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Academic Perspective on the Effects of Childhood Traumas on Dissociative Identity Disorder

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Abstract

It has been proven many times before that there are various connections between childhood and mental illnesses. There are also important connections between childhood and dissociative identity disorder (DID). When we look from the perspective of psychology or human mental health and when it comes to the human factor, that is, holistic health in terms of quality of life, we understand that childhood traumas have a special importance. As a child, a person passes through a tunnel from which he can never return, and in this tunnel, he experiences many things, meets many people, that is, he grows up. While this tunnel is beautiful, fun and colorful for some, it is full of nightmares and trauma for others. In this study, DKB was approached from a broad perspective with different and various topics. There is a gradual process in the treatment of DID and the treatment is focused on psychotherapy. Communication with alters during the DID treatment process is a process that requires sensitivity and professionalism. Sand tray therapy can also be used in communication with alters, especially with child alters. A sand tray on its own is not enough; but it facilitates communication between alters. Sand tray therapy provides non-verbal communication and relaxation with sand (Çınar, Sand Tray Therapy, 2023). Considering dissociative identity disorder only in the presence of sexual abuse and severe physical violence in childhood may cause patients with dissociative identity disorder, which progresses in a milder course, to be overlooked. Sometimes, although the person has a high dissociation capacity, dissociative identity disorder may occur in seemingly minor life events, and a severe DID patient may show low-level symptoms. The important thing is emotional division, which is when the child experiences unwanted experiences and a negative emotion strongly, and the mind responds to this strong emotion with division.

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Keywords: *Trauma, Dissociation, Psychohistory, Childhood Traumas, Dissociative Disorders, Treatment, Psychotherapy.*

Introduction

Especially stressful effects from environmental factors, namely neglect and abuse, play a major role in the emergence of the dissociation or division process. In this respect, dissociative disorders differ from psychiatric conditions such as schizophrenia and bipolar mood disorder, in which genetic and biological factors play a greater role in the individual. As a type of reaction inherent in human nature, we can say that it is possible for everyone to experience dissociative experiences under stressful conditions. Among all psychiatric disorders, dissociative identity disorder is the diagnostic group that most commonly reports childhood trauma as a chronic and developmental environmental stressor. In terms of the intensity of its symptoms, DID is also the most comprehensive among other dissociative disorders. Traumatic experiences reported in DID patients often occur in the dimension of interpersonal relationships and, due to the natural characteristics of early age, occur within the framework of family or caregiving environment. Childhood abuse (sexual, emotional, physical) and neglect (physical or emotional) occupy a large place among such traumas. The specific effects of such experiences on memory and consciousness, which deeply affect interpersonal attachment patterns, ultimately extend to the person's sense of identity. Multiple personality disorder, or dissociative identity disorder, is a psychiatric disorder that has been described since the 1800s, attracts the most attention among dissociative disorders, and is accompanied by memory and identity disorders. This disorder lost the importance it gained in the USA in the early 1900s, with the introduction of diagnoses such as schizophrenia and then borderline personality disorder, and for many years, very few patients were treated with this diagnosis.

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Aim

The aim of this study is to re-examine dissociative identity disorder and its processes by looking at a disease as important as dissociative identity disorder from different windows and from a broad perspective. For the first time in Turkey, the benefits of sand tray therapy, which is a different way of approaching alters, are mentioned in this article.

Of course, dissociative identity disorder has been addressed many times, over many periods of time. However, this is a wealth. This study serves to review all aspects of dissociative identity disorder. The aim of this study is to understand the current reflections of childhood traumas and analyze their dimensions and effects in detail, while revealing once again the historical development, symptoms and treatment methods of DID across societies. While the reviews and compilations serve the purpose, the importance of the subject comes to light once again. The study evaluates different approaches by comprehensively addressing different topics and dimensions of AIB.

Method

This article has been prepared by the compilation method and is based on systematically compiling and analyzing data and information obtained from existing sources. While the study deals with the relationship of the concept of dissociative identity disorder with childhood traumas, epidemiological data, symptoms and treatment methods and effects of dissociative identity disorder, it synthesizes the information obtained from various academic sources, research articles, books and other written sources and presents this comprehensive perspective. The review method aims to cover a wide range of literature on the subject and provide a comprehensive understanding by bringing together different perspectives.

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Childhood, Man and Dissociation

People may not react the same to the same events. The same events can leave different ethics in different people. Sometimes, starting a topic by giving academic examples can bring clarity as if making a deduction. A teacher yells at student A in a non-pedagogical way in front of his peers in class. The same teacher shouts at student B in the same classroom, with the same tone of voice, the same non-pedagogical attitude and the same words. This situation repeats many times. A, B, C and all students in the class are exposed to this situation. But each gives different examples of the situation. Each person experiences the situation differently. Some forget, some write in their diaries, some tell their mothers. Some of these students can neither tell, write nor express. There may be a student who absorbs this situation in the classroom, integrates it with himself, sees himself as cursed, labels himself as wrong or flawed, loses his self-confidence over time, carries this situation to other stages of his life and develops dissociation.

Children are exposed to neglect and abuse in many ways. This situation may affect their future lives. Sometimes, when dealing with a child, it may be necessary to consider the whole family. Because a problem that is not attributed to the child may originate from the family.

In cases of dissociative disorder, the person's negative life experiences during childhood, starting before the age of 10, are encountered. What are these negativities? These are usually traumatic experiences such as physical violence and beating, being judged, being subjected to excessive criticism, sexual abuse, or some form of neglect. Some families present a seemingly good family image; However, they tend to normalize this situation by reflecting their own problems on the child and imposing different pressures and hidden authoritarianism on their children. There are traumatic factors such as arguing in front of the child, internal conflicts within the family, secret confrontation, masked fake harmony within the family, which cannot be observed from the outside and do not attract attention at first glance but can only be understood when the experiences are examined more closely.

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Discriminating between children, making gender discrimination deeply felt, taking away the right to education, making children work at an early age, normalizing child labor, marrying at an early age, not taking them to a doctor in case of a psychological or physical illness, and pampering them can also have traumatic effects on children's mental health and cause them to become dissociated. can. To give an example of a common trauma model, trying to portray the situation of children who were separated from their mothers at a young age or sent to boarding schools as if nothing had happened, and making it routine as a necessity of life is also a form of abuse.

History of Trauma and Dissociative Disorders

The older humanity is, the older childhood is, the older childhood traumas are but the data and records available are of course limited and specific.

In different pages of history, in various societies and in different ways, it is seen that children were abused, subjected to living in bad conditions, killed, sacrificed, and sold to others as slaves. Children have been exposed to bad attitudes by adapting them to different ways and procedures of different societies, by putting forward traditions or by using various religious beliefs. The understanding that child education and raising children is the duty of parents came to light at the beginning of the last century, when it was understood that there were thousands of children who were especially affected by wars and left orphaned. As it is known, the devastating effects of both world wars on children were realized, especially during World War II. The action taken by many national and international organizations aiming to protect children after the World War can be considered among the biggest developments in this field. The first scientific records and definitions regarding the effects of childhood traumas on mental illnesses date back to World War II. It consists of several psychological reactions observed in children who were victims after World War II, lost their parents, or survived concentration camps. later _ in years if more A lot of various natural disasters in children from where is spiritual with reactions relating to

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studies is encountered. position what we call keeping a person in public or distortion _ aspect named and other _ _ One your existence Going into one's mind has been seen in many societies. To make the issue concrete, children are exposed to witches, demons, devils, etc. People have subjected children to violence and even killed them with the thought of beings entering. As we all know, until the end of the 18th century, many people in Western societies were tried to be treated with exorcism approved by the culture and paradigms familiar to them of that age, were tortured and burned as witches. Studies focusing on dissociative identity disorder came to the fore with the works and efforts of Pierre Janet towards the end of the 19th century. This interest was short-lived within psychiatry; but this issue was revived in the 1980s. It is known that in the 1990s, studies in the USA were damaged by an opposition called " backlash ", in which academics also participated. The studies on dissociative identity disorder that started in our country in the 1990s and led to important scientific publications are of historical importance in terms of breaking this dynamic and globalizing the subject of dissociative identity disorder.

Causes and Comorbidity of Dissociative Disorders

It has been demonstrated that dissociative identity disorders can occur because of childhood abuse and neglect, attachment problems, especially insecure attachment, family psychopathology, and the dissociative effect of society (Loewenstein 1991, Lewis, 1997, Ogawa et al. 1997, Öztürk 2003, Şar 2010). Studies, observations, inventories and tests show that the origins of dissociative disorders are nourished by the dissociation caused by traumatic experiences in childhood. Previous brain imaging studies have shown that the hippocampus and amygdala of dissociative identity disorder patients begin to shrink compared to the normal control group, and dissociation and parahippocampal changes occur. There are studies showing a relationship between shrinkage in the gyrus (Vermetten et al. 2006, Ehling et al. 2008). Many mental illnesses share some common symptoms. It shows high comorbidity with dissociative disorders, post-traumatic stress disorder, schizophrenia, various post-traumatic eating disorders,

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conversion disorders, mood disorders, obsessive-compulsive disorder, somatization disorder, and borderline personality disorder. (Ross and Keyes 2004, Ross 2007, Shar 2010). In addition to the high rate of comorbidity, dissociative disorders are one of the disorders in which suicide attempts are most frequently experienced in people with mental disorders (Öztürk and Şar, 2008). There are many causes of dissociative disorders, these various causes are related to the framework we mentioned above, where we look at it from the perspective of psychohistory and discuss the effects of childhood contacts.

Childhood Traumas

Childhood traumas can be defined as sexual, physical and emotional abuse and neglect experienced in childhood, that is, before the age of 18, as well as the death of a parent, separation from parents, divorce, migration, witnessing violence, accidents and natural disasters (Herman, 2011). Child abuse or neglect, which falls under the category of childhood traumas, refers to actions and inactions directed at the child by an adult such as a parent or caregiver, which are considered inappropriate or harmful by social rules and professional people, which prevent or restrict the child's development, and the consequences of these. It is a situation where one is harmed physically, mentally, sexually or socially, or when one's health and safety is endangered. (Oral, Can, Kaplan, Polat, Ates, Çetin 2001, p279). According to Yurdakök, child maltreatment is committed by parents, other caregivers or other adults without any accident; It includes behaviors and experiences that are likely to cause physical or emotional damage to children and that are contrary to acceptable norms, that are intentional or unknowingly done, or that are not done even though they are essential (Yurdakök, 2010, p. 423). Childhood trauma is the most difficult type of trauma to identify and treat due to its repeatability, the fact that it is usually inflicted on the child by those closest to him, such as family and relatives, and the long-term effects that can affect the child even in the later years of his life (Yılmaz, İşiten, Ertan, Öner, 2003, p 295). Childhood traumas cannot be easily lumped together; they can be seen in

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different cultures, different social classes, every ethnic group and every socioeconomic level. Various forms of abuse and neglect are a public health problem that affects not only families, but also society, social institutions, legal systems, education systems and businesses. (Taner, Gökler, 2004, p. 35). The state health organization defines child abuse as "behaviors committed knowingly or unknowingly by an adult that negatively affect the child's health, physical development and psychosocial development." When we consider this definition, what is important is not the adult's intention, but the effect of the action on the child. Child abuse and neglect is a health problem that harms the child's health and leaves permanent scars throughout his life. Neglect and abuse are different concepts, and the point that distinguishes neglect and abuse is that neglect is passive, and abuse is active (Aral, Gürsoy, 2001, p. 151). Neglecting the child is passive, abusing the child is active. Although different practices for child abuse in the context of traditions and beliefs depending on cultures and societies make it difficult to define; They meet at such a common point in that they are non-accidental, have a high probability of recurrence, and negatively affect the child's physical and mental health as well as psychosocial development. It has been observed that child-rearing attitudes vary in families where child abuse and neglect occur. According to some research results, in families where child abuse or neglect occurs, these parents may have been exposed to some types of abuse in their own childhood, and psychiatric disorders such as schizophrenia, depression, substance addiction, alcoholism, and anxiety disorder have been detected in the parents. Childhood traumas are related to the characteristics of the parent, social problems, unhealthy interaction within the family and the developmental problems of the child.

Factors that predispose to the emergence of neglect and abuse:

- Low socioeconomic level structure,
- Narrow and limited living space,
- Parents' own childhood traumas
- Parents' illness history

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- Second spouse or stepparent problems
- Family structure surrounded by extended individuals,
- Large and difficult forced migrations,
- Low education level,
- Family order that is tried to be achieved with a single parent,
- Low marital quality,
- Poor parent-child relationship,
- Parental history of substance abuse,
- Reflecting traditional impositions on the child,
- Separation of boys and girls
- Becoming a parent early, before reaching emotionally competent adulthood

These substances have a negative impact on the child's future life, create problems in establishing an emotional bond with the child, and may cause child abuse and neglect. It is seen that children who cry constantly, have eating problems, are sick, display irresponsible behavior, have aggressive attitudes, cannot establish good relationships with their parents, and have mental or physical developmental delays are more abused than other children. Being away from parents or parental deprivation, and the situation of children who must separate from their parents at a young age for various reasons, can be considered as a separate internal stress factor. Families broken up due to death, illness, migration, divorce or working in separate places constitute an important risk group for child abuse. Emotions created in the child by being neglected and abused by the mother and father, witnessing the incompatibility between the mother and father, coming from a broken family or various family problems significantly affect

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the child's way of life and life-related relationships, causing the child to imitate these through learning, thus causing the child to become an abuser. It can cause him to gain a personality. (Bulut, 1996, p33). While some children are exposed to sexual attacks by adults; Some of them are forced to work under harsh conditions and in inappropriate jobs at a young age and take on great responsibilities with non-pedagogical attitudes. In Turkey, many children and young people enter working life at an early age either to contribute to the economic livelihood of their families or to support themselves and are faced with various forms of abuse and neglect.

Alter Identities in DKB

The concept of alter does not exist in any other disease or disorder of psychiatry. What is alter identity? Alter identity is a person's mental organization. For this reason, it shows the general working principles of the human mind in this formation process. It has a sense of self. He thinks, is emotional and possesses memories. DID therapy; It is a therapy that directly addresses the alters and the alter system formed by the dynamic interaction of alters with each other. In this respect, DID therapy progresses in its own way. DID psychotherapy is a process and trauma treatment carried out through alters. Treatment approaches that ignore the person's alter identities are doomed to be treatments that last for years but are ineffective. Each alter identity in a person has a unique reason for existence and moment of existence. Alters, that is, alter identities, tend to continue themselves in a way that is faithful to this reason for existence. Sometimes, over the years, they can change and transform for a new function depending on the process. Each of the alter identities has an “alter system” consisting of the sum of the function. This alternator system is generally somewhat complex, has several layers and a hierarchical structure in terms of power distribution. This alters system in the person seems to have an order. In DID, the alter system varies from person to person and from level to level. In fact, sometimes there is chaos as well as order, and chaos may also prevail. Witnessing such a plural or crowd can be ostentatious and fascinating. One should not get carried away by the fact that there are

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many alter beings or crowded structures and that there is essentially a "single person". It should not be forgotten that he is essentially a single individual. It should be known that alter identities are not separate persons or people. Alter is the different organization of a single mind of a single human being that has undergone the process of dissociation. The therapist should have equal approach and distance to each alter identity, should not discriminate between these alters he encounters, and should deal with each alter separately at every time. The alter system of each dissociative identity disorder patient has a unique and special course; However, when hundreds of cases are brought together and a classification is made, common general alter types can be mentioned.

Common alter types in people:

Host Alter: It is an alter identity that manages and controls the body and manages daily life, like a leader. The person with DPD refers to this alter as "I" or "the main person" when talking about himself. Usually this alter bears the official name of the person, that is, the body. It is not existentially different from other alter identities. It differs from other alters only in terms of its role. In general, this house alter has low energy or a depressed attitude. If the host alter identity; If the patient is strong, can control the whole day, and can work actively with the therapist, the stages and course of the treatment progress very positively and the desired progress can be made in the treatment. Sometimes, in difficult cases, the host alter may tend to move away or disappear. In such a case, he may be incapable of managing his body and performing the function of communicating or negotiating with other existing alter identities. In such cases, it is necessary to encourage and work towards strengthening the identity of the host. Because the constant change of alter identities in terms of controlling the body can negatively affect both daily life and the therapy process and slow down the process.

Bad Alter: These are the negative and bad alters in the movies. These alters take on negative roles. With their orientation, they want to manage the identity of the host through their inner voice and by intimidating and putting pressure on others. This alter is not bad in nature. They choose bad, scary and oppressive attitudes because they think it is better that way. However,

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over time, they get caught up in their roles and influence the person to their detriment or detriment. These alters sometimes describe themselves as evil, sometimes as murderers, sometimes as bosses, sometimes as evil, and sometimes as cruel. During the therapy process, this alter should never be treated as a real evil, but rather should be viewed as an ally. In addition, working with these bad named alters, trying to understand them and turning them into helpers can have a very positive impact on the treatment process.

Auxiliary Alter: It is in assistance with the other part of the structure. During this process, although the assistant alters seem hesitant or weak, these alters communicate positively with the therapist from the very beginning. They usually give positive advice to the host identity. But mostly, their effects on the system are weak, not dominant. They can become stronger during the therapy process and make a more positive contribution.

Child Alters: It is necessary to be careful when communicating with child alters. Although it may seem easy, child alters indicate a complex situation and can be drama-filled and difficult. They have bad memories of the traumatic period of childhood. They are usually stuck or stuck in that time, moment and place where the traumatic events took place. While some of them stay inside and do not directly affect daily life, some of them exist in daily life and cause childish reactions and behaviors with their childish attitudes and actions. Child alters have a dramatic impact on the course of the treatment process. Understanding child alters well is an important stage of the treatment process.

Opposite Sex Alters: Not every alter must be seen in every dissociative identity disorder. Not every person with dissociative identity disorder has an opposite-sex alter. If opposite-sex alters are present, they can cause masculine behavior in women and feminine behavior in men. The presence of a male alter in women is often expressed as "I would be stronger if I were a man." It exists because of thought. The male alter, on the other hand, takes on the task of protecting the existing thing or the body. Opposite sex alters can sometimes influence sexual orientations as well. They may be trying, tiring, or ineffective.

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Copy Alters: It is referred to as a copy, but the person is not aware that his alter is a copy and treats him as a real person. Copy alters are copy structures made in the mind of people who affect life positively or negatively. The copy alter can be a person who disturbs or harasses the person or can even be a copy of the therapist. People with dissociative identity disorder treat the copy alter as a real person in their inner world. The duplicate alter is treated as if he were really that person. As a result of dissociation, one becomes detached from reality. The patient should be told that the person outside and the copy inside are not the same person, and that the copy alter is something that belongs to the person. The process, stages and the impact of traumas must be carefully analyzed and recorded.

Emotional Alterations: Sudden emotional shifts are frequently observed during the DID process. Sudden and rapid emotional transitions may reach their peak with inner voices. They are formed through intense emotions and emotional coping strategies that are intended to confront painful events experienced during childhood. They are called angry, sad, depressed, joyful. When the body is controlled, emotions are expressed. The person may experience sudden and rapid emotional transitions due to the physical control of emotional alters. This condition can sometimes be confused with bipolar disorders. While the control or regulation of emotional alterations contributes greatly to the improvement of a person's daily life, it is necessary for the treatment process to go well.

Sleepy Alter: As a result of dissociation, the person may see sleep as a solution to stay away from the troubles he is experiencing. As it is known, sleep is assumed to be a kind of escape state. It is produced as one of the ways to escape from traumatic experiences. Not having the potential to sleep 16 hours a day is generally a cause of illness. When they control this alter body, they tend to have a state of sleep continuity that is very difficult to control. Sometimes they can make the person sleep for long hours, for days or weeks. Collaborating and making change may require effort and care.

Sexual Alter: If a DID patient has this alter, they should be listened to, and the purpose should be investigated. It is an alter that differs in each DID case. It involves abnormal sexual acts.

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This alter represents the person's excessive and sometimes inappropriate relationship with sexuality. While trauma patients, on the one hand, exhibit anxiety, fear and avoidance behavior towards sexuality, on the other hand, they may produce an alter that is comfortable and interested in sexuality. When the sexual alter acts, he may expose the person to sexual activities that he does not want.

Supervisory Alter: Some people with dissociative identity disorder have a master alter identity that directs and constantly monitors the course of events. This dominant person may see himself as the protector of the system, the manager and the boss of the body. This alter may even see the therapist as a rival. This identity usually reveals itself in the later stages of the therapy process. As I mentioned before, it is not possible for every DID patient to have every alter. This superior executive alter can sometimes negatively affect the therapy relationship and undermine the process. Often different alters criticize the therapist for different reasons. The alter manager may accuse the therapist of trying to disrupt or change the system he has established. If the therapist manages the process successfully and balancedly and manages to cooperate with the manager alter, resistance can decrease, change can accelerate, and progress can be made.

Observer Alter: In dissociative identity disorder There are many alters; the observer alter is just one of them. The observant alter constantly monitors daily life events, happenings, alter activities and the therapy process, as an observer. Tries to understand the intentions of strangers and especially the therapist. He observes the people he meets or meets recently in life and observes whether the therapist is also a traumatist. Until he trusts different people in the group and the therapist, and until he makes his own analysis, he does not show himself immediately, does not reveal himself, and proceeds by observing.

Dilemma Alters: Being one way or the other, defending something while defending the other side, that is, dilemmas about life, tires the patient and puts him in a difficult situation. This alter may arise from unstable and fluctuating dilemmas in one's life. Believer or non-believer through the dilemma of believing or not believing; Due to the tensions in determining the ideological position, left-wing or right-wing alter identities may arise, loving or blaming and hating the

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parents against the dual feelings of father and mother. While these alters affect the person's lifestyle and social relationships, they also cause fatigue and social problems.

Epidemiology of Childhood Traumas

In the epidemiology of childhood traumas There are regional and cultural differences. The concepts of abuse and neglect are defined differently, different sample groups are used, and because of these and similar reasons, studies in this field have produced different results. Additionally, there is no clear consensus regarding the prevalence of child abuse (Sadock, Sadock, 2004, 370). WHO reports that the inability to compare child abuse and child neglect as an important problem because different definitions and methods are used in studies conducted all over the world. 38 independent articles examining the prevalence of childhood sexual abuse in twenty-one different countries and 39 corresponding prevalence studies report that the prevalence of childhood sexual abuse varies between 0 and 50% for women, while this rate varies between 0 and 60% for men. It should be known that these numerical data and rates are constantly changing. However, registered scientific data results are taken as basis. These findings from various countries are an indication that childhood sexual abuse remains an international problem. Cases of sexual abuse are most common during adolescence. When the frequency of sexual abuse is evaluated in terms of gender, the frequency of sexual abuse in teenage girls is 3 times higher than in boys (Kanbur, Akgül, 2010, p. 502). When we look at our country, the prevalence of dissociative identity disorder is reported to be 5.4% on average in psychiatric wards and 4.0% in psychiatry outpatient clinics. 75 to 90% of the population is recorded as female. Considering the research on the prevalence of childhood trauma in the literature, it is stated that although emotional abuse and neglect are the least studied forms of child maltreatment, they may be the most common. (Wright, Crawford, Castillo, 2009, p33). The most common childhood traumas are emotional abuse, followed by physical abuse, exposure to domestic violence, forms of neglect, and sexual abuse. Emotional abuse

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accompanies all other types of chronic abuse and is more common in all societies compared to physical abuse and sexual abuse. In a study conducted on a psychiatric sample, emotional neglect was found to have a frequency of 81.6%. Since it is more difficult to measure the prevalence of emotional abuse and neglect in childhood and to quantify this sensitive situation, the consequences of emotional abuse attract less attention than others. You can observe the effects of physical violence on a person in a shorter time and with more primitive methods; But emotional abuse cannot be measured easily, which may be attributed to the fact that emotional abuse cannot be studied as widely as physical violence, and the effects of physical violence are more easily observable.

A national prevalence study conducted periodically by a government agency in the USA found that more than a quarter of the victims were children under the age of 3, and the gender ratio in trauma exposure was similar. These rates are 48.6% boys and 51% girls. It was reported that three quarters (74.8%) of the victims were exposed to neglect, 18.2 percent to physical abuse and 8.5 percent to sexual abuse. It was noted that 14% of the victims were exposed to more than one trauma, and the most common combination of multiple traumata with 5.2% was physical abuse and neglect. In the same study, 9 risk factors for the child and 12 risk factors for the caregiver were identified; The most common risk factors in caregivers were alcohol and substance use, financial difficulties and inadequate housing (Child maltreatment US. Department of health and human services, 2016). United Nations Children's Emergency in Georgia in a national study conducted within the scope of Fund), 59.1% of 100 children between the ages of 11-17 experienced emotional abuse, 54% physical abuse, 28.6% exposure to violence, 24.8% neglect and 7.8% sexual abuse. They stated abuse (Lynch, Saralidze, Goguadze, Zolotor, 2008). The prevalence of physical abuse was investigated in five countries: the USA, Chile, the Philippines, Egypt and India. Prevalence rates for these countries; It is stated that it varies between 4% and 85% in the USA and Chile, 21% and 82% in the Philippines, 26% and 72% in Egypt, and 36% and 70% in India (Runyan, May Chahal, Hassan, 2002, p 57). As can be seen, the prevalence rates are quite striking. In a study conducted in England, it was reported that 7% of children were exposed to physical abuse by their caregivers, and 6% of

young people were exposed to physical neglect at home (May-Chahal, Cawson, 2005, p. 969) Colombia , India, In an international study conducted in Russia and Iceland with a total of 459 children, 66% of the children were subjected to emotional abuse, 55% to physical abuse, 51% to violence at home, 37% to neglect and 18% to child abuse in the last year. It was determined that many people were also exposed to sexual abuse (Zolotor, Runyan, Dunne, Jain, Péturs, Ramirez, 2009, p83). When it comes to a person or even a child, these rates are high and reveal how many children are victimized. As a result of its international studies, WHO has determined that approximately 20% of women and 5-10% of men were sexually abused in childhood, and 25-50% of all children were physically abused (World Health Organization (WHO), (2010). http://www.who.int/mediacentre/ factsheets /fs150/en/index.html.). As can be seen from these rates, many children in many societies have been exposed to forms of neglect and abuse. No child in the world deserves to suffer. The decrease in abuse and neglect rates in these studies is extremely important not only for a child but for a society for many reasons.

Symptoms of Dissociative Identity Disorder

Although every mental illness has symptoms within its structure and framework, it also has common characteristics with other mental illnesses. For this reason, during the DID process, all symptoms in the patient should be analyzed thoroughly and no symptom should be ignored. Dissociative identity disorder patients often tend to keep their current mental state a secret. In addition, since DPD patients have been in this condition from an early age, they may not be fully aware of their disease or try to treat themselves for a long time. This awareness may not have occurred at the desired level in every DID patient. As a result of this process, the patient with dissociative identity disorder usually does not present to the clinician complaining of identity or memory impairment, which are the main features of the disorder. DID patients usually present with emergencies or acute crises. It should be known that indirect or secondary symptoms, syndromes, complications that occur over time, complaints arising from co-morbidities, or acute crises that create emergency situations cause patients to apply. Does the

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person have an alter personality or not? Is the inner voice of a person dominant or not? Does the person experience memory loss? These questions should be the focus. The clinician who wants to make a differential diagnosis of DID should focus on the following three symptoms: Inner voice/inner speech, rapid change in facial expression/emotions, and memory problems. These three symptoms mark the main symptoms and are indicative of the alter personality, which is the most fundamental issue of DID. Alter means a separate organization of the mind that has gained autonomy. In dissociative identity disorder, there are two or more separate alter personalities that have gained autonomy. All existing symptoms of dissociative identity disorder occur through the activities and actions of these alter identities. An inner voice and an inner conversation are formed as alter identities communicate among themselves. This inner voice is a very important focal point and indicator for the therapist. There are changes in facial expression and affect due to the sudden and rapid displacement of alter identities in body control, that is, the area we call affect change occurs. These things are different and variable in each DID patient. The number of alters and alters are different. In addition, depending on the severity and level of deactivation of the host personality while each alter controls the body, loss of focus, inability to concentrate, wandering, gaps that cannot be remembered, or great forgetfulness may be observed and may occur. While these complaints may be based on the person's own inner world, they sometimes spread to the society and can be experienced and observed in the dimension of interpersonal relationships, business world or educational life problems. Sometimes, it is possible for some cases in the DKB to enter the judicial system directly because of criminal actions. Psychogenic physical symptoms, migraine pain, and some physical complaints that cannot be fully explained medically cause referral to non-psychiatric clinics. A person with dissociative identity disorder should not be understood and thought of as an individual who lives with different identities, becomes plural, and lives a happy life without any problems. In fact, on the contrary, the person with DID disease lives a "confused" or "confused" life between interventions that originate from his inner world but that he cannot control, that is, the activities and discourses of alter personalities and inaccessible abilities (such as memory and amnesia disorders, consciousness interruptions). This is a difficult and risky

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situation. Indirect symptoms are extremely important in the diagnosis process of DID; they can be overlooked and confused with other diseases.

Indirect symptoms seen in DID are as follows:

1. Alter Personality Symptoms

Passive influence

The person feels that his/her emotions, thoughts and behaviors are being interfered with outside of him/her. However, unlike the symptoms of schizophrenia, this intervention does not come from people in the outside world, but from alter personalities whose existence is felt as real and perceived as foreign, as if they were a separate person in the inner world. This situation arises from the tendency of the alter personalities in the person to manage each other or to manage the host personality, instead of taking full control of consciousness (Şar, Tutkun, Alyanak, 2000, p. 216).

Hallucinations: One of the main symptoms. Almost 80% of patients with dissociative identity disorder experience auditory hallucinations or hallucinatory internal voices. These inner voices that the patient complains about and cannot stop, that is, cannot prevent, mostly belong to alter personalities. While they cause enthusiastic internal dialogues, unlike hallucinations in schizophrenia, these voices are often heard “inside the head” as described by the patients and continue their existence through dialogue with the interviewer. Alter inner voices respond to the interviewer's questions from within. Sometimes the alter personality becomes dominant, and if the alter personality takes control of the consciousness, this situation ceases to be a hallucination and turns into real speech coming out of the patient's mouth.

Childish behavior: Childish alters, where traumas become clothes and never come off, are not cute but full of drama. When one of the alter personalities in childhood, which is generally found in almost all patients with dissociative identity disorder, takes control, behavior in this

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direction occurs. While this type of behavior is criticized from the outside, it may be considered abnormal, some of these childish behaviors may not be perceived as inappropriate by the environment, but playing with children like a child, talking like a child in a child's voice are situations we encounter in society. Although some of these behaviors may be disturbing, they cannot be interpreted in this way. We can give examples of behaviors such as buying large amounts of children's toys that are not appropriate for their age, wanting to wear children's clothes, and acting cute. Some of them are incompatible with daily life. For example, we can list actions such as wanting to suck one's finger in public like a baby, wiping one's snot on one's arm as one did as a child, defecating in public, losing one's time orientation, and thinking that traumatic memories and experiences related to that age are continuing in the current time.

2. General Symptoms Mood Changes: Impulsivity:

Mood changes may also be a symptom of some diseases other than DID. Personality shifts are among the symptoms that should be taken into consideration. In some patients with dissociative identity disorder, "personality jumps" manifest themselves in the form of rapid and sudden mood changes. Changes in a person's mood may recur many times during the day, occur suddenly, and may put patients in difficult situations and disturb them. Sometimes personality lapses can lead to impulsive behavior. This discomfort and sudden mood changes are clearly observed in adolescent patients and may require hospital supervision. Dissociative identity disorder is seen at a higher rate in patients under the age of 18 who are admitted to the psychiatric ward compared to the adult patient population.

Unremembered times and fugue experiences: Dissociative identity disorder is often the underlying cause of dissociative fugue states, in which the person finds himself/herself in another place without knowing how it happened. A patient with dissociative identity disorder may not remember some of his or her own actions or even conversations. Not every DID patient may show the same symptoms, but there may be periods of time during which a large portion

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of the day is not remembered. Sometimes, some people cannot remember a part of their lives, only a part of their lives, such as their high school years, their wedding day, or just their childhood. There may be people who cannot remember the traumatic experiences they experienced and want to forget. Fugue experiences may be a reason for DID patients to apply to the psychiatric emergency department.

Depersonalization: Dissociative identity disorder patients may be in a state of alienation from themselves and their environment and may have difficulty perceiving their true self. There is a feeling of being outside your body. Symptoms of clinical depersonalization, such as looking at one's own body from outside and finding one's face unfamiliar when one looks in the mirror, are also quite common. Some DID patients may even have normalized this condition.

Trance: The trance state of DID patients appears as a state of staring blankly at a wall or space in a wedding dress. In dissociative identity disorder, wandering and spending time staring into space without thinking about anything is a common situation encountered by the therapist. Trans states or sleepwalking are common in DID patients since childhood.

Supernatural experiences and possession: DID patients sometimes present supernatural or metaphysical narratives. Supernatural experiences such as contact with metaphysical creatures, having a demon or which enter a person, traveling between times, communicating with spirits, knowing what will happen in the future, and being able to telepathy are common in DID patients. In fact, contrary to popular belief, this situation is not entirely due to cultural reasons. DID studies conducted in different countries give similar results, and it is also seen that people with supernatural experiences in the general population report childhood traumas more frequently.

Physical complaints: While physical complaints are important symptoms, they can also be confused with other diseases. For example, the symptom of headache is also a symptom of many diseases. Patients with DID experience many physical symptoms and complaints that cannot be medically explained. These may reach the level of a somatization disorder.

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Particularly in Turkey, conversion symptoms and some of them, especially psychogenic fainting seizures resembling epilepsy, are observed quite frequently in DID patients.

3. Post-traumatic Symptoms "Flashback" Experiences: Reliving is a symptom in dissociative identity disorder. It is the state of suddenly returning to the past, usually related to a traumatic experience, and feeling like reliving that situation and period. The person may remain amnesic to the "flashback" experience. When viewed from the outside, the patient appears in a state of crisis; the inappropriateness of the patient's behavior and sometimes accompanied by visual and auditory hallucinations may give the impression that the person is in a psychotic state.

Sleep disorders:

As it is known, sleep disturbance is a symptom of many mental illnesses. From the perspective of our topic, many dissociative identities disorder patients experience chronic sleep problems. This usually occurs in the form of not being able to fall asleep at night or waking up from sleep. DID patients may have nightmares. An individual who was subjected to violence by his mother as a child and experienced the trauma of this may see his mother chasing him in his sleep at night. These dreams are about childhood traumas and old traumatic experiences. Some people try not to sleep because they cannot get the feeling of security.

4. Combined Symptoms Dissociative "crisis": Many dissociative identities disorder patients enter crisis states, especially during periods of instability due to internal or external stress. These crises result from the combined and acute emergence of symptoms such as alter personality conflicts, conversion symptoms, flashback experiences, and amnesia as defined above. Such crisis situations are frequently encountered both in the inpatient wards of the psychiatry department and in the emergency units (Şar, Kundakci, Kiziltan, 2003, p. 119).

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Treatment Process of Dissociative Identity Disorder

dissociative identity disorder progresses systematically and develops step by step. The treatment process for dissociative identity disorder, which responds very well to treatment, consists of three stages. The first stage in the treatment process consists of making a diagnosis, educating the person about the disease, recognizing the alter system and ensuring stabilization. In the second stage of DID treatment, the traumatic memories that caused the split are worked on. Experiences from childhood appear harshly at this stage. The third stage of the treatment consists of integration and non-redivided work, which means combining different alters. Although the general rules and interventions of psychotherapy are valid for the treatment of dissociative identity disorder, there are also some techniques that are specific to dissociative identity disorder by its nature. The five most frequently used of these techniques are appropriate communication with alters, mapping technique, reality orientation technique, round table technique and unification rituals. In the treatment of dissociative identity disorder, there is no clear medication that completely cures the psychopathology of the disorder. Additionally, EMDR and hypnosis can be used for traumatic memories that are common in DID.

DID psychotherapy is a semi-structured treatment consisting of three separate periods (International Society for the Study of Trauma and Dissociation 2011, 188, Howell EF, 2011, p 167). The first period is a kind of phase of understanding, progressing through diagnosis and stabilization. In the second period, traumatic memories are addressed. Management of these traumatic memories is very important. In the third period, Efforts are made to integrate and deal with problems without re-dividing. In practice, these three periods are not always consecutive periods that start when one ends and the other begins; they can often be intertwined, and it is a special process that requires professionalism, patience and attention.

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First Period in DID Treatment

During this period, there are five separate interlocking processes that must be completed carefully and collaboratively. These processes: These include making a diagnosis and understanding the alter system correctly, establishing therapeutic cooperation and trust, providing training on dissociative identity disorder, ensuring security and providing stabilization for daily problems. Both individuals alter identities must be recognized correctly and this special holistic system formed by the interaction of all alters must be understood. "Mapping technique", which is an important technique, can be used to complete the system. Keeping therapy collaboration under control and establishing a healthy trust relationship is the basic rule of psychotherapies. In dissociative identity disorder patients, it is necessary to establish cooperation with all alters without losing the single human perspective. Dissociative identity disorder patients are in the trauma patient group. Therefore, since there is sensitivity to drama, trauma and trust, establishing a trusting relationship may be much more important than other patient groups. This process also has a more difficult process than other patient groups. Dissociative identity disorder patients test whether the therapist they are dealing with is trustworthy from the very beginning to the end of the therapy process. There is even an alter called the observer alter, which is solely responsible for this surveillance work. This situation closely affects the treatment cooperation and treatment effectiveness, whether the person understands dissociative identity disorder or not. At this stage, ensuring security is an important step. Essentially, it is a difficult and demanding process. Previous studies have shown that 70% of DID patients attempt suicide at least once during this difficult process. This is a serious rate. When I first heard about it, this rate made me think a lot. Alter communication is important in this sensitive issue. Ways to prevent suicide attempts or prevent suicide; It may be useful to question the idea of suicide, to identify and communicate with alters who have suicidal tendencies, and to try to make an agreement, especially a written agreement, not to attempt suicide. In patients with dissociative identity disorder, Self-harming behaviors such as physically harming their own body, that is, cutting their arms and legs, scratching different parts of their body, sticking a sharp object into their body, squeezing their own skin, can be observed.

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This is among the very secret or normal behaviors for them. Self-harming behavior is also usually the action of certain alters. These alters generally do not feel pain during self-harm. In the initial period, it may be helpful to contact these alters directly and try to make an agreement to stop or stop self-harming. A positive, moderate, direct and clear communication style always works. In this process, daily life problems arising from dissociative identity disorder are tried to be controlled and stabilization is achieved.

DID Treatment Second Period

This period is the middle period of dissociative identity disorder treatment. The difficulty or main feature of this period is the intense work on traumatic memories (abreaction). Often the patient's childhood is reverted to. At this stage, the traumatic stories of the person and the alters are carefully considered. What does Alter ID say? What is Alter ID upset about? What does Alter ID want? Who is Alter ID angry with? How many alter identities are there? The answers to these questions should be found systematically and a road map should be drawn according to these answers. It is aimed to complete the person's own colorful life story and to ensure continuity in his memory. If there is amnesia for traumatic memories, the memories must be recalled. There can be no real healing without remembering these traumatic memories and revealing the repressed memory. Forgotten traumatic memory is like an abscess in the body. Just as birth is painful, just as relief is provided when the thing causing abdominal pain comes out, or the abscess inside needs to be drained for healing, traumatic memories are also revealed and healed in some way. In fact, if necessary, mourning must be experienced. Once reminded, EMDR (Eye movement desensitization Memories do not need to be reminded or kept alive again and again unless reprocessing (reprocess) treatment is performed. If the person remembers traumatic memories, efforts are made to systematically make sense of what happened. It is important for the patient with dissociative identity disorder to distinguish between the abusive structure and the victim structure. Dissociative identity disorder patients often tend to see themselves as guilty, at fault, sinful, or cursed, even though they have been

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victims of trauma and have been subjected to pain and abuse. Moreover, they are not aware of these wrong thoughts. It is the therapist's job to hold a mirror and create this awareness. By systematically working on these distorted ways of thinking and feeling, a correct interpretation of the trauma should be provided, and the person should be able to complete his/her mourning without blaming himself and the process should be progressed.

DID Treatment Third Period

dissociative identity disorder, this is a period in which what has been sown is reaped. Now that the infrastructure is completed, collection and assembly must be done. Merging already means the green light for recovery. This period of treatment in DID is the completion period of the treatment, and its main feature is to work on coping with the problems for the purpose of integration and preventing re-division, that is, to start implementation. The aim is to try to make the mind, whose unity has become pluralized with the damage caused by the dissociation process, a holistic and integrated whole again (Kluft, 1999, p. 53). The main purpose here is to combine alter identities with the host identity. Various unification rituals are performed to unite different alter identities that exist together. Uniting rituals can become enjoyable if the patient's trust is ensured in the above-mentioned stages and they are established with the trust of the observing alter and the approval of the manager alter. If the conditions are fully met, identities will merge, and healing will begin. What is essential in the merger is that the alter identities are willing and ready for this process, that is, the merger, rather than the merger technique. There are such patients with DID that the alters inside them are tired, old and worn out. Even if alters in this structure fight, they can somehow cooperate and support the process. It means that the alters and the treatment process are ready; It means fully understanding the discomfort experienced, providing the necessary stabilization, and completing the mourning of traumatic memories. In this case, it is easy to merge. When these conditions are not met, it is difficult for alter identities to merge. With the integration of alter identities, the existing AIB process is not

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considered finished. It should be ensured that the existing structure of the person does not divide again. For this, it is necessary to work on how to cope with life stresses and struggle without division. Just because the mind becomes singular and integrated does not mean that one's problems are over. This, too, is a journey; the experiences, the person's condition, the physical and mental damage, and the patient's ability to evaluate his own journey all create a picture.

Sand Tray Therapy for DID

Sand tray therapy helps people express themselves through nonverbal communication. Sand tray therapy addresses the unconscious area. It can be useful in patients or situations that cannot communicate verbally (Çınar, Sand Tray Therapy, 2023). In some DID patients, the trust problem does not disappear, and verbal communication may become difficult. In this case, it may be necessary to perform sand tray therapy with alters. Treatment can be supported by performing different sand tray therapy sessions with each alter. Sand tray therapy is a helpful factor in the process of DID disease, as in many mental illnesses. Sand tray therapy is not a stand-alone treatment; However, in communication with alters, it both accelerates the therapist's progress and gains the trust of some alters. Although child alters are a very common group in the DID process, they have a structure that is not very easy. Some alters' trust in the therapist is also important. Especially when working with a child alter, sand play therapies or sand tray scenes give the therapist a lot of insight. It is very important to understand traumatic memories in DID. Since we are talking about childhood traumas, it is not easy to express them. For example, while a person who has been abused cannot explain this with words, he can explain it more easily with miniatures placed in the sand. While people sometimes have difficulty expressing themselves with sentences, they can express themselves more easily through miniatures and symbols (Çınar, Sand Tray Therapy, 2023).

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Other Techniques Used in Treatment

There are different treatment interventions specific to DID. Many individual and situation-specific techniques can be applied. The DID treatment process is compatible with general psychotherapy processes and techniques. Cognitive remediation techniques can also be used for alters' thinking errors. Behavioral techniques can be applied to behavioral changes in alters. Attitudes and behaviors caused by childhood traumas can be understood with a dynamic approach. DID psychotherapy is open to being eclectic. Talking to different alters separately, using the mapping technique, orientation to reality, round table technique and unification rituals. Alter is a separate mind organization that is separated from the whole mind and has gained autonomy. For this reason, it has its own perception of age, gender, body, feature and function. The therapist needs to talk to and meet the alters either through the host or directly, if possible. For DID treatment, meeting each alter and dealing with them individually is a must for the DID therapy process. Changing the alter that controls the body is called " switching ". Seeing this change is also necessary for diagnosis. With the change in the alter's body, facial expression, tone of voice and attitude change very noticeably in severe cases, while in mild cases only the content of the thought may change. Another technique is mapping; for the treatment of DID, a continuous record of all individuals alters, and the system created by alters must be kept. For this reason, the therapist dealing with the treatment of dissociative identity disorder must make a "mapping" showing the names, ages, physical characteristics, reasons for existence, characteristics and place of all alters in the system (Ross, 1997, p. 313). This mapping can be done in two ways. In the first one, they are given a blank paper and a pen, and each of the alters inside is asked to write their own name and mark their place according to their proximity to the other alters. This method does not always work for every patient. The second method is that during interviews, the therapist must work with the patient to remove the alter system. This map showing the alter system requires constant updating. One of the most important goals of therapy is to orient the person to "physical reality". Dissociative identity disorder the round table technique is also among the techniques used in the treatment. Sitting the patient's alter identities around a round table is a powerful technique to increase interaction

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and shared decision-making between alters. Alters are expected to sit around the table and discuss life-related issues and make decisions. The fact that the table is round indicates that it is democratic rather than hierarchical. This technique can also be applied when the therapist wants to address all alter identities.

EMDR (Eye movement desensitization Reprocess) is one of the auxiliary treatment methods used in DID. Amnesic or excessive recall of traumatic memories is a common condition in DID. EMDR can be applied to traumatic memories that come in the form of flashbacks or are remembered through the body (somatic memory) (Twombly, 2000, 61).

Hypnosis: As it is known, hypnosis is a method that is used and beneficial in many treatments. It may not be easy to communicate with every alter. In this context, treatment can be resorted to with the effects of hypnosis. In some cases of DID, one or more unreachable alters or a traumatic memory can be accessed through hypnosis. Hypnosis can also be used to treat some symptoms (International Society for the Study of Trauma and Dissociation. 2011, p. 188).

Psychopharmacology is one of the frequently used adjunctive treatment methods in DID. Patients can generally hope for recovery or even full recovery by using medication. There is no medication that treats the main psychopathology in DID by combining alter identities. The use of psychopharmacological drugs is aimed at reducing symptoms. If depression is common in the alter system, if there is a picture that appears psychotic, or if there is a comorbid diagnosis such as obsessive-compulsive disorder, medication can be used (Chu, 2011, 246).

Etiology of Dissociative Identity Disorder

Psychogenic factors

Childhood traumas: The relationship between childhood abuse and neglect and dissociation has been shown both in retrospective studies, based on documents, and in prospective studies

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(Lewis, Yeager, Swica 1997, p.154) (Ogawa, Sroufe, Weinfield, 1997, p. 32). In a case series in our country, sexual abuse in childhood was found to be 57.1% (some of it incestuous), physical abuse 62.9%, emotional abuse 57.1% and neglect 62.9% (Şar, Yargic, Tutkun, 1996; p. 1329). 88.6% of cases reported at least one of these. These stories are verified by third parties in many cases. (Şar, Tutkun, Judge, 1999, p. 95). In cases of dissociative identity disorder, childhood traumas other than abuse and neglect are also encountered. For example, long-term and repetitive exposure to painful medical procedures in childhood may cause dissociative disorder. Studies are also being conducted on the biological effects of childhood traumas (Diseth, 2006, 233).

Interpersonal attachment problems: A relationship has also been established between dissociation in individuals and insecure attachment problems (Barach, 1991, pp. 117-123). Disorganized attachment behavior in the baby has been seen as a precursor to dissociation in later life (Liotti, 1992, p. 196-204) (Lyons -Ruth, Dutra, Schuder, Bianchi, From 2006, p. 63-86). Abuse and neglect, especially those caused by people responsible for the child's care, lead to a psychological structure in the person who is a victim of trauma, called attachment to the abuser. The main reason for this is that for early life attachment is a necessary condition for growth. The dissociated individual creates a copy of the abuser in his inner world and fantasizes that he can control the abuser in this way. This leads to a shift in the locus of control, and after a while the person falls under the domination of the internal abuser, who continues to exist as a foreign entity in his inner world. Some alter personalities seen in DID patients have undertaken this task. Alter personalities that are more dependent and obedient to them are also present in the system. Therefore, successful results in the treatment of DID are only possible by resolving attachment to internal and external abusers (Şar 1998, p. 44) (Şar, 1999, p. 45-68).

Family psychopathology: As in many issues, when it comes to DID, the concept of family is a dominant area, but it can also be the starting point or source of some things. As a result of recent developments in technology, the importance of biological and genetic factors in the etiology of schizophrenia and the limitation of the definition of schizophrenia to relatively chronic cases have highlighted the role of relationship and communication disorders in families in

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dissociative disorders. There are connections and parallels between the structure of the family, many dynamics within the family, family experiences and childhood traumas. That is, it is impossible to assume that the family environment in which childhood traumas occur is healthy. Although there are many subtypes of such families, emotional fluctuations and anger outbursts, distortion of facts, family crises, deceptions, and the dominance of rigid and one-sided views are typical for such families, and in fact, we are talking about a completely "dissociative" family here. On the other hand, childhood traumas are transmitted between generations. Trauma in one generation of the family due to external factors may lead to trauma-related psychopathologies in the next generation. Parents may project their own childhood traumas and negative experiences of problematic family structures onto their own children.

Impact of Society

While societies change the age and the person with different sociological combinations, of course they also affect a child. Society has undeniable effects on the AIB process, either directly or indirectly and in various dimensions. When it comes to traditional societies, importance is given to the thought of customary traditions and communities rather than the individual's opinion or the individual's health. Individuals who are worn out by this sociological pressure or authority reflect these experiences to their children. There is also an indirect negative effect here. The problems in modern societies are no less than those in traditional societies. All children have certain rights, all children are without fault, all children are innocent, because they are children. There is a need for legal rules, strong sanctions and the rise of non-governmental organizations. Society is strong, the child is defenseless. When we look at the etiology of dissociative identity disorder, the role of sociocognitive factors is very important. Even if the effect of local cultures on dissociation is left aside, considering the unfair economic structure in the world and the effect of the existing political order on individuals, it is quite expected that society will have a dissociative effect. In today's societies shaped by power and power, being abused and neglected, neglected and neglected have become a part of life that is

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not only in the middle but cannot be easily prevented. Burning traditions, crushing beliefs, collective selfishness, negative rituals and perspectives, prejudices, modern slavery, child brides, child workers... Children are not only hit by their parents. From all the people on a street, from the attitude of a neighbourhood, from a school, a classroom, a market tradesman, groups, classes, communities and societies... Groups are in a strong position to provoke each other, to give each other power and to cover up each other, where they are in the majority against a part. The feeling of courage prevails in what they feel. Groups may damage the part. This appearance is a state between clinical dissociation and the dissociation of normal life. The dissociative effect of society is a somewhat grey, somewhat marbled, deep and broad subject that is the subject of psychohistory, philosophy, discussions, articles, sociology and psychology, which you mentioned at the beginning. In the process of DID and even in many mental illnesses, it is observed that underneath some childhood traumas and memories, there are unwanted memories experienced in society. It is expected that new research and studies will emerge, revealing once again how great and how important the impact of society is and its importance.

DID and Neurobiological Factors

Brain imaging studies: Biological studies on DID are still in their early stages. Brain imaging studies have focused on two points: examining variables related to dissociation and comparing DID patients with healthy controls or other psychiatric patients. In this area, differences between personality states in DID patients; dissociative and non-dissociative reactions to trauma-related issues in post-traumatic stress disorder patients; Studies have been conducted on the brain perfusion changes that occur before and during the personality jump in DID patients and the differences in brain perfusion between dissociative patients and normal controls. It is known that the orbitofrontal lobe is affected by early psychological trauma (Shore, 1996, pp. 59–87). Based on this point, a neurobiological model centered on the orbitofrontal region of the human brain has been proposed for dissociative identity disorder. The fact that orbitofrontal hypoperfusion was shown in two separate studies conducted in Turkey in DID patients supports

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this idea. In addition, in patients with dissociative identity disorder, the hippocampus and amygdala begin to shrink gradually compared to normal controls, and the parahippocampal It has been shown that there is a strong correlation between shrinkage in the gyrus and psychological and physical dissociation (Ehling, Nijenhuis, Krikke, 2008, pp. 307-310).

DID and Genetic Studies

As with many mental illnesses, there are not yet sufficient genetic studies on DID. Genetic studies on dissociative disorders are limited. A study did not find a relationship between dissociation and temperament and character in male alcohol addicts (Evren, Şar, Dalbudak, 2008, pp. 717-727). Grabe et al. found a relationship between dissociation and genetically based characteristics such as high transcendence and low self-centered management. A study in OCD patients found no differences in genetic polymorphisms associated with monoamine functions between high- and low- dissociation subgroups. In a subsequent study, it was revealed that childhood physical neglect and 5-HTT genotype were linked to dissociation. Lochner, Seedat, Hemmings, 2007, p56) Genetic studies on dissociative disorders are far from reaching a common conclusion yet. Some experts state that there is a direct link between DID and genetic factors. They argue that this identity disorder is passed from generation to generation through genetic transmission.

Conclusion

Dissociative identity disorder is an important mental illness that has many subheadings, has important details in itself, requires a multifaceted approach, and emphasizes childhood traumas and inner voice. A person with DID may face the guidance of their alters while struggling with

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their inner voice. Dissociative identity disorder is a mental disorder that is closely related to environmental stressors and can be treated with unique psychotherapy methods. Dissociative disorders are mental disorders closely related to childhood traumas, characterized by frequent suicide attempts and a high rate of psychiatric comorbidity, and they have stages and different levels of labels. The treatment process of dissociative disorders proceeds systematically, in a principled and gradual manner. Medication and hypnosis alone are not sufficient in the treatment of dissociative disorders. Full recovery can be achieved by combining the alters with the gradual psychotherapy process specific to dissociative identity disorder. Since dissociative disorders are a psychiatric diagnosis group that is of great importance for the recognition of early-onset and recurrent traumas both at the psychotherapy stage and the prevention of chronic childhood traumas, the treatment and therapy interventions of these cases by clinicians and therapists who do not specialize in the field of dissociative disorders have been evaluated in terms of malpractice in recent years. It has become a very important problem. After a diagnosis of DID, sand tray therapy can be tried to communicate more easily with the patients alters. Sand tray therapy facilitates communication and taps into the patient's unconscious, especially when the child engages in dialogue with tools. Sand tray therapy has a relaxing effect (Çınar, Sand tray therapy, 2023). Establishing an environment of communication and trust with the patient is an important step in the DKB process. Establishing healthy communication with alters and gaining the trust of alters is considered progress in treatment. As we enter the 21st century, the studies carried out in the field of dissociation in Turkish psychiatry have positively affected the fate of the subject on a universal scale. As a result, knowing that different types of traumas other than sexual abuse can cause dissociative identity disorder can prevent the diagnosis of dissociative identity disorder from being missed. In fact, it is a more functional approach to go from diagnosis to trauma, rather than from trauma to diagnosis. It is best to question the diagnosis of DID like other diagnoses when making a differential diagnosis in the first interview. To gain professional experience on dissociative disorders, receiving various supervisions in addition to training, conducting innovative academic studies, providing economic contributions to field studies, and carrying out volunteer activities will ensure a better understanding of these disorders and the application and development of more appropriate

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treatment methods. In the light of the topics and topics discussed in this study, there is a need to develop preventive and protective mental health policies for patients with dissociative disorders in our country, and the studies carried out should also be supported.

RESTRICTION

The research is limited to scientific research that has been previously conducted around the world and reported in the literature.

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