

Dissociative Disorders: A critical examination of classification, diagnosis. Treatment and contemporary debate

Component 2: written report

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Module code and title:

Word count:2,038

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Introduction

Dissociative disorders occupy a distinctive place within Chapter 6 of the International Classification of Diseases, Eleventh Revision (ICD-11), reflecting a substantial revision of how the World Health Organisation (WHO) conceptualises disruptions to identity, memory and consciousness (World Health Organisation, 2024a). Historically, dissociative presentations have occupied an uneasy position within psychiatric classification, moving between neurological, hysterical and psychiatric framings across successive diagnostic systems, and frequently attracting scepticism from both clinicians and the wider public regarding their authenticity and aetiology. This uncertainty has had tangible consequences: individuals experiencing dissociative symptoms have historically faced long delays to diagnosis, inconsistent access to appropriate treatment, and a body of professional literature markedly smaller than that available for many other serious mental health conditions.

The publication of ICD-11 in 2019, and its implementation from 2022 onward, represents an important juncture for this diagnostic group. At the same time, the visibility of dissociative identity disorder (DID) has grown considerably in public discourse, driven in large part by social media platforms, bringing both greater awareness of the condition and renewed controversy over its causes, prevalence and legitimacy as a clinical diagnosis. The revision itself introduces clearer diagnostic language, a new intermediate category termed partial dissociative identity disorder (partial DID), and explicit exclusion criteria distinguishing pathological dissociation from culturally sanctioned trance and possession states, all of which have implications for how clinicians identify, discuss and treat these conditions.

This report critically examines dissociative disorders as classified under ICD-11, with particular focus on DID and partial DID as the most clinically significant, extensively researched and contested presentations within the group. This focus is deliberate: DID and partial DID sit at the centre of the most active debates in the field, concerning aetiology, diagnostic validity, treatment approach and, increasingly, whether some presentations of multiplicity are better understood through a neurodivergence lens than a purely clinical one, making them a particularly instructive lens through which to critically evaluate the wider classification of dissociative disorders as a whole. The report first considers the classification and diagnostic framework set out in ICD-11, examining both the criteria themselves and the language used to describe them. It then evaluates the standard approaches to treatment and rehabilitation, assessing their evidence base, effectiveness and limitations in practice. The report proceeds to explore current debates and emerging issues, including the long-

standing tension between trauma based and sociocognitive models of aetiology, the influence of social media on presentation and self diagnosis, and the implications of framing multiplicity as neurodivergence rather than disorder. Finally, the report offers a set of recommendations intended to improve classification, diagnosis, treatment and rehabilitation, together with their implications for practice, policy and future research.

Classification and diagnosis

ICD-11 groups dissociative disorders together on the basis of an involuntary disruption or discontinuity in the normal integration of identity, sensation, perception, affect, memory, bodily control or behaviour (World Health Organisation, 2024a). This disruption may be complete but is more commonly partial, and can fluctuate over short periods. Importantly, the WHO's diagnostic guidance explicitly excludes presentations that form part of an accepted cultural, religious or spiritual practice, distinguishing pathological dissociation from culturally sanctioned trance and possession states. The subtypes within the grouping include dissociative neurological symptom disorder, dissociative amnesia, trance disorder, possession trance disorder, depersonalisation-derealisation disorder, DID and partial DID.

DID (coded 6B64) is defined by the presence of two or more distinct personality states that recurrently take executive control of an individual's consciousness and functioning, each associated with its own pattern of experiencing, relating to and perceiving the self, body and environment (World Health Organisation, 2024b). Changes in personality state are accompanied by related alterations in sensation, perception, affect, cognition, memory, motor control and behaviour, and are typically, though not always, accompanied by amnesia between states. Partial DID (6B65) is a diagnostic addition unique to ICD-11 – one dominant personality state manages daily functioning but is intruded upon by one or more non dominant states that do not fully assume executive control, producing cognitive, affective, perceptual, motor or behavioural intrusions that the dominant state typically experiences as aversive (World Health Organisation, 2024b). This distinction represents a notable refinement over ICD-10 and DSM classifications, which previously offered no equivalent intermediate category, potentially improving diagnostic precision for presentations that fall short of full DID criteria while still causing significant impairment.

The diagnostic process for DID and partial DID is clinical rather than purely instrument based, relying on structured interview, longitudinal history taking and exclusion of alternative explanations, since dissociative symptoms overlap considerably with mood, psychotic, neurodevelopmental and neurological presentations. Both diagnoses require that the disruption produces significant impairment in personal, family, social, educational or occupational functioning, anchoring the classification firmly to functional consequence rather

than symptom presence alone (World Health Organisation, 2024b). This functional threshold is clinically significant because it means that transient or non impairing experiences of multiplicity, however they are subjectively understood by the individual, fall outside formal diagnostic criteria, a point that becomes central to later debates about neurodivergence and self identification.

The language used throughout the ICD-11 dissociative disorders grouping is consistently that of disorder rather than illness or condition signalling the WHO's broader move toward terminology framed around functional impairment rather than disease pathology. Diagnosis further requires that symptoms are not better explained by another mental, behavioural or neurodevelopmental disorder, are not attributable to a substance or medication, and are not due to a disease of the nervous system, underlining the differential diagnostic complexity clinicians face (World Health Organisation, 2024a). Young (2024) observes that although classification of DID has historically been inconsistent and diagnosis rates remain low relative to estimated prevalence, the refinements introduced in ICD-11 offer grounds for cautious optimism regarding more reliable identification in clinical practice.

Treatment and Rehabilitation

Standard treatment for DID and related dissociative presentations is guided principally by the International Society for the Study of Trauma and Dissociation (ISSTD), which recommends a trauma informed, phase oriented treatment model comprising stabilisation, trauma processing and identity integration or rehabilitation (Griffiths et al., 2025). Notably, ICD-11 itself, as a classification system, does not prescribe specific treatment or rehabilitation protocols, it provides diagnostic guidelines only, leaving intervention standards to be developed by professional bodies and national health services. This creates a degree of inconsistency in how rehabilitation is operationalised across services and countries.

A systematic review by Griffiths et al. (2025), the first of its kind to evaluate phase oriented treatment specifically, screened over six thousand studies and identified nineteen meeting inclusion criteria. All treatment types examined were associated with improvements across dissociation symptoms, general mental health, psychopathology and everyday functioning, though no single approach demonstrated clear superiority, and the authors concluded that the evidence base, while emerging, remains limited by small samples and heterogeneous outcome measures. This matters for rehabilitation in particular, since functional recovery outcomes, rather than symptom reduction alone, are comparatively under researched.

In practice, rehabilitation is undermined by structural barriers to access. Nester, Hawkins and Brand (2022) found that individuals with dissociative symptoms most frequently reported structural barriers, including cost, inadequate insurance coverage and a shortage of appropriately trained providers, as obstacles to both accessing and continuing treatment. Shakya et al. (2024), in a cross sectional study of dissociative disorder patients, similarly identified availability barriers, stigma and low public awareness as significant impediments to timely help seeking, with many patients first consulting nonspecialist practitioners before reaching appropriate psychiatric care. Within the UK context, the mental health charity Mind (2026) notes that effective talking therapies for dissociative disorders typically require several years of sustained work, whereas NHS provision is generally structured around short or medium term interventions, meaning that standard care pathways are frequently insufficient to meet clinical need. Specialist NHS rehabilitation, such as that offered by the Trauma and Dissociation Service at South London and Maudsley NHS Foundation Trust, exists but is concentrated in a small number of national centres, creating substantial geographic inequity in access (South London and Maudsley NHS Foundation Trust, 2025).

A further point of critical evaluation concerns the assumption, embedded in the phase oriented model, that stabilisation must always precede trauma focused work in dissociative patients. Some emerging clinical evidence suggests that certain patients with elevated dissociative symptoms may safely engage with trauma focused cognitive behavioural approaches without extended prior stabilisation, which would, if substantiated by larger trials, meaningfully shorten treatment pathways and reduce the resource burden on services. This remains contested, however, and mainstream guidance continues to favour the cautious, staged approach as the safer default for complex presentations such as DID.

Rehabilitation, understood as the restoration of everyday functioning rather than symptom remission alone, is comparatively underdeveloped in both the ICD-11 text and the wider literature. Where rehabilitation is addressed, it tends to focus on occupational and social reintegration following the later stages of phase oriented treatment, supported by psychoeducation, family or support-network involvement, and gradual reengagement with education or employment. However, because so few patients reach the final integration phase, and because robust data on partial DID are almost entirely lacking, the evidence base for rehabilitation-specific outcomes is markedly weaker than that for symptom-focused treatment, representing a clear gap for future research and service development.

Taken together, while phase oriented treatment shows consistent, if modest, evidence of effectiveness across the domains most affected by dissociative disorders, its real world impact is constrained by workforce shortages, funding limitations, an underdeveloped rehabilitation evidence base, and the mismatch between the lengthy course of treatment

required and the shorter term therapeutic models commonly commissioned within public health systems.

Current Debates and Emerging Issues

The most enduring debate surrounding DID concerns its aetiology. The post traumatic model regards dissociative identities as an adaptive response to severe, chronic childhood trauma, whereas the sociocognitive, or fantasy, model attributes presentations to suggestibility, fantasy proneness, media exposure and inadvertent reinforcement within psychotherapy itself, a phenomenon termed iatrogenesis (Young, 2024). Although Young (2024) notes that the weight of contemporary evidence increasingly favours the trauma model, the debate has not been resolved, and it continues to shape clinical scepticism toward the diagnosis in some quarters.

This long standing debate has been reconfigured by the rise of social media. Salter et al. (2025) document a marked increase in self diagnosis of DID among children and young people, coinciding with the global popularity of DID related content on platforms such as TikTok, and argue that online communities may be actively shaping how dissociative experiences are recognised, described and presented for clinical assessment. Rondel, Dorahy and Liew (2025) directly compared the symptom content of popular TikTok videos against established clinical measures of DID and found that online portrayals did not closely reflect the diverse symptomatology seen in genuine clinical presentations, raising concerns about public misunderstanding, potential misdiagnosis, and the risk that some viewers may adopt a DID identity without an underlying dissociative disorder. This intersects with, rather than settles, the older trauma-versus-sociocognitive debate, since social media may function simultaneously as a trigger for genuine identification of previously unrecognised symptoms and as a novel vector for sociocognitive or iatrogenic like influence.

A further and increasingly prominent debate concerns whether experiences of multiplicity should be understood exclusively through a disorder framework or, for some individuals, reframed as a form of neurodivergence or identity variation, sometimes referred to as plurality. Advocacy and academic commentary drawing on neurodiversity and Mad Studies perspectives argue that not all experiences of multiplicity are inherently distressing or trauma based, and that a rigid disorder framing risks pathologising a valid form of self experience, drawing an explicit parallel with ICD-11's own removal of gender incongruence from its mental disorder classifications.

Clinicians and trauma researchers caution, however, that this reframing must be balanced against the substantial impairment, trauma histories and safety risks documented in clinical DID populations, meaning that a single classificatory approach may be poorly suited to the full range of presentations. The implications for practice and policy are considerable: diagnostic thresholds, service commissioning, and clinician training priorities may all need to differentiate between presentations requiring intensive trauma focused rehabilitation and those better supported through affirmative, nonpathologising approaches. Stigma compounds all of these debates, individuals presenting with dissociative symptoms frequently report disbelief from professionals about their trauma histories, delayed or absent diagnosis, and reluctance among services to commission appropriate care, which reinforces the treatment access barriers discussed above and slows the accumulation of research evidence needed to resolve these debates.

Recommendations

Several recommendations follow from this analysis. First, clinician training should be strengthened to support confident differentiation between DID, partial DID and other specified dissociative presentations, given that partial DID remains comparatively under-researched despite its formal recognition in ICD-11. Second, health systems should expand specialist dissociative disorder pathways beyond the small number of existing national centres, reducing the geographic inequity in access identified in this report. Third, given the extended treatment duration typically required for meaningful recovery, funding models should move away from standard short term therapy allocations toward need based, longer-term commissioning for this population. Fourth, the absence of dedicated national clinical guidance, such as NICE guidelines specific to dissociative disorders, should be addressed to establish consistent, evidence based treatment standards across services. Finally, public health and media literacy initiatives are needed to help young people and clinicians alike critically evaluate social media content on DID, without dismissing or further stigmatising genuine help seeking. For research, longitudinal and cross cultural studies examining outcomes for partial DID and for individuals who identify with a neurodivergence based understanding of plurality would meaningfully inform future revisions to classification and practice.

Conclusion

Dissociative disorders, and DID in particular, sit at the intersection of complex diagnostic, therapeutic and social debates. ICD-11 has introduced meaningful refinements to

classification, notably through partial DID and clearer diagnostic language, yet treatment and rehabilitation remain constrained by an emerging evidence base, workforce and funding limitations, and unresolved debate over aetiology. The growing influence of social media and neurodivergence based reframing further complicates an already contested field, underscoring the need for flexible, well resourced and continually updated approaches to diagnosis, treatment and policy.

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