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Examining the relationship between dissociative identity disorder and adverse childhood experiences

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AUTHOR BIOGRAPHY

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ABSTRACT

Dissociative identity disorder (DID) is a complex psychological condition characterized by the presence of two or more distinct identities or personality states in an individual. It has been widely associated with early childhood trauma. This systematic review aims to explore the relationship between adverse childhood experiences and the development of DID. The findings of 26 peer-reviewed studies published between 2015-2024 were synthesized on their discussions of said relationship. This review revealed consistent evidence that traumatic experiences during childhood significantly contribute to the development of dissociative symptoms. These early experiences will disrupt the formation of a cohesive sense and promote dissociation as a protective coping mechanism, leading to fragmented identity structures throughout adulthood. Furthermore, attachment disruptions and dysfunctional parental dynamics, as well as the lack of stable nurturing relationships, further exacerbate the risk and development of DID. Neurobiological findings also indicate that trauma-induced changes within brain regions associated with memory, emotional regulation, and self-representation play a pivotal role in the dissociative process. Therefore, this review ultimately underscores the important relationship between adverse childhood experiences with the development of DID and dissociative symptoms, thereby highlighting the need for trauma-informed interventions and early treatment to address the root causes of DID, combining both trauma-focused therapies and cognitive strategies to improve long-term outcomes of affected individuals.

Keywords*: Dissociative identity disorder, childhood, trauma, abuse, psychology, dissociation, coping mechanism, compartmentalization*

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Identity disorders, particularly dissociative identity disorder (DID), represent one of the most complex and misunderstood mental health conditions within the psychological and psychiatric fields. DID, previously known as Multiple Personality Disorder, is characterized by two or more distinct identity traits or personalities that take control of a person's behaviour (Mitra & Jain, 2023). These identities may include distinct names, ages, histories, and characteristics, leading to a fragmented sense of self. This disorder is often accompanied by significant memory gaps (dissociation) where individuals may have no recollection of events or actions performed by their alternate identities (Moini et al., 2021).

Although the term 'identity disorder' may seem to suggest a singular disturbance, the reality is much more complex; DID is a multifaceted psychological phenomenon that manifests in a variety of ways. DID is thought to impact 1.5% of the general population (Mitra & Jain, 2023) and often goes undiagnosed, in part due to its complexity and the fact that individuals with DID may not be aware of the existence of their alternate identities. Many dissociative symptoms, such as memory loss, blackouts, and identity shifts, are frequently misdiagnosed as other mental health conditions such as mood disorders, post-traumatic stress disorders (PTSD), or personality disorders (Saxena et al., 2023). For many individuals who suffer from DID, the disorder may disrupt their ability to function in day-to-day life, affecting everything from their relationships to their overall emotional well-being. Given the impacts of DID on an individual's daily functioning, it is crucial to understand the underlying factors contributing to its development, particularly within the role of childhood trauma.

Childhood trauma, especially involving prolonged and severe forms of abuse such as physical, emotional, or sexual maltreatment, plays a pivotal role in the development of DID. During early childhood, the brain and psyche still form a coherent sense of self. When a child experiences overwhelming trauma, such as chronic abuse or neglect, their ability to process and integrate these traumatic experiences into a unified identity is severely disrupted. Trauma within childhood will often trigger dissociation as a coping mechanism, where the individual disconnects from the painful emotional experience to endure the distress (Boyer et al., 2022). For example, a child who is abused might dissociate during or after traumatic events, mentally distancing themselves from the pain or fear they experience. This response may allow the child to survive psychologically, but when repeated over time, can lead to the formation of distinct and separate identities that hold the fragmented experiences, emotions, and memories associated with the trauma. Over time, these dissociative responses may evolve into a more stable dissociative identity structure, resulting in DID. This pattern of dissociation is often seen as a defence mechanism that protects the child from the overwhelming psychological consequences of abuse, but when it becomes ingrained, it can manifest as a full-fledged identity disorder (Begum, 2023).

The impact of trauma on a child's psychological development extends beyond the immediate dissociative responses. Oftentimes, chronic exposure to abuse or neglect during critical developmental stages may alter the structure and function of the brain, particularly within areas responsible for memory, emotional regulation, and identity (Teicher & Samson, 2017). For instance, research has shown that prolonged stress and trauma within childhood can lead to changes within the hippocampus and

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amygdala–brain regions involved in memory processing and emotional responses (Cross et al., 2019). These neurological changes can hinder the brain's ability to integrate memories and emotions, making dissociation a response more likely to take effect in future stress. Moreover, children who experience neglect or emotional unavailability from caregivers may develop disrupted attachment patterns, leading to an unstable sense of self. Without secure attachment, children are at a greater risk of dissociative behaviours, as they have not learned to form a cohesive and integrated sense of identity within a stable, nurturing relationship (Doyle & Cicchetti, 2018). In such cases, dissociation becomes a maladaptive coping mechanism that not only helps or supports the child to survive the trauma they experienced but also contributes to the development of a fragmented self (Lyons-Ruth, 2009).

The central role of childhood trauma in the development of DID highlights the importance of early intervention and trauma-informed care. When trauma occurs during the formative years, it can create a lasting impact on the child's psychological and emotional functioning, often leading to dissociative tendencies that may persist into adulthood. For many with DID, the dissociative coping mechanism developed in childhood is not adequately addressed, leading to the perpetuation of the disorder into the later stages of life. This underscores the importance of early recognition of dissociative symptoms and providing trauma-informed therapeutic interventions to address the root causes of DID. By understanding the connection between childhood trauma and DID, clinicians can better identify individuals who are at risk for the disorder and offer early interventions that focus on integrating fragmented identities and addressing the underlying trauma.

This systematic review has aimed to explore the relationships between childhood trauma and the development of DID, specifically how early life experiences, especially traumatic events, can shape and/or trigger the onset of dissociative identity symptoms. Through a synthesis of existing research, childhood abuse, neglect, and other forms of trauma will be explored in their contributions to the fragmentation of identity.

CASE STUDY

DID can cause a person to experience the fragmentation of one's identity into distinct personalities, often as a response to trauma or severe stress. Rehan et al. (2018) describe a 55-year-old Caucasian woman with a history of substance use disorder who experienced the fragmentation of her personality into seven identities. These identities include a seven-year-old child, a rebellious teenager, a male persona, and her 'default' 55-year-old self. She reported that her alternate personalities had dominated her and she became aware of their existence through people around her. Transitions between these personalities were involuntary and triggered by stress or substance use. The patient often exhibited violent and harmful behaviours during these transitions, including self-harm, aggression, and homicidal tendencies, even leading to arrests and hospitalizations. Her alternate personalities were distinct: the child showing mood swings and self-centeredness, the teenager engaging in risky behaviours, and the male adopting male attire and behaviours. The patient's default personality was often anxious during transitions, accompanied by memory gaps, and unable to recall events during or between identity shifts.

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This case is an example of how DID can be triggered by various factors. While this case is linked to substance usage, DID can also result from childhood experiences, which this paper will focus on.

METHODOLOGY

A systematic search was conducted through the ScienceDirect database. Only peer-reviewed research articles were selected. To focus on the specific scope of DID and childhood experiences, the following keywords were used in ScienceDirect: *'"dissociative identity disorder,"* and *childhood brain'*.

ELIGIBILITY CRITERIA

Specific inclusion and exclusion criteria were established to ensure the review focused on high-quality and relevant studies. The studies reviewed were all peer-reviewed research studies that focused on individuals and studies around dissociative identity disorder (DID) or the exhibiting of similar dissociative symptoms, particularly concerning childhood experiences. The studies needed to examine the associations between adverse childhood experiences (eg, trauma) and DID. Only studies published in English and within the last ten years (2015-2025) were reviewed.

Studies were assessed based on their focus on childhood experiences or childhood trauma, dissociative identity disorder (DID), and possible associated neurological or psychological processes. Studies that did not fit into the required scope of the review were disregarded due to one or more of the following reasons: a focus on clinical treatments or interventions; a lack of exploration the underlying causes or connections to childhood experiences; discussion of symptoms in general without considering connections to childhood, a basis in populations outside the target age group; no focus on DID; and/or adherence towards animal models. If studies adhered to one of these structures, they were considered outside the range of this review and therefore removed from evaluation.

STUDY SELECTION PROCESS

With the chosen range and filters, the initial search yielded a total of 139 articles. The titles and abstracts of all these studies were screened to determine whether or not they met the necessary inclusion criteria. Therefore, a total of 60 of the 139 articles were screened. Studies that did not focus on childhood experiences and/or DID were outside the scope of this review and, therefore, disregarded. After the screening process, 34 articles were excluded because they did not meet the eligibility criteria, leaving 26 studies to be included in this systematic review.

RESULTS AND DISCUSSION

The literature review revealed consistent findings across studies regarding the connection between childhood experiences, especially traumatic events, and the development of DID. A total of 26 studies were included in this review, and the studies examined have been organized into groups focusing

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on childhood traumas, chronic trauma, parental dynamics, social or cognitive factors, and neurobiological mechanisms involved.

CHILDHOOD TRAUMA AND DID DEVELOPMENT

11 of the 26 selected studies highlighted the significant role of childhood trauma, specifically sexual, physical, and emotional abuse, in the development of DID. Luate & Pope Jr. (2024) and Chiu et al. (2017) both emphasize the strong connection between sexual and physical abuse throughout childhood with the development of DID. The trauma model of DID was strongly supported, where childhood abuse forces children to dissociate as a protective coping mechanism.

Luate & Pope Jr. (2024) explore how trauma, particularly sexual abuse, contributes to the fragmentation of identity, with dissociative parts serving as a psychological defence mechanism to shield individuals from the pain of their experiences. Similarly, Chiu et al. (2017) observe a strong correlation between physical and sexual abuse and dissociative symptoms in Taiwanese psychiatric patients, supporting the notion that childhood trauma plays a significant role in the development of DID. Their results are further corroborated by Yilmaz & Akcan (2022), which examines the Turkish adaptation of the Scale of Dissociative Activities. Their findings reveal a significant positive correlation between dissociative symptoms, such as dissociative amnesia and depersonalization/derealization, and childhood trauma, specifically physical and sexual abuse. These results align with previous research, demonstrating that the severity of childhood trauma is directly linked to the degree of dissociative symptoms and identity disturbances in adulthood. Furthermore, dissociation is associated with heightened psychological distress and reduced mindfulness, suggesting that dissociative behaviours function as a coping mechanism to manage emotional pain.

Dimitrova et al. (2024) expand upon trauma-based models of DID, proposing that the disorders involve not only the compartmentalization of trauma-related memories but also a form of cognitive avoidance. The findings indicate that cognitive control networks in the brain, particularly the prefrontal cortex and parietal regions, are activated in response to trauma-related stimuli. This neural activity reflects a protective strategy originating in childhood, where dissociation and the formation of distinct identities function to shield the individual from the emotional impact of traumatic experiences. The study reinforces the view that DID is deeply rooted in trauma-related mechanisms, with childhood abuse playing a pivotal role in its development.

Similarly, Reingold & Goldner (2023) examine the profound impact of female-perpetrated child sexual abuse on survivors, emphasizing its influence on gender identity and sexual self-perception. Survivors, especially those abused by maternal figures, often face significant challenges in internalizing a positive maternal or gendered self-concept, leading to identity disorders marked by gender confusion. These disruptions hinder the development of a stable sense of self, contributing to dissociative symptoms and identity fragmentation commonly associated with DID. The trauma-induced dissociation manifests as a fragmented sense of self, while survivors also express fears of replicating abusive dynamics in adult relationships. These fears exacerbate struggles with intimacy and self-trust, compounding their

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psychological distress. Schlumpf et al. (2019) examine the role of childhood abuse and neglect in the development of DID symptoms. The findings indicate that childhood trauma disrupts emotional regulation, leading to the formation of dissociative parts (Apparent Normal Personality and Emotional Parts) as coping mechanisms. Using EEG functional connectivity, the study identifies altered neural responses to both neutral and unpleasant stimuli in patients with DID, reflecting trauma-related emotional dysregulations. Although trauma-focused inpatient therapy improved emotional regulation, residual dissociative symptoms persisted, underscoring the enduring impact of early trauma.

Huntjen et al. (2016) further examine how early trauma shapes self-defining memories and goals across dissociative states, reinforcing the idea that trauma underpins the development of DID. Trauma-related memories and goals influence both trauma-oriented and avoidant identities, even though avoidant identities are designed to detach from trauma. This supports the trauma model of DID, which posits that early trauma drives dissociative responses and the formation of multiple identities. The study also draws parallels between DID and post-traumatic stress disorder (PTSD), suggesting that childhood trauma serves as a common foundation, shaping how individuals process past experiences and formulate future goals. Okano (2019) explored the role of childhood aggression, neglect, and abandonment in the formation of "shadow personalities." These dissociative parts often represent internalized anger stemming from a child's inability to process or express trauma. The paper suggests that children may identify with the aggressor, internalize aggression, or adopt a bystander role, all of which may shape the dissociative parts that manifest in adulthood. The findings highlight the disruptions in self-concept caused by childhood trauma and the resulting dissociative mechanisms.

Broadening the scope beyond DID, Beghi et al. (2020) examine the relationship between dissociative symptoms and psychogenic non-epileptic seizures (PNES). Although primarily focused on PNES, the findings revealed that individuals with PNES often have a history of childhood violence or maltreatment, highlighting the shared role of trauma in dissociative conditions. The findings emphasize the importance of addressing childhood abuse in the treatment of DID and related disorders.

Bregmanhai et al. (2018) connect dissociative adsorption to childhood trauma, positing that dissociation can manifest as a coping mechanism (as discussed in previous papers). The study posits that individuals with high absorption (those who exhibit heightened imaginative involvement and dissociative tendencies) may display cognitive features similar to DID. Although this study doesn't assess childhood trauma, it supports the broader notion that dissociative experiences–including those seen in DID–can arise from early traumatic experiences.

Lastly, Arntz et al. (2015) examine how trauma, particularly physical abuse, leads to the development of dissociative coping mechanisms that interfere with treatment and result in difficulties in processing trauma. Dissociation, a defence mechanism against overwhelming trauma, often persists into adulthood, affecting patients' ability to engage fully in therapy. The study suggests that to improve treatment outcomes for individuals with DID, therapists need to develop specialized skills to address in-session dissociation and help patients process the trauma underlying their dissociative symptoms.

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CHRONIC TRAUMA

Five out of the 26 papers connected DID to childhood trauma, specifically, in a chronic context. Chronic means that the trauma persisted over a long time (constantly recurring) instead of only a few instances. Each paper highlights how chronic trauma and abuse (physical, sexual, and emotional) exacerbate the development of DID. Without stable relationships, children cannot develop a cohesive and integrated sense of self.

Sawchuk et al. (2020) and Marin (2019) point to the pivotal role of severe abuse and attachment disruptions in the development of DID. Sawchuk et al. (2020) discuss how trauma disrupts the child's ability to form a cohesive sense of self, leading to dissociative coping mechanisms where different identities or personality states emerge to protect the child. Insecure attachments, neglect, and dysfunctional caregiver relationships further exacerbate the development of DID by preventing the child from forming stable, nurturing bonds. They also note that neurobiological changes that occur due to early trauma may also contribute to dissociation. Marin (2019) also explains how a child's brain may become overwhelmed by traumatic experiences, leading to dissociation and the creation of distinct identity states. As the trauma persists, the dissociative states become more rigid, fragmenting the child's sense of identity and contributing to the development of DID in adulthood. The study also points out that attachment disruptions, including the absence of safe, nurturing relationships, make it difficult for the child to integrate traumatic memories into a cohesive self, further perpetuating the cycle of dissociation and DID.

Building from the idea of a coping mechanism as highlighted by Marin (2019), Moskowitz & Hart (2018) emphasize that DID is not simply an exaggeration of normal personality divisions but a response to unintegrated traumatic experiences.

In addition to identity fragmentation, Mitchell & Steele (2019) explore how dissociation will impair certain mental abilities, such as the ability to understand and reflect upon others' mental states. They explore how early experiences of severe physical, sexual, and emotional abuse or neglect often lead to dissociation as a coping mechanism, where parts of the self are fragmented to protect the child from their emotions and memories. This results in impaired mentalizing, or the inability to reflect one's own or others' mental states. Trauma-induced dissociation can lead to the development of dissociative parts, each holding specific aspects of trauma-related memories and emotions. Additionally, disorganized attachment and the internalization of abusive figures can result in psychic equivalence, where the child loses the ability to distinguish between their thoughts and the abuser's. These early experiences of trauma and dissociation severely disrupt self-regulation and mentalizing abilities, often continuing into adulthood.

Finally, Brand et al. (2016) note that increased complexity of the trauma, especially when prolonged, increases the likelihood of the development of DID. Similar to other papers, it argues that dissociation functions as a coping mechanism, allowing mental separation from the trauma they are unable to process. This dissociative response can prevent the trauma from overwhelming the child, but it disrupts normal identity formation and leads to the development of distinct dissociative states or

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alternate personalities. The disorder is more likely to develop in those who have experienced complex trauma, prolonged abuse or neglect, particularly without the presence of protective or supportive caregivers. The paper suggests that this early relational trauma contributes to the psychological fragmentation seen in DID, where dissociation becomes a way to manage the overwhelming emotional and psychological pain.

ATTACHMENT ISSUES AND PARENTAL DYNAMICS

Four of the 26 papers discussed primarily how dissociative symptoms and DID can be influenced by early attachment disruptions and harmful parental dynamics, highlighting the role of trauma and neglect in shaping DID.

Lyons-Ruth et al. (2016) and Kate et al. (2023) underscore the importance of disorganized attachment in infancy as a critical precursor to dissociative symptoms. Lyons-Ruth et al. (2016) specifically touch on maternal withdrawal and contradictory behaviours leading to increased left amygdala volume. This structural change is linked to heightened emotional sensitivity and dissociative symptoms in adulthood. The study emphasizes that early attachment disturbances, especially in the first two years of life, may alter brain development, particularly the amygdala, contributing to long-term emotional dysregulation and dissociation. These findings suggest that early intervention targeting attachment disturbances could potentially prevent or mitigate the development of dissociative disorders like DID.

Kate et al. (2023) find that negative parental relationships, such as emotional neglect, unpredictable behaviour, and lack of support, are strongly associated with dissociation, as they contribute to feelings of powerlessness, insecurity, and a lack of control. These dynamics can lead children to become dissociative as a coping mechanism, particularly when parents fail to protect them from trauma or provide emotional care. Their research suggests healthy parental involvement acts as a protective factor against dissociation and points out that gender differences can also play a role in identity disorders. Martin et al. (2021) further elaborate on the role of attachment within dissociation, particularly in those who have experienced chronic sexual abuse or maltreatment, often in foster care settings. The paper found that these children exhibit high levels of dissociation with emotional and behavioural difficulties. The research underscores the role of attachment, noting that children with poor attachment representations tend to show more dissociative behaviours, while stable relationships appear to offer some protection. The findings therefore suggest that dissociation may be a key framework for understanding the consequences of trauma and relational instability in vulnerable children. This ties directly into the findings of Lyons-Ruth (2016) and Kate et al. (2023), all stressing how insecure or disorganized attachment will increase the vulnerability to dissociation, disrupting the child's emotional regulation and possible coping mechanisms.

One specific case study conducted by Yeh (2016) focuses on Zheng Yi, a person who showcased dissociative symptoms, including depersonalization and glance stealing, as a link to personal childhood experiences of emotional neglect and family pressures. Growing up as the only son in a family that

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valued him over his sisters, Zheng internalized feelings of inadequacy and fear of rejection, which contributed to his dissociative tendencies. His mother's initial dismissal of psychotherapy and reliance on traditional remedies reflected a broader lack of emotional support, leaving Zheng to cope with anxiety and low self-esteem in unhealthy ways. Therapy helped him explore these early family dynamics, gaining insight into how emotional neglect and high parental expectations shaped his symptoms, and highlighting the importance of addressing childhood trauma and family relationships in the treatment of dissociative disorders. These studies serve to showcase how DID does not only stem from abuse or trauma but also from general, negative family dynamics and behaviours.

SOCIAL AND COGNITIVE FACTORS

Two out of the 26 papers disagreed with the notion of adverse childhood experiences having a strong impact on the development of DID (although they do not suggest there is no influence whatsoever). Instead, they propose that social and cognitive factors play a more influential role in the development of DID.

Dodier et al. (2021) challenge the view of childhood experiences influencing and developing DID by arguing that socio-cognitive factors such as suggestibility, media influence, and therapeutic interactions instead drive the development of dissociative symptoms such as memory loss or the formation of multiple personalities. This is referred to as the Sociocognitive Model (SCM). They emphasize that dissociative symptoms, including memory loss and the formation of multiple identities, are influenced by cultural, social, and cognitive factors alongside trauma. For future solutions, they call for a multifactorial approach to understanding DID, highlighting the role of sleep disturbances, emotional regulation, and other psychological factors that lead to the development of dissociative disorders.

Lebois et al. (2020), while supporting the findings of Dodier et al. (2021), acknowledge the importance of childhood maltreatment as a contributing factor to the development of DID. Other factors, such as emotional processing and therapeutic interventions, should be held to a higher priority in the recovery process (not only trauma-focused solutions). The findings, therefore, highlight the central role of childhood abuse and neglect in the development of DID. Taken together, these two studies highlight that childhood trauma, while undeniably a central factor, is not the main factor at play. Both emphasize the multifaceted nature of DID, where a comprehensive approach should be taken to address both social cognitive and psychological factors alongside treating symptoms linked to childhood experiences.

NEUROBIOLOGICAL MECHANISMS INVOLVED

Four out of the 26 papers discussed how childhood trauma plays in the development of DID, specifically the neurobiological mechanisms involved in said development. They discuss how trauma shapes brain structures and functions, which contribute to dissociative symptoms, as well as overlapping conditions with post-traumatic stress disorder (PTSD) and complex PTSD (cPTSD).

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Chalavi et al. (2015) highlight how childhood trauma, particularly severe early abuse, leads to changes in the brain, particularly in regions like the hippocampus, inferior parietal cortex, and areas involved in stress regulation. It finds that smaller hippocampal volume in both DID-PTSD and PTSD-only patients was correlated with the severity of childhood trauma, suggesting that early traumatic experiences contribute to structural brain changes, particularly in regions like the hippocampus, which is involved in memory. Additionally, the inferior parietal cortex, linked to body awareness and sensory integration, showed alterations in DID-PTSD patients, which may explain dissociative symptoms like depersonalization. The findings support trauma-related models of DID, emphasizing that early and severe childhood trauma plays a crucial role in shaping the neurobiology and dissociative symptoms of DID and PTSD, suggesting that these disorders are deeply intertwined with early life stress. This is coherent with the findings of Joss et al. (2024). It emphasizes the role of adverse childhood experiences (ACE) in the development of identity disorders. ACE can alter the development of key brain regions, such as the amygdala and prefrontal cortex, which are involved in emotional processing, memory, and self-regulation, further contributing to the formation of fragmented identities. While not all individuals who experience childhood trauma develop identity disorders, ACE significantly increases the risk. However, interventions like therapy and trauma-focused treatments have shown promise in helping individuals with ACE-related identity disorders.

Similarly, Seriès et al. (2024) demonstrate how childhood trauma leads to disruptions in the self-model, contributing to dissociative symptoms like depersonalization and identity fragmentation. They discuss these symptoms within cPTSD, which can still relate to DID, as the symptoms of both are similar. In cPTSD, the brain's internal model undergoes hierarchical remodelling, and the self-representation may become weakened, possibly as a way to cope with overwhelming emotional distress. This is similar to DID, where trauma-induced dissociation results in the development of distinct identities or alters to manage unprocessed emotional pain. Thus, the paper suggests that the disruption of the self-model due to childhood trauma can contribute to both cPTSD and DID, with the former resulting in more generalized dissociative symptoms and the latter in more severe identity fragmentations.

Lastly, the SPLIT-10 diagnostic scale is introduced in the findings of Gayraud & Auxérémy (2022), which expands on the understanding of dissociation by linking linguistic markers of dissociation, such as depersonalization, derealization, and re-experiencing, to the fragmentation of identity. The SPLIT-10 diagnostic scale is a psycholinguistic tool designed to assess dissociative symptoms in trauma survivors by analyzing linguistic markers in their narratives. It identifies key indicators of dissociation, which reflect the fragmentation of identity in response to overwhelming trauma. The findings of Gayraud & Auxérémy (2022) support the neurobiological models of DID discussed in the works of Chalavi et al. (2015) and Seriès et al. (2024), discussing how dissociation is not only a neurobiological phenomenon but also a cognitive and linguistic process.

Together, these studies provide a comprehensive view of the role of childhood trauma in the development of DID and related dissociative conditions, while highlighting the enduring effects of trauma and the importance of tailored therapeutic approaches.

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CONCLUSION

This systematic review highlights the critical role of childhood trauma in the development of dissociative identity disorder (DID), offering a comprehensive synthesis of research on the topic. The findings consistently support the trauma model of DID, underscoring the significant impact of early abuse, particularly physical, emotional, and sexual maltreatment, in shaping DID as a coping mechanism, ultimately leading to the formation and fragmentation of distinct identities. Childhood trauma, especially when chronic or severe, disrupts the child's ability to integrate experiences into a cohesive sense of self, triggering dissociation as a psychological defence. Over time, this fragmented sense of self can evolve into DID, where multiple identities emerge to manage overwhelming emotional and psychological pain or unprocessed trauma.

Many studies discuss how prolonged trauma exacerbates the dissociative process, manifesting it in the form of distinct alternate states. The neurobiological findings also suggest that childhood trauma can lead to structural and functional brain changes in regions associated with memory, emotional regulation, and self-representation, such as the hippocampus, amygdala, and prefrontal cortex. These alterations may contribute to dissociative symptoms, emphasizing the complex interplay between childhood trauma and brain development, causing DID.

While the role of childhood trauma in DID is undeniable, the review also acknowledges that DID is a multifaceted disorder, shaped not only by traumatic experiences but also by cognitive, social, and cultural factors. These factors can be just as or even more impactful in the development of DID. Therefore, addressing dissociative symptoms early in life, particularly in vulnerable populations, may help prevent the development of DID or reduce its severity.

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