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Dissociative identity disorder as interdisciplinary problem. Part I – psychiatric and psychological aspects

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Summary

Dissociative identity disorder (DID) belongs to the complicated issues of psychiatry and psychology areas. The specificity of the disorder and its clinical picture imply numerous difficulties in the diagnosis and treatment process. The diagnosis of DID can also have significant legal consequences, especially in the context of criminal liability or the general ability to be a witness. Thus, DID is an interdisciplinary problem.

In practice, DID is rarely diagnosed, although it is estimated that it occurs in about 1% of the general population. In many cases, the period from the first contact with the healthcare system to a correct diagnosis exceeds several years (on average, 6.7 to 8 years). The average misdiagnosis rate is 2.8 per patient. The lack of a quick and proper diagnosis makes it impossible to undertake adequate treatment, which extends the entire therapeutic process, affects its effectiveness and significantly increases costs. There is no doubt that in educating psychiatrists and clinical psychologists, greater emphasis should be placed on correctly detecting dissociative symptoms and the use of adequate diagnostic tools.

The aim of this article is to present and identify the main problems that DID implies in the diagnostic and therapeutic (psychological and psychiatric) areas. The article discusses the existing diagnostic tools, the issues of comorbidity and the causes of incorrect diagnoses. The issues of false-positive diagnoses and difficulties in differentiating patients with DID from simulators were also discussed. The primary mistakes made during the therapy, such as the strategy of minimization or the actions leading to multiple therapist disorder, were analyzed. Legal aspects will be presented in a separate article.

Key words: dissociative identity disorder, multiple personality, post-traumatic disorders

Introduction

Dissociative identity disorder (DID), also known as multiple personality, is one of the intricate issues on the border of the field of psychiatry and psychology. This

disorder is characterized by the presence of two or more distinct personality states (dissociative identities) [1], each of which has its behavioral patterns, memories, or preferences [2]. Each of these identities can, therefore, independently interpret their person and the surrounding environment.

Such a clinical picture implies many diagnostic difficulties. In practice, DID is rarely diagnosed, and the disorder remains poorly studied [3], although its frequency in the general population is estimated at about 1% [4, 5]. The literature on the subject also draws attention to the issue of effective differential diagnosis, especially in the context of differentiating patients with DID from simulators [6, 7]. In the past, there were also views on the iatrogenic etiology of DID [8].

Due to amnesia episodes and autobiographical memory disorders in the clinical picture, this issue also has significant legal implications. It applies in particular to the possibility of assigning criminal liability for committing a prohibited act, the general ability to be a witness in the course of court proceedings or the possibility of applying particular procedural institutions to a trial participant suffering from DID (such as coercive measures).

The problem of dissociative identity disorders has an interdisciplinary nature. This article aims to present and identify the problems that DID implies in the diagnostic and therapeutic (psychological and psychiatric) areas. Due to the limited framework of the study, legal issues will be presented in a separate article (the second part of the study).

The authors reviewed the literature on DID and other post-traumatic disorders. The research took into account the data contained in the MEDLINE (PubMed), Scopus and Google Scholar databases. The analysis covered original articles containing the results of clinical research, review articles, case studies, and meta-analyzes.

Diagnostic and classification aspects

Dissociative identity disorder as an independent diagnosis (300.14) is present in the American *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) [9]. The *International Statistical Classification of Diseases and Related Health Problems* (ICD-10) [10] in force in Europe does not use the term DID. The above nosological unit matches in this case to the diagnosis of "multiple personality" (F44.81). This terminological inconsistency was noticed by the authors of ICD-11 [1]. The 11th version of the ICD adopted the terminology identical with DSM-5, abandoning the term "multiple personality" in favor of DID (6B64).

The disease entity discussed here belongs to the group of complex dissociative disorders [11]. DID is characterized by presence of at least two distinct personality states and recurrent dissociative amnesia [9]. As mentioned, each dissociative identity has its own memories, preferences, and behavioral patterns [2]. Persons suffering from this disorder experience memory gaps related to current events (e.g., daily activities undertaken under the influence of dissociated identities), basic personal information,

or past traumatizing events. Patients with DID lose their sense of identity continuity and self-control. Other symptoms that may occur in this disorder are depersonalization and derealization, intrusion of thoughts or memories (a sense of interference with consciousness) [12].

Dissociative identities usually do not know about themselves, nor do they have insight into memories of other parts of the "self". Only one aspect of the personality is revealed at a time. The transitions between the identities are usually sudden and follow a trigger, which causes the individual to return to highly traumatic memories [13]. Then a given dissociative identity temporarily takes control of the person's behavior.

To diagnose DID, it is necessary to first state that the presented symptoms are not a consequence of organic changes (F00–F09) or the use of alcohol or psychoactive substances (F10–F19).

Undoubtedly, a usual feature for patients with DID is exposure to recurrent stress in the early years of life (early childhood trauma) [14]. Hence DID belongs to the group of post-traumatic disorders [11]. These traumatic experiences can be caused by events such as sexual harassment and physical violence. It is estimated that as many as 90% of people diagnosed with DID were victims of sexual harassment in their childhood [9]. Physical violence was used against 79% of patients with dissociative disorders. Such a high rate of early childhood trauma did not occur in any other group of studied mental disorders [15]. Other data indicate that as many as 97% of patients diagnosed with DID admit to being abused in the early years of life [16].

Experiencing trauma in childhood disturbs the process of building a coherent personality [3] and is the most important environmental predisposing factor for DID. The first change in dissociative identity in life is directly related to the time of the activity of the stress factor. The then-emerging defense mechanisms, consisting of the denial of memories and emotions accompanying the trauma, are aimed at reducing the negative consequences of these events. These protective activities can lead to long-term dysfunction in the field of autobiographical memory [17], which results in the lack of insight into memories of other parts of the "self" and the perception of these memories as foreign.

It is also worth emphasizing that studies conducted on sibling pairs, including identical and fraternal twins, confirm that the occurrence of DID is related not only to environmental but also genetic factors [4]. The gender of the patient is also relevant. Women suffer from DID nine times more often than men [18].

The ability to detect subtle, not necessarily specific symptoms of DID, is crucial. It constitutes the basis for further work and the correct diagnosis of this disease entity. In this context, it should be noted that many clinicians do not take into account the symptoms that may point out dissociative disorders during the diagnostic process and do not ask the patient about them [19]. The patient may consider dissociative experiences insignificant and omit them if an examiner does not raise this topic directly. Only questions focused on the symptoms of the dissociation spectrum allow for a complete

anamnesis, and thus a correct diagnosis and avoidance of errors in this area [12]. DID is a disorder related to the "hiding" of individual parts of the identity. The inexperienced clinician may have a problem detecting subtle changes in switching these parts if the original diagnosis, based on an incomplete interview, did not include DID as one of the potential diagnoses. For example, a patient's amnesia caused by dissociation, which makes it impossible to answer questions about the past, maybe misinterpreted as negativistic behavior [15]. Incorrect diagnosis may result in the abandonment or low effectiveness of the therapy [12].

Diagnostic tools

Various, more or less complex scales and questionnaires have been used in the diagnosis of DID. Currently, the most practical is the SCID-D-R questionnaire (Structured Clinical Interview for DSM-IV Dissociative Disorders – Revised), which is considered the "gold standard" in diagnosing dissociative disorders. This tool covers five primary groups of symptoms of dissociative disorders, relating respectively to: (1) dissociative amnesia, (2) depersonalization, (3) derealization, (4) identity confusion, and (5) identity alteration. The questionnaire assesses the presence of the above symptoms and intensity and frequency of their occurrence. Each symptom is assessed separately on a four-level scale (1 – no symptom; 2 – mild symptom; 3 – moderate symptom; 4 – severe symptom) [20].

The SCID-D-R is based on the DSM-IV classification. The questionnaire has not yet been revised to the current DSM-5. The differences between the aforementioned editions of the American classification may potentially reduce the diagnostic value of the discussed tool. Nevertheless, the literature indicates that the current form of the SCID-D-R can still be used (despite the lack of updates) to diagnose DID, including the differentiation of DID from other specific dissociative disorders [20].

In addition to the SCID-D-R, the following tools may be useful in the diagnosis of DID:

(1) Dissociative Experiences Scale (DES), consisting of 28 questions concerning the frequency of experiencing dissociation symptoms in everyday life (on a scale from 0 to 100%). It is a screening tool [21];
(2) Dissociative Disorders Interview Schedule (DDIS) – a structured interview of 131 items that can be used to diagnose dissociative disorders, somatization disorders, major depressive episodes, borderline personality disorders, and disorders caused by alcohol and psychoactive substances abuse [22];
(3) Multidimensional Inventory of Dissociation (MID) – a large-scale instrument for the clinical evaluation of patients with symptoms of dissociative, post-traumatic and borderline disorders. The final MID version consists of 218 items. It enables the assessment of 14 main aspects of dissociation (including memory disorders, depersonalization, derealization, the feeling of loss of continuity in the passage of time, the presence of voices, or somatoform symptoms) [23].

A new diagnostic tool has also been tested in recent years, introduced under the name Trauma and Dissociation Symptoms – Interview (TADS-I). This tool is a partially structured interview designed to identify dissociative disorders based on the DSM-5 and ICD-11 diagnostic criteria. TADS-I allows the assessment of somatoform dissociation symptoms and other trauma-related symptoms (which is relevant in the differential diagnosis of PTSD). It also provides for the differentiation of complex dissociative disorders from personality disorders and false-positive DIDs. Validation tests of the tool discussed here are currently underway [24].

Terminological issues

In the light of the upcoming classification changes provided for in ICD-11, the current method of describing the symptoms of DID should also be revised. In the Polish literature on the subject, there is a relatively well-established tendency to use the statement that DID (or, more precisely, a multiple personality) is the presence of two or more "personalities" in one person [2, 13, 25, 26]. This approach may lead to an erroneous conclusion, suggesting the existence of many separate personalities, whereas all of them are parts of one person who only subjectively perceives them as separate entities [15].

The use of the term "separate states" of (one) personality seems to be much more precise. These states are named "dissociative identities" [1]. This approach is also justified by the arguments underlying the introduction of the term DID to DSM (the change was made in the fourth edition of this classification). As emphasized by D. Spiegel (chair of the DMS-IV work group on dissociative disorders), the change of terminology was aimed at highlighting a fundamental problem – the difficulty in integrating various aspects of the same personality and not the multiplicity of these personalities [27]. For this reason, the term "multiple personality" has been replaced by "dissociative identity disorder."

Another argument confirming the correctness of the terminological changes is the general aim of treating patients with DID. This purpose is to integrate all aspects of the personality into one coherent whole. If the essence of DID were the plurality of different personalities, their subsequent integration would be a priori impossible.

Although the term "multiple personalities" is often an expression of a mental short-cut, such a literal construction can cause numerous difficulties in the proper diagnosis and treatment of DID, leading to a misunderstanding of the nature of this disorder.

Patients with DID and simulators

One of the most problematic aspects, and at the same time the accusations made against DID, is the potential possibility of simulating DID symptoms [28], and thus the inability to distinguish a patient with a dissociative identity disorder from a simulator. This issue becomes especially problematic when disorders are diagnosed in offenders

of a crime who would avoid criminal liability on this basis [5, 29]. The above objection should be considered ineffective for two reasons.

First, there are effective diagnostic tools to distinguish DID patients from simulators. The latter include the already mentioned SCID-D questionnaire, which effectively differentiates patients with DID from simulators [20] and other diagnostic tools discussed above, including the new TADS-I scale. Other studies indicate the usefulness of the MMPI-2 questionnaire. With its help, 86% of DID cases and 83% of simulators were correctly classified, although the latter group had previously been trained in the characteristic symptoms and behavior of people with DID [29]. This means that simulators are unable to imitate DID in a way that makes it impossible to detect cheat [5]. Even individuals well-prepared for the role of a DID patient were not able to present such a complex range of symptoms as associated with DID. These people omitted less transparent signs and symptoms of coexisting disorders (e.g., depression, sexual dysfunction, PTSD). Simulators are also unable to recreate the characteristic features of individual personalities.

Another study demonstrated the value of neuroimaging techniques by observing significant differences in cerebral blood flow, between patients with DID and the control group [30]. The comparison of the brain structures also allowed distinguishing patients with DID from healthy people (and thus simulators) with 72% sensitivity and 74% specificity. The mean hippocampus volume was 19.2% lower in patients with DID compared to the healthy group. The same trend applied to the amygdala, the volume of which was on average lower by 31.6% in the DID patient population [14]. Of course, neuroimaging tests cannot be a routine differential diagnosis tool (mainly due to their high cost). However, use of neuroimaging may be justified in particularly doubtful cases, when the finding or excluding DID will imply significant legal consequences (e.g., in terms of liability for a committed crime). It is worth emphasizing that due to the same etiological factor (trauma), these methods will not be useful for differentiating DID from other post-traumatic disorders, in which changes in the volume of the above-mentioned brain structures are also present [14].

Secondly, to avoid criminal liability, people who simulate mental disorders, as a rule, aggravate alleged symptoms. In the case of DID imitation, one should expect an extreme manifestation and accentuation of one's own traumatic experiences and sensations. Meanwhile, in a study of twelve inmates diagnosed with DID who were convicted of manslaughter, most denied or downplayed the fact that they had been mistreated. Four people categorically rejected the occurrence of such events, even when they were presented with documentation confirming it. For seven inmates, the memories of harassment were only fragmentary. Meanwhile, 11 cases of traumatic experiences have been objectively verified [31].

If the perpetrators, wanting to avoid punishment, were to simulate DID, they should rather exaggerate the harm suffered and not depreciate or categorically deny it. Simulators show exaggerated and dramatic symptoms and show a very high willing-

ness to be diagnosed with DID. At the same time, these symptoms "occur" only when the person is aware that they are being watched or monitored [32].

In ambiguous cases, attention should be paid to factors such as lack of objective evidence for the existence of dissociative symptoms in the patient's medical history, many inconsistencies in the scope of the life history described by him/her, and the manifested behavior. These people also often refuse to consent to detailed psychological or psychiatric interviews, fearing the disclosure of circumstances, which indicate to deliberate aggravation of symptoms and simulation of DID.

The problem of misdiagnosis

DID is rarely diagnosed in clinical practice. However, it should be considered whether the frequency of diagnoses reflects the real number of these disorders, or is it the result of errors in the diagnostic process. Since the prevalence of DID in the general population is approx. 1% [5], and in the population of psychiatric hospital patients, even above 14% [33], the reasons should rather be looked for in diagnostic abnormalities.

A study conducted in 1993 on a group of 71 patients with DID showed that before making the correct diagnosis, these people were given an average of 2.8 incorrect diagnoses. The average time from the first contact with the mental health care system to the proper diagnosis of DID was 8.2 years [34]. Similar results were obtained in a study conducted by C. Ross et al. [18], in which researchers analyzed the diagnostic process of 236 patients with DID. The data indicated an average of 2.74 misdiagnoses and 6.7 years of waiting for a correct diagnosis. The most common disorders misdiagnosed in patients with DID included: affective disorders (63.7%), personality disorders (57.4%), anxiety disorders (44.3%), and schizophrenia (40.8%) [18].

Schizophrenia is often misdiagnosed in patients with DID, most likely due to type I Schneiderian symptoms in this group of patients [18]. Patients with DID show an average of 8 out of 11 of these symptoms. The distinctive feature is the criticism of the experienced symptoms. A person who has schizophrenia is convinced that the productive symptoms are real. Patients with DID generally have better cognitive insight and are capable of self-reflection without the hallmarks of psychosis [5]. This group of patients remains aware of the abnormal nature of the experiences they experience [15]. Patients with DID and schizophrenia can experience hallucinations or pseudohallucinations of any modality. In the Australian study by Middleton and Butler [35] (1998), it was shown that as many as 98% of the studied patients with DID ($N = 62$) experienced auditory hallucinations or pseudohallucinations. On the other hand, visual hallucinations occurred in 74% of patients with this diagnosis [35]. When it comes to patients with schizophrenia, visual hallucinations were reported less frequently, i.e., in about 27% of cases [36].

Problems of comorbidity

Misdiagnosis should be distinguished from situations where DID really coexists with other mental disorders out of the spectrum of dissociative disorders. The most common ones include the already mentioned depression and anxiety disorders (most often in the form of panic disorder) [5]. Common symptoms that accompany DID are suicidal thoughts and tendencies and self-destructive behaviors [34], including incidents of self-harm [9]. Research indicates that as many as 61–72% of patients with DID attempted suicide, and a successful attempt concerned 1–2.1% of them [15]. According to DSM-5, more than 70% of DID patients attempted to kill themselves more than once. It means that people diagnosed with DID belong to the group of patients at high risk of dangerous behavior. Notably, younger patients with DID manage these behaviors much faster than older patients [5].

Early childhood psychological trauma is present in the etiology of DID and borderline personality disorder (BPD) or PTSD [37], which belong to the group of the aforementioned post-traumatic disorders. According to some researchers, DID does not coexist with BPD but only creates a phenocopy of this disorder [38]. However, this assumption does not seem to be entirely correct.

BPD (301.83) belongs to the personality disorder from cluster B [9]. The symptoms of this disorder manifest in adolescence and stabilize in early adulthood [39], while the symptoms of DID may also appear at an earlier stage of individual development [27]. In a study verifying the relationship between DID and borderline personality disorder, conducted on a small group of 33 patients with DID, it was shown that 70% of them also fulfill the criteria for the diagnosis of BPD [40]. Another study showed such a relationship for 60% of respondents (N = 20) [41]. In turn, Ford and Courtois [37] report that as many as 82% of patients diagnosed with DID met the BPD criteria [37]. Thus, it is possible that the disorders discussed here may actually coexist.

Research shows that 30% of patients who are entering DID treatment and who were also diagnosed with BPD very quickly stopped showing symptoms of this personality disorder. In another 30% of patients with dual diagnosis, symptoms of BPD disappeared with the resolution of DID symptoms. In 30% of cases, symptoms continued after the integration of dissociated aspects of the personality [38]. The co-occurrence of the discussed disorders also influences the intensity of the disease symptoms presented originally. The latter remain most severe in the group of patients with dual diagnosis (DID and BPD), followed by “isolated” DID and “isolated” BPD [42].

Despite many common features, the most relevant differentiating points are dissociative symptoms, especially amnesia episodes, and the severity of childhood trauma [34]. The “severity” of the traumatizing stimulus also depends on individual differences. Theoretically, the same factor may, to a varying degree, disturb the process of creating the child’s personality, in some cases leading to DID [15]. Thus, the post-traumatic reaction will depend on such factors as: resilience existing at the time of

the mental trauma, previous traumas, the level of support obtained subsequently from the environment, or the period of individual development in which the psychological trauma occurred [43].

The latter factor is associated with structural changes in the brain of a developing child, leading to the ability to become aware, process, and respond to dangers [44]. For example, the primary development goal in infancy is learning to trust (or distrust) your surroundings. This stage is related to a safe environment and attachment [45]. The amygdala responsible for feeling fear begins to function almost immediately after birth. Hence, infants are able to feel it relatively quickly, which affects the perception of the environment as safe or not. Psychological traumas occurring during this period may lead to the development of pathological (insecure) attachment models, resulting in BPD development in the future [46]. The insecure bond is not enough for the development of DID, although it may predispose to it [47], while in the case of BPD, it is a sufficient etiological factor [48].

The dissociative way of reacting to psychological trauma requires understanding the threatening situation (trauma) as being related to one's own person [49]. The process of gradual shaping of an individual's autonomy and sense of separateness takes place in early childhood. Also, the hippocampus, which is necessary to place a threat in a spatial context, matures gradually over the first five years of life [50]. In this context, DID appears to be a developmentally latter disorder than BPD.

In fact, DID does not exist without PTSD [5, 14], which is a set of symptoms appearing as a result of the experienced trauma [51] and often correlates with dissociative symptoms in response to it [52]. The incidence of both these disorders is estimated at 85–95% [38]. Boon et al. [51] indicate that dissociative disorders are a more complex form of PTSD, in which, in the course of the experienced dissociation, early childhood trauma results in abnormal personality development. In the clinical picture of DID, there are no symptoms typical of PTSD related to the persistent, repeated experience of a traumatic event in the form of persistently recurring memories, rumination, or dreams [2]. The reason for such a state is the dissociation processes, which are a sui generis protective mechanism of a neurotic nature (especially in relation to amnesia) [4].

The problem of iatrogenic etiology of DID

Another problematic issue is the possibility of iatrogenic induction of DID by therapists treating the patient. For example, Spanos [8, p. 114] pointed out that "therapists routinely encourage patients to construe themselves as having multiple selves, provide them with information about how to convincingly enact the role of 'multiple personality patient,' and provide official legitimation for the different identities that the patients enact." The therapeutic methods used to treat DID may, according to some, worsen or even cause DID. This objection relates especially to hypnosis, which is used in the treatment of DID [8].

The thesis about iatrogenesis of DID has been unequivocally questioned in the literature [27, 53]. One of the arguments against the iatrogenic etiology of DID is the time of origin of dissociative symptoms, which may manifest long before appropriate treatment is undertaken and regardless of its initiation. In the case of DID, behavioral changes and other symptoms are also noticeable by the patient's surroundings [27] (confirmed by an objective interview).

Authentic dissociation, caused by long-term childhood trauma, is a disorder that cannot be produced intentionally based on socio-cultural influences [29]. There is also the issue of physiological changes that cannot be produced by auto-suggestion. For example, the literature knows the case of a patient who was acquiring or losing the ability to see, depending on which dissociative identity was active [54]. Moreover, artificially produced symptoms differ from those presented by DID patients. Artificially induced "personalities" have no history of their own. They do not have the features of subjectivity and initiative, and they do not last too long [15].

Treatment of DID

It is indicated that the effectiveness of DID treatment is generally low [2]. Undoubtedly, psychotherapy is the basis of the therapeutic process. Drugs play only a supporting role here [26]. The general aim of treating people with dissociative identity disorder is to integrate all aspects of identity into one coherent one [3]. Treatment should be conducted to enable the patient to understand that the dissociative identities he creates are aspects of one personality [27]. The therapy should also lead to the fragmentary memory of traumatic events being turned into a continuous narrative memory [15].

As a general rule, it is not recommended to work on trauma experiences in the first phase of therapy because it may deteriorate the patient's condition [11]. Switching between the dissociative identities is usually sudden and quite fast, which may not be observed by an inexperienced therapist [55]. Changes are not always entirely noticeable and transparent [26]. The most common initiating factor is stressful situations [32]. Subsequent aspects of personality can be produced as a response to such stressors, being a form of adaptation to the surrounding reality.

The sub-aim of therapy is to reach out to all aspects of the personality. Their data and characteristics, such as age and sex, should be established as detailed as possible. These procedures are to determine the event that caused the primary dissociation, i.e., the time and reason for the origin of individual dissociative identities and their position and relation to the others [56].

It is very important to avoid the wrong and non-therapeutic "minimization strategy." This is based on the premise that if the therapist's attention does not adequately enhance the symptoms of a DID patient, they will cease to be presented. Studies show that the patients for whom the diagnostician acted in a minimizing way continued to exhibit symptoms characteristic of DID [57]. Although the approach based on the lack

of attention from the therapist may temporarily suppress some signs of the disorder, it does not disappear in the long run [57]. Failure to treat dissociative states does not lead to any beneficial changes in the mental state of an individual [27].

Additionally, the therapist should not present different attitudes towards particular dissociative identities. The differentiated approach disturbs the patient's perception and may lead to the development of multiple therapist disorder [58]. In this case, the patient deliberately avoids presenting some aspects of the personality and presents others more often (e.g., those which protect the cause of dissociation more effectively). Consequently, some identities may not be disclosed at all, which significantly hampers the process of their subsequent integration. Therefore, it is necessary to present the same attitude towards each of the aspects of personality. In this situation, identities do not have the opportunity to "escape" from the therapist by manifesting only the preferred ones. Adopting the same therapeutic approach is necessary to overcome the dissociative barriers of the patient [58].

Once these barriers are overcome, traumatic memories may first come back in a sensorimotor form and not as a narrative between individual aspects of the personality [5]. Proper therapy should deepen self-awareness about having the disorder, especially on the part of the so-called personality of the host. The latter is found in 92.5% of patients with DID [34] and most often remains the least aware of experienced dissociation [15]. As a rule, the passive identities have less thematically and quantitatively attractive memories than identities whose role is to control and protect the entire system [55].

Patients with DID may report that they hear the aforementioned "voices" of other dissociative identities in their heads, which prohibit them from answering the therapist's questions or disclosing more detailed information on the explored topics [34]. These voices most often take the form of arguing (71.1%) or commenting (66.1%) voices [18]. As already mentioned, these symptoms should be treated as a manifestation of defense mechanisms created in the course of dissociation.

A very important point of the therapy seems to be gaining trust from all aspects of the personality. This process may take years. Therefore, therapists should be prepared for the necessity of long-term work and for the slow dynamics of change. At the same time, prompt diagnosis and initiation of directional psychotherapy is of great prognostic importance. Such activities reduce the negative consequences that DID implies both in the social and personal areas [59, 60]. Incorrect diagnosis may result in an increased percentage of suicide attempts and retraumatization or intensification of dissociative symptoms [12]. A study showed that attempts to treat other comorbid mental disorders without taking into account DID are not effective [34].

Currently, there are no drugs approved for the treatment of DID. In the treatment, only auxiliary drugs are used: atypical antipsychotics, timoleptics (mainly SSRIs, SNRIs and TCAs [61]) or sedatives drugs [4]. However, it should be remembered that the use of benzodiazepines may intensify dissociative symptoms [61]. In the literature, attention is drawn to the potential use of kappa-opioid receptor antagonists in the treat-

ment of dissociative symptoms [62]. At the same time, the abnormal serotonin neurotransmission in the frontal and temporal areas occurring in the course of dissociative amnesia justifies the use of the above-mentioned serotonergic drugs. The latter may be useful not only in relieving depressive symptoms but also in treating dissociative symptoms. At the moment, no sufficient clinical trials have been conducted that would allow the development of a dedicated pharmacotherapy for DID [62].

Recapitulation

Dissociative identity disorder still causes many difficulties, both in the diagnostic and therapeutic areas. In practice, it is rarely diagnosed, although it is estimated that it occurs in approx. – 1% of the general population. The lack of an appropriate diagnosis makes it impossible to undertake adequate treatment, leading to prolonging the entire therapeutic process and affecting its effectiveness. Research indicates that this process may be delayed by an average of several years. The use of inadequate therapeutic methods may result in retraumatization and intensification of dissociative symptoms.

There is no doubt that in the process of educating psychiatrists and clinical psychologists, greater emphasis should be placed on the ability to correctly detect dissociative symptoms [62] and on the use of proper diagnostic tools. It is also necessary to broaden the knowledge about disorders coexisting with DID and to use terminology that accurately reflects the essence of the disorder. This applies in particular to the use of the term "dissociative identities" or "separate aspects of one personality" in place of claims that there are several personalities.

Currently, the views on the iatrogenic etiology of this disease have been unequivocally questioned. There are also effective tools to distinguish patients with DID from simulators, which significantly reduces the risk of false-positive diagnoses in this respect. In extremely doubtful cases, it is possible to use neuroimaging techniques that use the differences in the volume of individual brain structures (mainly the hippocampus and amygdala).

Treatment of DID requires the cooperation of a psychiatrist and a psychologist. Undoubtedly, the basis of this process is well-conducted psychotherapy, which is to lead to the integration of all dissociative identities. In this matter, emphasis should be placed on avoiding minimization strategies or attitudes that may cause multiple therapist disorder. While there are currently no drugs approved for the treatment of DID, some timoleptics, neuroleptics and sedatives may play an important role in helping to alleviate the associated non-dissociative symptoms. Reports on the use of kappa-opioid receptor antagonists to alleviate dissociative symptoms have not been sufficiently verified in controlled clinical trials.

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