorder. Meanwhile, complex dissociative disorders are subdivided into acute and chronic, with DID falling into the chronic category (Şar 1998). Dissociative Identity Disorder is the most extensive, severe, and chronic disorder among dissociative disorders, with core symptoms related to identity and memory (Şar 2017).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) (APA 2013), the diagnostic criteria for DID are as follows:

A. The presence of two or more distinct identity states or personalities (each having its own enduring pattern of perceiving, relating to, and thinking about the environment and self. Others or the individual themselves must observe these signs).

B. The individual struggles with remembering important personal information, to a degree too severe to be explained by ordinary forgetfulness.

C. The symptoms cause significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not part of normal cultural or religious practices.

E. The symptoms are not attributable to the physiological effects of a substance or another medical condition.

Due to the overlap of some symptoms of DID with other diagnoses, some clinicians believe that relying solely on diagnostic criteria might lead to misdiagnosis. Therefore, approaching a person suspected of DID should involve a combination of diagnostic classifications, clinical observations, scales specific to DID, and the individual's history (Kluft 2007).

The acceptance of dissociative disorders and DID as both a symptom and a diagnosis has not reached a consensus as robust as other psychological disorders. A significant reason is the existence of opposing views that have been skeptical about the reality of dissociation as a symptom from the beginning. An example of this is Freud's assertion that traumas were not real; instead, psychological problems originated from fantasies of childhood (Öztürk ve Derin 2020). Subsequently, Breuer's consideration of dissociative disorders within the scope of schizophrenia has led to significant neglect in the recognition and acceptance of dissociative disorders and DID (Öztürk 2018). These oversights and disagreements continue to influence academic fields today as they did in the past. For instance, while researchers accepting dissociation name memory losses caused by trauma as dissociative amnesia, others argue that the problems arise from false memories created by individuals who have experienced traumatic experiences, not from dissociation (Lynn et al 2022).

Alter Identities

Alter identities are organized patterns of behavior and experience that are fundamentally connected yet dissociated states of self and mental functions (Kluft 2006, Şar 1998). These mental functions are continuous and can manifest in behavior, possessing their own identity and thought structures (Şar 1998). According to researchers' approaches, identity and self can be depicted differently, such as representations of interactions or reflections of emotions (Kluft 2006, Watkins and Watkins 1997).

How alter personalities are active and present in the mind is viewed differently by various researchers and clinicians. For instance, Kluft suggests that the overall character of a person diagnosed with DID reflects the totality and interaction of their alter personalities (Kluft 1996). According to Kluft, the common perception related to the mind of a person with DID is not to see alter identities as separate parts but as a restructured mind encompassing all together (Kluft 1996). However, another approach argues that it is more appropriate to consider each alter personality as an agent that can activate the person's mental content and functions. In other words, seeing alter personalities as a whole can be a mistaken step in understanding DID. Each alter should be recognized as having its distinct characteristics, age, gender, cognitive capacity, mind, and consciousness (Kabene et al. 2022).

Yanık (2018) stated that the mind, which creates an alter identity once, then sees this situation as a convenience and responds with new identity formations in minor and similar difficulties. In addition, it is seen that the multiplying alter identities group themselves over time, have positive or negative perspectives on each other, and sometimes even exhibit a hierarchical distribution. However, it is also observed that alter identities are in solidarity and can be in harmony or in conflict with the host identity. The host identity may experience various difficulties such as staying between the alter identities and having difficulty in managing the conflict with the conflict or solidarity of the alters in the mind (Yanık 2018).

There are some criteria for deciding how separate and different alter personalities are from the 'host' personality. For example, if one alter personality believes that it will continue to live when the other dies, then separation

has occurred. In the case of being different, alter personalities have different characteristics from each other (Şar 1998). Şar (2018) stated that alter personalities repeatedly take control in line with their own perceptions. Some of these personalities may even show different situations from the person's own physical characteristics such as voice, appearance, body movements, facial expressions, symptoms, glasses number. However, despite these, in the majority of the day, the 'host' personality, which is in a challenging mood with the presence of alter personalities, dominates the body.

Another issue that needs to be added while addressing the characteristics related to alter identities is the formation process of alter identities and thus of DID. As many researchers who have investigated the relationship between trauma and DID have stated, it is very important to understand the reasons that lead people to form alter identities. The relationship between trauma and DID, which will be discussed in the following pages, has also been stated by many researchers and clinicians (Dorahy et al. 2015, Şar 2018, Yanık 2018). Şar states that DID occurs due to chronic traumas experienced especially in childhood (Şar 2018). People diagnosed with DID have emotional, physical, sexual abuse.

Abuse is often evident, and even if a family is not directly subjected to trauma, negative experiences within the family can implicitly lead to the development of Dissociative Identity Disorder (DID). Yanık (2018) explains that alter identities form in the mind as a reaction to childhood traumas. These traumas shape the brain's structure, activate stress hormones, and cause disruptions in the mind, resulting in dissociation (Yanık 2018). Additionally, developmental structures and theories, imagination capacity, attachment theory, and various personal processes contribute to the development of DID (Forrest 2001). For instance, even in the absence of a traumatic experience, a lack of healthy attachment to parents, particularly disorganized attachment, can lead to dissociation in adulthood (Liotti 1999).

Treatment of Dissociative Identity Disorder

As the treatment of DID has become accepted and established as a diagnosis in the world of psychology, treatment methods have also started to increase. Treatment methods include individual psychotherapy, group therapy, family therapy, expressive therapies such as art therapy; hypnosis, psychoeducation types, drug therapies, and in addition, hospitalization is required depending on the severity of the disease (Pais 2009). Depending on the severity, history and condition of the disease, one or more of the treatment types can be applied together. In addition, psychotherapy is the most common type of treatment used for DID. The high rate of suicidal and self-harm tendencies of patients diagnosed with DID causes the treatment protocol to be detailed and prolonged (Gentile et al. 2013).

The existence and perception of alter identities has led to different opinions in the treatment of DID as well as in its diagnosis. Seeing the client with alter identities as a single personality in the treatment protocol, or accepting alter identities as different different personalities and continuing the treatment. The treatment of DID has become one of the most debated topics. For example, according to the International Society for the Study of Trauma and Dissociation, the main perception that should be adopted in the treatment of DID is not to see the patient as a single body sharing different identities, but as a single person carrying out daily life responsibilities together with different personalities (International Society for the Study of Trauma and Dissociation 2011). However, the important point in the treatment of DID is to combine the existing alters, that is, to 'integrate' the patient. According to research, clients who are 'integrated' show more improvement than others. In addition, it has been observed that the symptoms of DID also decrease; symptoms of depression, anxiety, somatic disorders, 1st axis and 2nd axis disorders also decrease more (Brand et al. 2009). It is reported that the rate of patients who achieved complete integration varied from 16.7% to 33% (Ellason and Ross 1997).

Some clinicians have argued that the main part of the treatment of DID is to be aware that DID is a trauma-induced diagnosis and to intervene in traumas that lead to personality splits accordingly (Öztürk 2018, Şar 2018). For example, Şar (2018), who divided DID psychotherapy into three phases as stabilization, addressing traumatic experiences and integration, mentioned the importance of addressing the traumatic process that causes personality dissociation. Öztürk (2018), on the other hand, stated that the treatment of DID is a 'crisis intervention' process carried out by a mental health specialist and, again like Şar, mentioned that there is a three-stage protocol. These stages consist of 'stabilization' focused on calming daily crises, 'trauma studies' and 'integration' consisting of integrating different personalities.

Yanık (2018), who mentioned the three stages of DID treatment like Şar and Öztürk, also mentioned the importance of emphasizing one person in the treatment. The therapist, who constantly talks to alter identities

with different characteristics, should constantly remind himself/herself and the client that alter identities are not different people, but separated parts that are the product of one body and mind.

Trauma in the Etiology of DID

Unlike other diagnoses, the relationship between trauma and DID seems to be closer and cause and effect. The reason for this is that the majority of people diagnosed with DID or with derealization and depersonalization symptoms have a history of trauma in their psychological history. DID is known to be caused by childhood trauma by definition, and it is reported that childhood trauma is the most common psychological history of people diagnosed with DID (Özden 2018, Yanık 2018).

Since 1980, it has been known that the etiological history of DID includes physical and sexual abuse in childhood. Kluft reports that DID is primarily a disease of sexually abused women (Ganaway 1995, Kluft 1991). However, the incidence of dissociative disorders such as depersonalization and derealization is also high in other traumatic events. For example, after the Buffalo earthquake, the prevalence of derealization in earthquake victims was 40%, while the prevalence of depersonalization in earthquake victims was 25% (Spiegel 1997).

Many studies examining the etiology of dissociation report that trauma has an inseparable relationship with dissociation (Howell 2011). Stating that DID is mainly caused by childhood trauma, Yanık (2018) stated that three different types of trauma lead to dissociative disorders. In the first type of trauma, the child himself/herself is targeted and neglect or abuse occurs. Second type of trauma, the child is not a direct or indirect target, but is affected by the negative situation and environment by witnessing the trauma through situations such as domestic violence and divorce. In the third type of trauma, the child is not a direct or indirect target. It occurs as a result of situations that the child and his/her environment cannot control, such as illness, disaster or war.

When considering the relationship between trauma and dissociation, it is important to focus mostly on traumas experienced during childhood. According to Şar (2000), susceptibility to dissociation is much higher in childhood and this susceptibility decreases with age. Dissociative formation is initially used by the child to cope with the trauma. This then progresses pathologically in adulthood and leads to the formation of alter identities. As a result of the severity of the traumas experienced, the child wants to believe that what he/she experienced was experienced by someone else, not himself/herself, and this situation, which is functional and beneficial in the first place, results in the establishment of the imaginary identity as an alter identity over time (Yanık 2018).

In studies examining the effects of trauma on dissociation in childhood and adolescence, it has been discussed that parental approaches are another risk factor. According to Spiegel's approach, in the childhood of dissociative individuals, the story of a child who feels helpless as a result of the aggressive, oppressive and authoritarian management of the parent is frequently encountered (Spiegel 1984). Chu and DePrince (2006), on the other hand, looked at the issue from a different perspective and emphasized that women who were neglected and abused in their childhood are more aggressive and harsh parents, and therefore they may also neglect and abuse their own children.

In a study conducted on people diagnosed with DID, it was observed that 38.7% of the participants' mothers were conscious parents and did not have an abuse pattern in their behaviors towards their children; 45.3% of them behaved unconsciously and committed emotional neglect and abuse, and 16% of them abused their children (Kluft 1987b). AlsoIt was observed that the rate of dissociative symptoms of mothers who were abused as children and who also abused their own children was higher than that of mothers who were abused as children but did not abuse their own children (Egeland and Susman-Stillman 1996).

Considering all this information, it is concluded that, in addition to trauma, factors such as parental approach, child-rearing styles, and the presence of neglect and abuse in a child's upbringing history contribute to the formation of DID. Moreover, repetitive and prolonged trauma experienced during critical developmental periods in adolescence and childhood, especially when caused by caregiver abuse or neglect, is known as developmental trauma (Herman 1992, Fırat and Baskak 2020). Van der Kolk (2009), a leading trauma researcher, emphasized the importance of recognizing developmental trauma in the clinical field, noting that the diagnosis of posttraumatic stress disorder is often inadequate for individuals who were systematically exposed to interpersonal trauma during childhood and adolescence.

Neurobiological studies on people with a history of trauma have revealed that memory disorders are observed as a result of some changes in the brain structure and that dissociative symptoms may also be caused by these changes. For example, it is known that hippocampal functioning slows down in traumatized people and as a

result, memory-related problems are observed (Spiegel 1997). Considering that the hippocampus is involved in recording and storing information in memory, memory problems and dissociative amnesia seen after posttraumatic stress disorder become understandable. Therefore, the fact that decreased functionality in the hippocampus after trauma leads to amnesia and dissociation makes the amnesia seen in DID explainable.

The relationship between hippocampus and trauma has been supported by many studies on the neurobiological effects of trauma (Stein et al. 1997, Vermetten 2006). One of the most frequently cited data on this subject is that people with a history of trauma shows that hippocampus is less in the brain compared to people without a history of trauma (Chalavi et al. 2015). It is also known that this structural impairment in the hippocampus varies according to the severity of the trauma, especially in cases where trauma is associated with dissociative disorder (Chalavi et al. 2015).

In one of the other studies examining trauma and brain function, it was shown that the amygdala was also affected by the traumatic pattern. It has been observed that the amygdala also strengthens the memory structure as a result of affective arousal, creating a parallel relationship between arousal and memory (Christianson and Loftus 1987). However, after the trauma, dissociative mechanisms lead to numbness and numbness in affective arousal, resulting in dysregulation in the function of the amygdala (Spiegel 1997). The relationship between trauma, dissociation and memory impairment and amygdala is explained in this way.

Along with the amygdala and hippocampus, the corpus callosum has also been found to be involved in the dissociative process. Problems in the functioning of the corpus callosum cause a lack of communication in the two cerebral hemispheres and memory impairment occurs. It has been reported that the corpus callosum shrinks after trauma and takes up less space in the brain compared to healthy individuals (De Bellis et al. 1999, Christensen 2022). However, in a study comparing the size of the corpus callosum in people with and without a history of sexual abuse, no difference was observed between the two groups (Kitayama et al. 2007).The effect of trauma on brain structure and functioning on memory disorders has been supported by many studies, including the studies mentioned above. Therefore, it is known that dissociation is related to changes in brain functions as well as psychological history. In addition, the concept of hypnosis is also thought to be related to trauma and dissociation symptoms.

It is stated that people have a predisposition to hypnosis and are easily hypnotized (Cleveland et al. 2020, Ganaway 1995). Underlying this pattern is that the post-traumatic person resorts to avoidance and suppression of memories in response to the intense trauma experienced (Spiegel et al. 1988). However, this situation also enabled the person experiencing dissociation to reveal the suppressed traumatic memories through hypnosis and to benefit from hypnosis treatment (Cleveland et al. 2020). In addition, iatrogenic, that is, undesirable effects of hypnosis treatment in DID may occur due to the state of trance during the treatment; this effect may continue afterwards and the iatrogenic effect may increase the number of alter identities (Powell et al. 1999).

In addition to studies on neurobiology and trauma history, there are also approaches that look at dissociation from a broader perspective. Shalev's three-component approach is one of the examples of holistic approaches that do not base dissociation and the etiology of DID solely on trauma history and brain functions. The first component is a neurobiological process resulting in high arousal and stimulus dissociation, which is a permanent change; the second is conditioning by showing a fear response to trauma-related stimuli; and the last is mental schemas and social anxiety resulting from the incompatibility of the traumatic experience and the person's worldview. In this biopsychosocial approach, impairment and deficiency in one of the components prevents the person from having a say in the healing mechanisms in other components (Shalev 1996).

It would be more functional to approach dissociative symptoms in a holistic manner by addressing all biological, mental, and even social psychological aspects, rather than a single cause (Kluft 2000). As Şar and colleagues (2017) stated, DID should be addressed not only from a single perspective, but also by considering developmental traumatization, family and sociocultural characteristics, cognitive functioning, and neurobiological effects.

Comorbidity in Dissociative Identity Disorder

The presence of alter identities in DID complicates the diagnostic process due to the different characteristics of the identities. Therefore, before considering the comorbidity rate in DID, it is necessary to carefully examine whether the patient's own symptoms or the symptoms caused by the alter identity are the patient's own symptoms. For example, an alter identity that puts the host identity in a difficult situation may cause panic attacks, an alter identity that feels dirty may cause obsessive-compulsive symptoms, and the constant eating of an alter identity that is always hungry is understood as an eating disorder (Şar 2017).

İnanç and Semiz (2017) stated that the diagnoses accompanying DID are psychotic disorders, somatization disorders, bipolar disorder, major depression disorder, and conversion disorder. Conversion disorder, which is a comorbid diagnosis in DID, can occur in the form of fainting, as well as as a result of the struggle to take over internal control arising from alter identities (Akcan and Öztürk 2018, Öztürk and Şar 2016). In addition, anxiety, mood and other personality disorder diagnoses are frequently seen in patients diagnosed with DID (Johnson et al. 2006).

The diagnostic recognition of DID has historically been neglected in literature and psychology, and it was acknowledged later than other personality disorders. As a result, understanding the relationship between DID, which requires a more sensitive diagnostic process, and other diagnoses, identifying comorbidities, and shaping the treatment plan accordingly is particularly important (Aydın and Laçin, 2022; Mitra and Jain, 2023). This review aims to consider the trauma believed to cause DID and address the diagnoses most commonly confused with it. It is significant as the first Turkish source examining the relationship between DID and other commonly associated diagnoses in the literature. The study's importance also lies in evaluating the relationship between DID and other diagnoses, considering factors such as risk factors, etiology, symptoms, and psychopathology.

Posttraumatic Stress Disorder

Posttraumatic Stress Disorder (PTSD) is a disorder included in the section of Disorders Associated with Trauma and Stress in the DSM-5, in which symptoms of avoidance and strain in functions such as mind; mood, arousal and reactivity are seen (American Psychiatric Association 2018). There is a stronger relationship between PTSD and DID compared to other diagnoses due to common symptoms and trauma in the etiology (Atchley and Bedford 2020). The inclusion of derealization and depersonalization in the diagnostic criteria of PTSD is one of the examples of these common points (American Psychiatric Association 2018).

It is accepted that dissociative symptoms occur as a result of intense exposure to traumatic events and are an indicator of the person's attempt to escape from the stressor (Dalenberg and Carlson 2012). Van der Kolk (1995) suggested that dissociation contributes to the reduction of PTSD symptoms and reduces painful feelings and perceptions associated with trauma. Due to the high comorbidity rate of PTSD and DID, it was emphasized that treatment for PTSD symptoms should be applied in the treatment protocol, and it was stated that the function of DID symptoms decreased as a result of successful treatment (Minnen and Tibben 2021).

Van der Hart and Nijenhuis (2005) stated that in the structural theory of dissociation, there are divisions in the personality structure of people diagnosed with Complex PTSD; according to this theory, the intensity of dissociation will increase towards PTSD, Complex PTSD and DID. As a matter of fact, in subsequent studies, it was observed that there was less dissociation rate in uncomplicated PTSD compared to complex PTSD (Hyland et al. 2019). In addition to all these, a new perspective on the relationship between the two diagnoses was developed by including the approach suggesting that dissociation is a subtype of PTSD in DSM-5 (APA 2018). Neurobiological and clinical studies also support that PTSD has two main subtypes, re-experiencing type and dissociative type (Lanius et al. 2010, Swart et al. 2020).

Schizophrenia

Although they are very different diagnoses, the similarity of symptoms of schizophrenia and DID leads to confusion, misdiagnosis and inadequate treatment (Foote and Park 2008). The most prominent difference between them is that DID is caused by environmental factors, severe and prolonged traumas, childhood abuse and neglect, and the most effective treatment method is therapy (Foote and Park 2008). In schizophrenia, on the other hand, there is a genetic-based picture in which environmental factors have little effect and treatment is provided through pharmacotherapy (Moskowitz 2011).

Despite these differences, there are some common features in the etiology of DID and schizophrenia (Kompella and Kaushal 2024). For example, childhood trauma, abuse and neglect are known to cause psychotic symptoms and dissociative disorders at a later age (Read et al. 2008, Nesbit et al. 2022). In studies, child neglect and abuse was found to be one of the important risk factors for psychotic disorders in the majority of participants (Read et al. 2008). Considering the basic relationship between dissociation and trauma, it can be stated that a common point of schizophrenia and DID is that childhood abuse is frequently seen in people with both diagnoses.

Considering that more than 80% of DID patients show auditory hallucination symptoms, there is confusion as to whether this symptom is due to alter identity (Ross et al. 1990). In addition to auditory hallucinations caused by alter identities, visual hallucinations and even command hallucinations that shape the movements of the

person, which are also caused by alter identities, are also observed in DID. However, since DID is not positioned as a psychotic diagnosis in other diagnostic classifications, including the DSM, most DID patients encounter a psychotic diagnosis during the evaluation process (Foote and Park 2008). The rate of patients with both diagnoses at the same time is about 1%, and the presence of people with both diagnoses is almost never encountered in the data (Kluft 1996).

Ross and Keyes revealed a significant research between dissociative disorder and schizophrenia in their study with 60 participants with schizophrenia (Ross and Keyes 2004). The researchers, who applied scales related to DID to schizophrenia patients at the same time, revealed that 60% of the participants also had a high rate of dissociation symptoms and additionally had a history of abuse in their childhood. In addition, 44% of the participants were found to fully meet the diagnostic criteria for DID. Following this result, Ross and Keyes commented that there is actually a subgroup of people diagnosed with schizophrenia who are also diagnosed with 'DID'. In addition, it is known that there are cases with a direct relationship between dissociative disorders and schizophrenia; non-dissociative schizophrenic cases, schizo-dissociative cases and pure dissociative cases (Şar et al. 2010).

Şar and Öztürk (2010) examined the relationship between schizophrenia, DID and childhood trauma by applying DID scales on schizophrenia patients. As a result, it was reported that while there was a parallel relationship between childhood trauma and dissociative symptoms, there was no relationship between the basic symptoms of schizophrenia and these two conditions were different. There was a 'dissociative sub-group' among the participants and the rate of psychiatric comorbidities such as DID, Schneider delusions and somatic disorders was higher than the other group.

In addition to studies on the common symptoms of schizophrenia and dissociative disorders, there are also studies emphasizing that they are actually distinguishable (Steinberg et al. 1994). In a study conducted by Steinberg et al. (1994) on patients diagnosed with schizophrenia and schizoaffective disorder, it was observed that patients with DID were more likely to be diagnosed with schizophrenia and schizoaffective disorder after the Structured Clinical Interview for DSM Disorders (SCID) evaluation. The use of hypnosis as an additional method in the treatment of DID can be considered as a differentiating symptom from schizophrenia (Ross et al. 1990).

According to Moskowitz, DID and schizophrenia have been showing intertwined symptoms like a married couple for years, and for this reason, they cannot be differentiated from each other even in sources from a hundred years ago (Moskowitz 2011, Ross and Keyes 2004). In addition, schizophrenia and DID have neurobiologically common features. It is observed that hippocampal function is decreased in schizophrenia patients, just like in DID patients (Nelson et al. 1998). Therefore, when evaluating the relationship between DID and schizophrenia, it is necessary to take into account that they have both psychological and physiological common features.

Depression

One of the diagnoses also seen in patients with DID is depression (İnanç and Semiz 2017). Although the relationship between DID and depression is actually very clear, undefined comorbidity conditions prevent this relationship from being fully investigated (Şar et al. 2013). Although the relationship between depression and DID is not a topic that has been addressed by researchers, considering the impact of childhood traumatic experiences or any trauma experience on DID, its relationship with depression becomes more understandable. Although depression is not directly associated with DID like schizophrenia and trauma, it should be taken into consideration through traumatic history (Şar et al. 2013).

Firoozabadi and colleagues (2019) examined the dissociative symptoms of participants in a study conducted in Iran with 229 participants with depressive symptoms. According to the results of the analysis, it was found that one-third of the participants had moderate to severe dissociative symptoms. Firoozabadi (2019) interpreted this result as people with childhood trauma using dissociation as a defense mechanism. He stated that focusing especially on depressive symptoms in their treatment would contribute positively to the course of the disease.

In a study conducted with 628 female participants in Turkey, Şar et al. (2013) examined the dissociative and depressive symptoms of the participants. As a result, they found that 10% of the participants met the diagnosis of major depression and 40% of these people were also diagnosed with DID. The common characteristics of people with both depression and dissociation symptoms include suicidal thoughts, cognitive distortions such as feelings of guilt and worthlessness, concentration problems, and indecisiveness. It should also be noted that those who were diagnosed with DID and depression together had much higher rates of depressive symptoms than those who were diagnosed with depression alone. One of the features of this study is that the concept of

'dissociative depression' was used for the first time in the literature (Şar et al. 2013). The idea expressed and defended in this concept created by Şar is that childhood abuse and trauma are common in severe depression and chronic dissociative disorders (Şar 2015). According to the researcher, dissociative depression is characterized by more chronic and irregular depressive symptoms than other types of depression. In addition, the age of patients with dissociative depression is younger than that of patients with depression, and the age of the first appearance of symptoms is early, sometimes starting in childhood (Şar 2015).

It has been observed that some depressive cases are highly resistant to treatment; medical treatment alone is often insufficient, and even the combination of medication and therapy proves to be ineffective (Şar 2011). Şar (2011) suggests that these severe, treatment-resistant cases of depression, particularly those with persistent somatic symptoms, may actually be instances of dissociative depression, which typically stems from childhood trauma and prolonged stress experiences.

Depression cases with dissociative symptoms may delay the diagnosis and lead the treatment to focus on the medical process. However, in cases of depression and dissociation caused by trauma, the main focus should be on the treatment of trauma (Öztürk 2018). Trauma work, which is one of the three important parts of the treatment of DID, is to reveal and focus on the trauma experienced before. This treatment, which is also valid for dissociative depression, is disrupted in some cases of depression when dissociation is ignored. For this reason, the therapist should not overlook addressing the trauma, regardless of the symptoms (Öztürk 2018).

Soffer-Dudek (2014) stated that there was limited research on the relationship between DID and depression in the first place, but later the relationship between them was supported by the Dissociative Experiences Scale-Taxon (DES-T) and the differential questions in the scale. However, according to Soffer-Dudek (2014), researchers generally focus on subscales and do not take a comprehensive view when considering the relationship between dissociation and DID. Therefore, they ignore the relationship between the two diagnoses arising from symptoms. For example, depressive symptoms that reduce functionality such as sleep, eating, and impaired arousal cause dissociation through stress. In the author's relational model, dissociation triggers emotional symptoms in depression; physical symptoms such as sleep disturbance trigger dissociative amnesia and depersonalization; traumatic experiences and stress trigger both depression and dissociative disorders.

One of the important points to be addressed in DID and depression is their common neurobiological features as well as their common symptoms. In a study conducted on participants diagnosed with depression, serious impairments in hippocampal function were observed (Bob et al. 2008). At the same time, the damage to the hippocampal area causing dissociation symptoms and the fact that the same symptoms were found in patients with depression showed that the two diagnoses also have common neurological features. According to the researcher, hormonal changes caused by dissociation may increase susceptibility to stress and depression. Considering this situation, stress, depressive symptoms and dissociative symptoms should be evaluated together.

Borderline Personality Disorder

Borderline personality disorder (BPD) is closely related to childhood traumas just like DID. It is reported that 30-90% of patients with BPD have a history of abuse or trauma in childhood (Ball and Links 2009). Unlike DID, BPD symptoms are associated with emotional-behavioral-cognitive pattern inconsistencies in general, such as high impulsivity, self-questions, problems in interpersonal relationships, irregularity in one's mood, complaining of emptiness and loneliness (İlk and Bilge 2020).

There is a strong relationship between DID and BPD and childhood traumas. Therefore, there are similarities in psychopathological symptoms between them (Derin and Öztürk 2018). In particular, the fact that the person's childhood trauma originates from the family and is severe increases the likelihood of dissociation and amnesia. This picture also leads to the risk of developing BPD later (Derin and Özütrk 2018).

In their study, Şar et al. (2003) examined the comorbidity rate of DID and BPD in 240 participants obtained from a psychiatric hospital. As a result of the analysis, 10.4% of the participants were diagnosed with SDD and 13.8% with DID; at the same time, 64% of those diagnosed with BPD were also diagnosed with DID. Participants who met both diagnoses also exhibited a severe clinical picture, had a history of severe childhood trauma and abuse, other concurrent diagnoses, self-harming behaviors and suicide attempts. It was also supported by other studies that participants who met the diagnostic criteria for DID also met the diagnostic criteria for BPD and that this rate was high (Ellason et al. 1996, Yargıç et al. 1998).

According to Şar et al. (2013), the high level of comorbidity of both diagnoses can be explained by characteristics such as biological factors, genetic predisposition, temperament as well as childhood trauma (Şar 2017). The comorbidity of DID and BPD was reported in a study that the rate of childhood trauma in those with both diagnoses was 100% (Ross et al. 2013). In addition, it was observed that participants with both diagnoses had much higher rates of trauma, dissociation, depression, somatization, and suicide attempts compared to those with only DID and only BPD.

When we look at the neurobiological substructure of DID and BPD, some common features come to the fore. It has been observed that altered brain activity during dissociation affects neuro-psychological processes, cognitive structuring and emotional regulation through this mediation (Schulze et al. 2016).

The change in brain organization and cognitive activities caused by dissociation provides a better understanding of the relationship between dissociative disorders and BPD. Krause-Utz and colleagues (2017), who modeled the relationship between the two diagnoses by categorizing the symptoms, stated that there is a connection between dissociative symptoms and emotional memory-processing through brain structures such as amygdala, hippocampus and middle temporal lobe.

Laddis et al.'s (2016) approach to the relationship between DID and BPD is different from other researchers in that both diagnoses cannot be taken together according to the DSM criteria. According to DSM-IV criteria, since the symptoms of someone diagnosed with personality disorder cannot be explained by another disorder, the strong relationship between both diagnoses can be explained in two ways. Firstly, people who would really be diagnosed with DID are diagnosed with BPD as a result of misdiagnosis, and secondly, the DSM's diagnostic criteria are determined by ignoring the alter state in DID. This is because alter changes in DID, behavioral differences between the alters, and the symptoms of BPD shown by the alters may cause diagnostic error. According to Ross (2007), who concluded that the comorbidity rate of DID and BPD is high, one of the main reasons for this high rate is that the DSM-IV committee did not fully address the relationship between DID and BPD. In the DSM-IV, there is no information on the differential diagnosis of BPD in the section on DID. For this reason, in order to differentiate the two diagnoses more qualitatively, a subgroup of BPD should be created or a differential diagnosis description should be made in DSM-IV. The fact that the structure of BPD is more complex and multi-categorized compared to other personality disorders caused discussions in the versions of DSM, and in DSM 5, the necessity of personality disorders and pathological personality traits, which were not emphasized in DSM-IV, was stated (American Psychiatric Association 2018). In DSM-IV, the diagnostic criteria for BPD were stated as the presence of at least five of the nine items specified, leading to 256 different combinations in making this diagnosis, leading to a serious heterogeneity in people diagnosed with BPD (Gunderson 2010).

Somatization

The fact that people diagnosed with DID have a high number of somatic symptoms constitutes the basis of the relationship between DID and somatization. There is a unidirectional relationship between these two diagnoses with somatization being a subgroup of DID rather than a bidirectional relationship as in diagnoses such as trauma, schizophrenia, borderline personality disorder and depression (Nijenhuis 2001). Somatic symptoms seen in DID patients include headache, chronic pelvic pain, stomach pains, conversion, heart and lung related disorders (Saxe et al. 1994). However, according to one approach, the frequency of conversion in DID is much higher than the frequency of somatization (Esprito-Santo and Pio-Abreu 2009). Therefore, in addition to the relationship between DID and somatization, the relationship between DID and conversion should be considered.

The relationship between conversion and somatization is itself unclear. In a study in which 98 patients diagnosed with conversion and somatization were followed up for 4 years, it was observed that the diagnoses of 32 of the patients diagnosed with conversion disorder did not meet the same diagnosis at the end of the four-year period, and the diagnosis of 6 patients turned into somatization disorder (Kent et al. 1995). Researchers interpreted this situation as epiphenomenic; that is, that conversion disorder is an indirectly effective disorder rather than a direct one, and that it carries many diagnostic uncertainties (Kent et al. 1995). Although the incidence of dissociative symptoms is higher in conversion disorder, the incidence varies between 5% and 42% in those diagnosed with somatization disorder (Saxe et al. 1994). Due to the flexibility of the diagnostic symptoms between conversion and somatization, there are also comments on their relationship with DID and the uncertainty of the diagnoses (Güz et al. 2004). However, it may be the most accurate approach to see all three diagnoses as interrelated and to consider conversion disorder as a subgroup of somatization.

Although somatization and DID have common features, the relationship between the two diagnoses differs from other diagnoses in that DID has a subgroup related to somatization and is determined by the 'Somataform Dissociation' scale (Nijenhuis et al. 1996). Consisting of 20 questions and including questions about positive and

negative symptoms, this scale also determines the severity of somataform dissociation. These questions generally aim to reveal somatic, body-related symptoms of dissociation such as not feeling their body, numbness in certain parts of the body, inability to speak, paralysis (Nilsson et al. 2020, Nijenhuis 2001). Evaluation of these symptoms will reveal the importance of the effects of trauma and dissociation on the body beyond the relationship between somatization and dissociation.

Eating Disorders

Research on the relationship between eating disorders and dissociative symptoms shows that some people with dissociative symptoms also have an eating disorder (Demitrack et al. 1990). According to Everill et al. (1995), high levels of dissociation were found to be associated with eating disorder symptoms such as binge eating, self-induced vomiting, using laxative methods, excessive self-starvation, and problems in body perception (Nelsson et al. 2020). It has been observed that dissociation levels of people diagnosed with eating disorders are above average; the process of the relationship between the two diseases, common symptoms and mediators with axis one and two diseases have been examined (Gleaves and Eberenz 1995).

According to the multifactorial model presented by Vanderlinden and Vandereycken (1997), there is an ongoing, mutually nourishing and complementary dynamic relationship between traumatic memory and dissociation. The results of this relationship depend on a number of mediating roles such as evaluating, accepting and experiencing one's own body in dissociative symptoms in eating disorders. The importance of self-esteem and one's own body perception and coping with negative perception in the process of eating disorder formation is emphasized in such studies.

In their study of 118 participants with eating disorders, Beato et al. (2003) stated that 30% of the participants, especially those diagnosed with bulimia, had dissociative symptoms and that dissociation may be the underlying cause of eating disorders. Hallings-Potts et al. (2005) emphasized the statistically significant relationship between bulimia and dissociation and stated that there is an impulse control problem that feeds this relationship and eating disorder and added that dissociation and trauma should be addressed in the treatment process. In addition, it has been emphasized that there may be a relationship between childhood trauma and eating disorders and DID, that people diagnosed with bulimia experience a difficult childhood, and that the likelihood of having a history of sexual abuse is higher than people with other eating disorders (Schmidt et al. 1993).

According to another study, people with eating disorders show a 'voice' coming from within them as a justification for their behaviors, and they are not aware of their own eating, weight, body perception, etc. (Schmidt et al. 1993) they report that this voice is effective (Pugh et al. 2018). According to this study by Pugh et al. (2018), the severity of eating disorders depends on the traumas experienced in childhood and the dissociation associated with these traumas. The results of this study also coincide with the study conducted by La Mela and colleagues (2010). La Mela et al. (2010), in an experimental design study comparing people diagnosed with eating disorders and a healthy control group, found that the dissociation level of people with eating disorders was higher than the healthy group and stated that there was a relationship between uncontrolled overeating and dissociative experiences (La Mela et al. 2010).

In their book on the relationship between trauma, dissociation and eating disorders, Vanderlinden and Vandereycken (1997) reported that the rate of trauma history in people with eating disorders diagnosed with anorexia nervosa mixed type, bulimia nervosa, atypical eating disorder was 25%, 37%, 58%, respectively. They also emphasized that the trauma history of the individuals may be associated with sexual abuse, severity of abuse and dissociation caused by trauma. The researchers reported that participants with a history of trauma, especially sexual abuse, were more likely to be diagnosed with an eating disorder and interpreted these findings as the severity of trauma is related to the type of eating disorder. In this case, it is interpreted that dissociation associated with trauma also plays an important role in eating disorders.

Attention Deficit Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterized by difficulties with attention, focus, impulsivity, and hyperactivity, with symptoms manifesting in childhood and persisting into adolescence and adulthood (Coşkun et al. 2020). Epidemiological studies indicate a close relationship between ADHD symptoms and stress, and dissociative symptoms are prominently observed in individuals diagnosed with ADHD (Bob and Konicarova 2018). Furthermore, research has reported a high likelihood of dissociative symptoms, such as alienation from oneself and one's environment, in individuals with ADHD (Green 2023).

One of the common features of ADHD and DID is that childhood trauma is seen in the etiology of both diagnoses. While childhood traumas are known to underlie DID, it is also known that trauma history is a risk factor in individuals diagnosed with ADHD (Kandeğer et al. 2022, Sissons 2023). Symptoms of posttraumatic stress disorder caused by traumas such as childhood abuse are similar to ADHD symptoms, and the probability of simultaneous occurrence of these two diagnoses is high, making it difficult to make a differential diagnosis (Weinstein et al. 2000). Common features of ADHD and PTSD include symptoms such as insomnia, irritability, difficulty in focusing, and hyperarousal (Weinstein et al. 2000). In this context, for ADHD and DID diagnoses, it is stated that trauma is present in the etiology of both diseases and dissociation plays a mediating role between ADHD and DID (Matsumoto and Imamura 2007).

As a result of a study conducted in 799 adults with ADHD and DID comorbidity, 33% of the participants had childhood trauma, which supports the mediating role of dissociation (Matsumoto and Imamura 2007). In another study investigating the comorbidity of ADHD and DID, it was reported that one third of ADHD participants with a history of abuse were also diagnosed with dissociative disorder (Endo et al. 2006). Harrison and Wilson (2005) reported that many symptoms of ADHD and DID, such as difficulty in maintaining attention and focus, concentration problems, forgetfulness, following instructions in a study, overlap significantly.

According to the approach stated by Kandeğer et al. (2022), traumatic experiences and dissociative experiences are transdiagnostic factors that pave the way for the development of ADHD. Trauma-related symptoms such as motor dysfunctions, difficulty in emotion regulation, and focusing problems can trigger and reveal the symptoms of ADHD. Usta and Karas (2021) in their study, they found that ADHD played a role in the symptoms of DID and that the trauma experienced in childhood by individuals diagnosed with ADHD could reveal the symptoms of DID, and that the emotion regulation difficulty caused by trauma played a mediating role in both DID and ADHD symptoms.

Discussion

The main aim of this study was to investigate and review the diagnoses with which DID is most commonly associated and with which the rate of comorbidity is high. The importance of this review, in which trauma, post-traumatic stress disorder, schizophrenia, depression, borderline personality disorder, somatization, eating disorder and attention deficit hyperactivity disorder are discussed in relation to DID, is that, unlike the studies in the literature, the relationship between DID and the mentioned diagnoses is not discussed in general but individually.

DID is a psychological disorder that was recognized late, defined late and its definitional classification was made late in the literature (Tamam et al. 1996, Şar 1998). The basis of this is that DID leads clinicians to confuse it with other psychopathological symptoms due to the presence of alter identities and amnesia (Şar 2017). In particular, the fact that alter identities have been confused with hallucinations for years and thus associated with psychotic disorders has caused the treatment of people who actually have DID to be disrupted and misguided. Along with other dissociative disorders, DID has been one of the disorders that some researchers, both past and present, have been skeptical about its existence. The main reason for this is both the late recognition of DID and the delay in starting to experimentally study memory and its components. Today, there are still researchers who argue that the amnesia and memory losses caused by DID are not dissociation but false memories caused by trauma. In fact, the treatment of DID caused by childhood trauma should take place in the form of combining the alters by focusing on the trauma after stabilizing the patient (Öztürk 2018, Yanık 2018). However, what is important at this point is to address the underlying childhood trauma, abuse or neglect.

Trauma lies at the root of DID and exacerbates the symptoms of DID with its severity, making its treatment more difficult (Kluft 1991, Özden 2018). Therefore, the relationship between trauma and DID is one of the most researched topics and, unlike other diagnoses, it constitutes a more relational and causal infrastructure. There are studies supporting the relationship between trauma and DID both etiologically and neurologically. In particular, it is interpreted that chronic and severe trauma experienced in childhood shapes the brain structure and the changing neurobiological effect causes amnesia and dissociation (Christianson and Loftus 1987, Stein et al. 1997, Vermetten et al. 2006, Spiegel 2007, Chalavi et al. 2015).

The relationship between schizophrenia and DID does not contain causality, but rather exhibits a pattern based on confusion of symptoms and diagnoses (Ross et al. 1990, Kluft 1996, Foote and Park 2008). Although childhood traumas are seen as a risk factor for schizophrenia, the fact that schizophrenia is based on genetic and biological factors and its treatment is done through medication shows that there are completely different diagnoses with DID (Moskowitz 2011, Read et al. 2018).

The relationship between depression and DID has suggested that resistant depression seen in some patients may be associated with dissociative symptoms (Şar 2011). In addition, dissociative symptoms seen in severe depression cases led to the formation of the concept of 'dissociative depression' (Şar et al. 2013). Although there are common features in terms of neurological characteristics, symptoms and etiology in DID and depression, the fact that people with DID are treated for depression as a result of misdiagnosis prolongs the process (Öztürk 2018).

BPD, like DID, is a diagnosis that is mostly based on childhood trauma, neglect or abuse (Ball and Links 2009, Derin and Öztürk 2018, Ross et al. 2013). However, symptoms such as impulsivity, personal and interpersonal problems in BPD distinguish the two diagnoses (İlk and Bilge 2020). However, despite the differences in symptoms, the high rate of comorbidity between BPD and DID has led researchers to state that the DSM committee should introduce additional criteria for differential diagnosis (Şar et al. 2003).

The relationship between dissociative disorders and somatization is mostly in the form of somatization as a symptom and subgroup in DID (Saxe 1994, Güz et al. 2004). The presence of somatic symptoms in people diagnosed with DID has led to the formation of the concept of 'somataform dissociation' and the differential diagnosis between them (Nijenhuis 2001). According to some researchers, there is very little difference between conversion and somatization, and the diagnosis that is actually related to dissociation is not somatization but conversion disorder (Espirito-Santo and Pio-Abreu 2009).

The relationship between DID and ADHD is strengthened by the fact that childhood trauma, which is at the basis of both diagnoses, constitutes a risk factor and trauma increases the likelihood of both diagnoses. The common symptoms of both diagnoses such as attention and concentration problems, state of arousal, and dysfunctions are frequently mentioned in studies investigating the relationship between DID and ADHD.

Conclusion

Trauma plays a central role in the development of DID and related mental health conditions, making it a key factor in understanding their causality. While BPD and schizophrenia are distinct diagnoses that need to be carefully differentiated from DID, depression and somatization are often seen as co-occurring conditions or subsets within the broader framework of DID. This overlap highlights the complexity of trauma's impact on mental health, where multiple disorders may share common features but require different approaches to diagnosis and treatment.

To summarize the relationship between DID and the five diagnoses discussed: trauma is the unifying factor across all these conditions. DID is increasingly viewed as part of the trauma-related disorder spectrum, emphasizing the deep psychological impact of early, repeated trauma on identity and self-perception. Depression and somatization often coexist with DID as trauma-related symptoms, while BPD and schizophrenia are recognized as separate clinical entities with their own unique characteristics. Distinguishing these conditions is essential for accurate diagnosis and effective treatment, as it enables a tailored therapeutic approach that addresses the specific needs of each disorder. Ultimately, the interplay between trauma and these various mental health diagnoses underscores the importance of trauma-informed care in both diagnosis and intervention strategies.

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Authors Contributions: The author(s) have declared that they have made a significant scientific contribution to the study and have assisted in the preparation or revision of the manuscript
Peer-review: Externally peer-reviewed.
Conflict of Interest: No conflict of interest was declared.
Financial Disclosure: No financial support was declared for this study.