Living with Dissociative Parts: A Narrative Inquiry of Subjective Experiences in Dissociative Identity Disorder

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Abstract

Background: Dissociative Identity Disorder (DID) is conceptualised as an adaptive survival response to chronic developmental trauma, characterised by a felt sense of fragmentation through dissociative parts. While qualitative research has begun to capture the complex lived experiences of people with DID, there remains limited empirical first-person explorations of how DID systems navigate life through and with dissociative parts.

Methodology: Through narrative inquiry and thematic narrative analysis, this study explored how twelve participants with DID narrate and make sense of their subjective experiences of living with dissociative parts, whilst generating clinical insights to inform therapeutic practice. Grounded in a phenomenological and narrative framework, this study honours participants' authentic voices and perspectives.

Findings: Six narrative themes emerged which reflected the trajectory of participants' stories: (1) acknowledging the individual stories of parts; (2) the hidden nature of parts; (3) navigating a constantly shifting reality; (4) looking inwards and understanding the internal world; (5) remembering trauma through parts; and (6) building a home for parts. Dissociative parts were described as experientially real, embodied and purposeful, deeply rooted in trauma survival. Internal worlds served as relational spaces for internal communication, negotiation, memory regulation and healing. Interpretation of the findings invited a rethinking of multiplicity and selfhood; positioning DID as a trauma-mediated form of multiplicity which is functionally distinct. The findings also highlight dissociative amnesia as a part-mediated and active regulatory process which can evolve in response to therapeutic growth.

Implications: This study offers a novel trauma-informed, ethically sensitive and parts-informed research methodology to enable participants to engage safely and autonomously, drawing on expert by experience consensus. The findings advocate for a parts-informed therapeutic and diagnostic approach, emphasising the need to honour the existence and function of dissociative parts.

Table of Contents

Chapter One: Introduction

Overview

This chapter outlines the complex clinical, historical, and sociocultural context of Dissociative Identity Disorder (DID). It introduces key definitions central to understanding DID, including a definition of dissociative parts and related concepts. Diagnostic challenges and limited service provision in the United Kingdom (UK) are reviewed, alongside cross-cultural perspectives which highlight how cultural frameworks shape dissociative experience. Key treatment models and theoretical frameworks, including the Phase-Oriented Treatment Model and Structural Dissociation Theory, are critically examined. The chapter concludes by introducing a systematic qualitative literature review exploring how pre-existing lived experience research captures the subjective realities of those living with DID.

Dissociation and Dissociative Disorders

Dissociation has historically been inconsistently defined (Nijenhuis & Van der Hart, 2011). Dissociation is often described as an interruption or separation in the usual integration of processes such as memory, consciousness, identity, emotion, perception, embodiment, motor control and behaviour (Kennedy & Kennerley, 2013; Spiegel et al., 2011). Recent qualitative research has further emphasised the complexity of defining dissociation as participants described a pervasive felt sense of anomaly; that something was “wrong”, “unfamiliar” or “unreal”, highlighting the often-indescribable nature of dissociation (Černis et al., 2020; Černis et al., 2021). Dissociation has been conceptualised as an adaptive ability of the mind to disconnect from the self and reality, to disrupt conscious awareness as a coping mechanism for unresolvable danger (Nijenhuis & Van Der Hart, 2011; Sinason, 2002). Dissociative disorders are a response to complex traumatic injury, particularly when it occurs during key developmental periods (Chu, 2011; ISSTD, 2011).

Dissociation is understood to encompass a spectrum of experiences (Lyssenko et al., 2018). Some research presents dissociative experiences as existing on a continuum, ranging from normative and non-distressing everyday forms of dissociation, such as daydreaming, to increasingly debilitating dissociation associated with complex trauma and identity fragmentation (Gentile et al., 2013). Within this framework, dissociative disorders are positioned toward the more severe end of the continuum, characterised by chronic use of dissociation which significantly impairs functioning. This includes conditions such as depersonalisation and derealisation (Hunter et al., 2004). Further along the spectrum are conditions which involve more profound disruptions to memory, identity, and consciousness, such as Other Specified Dissociative Disorder (OSDD) and DID. However, Spiegel et al. (2011) challenge the continuum model of dissociation, suggesting that dissociative disorders are not merely an intensification of normal dissociative processes. Instead, they propose that dissociative disorders arise from a distinct clinical phenomenon with different underlying and trauma-related mechanisms.

DID is widely regarded as the most severe dissociative disorder, involving the presence of two or more distinct dissociative parts with significant amnesic barriers between them (APA, 2022). DID is understood as a highly sophisticated and creative survival adaptation, reflecting the mind’s attempt to preserve functioning through compartmentalisation of experience and identity (Nijenhuis et al., 2010). It typically emerges in the context of chronic, overwhelming relational trauma which often occurs during early development, although there are some exceptions to this trajectory (Sar et al., 2017; Schimmenti & Caretti, 2016). In OSDD, dissociative parts are present, but without the full structural fragmentation required for a DID diagnosis. Alternatively, OSDD is also diagnosed when DID is possibly present, but this is yet to be definitively established. An OSDD diagnosis is often provided to those who would be considered as having “almost DID”, yet they benefit from DID treatment protocols (ISSTD, 2011).

DID Specific Terms and Definitions

- **Dissociative Fragmentation**

Fragmentation refers to the psychological process which compartmentalises traumatic experiences, emotional states, memories or aspects of identity, often separating them from conscious awareness with dissociative amnesic barriers (Van der Hart et al., 2006).

- **Dissociative Parts**

Dissociative parts, alters, identity states or self-states are fragmented, discrete, survival-based states of consciousness which exist within a DID system (Fisher, 2017; Öztürk & Sar, 2016). Each part embodies a unique sense of self, reflecting the division of mental functioning as an adaptive response (Van der Hart & Steele, 2022). Parts are not merely metaphorical representations of mood or behaviour, they are experienced as separate, internally cohesive and experientially real aspects within the same person (Boon et al., 2011; Dorahy et al., 2014). Dissociative parts are considered to distinctly differ from one another in age, triggers, emotional needs, abilities, experiences, and autobiographical memories (Fisher, 2017).

- **System**

The term ‘system’ is commonly used by the DID community to describe their collective organisation and internal world of dissociative parts (ISSTD, 2011; Van der Hart et al., 2006). A system not only encompasses dissociative parts themselves, but also the relationships, communication patterns, roles, hierarchies, subsystems and cooperation dynamics among them (Howell, 2011).

- **Switching**

Switching refers to the process whereby bodily awareness, control and autonomy over consciousness and behaviour shift from one part(s) to another (Boon et al., 2011; Sinason 2002). Switching may be overt, with observable changes in voice, posture and emotional tone. Switching may also be unobservable, experienced internally as a subtle or powerful shift in emotional state, perspective or memory access (Putnam, 1989). Switching may be voluntary, involuntary or with variations in between, depending on unique system dynamics and functioning (Savoy et al., 2012).

- **Fronting**

Fronting refers to the process of a specific dissociative part taking primary executive control and autonomy of the body, perception and behaviour (Nijenhuis & Van der Hart, 2011). When a part is fronting, they are directly engaging with the external world, such as making decisions and communicating with others. During this process, other parts may remain passively observing, inactive or fronting alongside, depending on the degree of co-consciousness within the system.

- **Host**

The host typically refers to the dissociative part that spends the most time managing daily life responsibilities and external functioning (Sar et al., 2017). Whilst some systems identify a singular host, others may rotate hosting duties amongst parts. A common misconception is that the host refers to the ‘original’ or ‘core’ self. However, the host is often the part perceived as the most publicly facing and may or may not be aware of the existence of other parts (Howell, 2011).

- **Co-consciousness**

Co-consciousness refers to the phenomenon where two or more dissociative parts have direct influence over bodily autonomy and have awareness of each other’s thoughts, feelings, actions or experiences simultaneously (Chien & Fung, 2022). Co-consciousness can involve silent witnessing, internal communication, memory sharing or active collaboration from parts and varies on a spectrum of experience. Developing co-consciousness is often a therapeutic goal, fostering internal cooperation and reducing dissociative amnesia (ISSTD, 2011).

- **Integration and Fusion**

Integration refers to the process of reducing dissociative fragmentation, through increasing cooperation, communication and cohesion between dissociative parts. Some scholars have specified that the intended outcome of integration is to permanently fuse dissociative parts into a unified, singular sense of self, referring to full or final fusion (Kluft, 1991). It is also possible for systems to experience partial fusion, whereby only some parts permanently fuse. Fusion is often described as a profound emotional and somatic psychological event, reflecting a felt sense of becoming one from previously fragmented aspects of the self (Kluft, 1996). However, integration is now conceptualised differently across modern research and clinical literature; more recently defined as reducing dissociative barriers and switching, developing functional cooperation between parts, thus enabling them to work in harmony without eliminating or eradicating their individuality (Barlow & Chu, 2014; Boon et al., 2011; Fisher, 2017). Although once recognised as the final treatment goal for DID, integration is now considered to be a highly individualised process based on personal need (ISSTD, 2011; Miller, 2018; Somer & Nave, 2001).

Historical and Sociocultural Context

The treatment landscape for DID in the UK must be understood within its wider historical and sociocultural context, which reflects the evolving nature of society’s attitudes towards trauma and identity. In the late 1800s, some clinicians linked “multiple identities” to severe childhood trauma which had been banished from consciousness, mirroring contemporary biopsychosocial explanations for DID (Brand et al., 2016). However, in the early 1900s, Sigmund Freud altered his theory regarding the influence of childhood abuse on hysteria, stating that these memories were rooted in repressed sexual fantasy. This shift influenced the way in which psychiatry and psychology understood traumatic memories, leading to the minimisation of dissociation as imagination or fiction (Van der Hart & Dorahy, 2022). Consequently, the diagnosis that would become DID lay largely dormant for decades. However, whilst mainstream psychiatry largely minimised dissociation during this period, strands of psychoanalytic theory continued to engage with dissociative phenomena. For instance, Klein's work on the paranoid-schizoid position, psychic splitting and early object relations provided an initial conceptualisation to understand fragmented states of mind and the defensive function of psychic compartmentalisation (Sar, 2023; Segal, 2018). Although these psychoanalytic perspectives may not necessarily be directly applicable to DID in contemporary practice, they helped to preserve a clinical interest in dissociative processes during this time. Subsequently, in the mid-20th century, a few high-profile cases, particularly "The Three Faces of Eve" (1957) and "Sybil" (1973) led to a resurfacing of public attention, paving the way for the previous diagnosis of DID —Multiple Personality Disorder— to be formally recognised in the Diagnostic and Statistical Manual (DSM-III) (Brand et al., 2016).

In the UK, dissociative disorders remained relatively marginalised throughout the 20th century due to a biomedical dominance for treatment, sidelining psychological interventions and failing to address underlying trauma (Aquarone & Hughes, 2013). A long-standing factor for the dismissal of dissociative disorders has been the profound impact of societal stigma, diagnostic avoidance and cultural scepticism. Over time, the dramatisation of DID in popular culture and media, often depicting individuals with DID as sensational, unpredictable, rare and dangerous, has played a significant role in shaping public misunderstanding and stigma

(Chen, 2022; Snyder et al., 2024). As more DID patients came forward with accounts of severe childhood abuse in the late 1990s, there was powerful backlash from the False Memory Movement. They promoted the idea that memories of childhood abuse, especially those recovered in therapy, were implanted or false, reinforcing scepticism about the legitimacy of DID (Dodier et al., 2022; Spanos, 1996). The application of Goffman's (1963) theory of stigma suggests that the existence of DID may evoke visceral discomfort and fear because it challenges or discredits culturally normative assumptions of selfhood, memory and relational abuse. Furthermore, some scholars have since argued that this movement reflected a broader societal resistance to acknowledging the reality and prevalence of ritual abuse, mind control and other forms of extreme child abuse (Aquarone & Hughes, 2013; Friesen, 2019; Ost et al., 2013). DID became a focal point of the memory debate, with some clinicians and researchers defending the reality of trauma and dissociation, whilst others amplified cultural denial and named DID as a fad or iatrogenic condition (Brand et al., 2016). Although DID has re-emerged into public consciousness and is increasingly recognised, the legacy of the false memory debate continues to influence contemporary practice, fuelling concerns that therapeutic engagement may inadvertently reinforce dissociative symptoms (Dodier et al., 2022; Meganck, 2017).

Clinical and scientific understanding of DID has evolved in response to historical and cultural events. In 1994, the diagnosis was renamed from Multiple Personality Disorder (MPD) to Dissociative Identity Disorder, clarifying that the core of the condition is a fragmented identity arising as a protective adaptation to early trauma, rather than separate personalities (Cortez, 2022). This redefinition was also intended to reduce the sensationalism and stigma which was attached to the previous diagnostic term. However, DID research over the decades has continued to be marked by a preoccupation with legitimacy debates, often overshadowing qualitative and lived experience research (Brand et al., 2014). On one side of the debate, numerous studies established strong links between trauma and DID, documenting biopsychosocial evidence reinforcing DID as a real condition rather than a sociocultural artifact (Blihar et al., 2020; Dorahy et al., 2014; Lebois et al., 2022). On the other hand, critics proposed the Socio-Cognitive Model, positing that DID can be iatrogenically produced in suggestible individuals through therapist cues or cultural narratives (Gleaves, 1996; Lilienfeld et al., 1999). By early 2010s, comprehensive reviews established that there is limited clinical support for false memory or purely iatrogenic models, increasingly supporting trauma models for understanding DID and shifting toward a trauma-informed consensus (Dalenberg et al., 2012). Although acknowledgement has gradually increased in the UK, the legacy of systemic scepticism and misunderstanding continues to act as a barrier to the development of dissociation-specific care pathways within statutory services, particularly in relation to working therapeutically with dissociative parts (Aquarone & Hughes, 2013). Some studies (Greene et al., 2023; Launay et al., 2023) have examined how these cultural narratives are present in current social media, highlighting new complexities to the sociocultural shaping of DID such as some young people appearing to over-identify with DID symptomology online. Launay et al. (2023) caution that this trend may echo earlier iatrogenic narratives, now replicated through digital rather than clinical influence, risking a resurgence of scepticism around the disorder’s legitimacy.

Assessment and Diagnosis for DID

Currently in the UK, DID is recognised as a complex dissociative disorder within the National Health Service (NHS, 2023). DID is diagnosed based on criteria outlined in either the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) or less commonly, the International Classification of Diseases, Eleventh Revision (ICD-11) (APA, 2022; WHO, 2019). Access to specialist assessment for DID within the NHS remains limited, often held in specialist trauma or complex needs services. In these cases, diagnoses often emerge over time during long-term therapy rather than a single assessment, reflecting the complex and concealed nature of dissociation (Brand et al., 2016; Dorahy et al., 2014). In contrast, specialist assessment and treatment for DID is largely concentrated within the private and third sector, with some private clinics offering a limited number of NHS-funded spaces through local commissioning arrangements (Aquarone & Hughes, 2013; NHS England, 2022; Stubley, 2023).

DID is commonly screened by healthcare professionals using tools such as the Dissociative Experiences Scale (DES-II) and the Somatoform Dissociation Questionnaire (SDQ-20). Formal diagnosis is typically undertaken by specialist clinicians, incorporating structured diagnostic assessments such as the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) which is the most widely used tool for diagnosing DID in the UK (ISSTD, 2011; Steinberg, 1994). The SCID-D assesses the presence of DID against five domains (Steinberg, 2022):

- Dissociative Amnesia – Gaps in memory for significant personal information, life events or daily activities, including event amnesia, dissociative fugue and time loss.
- Depersonalisation – Detachment and disconnection from one’s body, thoughts, feelings, or actions; a sense of observing oneself from the outside.
- Derealisation – Disconnection and detachment from the external world, as if it were unreal, distant or dreamlike.
- Identity confusion – Uncertainty, conflict, or confusion about personal identity.

- Identity alteration – The experience that one is not in control of their body, thoughts, feelings and actions, including observable shifts which are consistent with the presence of distinct identity states and dissociative switching.

Not all five domains are required to be met for a DID diagnosis, as derealisation and depersonalisation are not always present. Therefore, a diagnosis relies primarily on the presence of identity alteration, identity confusion and amnesia, in combination with exclusion of other causes (APA, 2022; Steinberg, 1994). The ICD-11 also recognises Partial DID, in which there is a presence of one or more distinct dissociative parts, but without the presence of amnesia for everyday events (WHO, 2019). This reflects the reality that dissociative identity experiences exist on a spectrum, even when amnesic barriers are limited or absent.

Prevalence of DID

Brand et al. (2016) found that DID is present in prevalence studies and systematic assessments around the world, such as Canada, the United States, Germany, Turkey, Israel, Switzerland and the Netherlands. Recent research indicates that DID potentially affects approximately 1-1.5% of the global general population, increasing to up to 5% in psychiatric inpatient and outpatient populations, although many remain undiagnosed (Dorahy et al., 2014; Hawayek, 2024; ISSTD, 2011). DID has historically been viewed as a rare condition, yet research indicates that it is much more common than assumed as the prevalence of DID has been unclear, contested and under-recognised within research (ISSTD, 2011). A local audit conducted in one NHS trust in the UK found that over 30% of inpatients scored above clinical threshold for a dissociative disorder, yet they remained undetected due to a lack of dissociation-informed infrastructure (Aquarone & Hughes, 2013). However, as there is limited research conducted on DID in the UK, specific prevalence rates are under-reported or unknown. Across the globe, current estimates of DID prevalence are disproportionately low, likely due to stigma-informed scepticism, misdiagnoses, delayed diagnosis, and cross-cultural variations in the definition of dissociation and identity (Brand et al., 2016; Dorahy et al., 2014; Lewis-Fernandez et al., 2007; Reategui, 2019).

Cross-Cultural Considerations

A variety of dissociative-like phenomena have been observed across cultures, indicating multicultural diversity in the definition, expression and experience of dissociation (Sar, 2022). However, non-Western populations are significantly under-represented in dissociation research. Although dissociative experiences universally involve a sense of detachment from oneself, disrupted consciousness and a loss of agency due to unknown forces, what differs cross-culturally is how those forces and mechanisms are conceptualised (Lewis-Fernandez et al., 2010). In Western individualistic societies, those forces may be understood as parts of one’s own mind and as a psychiatric condition following adverse events. Contrastingly, in non-Western collectivist societies which are often governed by spiritual or religious ideologies, a person’s consciousness can be altered by external forces such as through spirit possession or trance states, and this is viewed as non-pathological and even valued in some contexts (Hollan, 2000; Kruger, 2020; Seligman & Kirmayer, 2008). Diverse definitions are also inextricably linked to cultural variations in the definition of selfhood and identity. Relevant research proposes that in Western contexts, dissociation is pathologised because dissociative shifts in identity, amnesia or altered consciousness do not align with expectations that the self should be unitary, autonomous and contextually consistent (Kruger, 2020; Sar, 2022). However, in non-Western collectivist societies, the self is often assumed to be relational, fluid, context dependent and connected to external community wellbeing. Therefore, experiences in which identity is temporarily displaced are expected, meaningful and spiritually valued experiences of the self (Markus & Kitayama, 1991). The DSM-5 and ICD-11 include “possession-form identities” and “dissociative trance” within DID diagnostic criteria, recognising that what may be viewed as pathological in one culture can be normative in another.

Psychological Intervention for DID

Currently, there are no National Institute for Health and Care Excellence (NICE) guidelines specifically addressing the assessment or treatment of DID in the UK, resulting in variability in diagnosis and treatment pathways (Crelin & Temple, 2021). However, there are some published guidelines for treating dissociative disorders, including DID (ISSTD, 2011; Kezelman & Stavropoulos, 2019), alongside clinical publications and workbooks offering therapeutic guidance based on clinical expertise (Boon et al., 2011; Dana, 2018; Fisher, 2021; Frewen & Lanius, 2015).

Research into the efficacy and effectiveness of treatment for DID is in its infancy, possibly due to significant barriers such as limited clinician expertise, persistent stigma and a long-standing history of diagnostic controversy (Floris & McPherson, 2015). As Hacking (2006) argues, diagnostic categories can be historically and socially shaped and are influenced and understood in relation to shifting cultural, clinical, and epistemic contexts (Tsou, 2007). Therefore, diagnostic inconsistency and ambiguity contributes both to the challenges of researching DID, and to its significance in understanding trauma, identity and cultural narratives. The most substantial body of outcome research to date is the Treatment of Patients with Dissociative Disorders (TOP DD) series (Brand et al., 2013). The study was a prospective, longitudinal investigation of therapeutic outcomes in a large international sample of outpatient clients who were being treated for a diagnosed dissociative disorder, including DID. The TOP DD study provided strong evidence that DID is treatable and as these improvements were observed in community-based outpatient settings, this suggested that it is possible to effectively treat DID in mainstream, non-specialist services, when clinicians receive adequate support and training (Brand et al., 2016). However, while the TOP DD study represents an important contribution to the evidence base, it has not yet been replicated in subsequent trials, and limitations remain regarding its non-randomised design and self-selected sampling biases (Brand et al., 2016). Further research is needed to confirm the generalisability of its outcomes across different clinical settings and populations.

Despite this, access to specialised care within the NHS is limited, with only a few dedicated services specifically set up for treating severe dissociative disorders (Stubley, 2023). In recent years, there has been growing awareness of the need for dissociation-focussed care within some NHS services, which have adapted their approaches to work more effectively with DID presentations (Stubley, 2023). However, a significant gap in nationwide service provision remains and continues to be filled by specialist private clinics in the UK (Aquarone & Hughes, 2013; Stubley, 2023). These specialist clinics have provided long-term psychotherapy tailored to complex dissociative disorder presentations, often following the International Society for the Study of Trauma and Dissociation (ISSTD) phased-oriented treatment approach, which may not be consistently available through the NHS due to resource constraints (Stubley, 2023). Whilst understanding and treatment of DID through non-medical psychotherapeutic methods has advanced in the private sector, the public sector has often lacked training, resources and clinical frameworks needed to recognise and address dissociation (Aquarone & Hughes, 2013; Stubley, 2023).

The ISSTD phased-oriented treatment approach is considered gold standard for psychological intervention for DID (Brand & Loewenstein, 2014; ISSTD, 2011). However, Sachs (2017) critiques this approach as it relies on the assumption of external safety and internal readiness, which may not be compatible for ‘Active DID’; referring to those that remain in the coercive and abusive relational contexts which formed their DID. In these cases, moving through the phases may be repeatedly undermined by external reinforcement of fragmentation and internal conflict between dissociative parts. The approach recommends that therapeutic modalities be adapted for DID using a structured, phase-oriented model comprising three stages, each building upon the previous stage to facilitate internal cooperation and psychological healing (ISSTD, 2011). The approach emphasises the importance of flexibility and non-linear progression, whereby some clients may need to revisit earlier phases.

- Phase 1: Safety, Stabilisation and Symptom Reduction

This phase focusses on establishing a sense of relational, physical and emotional safety, including building the therapeutic alliance and implementing emotional coping strategies to reduce crisis symptoms and acute distress. This phase typically involves interventions such as psychoeducation, grounding techniques, crisis planning, building internal communication and risk management.

- Phase 2: Trauma Processing and Memory Integration

This phase focusses on safe exploration, toleration and integration of traumatic memories and involves the use of techniques such as gradual exposure, narrative reconstruction, and internal negotiation to access trauma-related material. Therapies such as Eye Movement Desensitisation Reprocessing (EMDR) could be implemented here.

- Phase 3: Integration and Rehabilitation

This phase focusses on strengthening internal cooperation and developing a functional system or achieving integration or final fusion, depending on the client’s unique needs and preferences. This phase involves a shift away from the past, to the present and future, paying close attention to daily functioning, identity consolidation, interpersonal relationships, personal goals and aspirations. Continued support may be required after this phase to manage ongoing dissociative or relational patterns.

A trauma-informed framework is often considered best practice and essential for effective psychological treatment for complex dissociative disorders (ISSTD, 2011; NHS England, 2019). Within NHS services, trauma-informed care provides an overarching framework for understanding and responding to the impact of psychological trauma, rooted in principles such as relational safety, trust-building, collaboration and empowerment (UK Government, 2022). Trauma-informed care encourages clinicians to reflect on how their practices may inadvertently re-traumatise their DID clients, while also offering a framework through which dissociative symptoms can be understood as adaptive, rather than pathological, responses to trauma (Mosquera, 2019; Reeves, 2015). However, trauma-informed care has been critiqued for not necessarily advocating for the explicit recognition and understanding of trauma-related dissociation (Salter, 2023). Furthermore, some scholars caution that trauma-informed approaches, while valuable, may oversimplify the structural complexity of DID, potentially leading clinicians to overestimate their competence in treating dissociation without adequate training or adherence to dissociation-specific information (ISSTD, 2011; Sweeney & Taggart, 2018).

Some widely used psychological models which draw upon the language of parts have also been explored as options for providing psychological intervention to those with DID. For instance, one study found that Internal Family Systems (IFS) therapy was helpful for one DID client as IFS understands that the mind is composed of a core self, accompanied by multiple internal parts which hold unique roles and emotional responses (Pais, 2009).

Although, this aligns conceptually with DID on the surface, IFS assumes the existence of a central or core self which is often not present or autonomous in DID (ISSTD, 2011; Loewenstein & Putnam, 2022). Similar findings have revealed that Schema Therapy and Sensorimotor Psychotherapy can also be adapted for DID treatment as they acknowledge the existence of altered states and reframe parts (Bachrach et al., 2023; Huntjens et al., 2019; Ogden et al., 2006). However, concerns remain regarding the conceptual reductionism of DID and these studies emphasise the need for further research to explore how to suitably adapt these approaches.

EMDR has been widely recommended as an effective intervention for post-traumatic stress and complex trauma (NHS, 2022). Its utility for treating DID has been increasingly evidenced as being effective for processing and integrating traumatic memories, particularly when employed within a phased approach which emphasises stabilisation before processing (ISSTD, 2011; Twombly, 2000). However, clinical and research literature have cautioned that EMDR without adaptations may be particularly destabilising in DID, leading to a reduction in its efficacy (Boon et al., 2011; Twombly, 2005; Van der Hart et al., 2013). More recently, Rothwell-Blake et al. (2025) proposed an integrative model combining IFS with EMDR. This approach acknowledges the challenges of using IFS with DID, such as limited access to ‘self-energy’ and differing definitions of "parts," and instead offers a method that prioritises cooperation between parts and extended stabilisation before trauma processing begins. Taken together, these findings highlight that applying widely used psychological models, such as IFS, without modifications could oversimplify the complexity of DID, risking destabilisation and premature trauma processing.

Attachment, Trauma and Neurobiology

DID is widely conceptualised as a condition which is rooted in early, prolonged developmental and interpersonal trauma, often within the context of caregiver attachment relationships and dysfunctional family structures (Bistas & Grewal, 2024). Studies have shown that an average of 86% of DID patients have experienced some form of sexual, physical, or emotional trauma before the age of six (Hawayek, 2024).

Early neuroimaging found that a subset of traumatised participants demonstrated an unexpected pattern of increased prefrontal and reduced limbic activity (Lanius et al., 2018; Rauch et al., 1996), illustrating a shutdown response to traumatic material and providing neurological evidence for trauma-related dissociation. More recently, neuroimaging studies have observed distinct patterns of brain activation corresponding to different dissociative parts, demonstrating that switching is associated with measurable changes in neural activity and supporting the notion dissociative parts have distinct patterns of relating to the world (Lebois et al., 2022; Reinders et al., 2014). Recent research has also begun to conceptualise these neurobiological findings by proposing that early trauma leads to a fragmentation of neural networks into functional subsystems, experienced as dissociative parts (Skalbania et al., 2021). Whilst this body of research has sought to establish the reality of DID in response to historical scepticism, these studies cannot resolve the deeper challenges of understanding complex psychological and relational phenomena through brain imaging alone.

Some theories have been proposed regarding how early trauma leads to the development of DID and dissociative parts. However, the precise mechanisms underlying these processes remain only partially understood (Dorahy et al., 2014; Lanius et al., 2018). Early interpersonal trauma and/or abuse is nearly universally reported in DID (Bistas &

Grewal, 2024; Rostami & Mehdiabadi, 2024), often occurring in the absence of a consistent, secure attachment figure or supportive other and a lack of protective factors during adversity (Wilkinson & Dejong, 2021). While various trauma-based, attachment-based and neurodevelopmental models have been proposed, much of the existing research is based on retrospective accounts or clinical case studies which capture limited perspectives (Boysen & VanBergsen, 2013). Additionally, the theoretical and conceptual distinctions between neuroscience, trauma and attachment are often blurred in clinical reality, reflecting the complexity of the lived experience of dissociation and the reductionism of these models. Although the theories presented below differ in emphasis, they share common themes; particularly the idea that fragmentation and compartmentalisation arise as adaptive responses to manage internal conflict and preserve functioning.

Betrayal Trauma Theory (BTT)

BTT (Freyd, 2003; Freyd & Gleaves, 2007) provides an explanation for disintegration from an attachment perspective, emphasising the role of caregiver betrayal and attachment trauma (Loewenstein & Brand, 2023). The theory draws upon the assumption that maintaining the caregiver relationship is vital to ensure survival in early childhood. However, internal conflict arises when the caregiver is also a source of danger, fear and inconsistency. Similarly, disorganised attachment, which has been empirically linked to dissociative symptomology, emerging when the caregiver represents both a source of safety and threat, creating a situation of ‘fright without solution’ and disrupting the development of a coherent internal working model (Dell & O’Neil, 2009; Liotti, 2006). A disorganised attachment strategy is essentially a dissociative adaptation, as the child’s behaviour and attention become fragmented in the face of an unresolvable, inescapable and threatening caregiving context (Sachs, 2017; Van der Hart, 2018). Dissociative fragmentation offers a solution to these conflicts enabling the child to maintain their bond with their caregiver through adaptive unawareness, keeping the knowledge of the threat outside of conscious awareness through dissociative mechanisms. Over time, this attachment disruption leads to structural changes in information processing, identity fragmentation and compartmentalisation (Doychak & Raghavan, 2023).

Structural Dissociation Theory (SDT)

SDT integrates insights from developmental, attachment and evolutionary psychology, action systems theory (AST) and neurobiology (Van der Hart et al., 2006). AST postulates that human behaviour is organised by distinct motivational goal-directed systems (action systems), which guide adaptive responses to the environment (Nijenhuis et al., 2002). Each action system has a distinct purpose and responses which are organised around evolutionary principles such as survival, defence, attachment, relational connection and exploration. Early experiences shape how action systems develop, function and evolve over time (Nijenjuis et al., 2002). In non-traumatised individuals and non-disrupted development, these systems gradually integrate to enable collaborative functioning and a coherent sense of self. However, in the context of early chronic trauma, the simultaneous activation of incompatible action systems (such as attachment and defence) overwhelms the child's integrative capacity, leading to internal conflict and compartmentalisation (Nijenhuis, 2017). These unintegrated states may later develop into dissociative parts, where switching between parts reflects transitions between action systems (Lebois et al., 2022). Earlier developmental models, such as Putnam's Discrete Behavioural States Theory (Loewenstein & Putnam, 2022), similarly proposed that dissociative parts originate from unintegrated behavioural states in early childhood.

SDT builds upon these foundations, conceptualising the fragmentation of personality and emergence of dissociative parts in DID as an adaptive response to overwhelming psychological trauma (Nijenhuis et al., 2010; Van der Hart et al., 2006). SDT emphasises that dissociation is more than a defence mechanism, it involves adaptive structural reorganisation whereby action systems are fragmented into distinct parts with specific roles to preserve functioning (Søndergaard, 2017):

- The Apparently Normal Part (ANP): The ANP is responsible for managing the demands of daily life by maintaining unawareness of the trauma and prioritising functioning such as employment, personal care, social interactions, often at the cost of emotional awareness.
- Emotional Part (EP): The EP holds the traumatic experience(s), including the emotions, sensory memories and survival responses (e.g. fight, flight, freeze) which were associated with the trauma. EPs are often reactive and have a limited capacity to engage with the present.

SDT identifies three levels of structural dissociation based on the complexity of fragmentation and the nature of trauma (Nijenhuis et al., 2010). Primary structural dissociation, following single incident trauma, involves one ANP, who is responsible for managing daily life, and one EP, who is driven by trauma-related intrusions (e.g. flashbacks and nightmares). Secondary structural dissociation, often associated with complex developmental trauma such as personality disorder, features one ANP and multiple EPs, each associated with different aspects of the traumatic experience. Finally, tertiary structural dissociation includes the presence of multiple ANPs and EPs, reflecting the highly fragmented internal worlds of those with DID or OSDD (Fisher, 2014). From an SDT perspective, dissociative parts represent distinct survival strategies and defensive responses. For instance, one part may embody affiliative strategies to appease or placate potential threats ('fawn' response), whereas another may adopt confrontational strategies characterised by aggression or assertiveness ('fight' response) (Fisher, 2017; Van der Hart et al., 2006). However, this framework may oversimplify the complex internal systems described by DID clients, particularly when dissociative parts do not align neatly with binary distinctions between trauma-holding and daily functioning (Loewenstein, 2022; Sinason, 2020). This highlights the importance of lived experience research, which can offer more flexible, accurate, and person-centred conceptualisations of dissociative systems than those proposed by theoretical models alone. Therefore, the following chapter presents a systematic literature review examining existing qualitative research on the lived experience of DID, to explore how people with DID understand, navigate and give meaning to their internal systems and dissociative experiences.

Chapter Two: Systematic Literature Review

Introduction

DID research has mostly comprised quantitative studies focussing on clinical, diagnostic and neurobiological perspectives, with emphasis placed on symptomatic and diagnostic validity, myth debunking, prevalence and treatment efficacy (Blihar et al., 2020; Brand et al., 2014; Utomo et al., 2023). Similarly, a large portion of the evidence-base are descriptive case study research or non-empirical theoretical papers, presenting therapeutic success or clinical opinion from the clinician's perspective (Boysen & VanBergsen, 2013; Dorahy et al., 2014). Furthermore, several studies focus on dissociative disorders more broadly, without distinguishing findings specific to DID, thereby limiting applicability (Dorahy et al., 2022). There remains a notable gap in the literature of studies exploring the subjective experiences of DID, despite growing recognition surrounding the importance of understanding these lived realities from a first-person perspective (McRae et al., 2017; Marais et al., 2022; Parry et al., 2018). Lived experience research contributes essential supplementary information to clinical and diagnostic perspectives, revealing a deeper understanding of how DID clients make sense of their internal and external realities (Beames et al., 2021). Within qualitative paradigms, the term "lived experience" refers to participants' subjective and embodied understanding of their internal and external worlds, as directly encountered, felt, and interpreted by them (Finlay, 2006; Van Manen, 1990). This contrasts with accounts of experience which are derived from theoretical assumptions or external observation. In the context of DID, these externally constructed understandings may be susceptible to the influence of stigma and societal misconceptions, which risk obscuring the nuanced and personally meaningful aspects of living with DID.

Qualitative methodologies are particularly suited to exploring subjective and personal experiences which may not be externally observable (Creswell & Poth, 2016). Qualitative methods allow for a rich, nuanced and in-depth exploration of meaning-making, prioritising participant voice, subjective realities and complexity of identity (Finlay, 2006). Such elements are often restricted or omitted within quantitative research designs or studies which explore the perspective of clinicians or researchers. A small but growing body of qualitative literature has begun to explore the lived experience of DID (Floris & McPherson, 2014; Fox et al., 2013; Zeligman et al., 2017), revealing important insights into daily life, stigma, internal conflict, therapeutic processes and identity fragmentation. However, to date, no systematic review has synthesised this body of research to examine how empirical qualitative studies portray and interpret the lived experience. Therefore, this literature review aims to address this gap by conducting a narrative synthesis of qualitative research examining the lived experience of DID.

Research Question: How does empirical qualitative research present and interpret the subjective lived experiences of people with DID?

Methodology

Research Design

This systematic literature review employed a qualitative narrative synthesis methodology (Popay et al., 2006) to analyse and summarise qualitative research on DID lived experience. Narrative synthesis allows for a flexible approach to synthesise findings across diverse studies, accommodating a wide range of methodologies and data collection techniques (Barnett-Page & Thomas, 2009). This is particularly relevant for this review as eligible studies ranged from case studies, secondary data analyses, ethnographies and qualitative analyses. Additionally, narrative synthesis enables integration of studies that focus on different aspects of DID, while contributing to an overall understanding of lived experience, enabling studies with varied aims to be included.

Narrative synthesis differs from other qualitative methods, such as meta-ethnography and thematic synthesis, as it prioritises descriptive and interpretive analysis over conceptual development. Rather than generating new theories or re-interpreting study findings into distinct themes, narrative synthesis develops a coherent story which honours the complexity and subjectivity of participants' experiences (Popay et al., 2006). This is especially suitable for synthesising research on DID, where subjective experience is deeply personal, fragmented and non-linear (Thomas & Harden, 2008). Greenhalgh et al. (2018) highlight that a strength of narrative synthesis is its ability to preserve the individuality of each study while identifying shared threads and points of divergence. For these reasons, narrative synthesis was chosen as the most appropriate method to address the review's research aim.

Search Strategy

A systematic search of the literature was conducted across two databases, PsycINFO and Web of Science, which were selected due to their relevance, scope and depth in covering DID research (McKeown & Thomas, 2013). PsycINFO was selected due to its extensive coverage of psychology and mental health research, whilst Web of Science was chosen to broaden the search and capture relevant studies from inter-disciplinary perspectives, such as medicine, nursing, and social sciences. This combination ensured the inclusion of both specialised and multi-disciplinary perspectives, ensuring a well-rounded and thorough exploration of literature on DID (Bramer et al., 2017; Gough et al., 2017). The keywords and search terms (Table 1) were intentionally developed to be broad, aiming for inclusivity and expansiveness, with the view to synthesise findings on lived experience. Boolean operators were used to combine keywords. Limited search filters were utilised as this was not deemed necessary due to the limited quantity of research in this area.

Table 1.

Search Terms for Systematic Review

Databases searched		APA PsycINFO	Web of Science
Search no.	**Search Term**	**No. records**	**No. records**
1	(Title) “Dissociative Identity Disorder” OR “Multiple Personality Disorder”	999	795
2	"lived experience*" OR "subjective experience*" OR "narrative" OR "qualitative" OR "experience*" OR "exploratory" OR "perspective*" OR “phenomenolog*" OR "perception*" OR "interview*" OR "ethnograph*"	1,640,484 (Abstract)	6,150,881 (Topic)
	#1 *AND* #2	403	244
	#Studies included	8	7

Once a thorough database search had been performed, a manual citation review of relevant papers was conducted to locate further pertinent articles which might have been misclassified. This was combined with an electronic search on Google Scholar using the terms “Dissociative Identity Disorder” AND “qualitative”. This combination identified one additional article (see Figure 1). Furthermore, the reference lists of all included papers and key related articles were searched to identify any additional studies that may not have been captured through the database search. This process confirmed that the final set of included studies adequately covered the full scope of the review.

Selection Criteria

This review focused on empirical studies that used qualitative methods and were specifically designed to capture personal and subjective experiences (Creswell & Poth, 2016). Studies that explored an aspect of day-to-day subjective experience of living with DID were included, such as those examining identity, daily life, relationships and treatment; limiting the review to qualitative studies aligned with the research question. Peer-reviewed sources or those that employed similar reviewing processes were selected as the process of peer review increases rigour, and reliability, thereby enhancing the quality of the synthesised findings (Aveyard, 2014; Booth et al., 2016). Case studies which utilised formal qualitative analysis to explore lived experiences were included, to capture a significant portion of the evidence-base (Boysen & VanBergen, 2013; McAllister, 2000). Furthermore, studies focussing on broader populations, professionals or other dissociative disorders were not included due to the possibility of this diluting the focus and relevance of the review findings. Although professional perspectives were present in McAllister et al. (2001) and despite its broader focus on the nurse-patient relationship, patients' subjective narratives about care experiences were relevant to the review’s focus on lived experience, justifying its inclusion. Furthermore, studies were included if they explored experiences of those self-identifying with DID, recognising that DID is often under-diagnosed and under-recognised (Brand et al., 2016;

Foote et al., 2006). Studies which analysed secondary data from first-person accounts or content from people with DID were included to address the limited availability of qualitative research on this topic, thereby expanding the pool of possible studies and enriching the findings with a broader perspective (Bishop & Kuula-Luumi, 2017; Heaton, 2004).

Table 2

Exclusion and Inclusion Criteria.

Exclusion criteria	Remit	Relevant inclusion
1. Study type and publication status	Exclude non-empirical studies e.g. systematic literature reviews, books, position papers, theoretical reviews, and editorials. Exclude non-peer-reviewed studies e.g. grey literature, unpublished reports, self-published research, non-peer-reviewed academic repositories.	Peer reviewed empirical studies OR empirical studies that have undergone similar review processes and published in recognised journals.
2. Study design	Exclude studies that do not conduct formal qualitative analysis as their primary approach (e.g. quantitative studies, descriptive case studies, studies lacking thematic qualitative reporting).	Studies undertaking formal qualitative analysis and presenting findings thematically (including case studies)
3. Relevance to	Exclude studies that do not focus solely on people with a diagnosis or self-identification	Studies that sample people with DID,

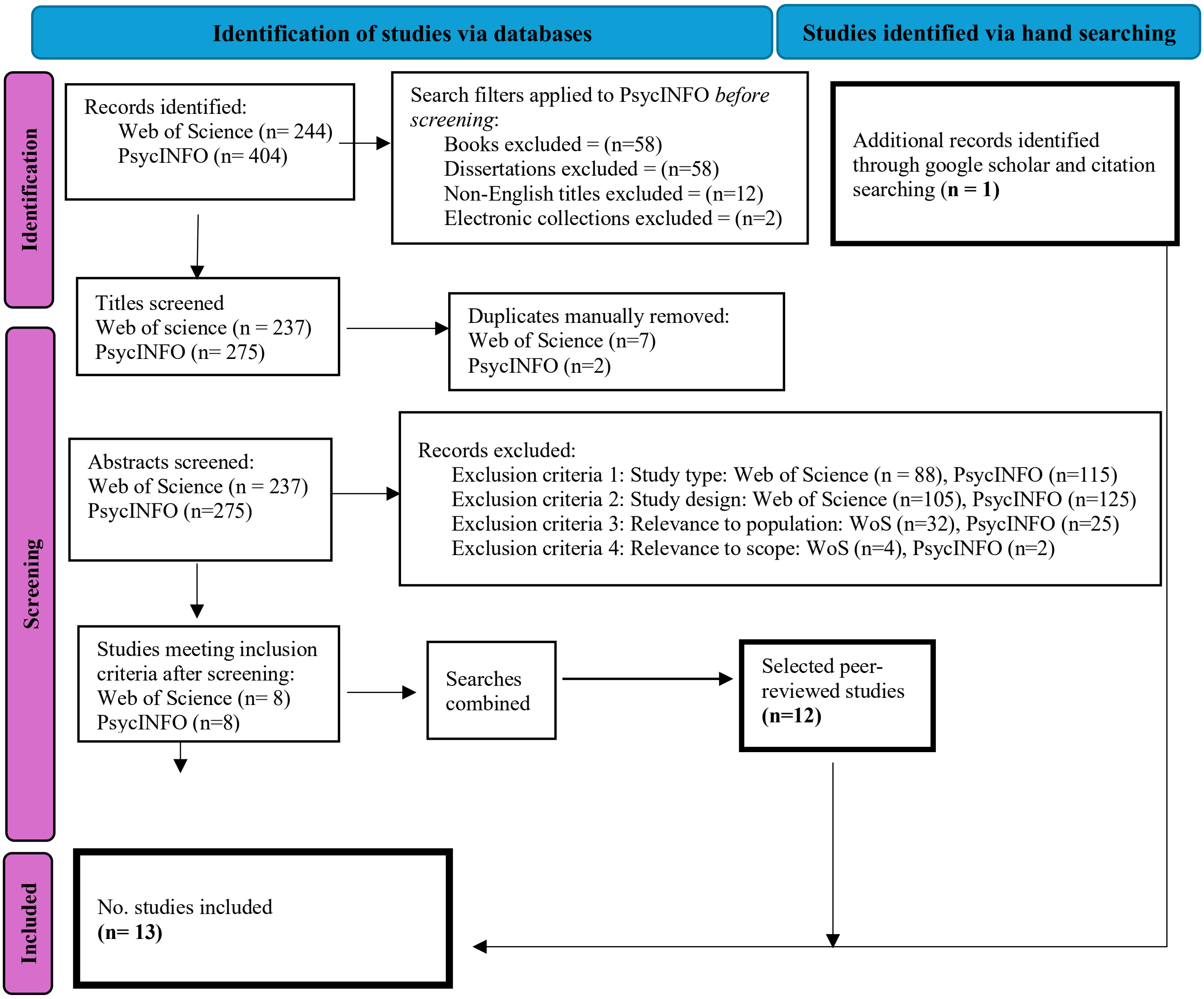
	participant population	of DID (e.g., studies focused solely on professionals/therapists or dissociation spectrum, co-morbidity and comparison studies).	focussing on experiences of DID specifically (including secondary data studies)
4.	Relevance to research scope	Exclude studies that do not focus on personal lived experiences or subjective perspectives related to understanding the day-to-day reality of DID.	Studies that focussed on an aspect of lived experience.

Screening Process

The initial search on both databases yielded a broad set of studies, which were screened manually by title and abstract according to the selection criteria outlined in Table 2. The final 13 studies met all inclusion criteria and were deemed relevant to the research question (Figure 1).

Figure 1

PRISMA Flow Diagram Outlining Screening and Selection Process



Quality Appraisal

The ‘CASP’ (Critical Appraisal Skills Programme) qualitative checklist framework was employed to appraise methodological quality for each selected study (Long et al., 2020). This checklist rates each study across ten domains, assessing credibility and quality, rated as either ‘Yes’, ‘No’ or ‘can’t tell’. An additional rating of ‘partial’ was added to capture more nuanced assessments of methodological strengths and weaknesses. Numerical values ranging between 0 to 2 were assigned to each rating, enabling the calculation of an overall quality score for each study. These scores were considered during the synthesis and analysis of findings, with lower-quality studies assigned less interpretive weight and higher-quality studies given greater emphasis. Furthermore, domain 10 *("the research was valuable")* of the CASP qualitative checklist, which typically evaluates the broader value of the study, was adapted to assess the value of each study in its relevance to the review's objective. Studies focusing on aspects of lived experience were deemed highly valuable and given a score of 2. Conversely, studies focussed on lived experiences of the therapeutic process, while important, were considered less directly relevant and thus given a lower score of 1. This adaptation was implemented to ensure greater interpretive weight was given to studies most directly examining subjective lived experience, addressing the potential limitations associated with the review's broad and flexible inclusion criteria.

Table 3.

Summary of selected studies (see Appendix B for full summary)

Author(s) and year of publication	**Sample information**	**Research question or focus**	**Data collection and type of qualitative analysis**	**Key findings**
Floris, J., & McPherson, S. (2015).	7 participants: 5f, 2m. Age range 22-48 yrs. Formal diagnosis of DID in past 5 yrs.	How do participants experience the diagnosis and treatment of DID?	Semi-structured interviews. Framework analysis.	• Diagnosis experienced as both validating and stigmatising; fears of rejection, self-doubt. • Barriers to care: limited knowledge among professionals, misinterpretation of behaviours, lack of engagement with parts, difficulty accessing specialist support.
Fox, J., Bell, H., Jacobson, L., &	One participant – 35yr old white	What is the experience of recovery for a female	Semi-structured narrative interviews at	• Recovery linked with increased self-esteem, empowerment, connection; disclosure risky due to stigma.

Hundley, G. (2013).	female with DID	survivor of DID?	three timepoints. Thematic analysis.	• Therapy aided trauma processing, alter organisation, and meaning-making. • Media stereotypes misrepresent DID and discourage help-seeking.
Greene, A. K., Maloul, E. K., Norling, H. N., Palazzolo, L. P., & Brownstone, L. M. (2023).	Secondary data – Social media signatures from 325 TikTok users who self-identified as having DID. Average age:20.9 yrs.	How is DID portrayed and discussed on TikTok, and what does this reveal about the social experience of DID?	Public TikTok posts selected using pre-selected hashtags. Codebook and reflexive thematic analysis.	• TikTok offered community, connection, and space for identity work. • System descriptions and diagnosis status used to gain credibility. • Online/offline boundaries blurred; maladaptive daydreaming and "reality shifting" influenced experiences.
Marais, L., Bezuidenhout, M., & Krüger, C. (2022).	15 participants: adult psychiatric inpatients, 19-54 yrs old, 10f and 5m.	How do patients diagnosed with DID experience internal conflict?	Secondary data of semi-structured interviews. Thematic analysis.	• Internal conflict pervasive; disagreements across alters over values, goals, and control. • Awareness levels shaped intensity of conflict and potential for integration. • Cultural and personal backgrounds influenced understanding of DID.
McAllister, M., Higson, D., McIntosh, W., O'Leary, S., Hargreaves, L., Murrell, L., ... & O'Brien, J. (2001).	Post-acute patients with DID, alongside nurses, in an acute care setting. Specific demographics and number not reported.	What are the experiences of nurses and patients with DID in acute care settings, and what challenges do they face?	Action research: Focus group interviews. Thematic analysis and narrative construction.	• Patients described struggles with trust, abandonment, and internal battles. • Consistency and communication from staff seen as crucial. • Group support and acceptance of multiplicity fostered resilience.
McRae, L., Hundley, G., Bell, H., & Fox, J. (2017).	12 participants with DID. Mean age: 39. All White.	What are the lived experiences of survivors with DID?	Semi-structured focus group. Classical content analysis.	• Core experiences: missing time, body dissociation, fluctuating emotions, amnesia, multiple identities. • Symptoms linked to childhood trauma and life stressors.

				• DID viewed as both survival strategy and source of stigma; desire for self-acceptance.
Parry, S., Lloyd, M., & Simpson, J. (2018).	5 participants with DID, all female – history of being an inpatient.	What are the lived experiences of individuals with DID and how do they explain their DID to others?	Secondary analysis open ended semi-structured interviews. Interpretive phenomenological analysis.	• Alters carried distinct life timelines, shaping memory and time perception. • Difficulties in explaining experiences to others; frequent misunderstandings. • Emphasis on recognising needs of alters and practicing compassionate acceptance.
Sagan, O. (2019).	One female participant with DID, White British.	How does art-making help the understanding of personal experiences of living with DID?	Open unstructured interviews. Thematic Analysis.	• Art-making enabled communication and differentiation between alters. • Helped process trauma memories and integrate experiences. • Visual expression often clearer than words.
Somer, E., & Nave, O. (2001).	5 former DID patients – considered to be 'healed', by themselves and their therapists.	How do former DID patients experience their identity and memory following therapy?	Ethnographic research method with semi-structed interviews. Cross case ethnographic analysis.	• Integration was gradual and uniquely defined; not a total loss of dissociative abilities. • Post-integration challenges included loss of coping strategies and relearning social skills. • Identity, memory, and relationships underwent major shifts during the process of integration.
Tomlinson, K., & Baker, C. (2019).	Secondary data – five published books on females personal experiences of DID	How do women's autobiographies and biographies reflect the lived experiences of individuals with DID?	Literary narrative inquiry – Secondary data. Thematic analysis.	• Dissociation understood as coping with severe abuse; alters held trauma and memories. • Survivors described neglect and lack of protection by others. • Diagnosis was a turning point despite barriers and misdiagnosis.
Zeligman, M., Greene, J. H., Hundley, G., Graham Jr, J.	5 men with DID. Ave age: 56 yo. 4 White.	What are the lived experiences of men with DID?	Semi structured interviews.	• Male survivors reported extensive trauma histories, multiple misdiagnoses, and stigma shaped by gender expectations.

M., Spann, S., Bickley, E., & Bloom, Z. (2017).			Phenomenological analysis.	• Alters took on varied roles and identities, influencing self-experience. • Difficulties with treatment access and relationships, alongside recognition of strengths.
Chametzky, B. (2022)	Secondary data - sources containing accounts and discussions from individuals who self-identified as living with DID	Grand tour question: What is it like living with a dissociative disorder, specifically DID?	Secondary data - 20 public online sources using grand tour question. Classic grounded theory.	• Developed theory of "discovering and uncovering": destabilising, opening up, and accepting. • DID experienced as non-linear, fluid, and shifting. • Stressed importance of societal acceptance and understanding.
Jacobson, L., Fox, J., Bell, H., Zeligman, M., & Graham, J. (2015).	13 survivors with diagnosed DID who had experiences with counselling or psychotherapy	What are the perspectives and experiences of survivors with DID on the therapeutic process and their therapists?	Semi-structured interviews – in two focus groups. Classical content analysis.	• Strong therapeutic alliance (trust, safety, empathy) was essential. • Effective therapy involved engaging alters and managing dissociation flexibly. • Ineffective approaches: abrupt endings, rigid methods, lack of DID knowledge.

Narrative Synthesis Methodology

This review employed narrative synthesis to systematically integrate findings from selected qualitative studies, following Popay's (2006) guidance. Initially, studies were grouped based on their CASP scores and studies rated highly on domain 10 and overall quality were prioritised to construct the core narrative, ensuring primary concepts reflected the lived experience of DID. Lower-rated studies were integrated to provide complementary insights. This weighting ensured the synthesis remained closely aligned with the research question.

The final synthesised themes were developed in accordance with Popay's (2006) step-by-step process. Firstly, each study was read multiple times to ensure deep familiarisation. Secondly, key phrases, sentences and sections related to subjective lived experience were identified within the core findings and systematically coded, noting convergence and divergence between studies. These codes were reviewed and grouped into preliminary themes, based on conceptual similarity. Preliminary themes were reviewed and refined iteratively, ensuring that each theme was distinct and coherent but also conveyed an emerging story across all included studies. Refined themes were integrated, with unique study contributions embedded within broader patterns across studies. Themes were critically evaluated in relation to study quality ratings and the interactions between themes, with participant perspectives prioritised throughout (Popay et al., 2006). In line with guidance (Popay et al., 2006), selected participant quotes from the original studies were included to preserve the richness and nuance of participant's experiences.

Findings

This section begins with a summary of findings from the study quality appraisal process. It then presents five themes derived from the narrative synthesis. The thematic structure is intentionally arranged to reflect a narrative arc, mirroring many participants stories, beginning with trauma and survival, culminating in experiences of healing.

Quality Appraisal Findings

Across the thirteen studies, methodological quality was generally strong, with CASP scores ranging from 15 to 19 out of 20 (see Appendix 1). Most studies clearly articulated their aims, employed appropriate qualitative designs and provided rich, nuanced themes capturing participants' lived experience. However, consideration of researcher positionality was often limited, which was particularly relevant in studies where the interviewer had a prior therapeutic relationship with participants (Fox et al., 2013; Somer and Nave, 2001). In these cases, a lack of explicit reflexivity does not enable an assessment of data collection or interpretive bias, influencing the subjectivity of findings within this review. Some studies conducted purposeful re-analyses of previously collected data (Marais et al., 2022; Parry et al., 2018) or drew upon publicly available autobiographical content (Chametzky, 2022; Greene et al. 2023; Tomlinson & Baker, 2019), which may have limited opportunities to explore specific questions or tailor data collection to their study aims. Furthermore, three studies (Jacobson et al. 2015; McAllister et al. 2001; McRae et al. 2017) collected data via focus groups, which may have constrained disclosure on subjective experience, especially given the sensitive nature of DID. Two studies (Fox et al. 2013; Sagan, 2019) were single-case studies, which limited applicability of findings. These factors were accounted for when scoring domain five *("data collection addressed research question")* as they may have impacted appropriateness of data collection and sampling methods to the review aims. The studies which directly explored lived experience (Parry et al., 2018; Somer & Nave, 2001; Tomlinson & Baker, 2019; Zeligman et al., 2017) were prioritised during the coding process as they aligned closely with the review aims, which contrasted with four studies (Floris & McPherson, 2014; Greene et al., 2023; McAllister et al., 2001; McRae et al., 2017) that explored lived experience but focussed on broader influences such as healthcare, treatment and social media. When conducting the narrative synthesis, greater interpretive weight was given to those studies demonstrating both strong methodological quality and clear alignment with the review's objectives.

Bearing the Unbearable: Survival and Coping

Participants’ narratives illustrated how their histories of trauma played a central role in the development of DID. This theme was endorsed across all studies, reflecting a shared understanding of DID as an adaptive survival response, enabling participants to bear the unbearable:

“You know how people become DID, is for a survival, so it helped me to understand that ... I’m not ill or I’m not less than you or somebody outside. I’m the same, I just have had terrible, terrible things happen to me and I needed some extreme coping mechanism and this ... is it”. (Floris & McPherson, 2014).

This theme captures both the pervasive nature of trauma and the dissociative coping mechanisms which emerged in response.

Participants in several studies (Fox et al., 2013; McRae et al., 2017; Tomlinson & Baker, 2017; Zeligman et al., 2017) disclosed developmental trauma during their early childhood, identifying sexual, physical and emotional abuse which was often perpetrated by close family members. Some exceptions were noted (Tomlinson & Baker, 2019), suggesting that while abuse is prevalent, other adverse experiences may also contribute to the emergence of DID. In many accounts, the absence of external protection left participants feeling trapped and helpless (McRae et al., 2017; Tomlinson & Baker, 2019):

“Who can we turn to other than ourselves? How can we deal with this terror, other than to put it into little cupboards in our consciousness, then lock the doors firmly so that the terror does not contaminate the rest of us?” (Tomlinson & Baker, 2019).

Similarly, others described DID as a creative and adaptive defence, even a “gift,” that enabled them to psychologically escape trauma when physical escape was impossible (Chametzky, 2022; McRae et al., 2017). Many studies highlighted the key role of dissociative parts in shielding the host personality from information about their trauma histories, enabling a simultaneous knowing and not-knowing, as if the trauma were not happening to them (Chametzky, 2022; McAllister et al., 2000; Somer & Nave, 2001).

This compartmentalised coping often persisted beyond the original trauma and became an ingrained pattern, as trauma-related responses were often triggered in present-day settings (McAllister et al., 2000; Parry et al., 2018). Participants reported dissociative and post-traumatic symptoms such as nightmares, depersonalisation, amnesia, panic attacks. Coping ranged from adaptive practices such as creative expression, journalling, and grounding (Jacobson et al., 2015; Sagan, 2019), to less adaptive strategies such as substance use, disordered eating, and self-harm (McAllister et al., 2000; McRae et al., 2017; Zeligman et al., 2017). Participants emphasised the protective intentions behind even destructive behaviours, which often occurred outside conscious awareness due to amnesia (McAllister et al., 2000).

Dissociation itself was consistently described as both a historical and ongoing coping mechanism, involving detachment from internal and external experiences:

"Dissociation used to be an automatic habit that protected me from pain and discomfort. Today, I still need to consciously work against automatic dissociation". (Somer & Nave, 2001).

Dissociation also blurred the boundaries between reality, imagination and fantasy, providing escape and refuge from life's harsh realities. Participants described maladaptive daydreaming, living in rich inner worlds, or recalling events which they later doubted were real (Greene et al. 2023; Somer & Nave, 2001). Parry et al. (2018) highlighted that whilst protective, dissociative coping creates disordered perceptions of time and threat, or limits engagement with everyday life or relationships (McAllister et al., 2000; Tomlinson & Baker, 2019)

Taken together, these narratives demonstrate the centrality of trauma in the development of DID, and the complex ways in which dissociation serves as both a shield and a challenge in participants' lives. Across studies, dissociation emerged as a meaningful, often necessary, strategy to bear what was once unbearable.

Fragmentation and Multiplicity: Dissociative Parts and Dissociative Identity

This theme captures the complexity of living with DID as participants navigated a fragmented identity, memory, experience, and reality. Participants across all studies described experiencing daily life through and with dissociative parts, highlighting how this shapes their functioning and sense of self. Studies providing the richest support for this theme (Chametzky, 2022; Greene et al., 2023; Marais et al., 2022; Parry et al., 2018; Somer & Nave, 2001; Tomlinson & Baker, 2019; Zeligman et al., 2017) were those that explicitly explored participants' lived experiences and the everyday implications of dissociation.

Across studies, participants described profound identify confusion, experiencing a fragmented and often contradictory sense of self. Many reported a fluctuating or absent core identity, such as one participant who described *"no identity",* only *"a dark internal emptiness"* (Somer & Nave, 2001):

"I never really knew who I was beyond my name... there was an 'I' who was feeling and an 'I' who could tell my history, and they did not match." – (Somer & Nave, 2001)

Participants frequently described periods of lost time, along with autobiographical memory gaps, selective amnesia for traumatic events, everyday forgetfulness and reduced awareness (Fox et al., 2013; Marais et al. 2022; Parry et al., 2018;). Participants linked these memory disruptions to dissociative processes and switching between dissociative parts (Chametzky, 2022; Marais et al., 2022; Sagan, 2019; Somer & Nave, 2001; Tomlinson & Baker, 2019). In many accounts, the host emerged as the default social self, often unaware when alters took control (Tomlinson & Baker, 2019). Switching was commonly described as involuntary and unsettling, often accompanied by physical sensations such as headaches and fatigue (Chametzky, 2022; Zeligman et al. 2017). Participants in several studies (Floris & McPherson, 2014; Greene et al., 2023; Marais et al., 2022; McRae et al., 2017) conveyed that this identity fragmentation was underpinned by internal conflict between dissociative parts. Dissociative parts had varying genders, sexualities, values, roles, ages, preferences, cultural identities, somatic experiences and even handwriting styles, shaping the way participants experienced their identity overall (Chametzky, 2022; Marais et al., 2022; Sagan, 2019; Zeligman et al., 2017).

Many participants came to view their parts as meaningful expressions of the self and learnt to co-exist with them, taking ownership for their wellbeing rather than resisting or denying them (Chametzky, 2022; Greene et al., 2023; Jacobson et al., 2015; Sagan, 2019; Somer & Nave, 2001). Although, this required constant and ongoing effort:

"There is technically still seven of me and trying to make a decision with seven people is hard. So everything just takes longer." — (Fox et al., 2013)

In addition to managing competing internal demands, internal questioning, often amplified by external disbelief and stigma, left individuals feeling confused and frightened of their own experiences (Marais et al., 2022: McRae et al., 2017). Participants highlighted that enabling parts to express themselves and building internal relationships was important for the whole system to navigate life successfully (Chametzky, 2022). This is supported by findings across studies (Chametzky, 2022; Jacobson et al., 2015; Marais et al., 2022; McAllister et al., 2000; Somer & Nave, 2001; Tomlinson & Baker, 2019) which highlighted that internal conflicts were reduced by increased communication and negotiation between parts.

Some studies (Marais et al., 2022; Somer & Nave, 2001) highlighted how participants drew upon diverse cultural and spiritual frameworks to make sense of their fragmentation, which often clashed with psychiatric models for understanding DID:

"When this first started happening, I assumed it was some, you know, like something demonic, because suddenly this apparently evil entity had taken over my body and was sort of screaming obscenities out of my mouth." – (Zeligman et al., 2017).

Greene et al. (2023) described how DID communities on social media drew upon the Japanese art of Kintsugi and metaphors such as "swarm", "coral reef" or "four squirrels in a sweater", highlighting creative and dynamic ways of understanding internal worlds (Greene et al., 2023). Ultimately, making sense of DID was portrayed across studies as an ongoing negotiation with fragmentation, multiplicity and the cumulative impact of dissociative processes. As one participant poignantly summarised: *"Who am I, if I cannot remember being me?" (Somer & Nave, 2001).*

Seeking Connection: Navigating Relationships and Stigma

This theme explores how participants navigated their desire for connection within personal and professional relationships. Across nearly all studies, participants consistently described the toll of relational trauma, dissociation and societal stigma on their ability to connect with others. This theme was particularly endorsed by studies which directly examined interpersonal experiences (Floris & McPherson, 2014; Fox et al., 2013; Jacobson et al., 2015; McAllister et al., 2000; McRae et al., 2017; Parry et al., 2018; Sagan, 2019; Zeligman et al., 2017).

Many participants described long-standing social isolation, loneliness and a lack of relational safety which accompanied their DID (Fox et al., 2013; McRae et al., 2017; Zeligman et al., 2017). For many, attempts to form or sustain relationships were undermined by mistrust, shame or fear of judgement, particularly after disclosing their diagnosis or experiencing dissociative episodes (Fox et al. 2013; McAllister et al. 2000; McRae et al., 2017). Some participants described sabotaging relationships pre-emptively, while others retreated from intimacy:

"I get to a point where I'm comfortable enough with people and I feel safe, and I know it's just going to be a matter of time before something will happen and I will switch . . . and so the way to protect them I typically sabotage my relationship ... well, maybe I'm protecting myself too ... I think I live a lot in fear". – (Zeligman et al., 2017)

Even within therapeutic or institutional settings, perceived abandonment or invalidation, such as being ignored, disbelieved or mocked, often led to self-protective withdrawal and a profound longing for connection (McAllister et al., 2000; Parry et al., 2018).

Across multiple studies, societal stigma emerged as a pervasive factor which shaped how participants engaged with others and accessed support (Floris & McPherson, 2014; Fox et al., 2013; McRae et al., 2017; Zeligman et al., 2017):

"Sometimes they ask a few more questions about my experience... but... still a lot of the time they kind of feel afraid, like you're gonna switch and... hurt them or something." (Floris & McPherson, 2014)

Zeligman et al. (2017) identified that gendered cultural norms for men amplified stigma and further limited their ability to seek support. Stigma was not only externally imposed but also internalised, contributing to reduced self-esteem, self-doubt, and hesitance to share personal experiences (Floris & McPherson, 2014; McRae et al., 2017). Participants often altered their social behaviours to avoid judgement or disbelief, especially in contexts where credibility was vital. This dynamic was compounded by a systemic lack of understanding, which left many feeling misunderstood, disbelieved and struggling to explain their experiences even to themselves, let alone to others (Parry et al., 2018).

Some participants highlighted the importance of forming distinct relationships between loved ones and specific parts, adding an additional layer of complexity to relationality:

"My alters talked to [my wife] before I knew they were there," describing his partner's recognition and acceptance of each part as a vital form of support (Zeligman et al., 2017).

Others described painful experiences when their parts were dismissed, particularly in clinical settings, emphasising the need for others to engage respectfully with parts to support the whole system (Floris & McPherson, 2014; McAllister et al. 2000; Parry et al., 2018). Participants highlighted that therapeutic relationships were most effective when clinicians demonstrated empathy, trustworthiness, and a willingness to understand and work collaboratively with all parts (Fox et al., 2013; Jacobson et al., 2015; McAllister et al., 2000).

Collectively, these accounts underscore the importance for loved ones and therapists to build trust and relational safety, highlighting that healing and connection is shaped by how multiplicity is recognised, respected, and responded to by others.

Negotiating Care: Diagnosis, Professional Scepticism, and Treatment Barriers

This theme captures the often complex and challenging journeys participants endured when navigating mental health systems to access appropriate support. Experiences of professional misunderstanding, scepticism, systemic barriers and misdiagnosis emerged across multiple studies which explored lived experience of treatment (Floris & McPherson, 2014; Fox et al., 2013; Jacobson et al., 2013; McRae et al., 2017; Parry et al., 2018; Sagan, 2019; Tomlinson & Baker, 2019; Zeligman et al., 2017). A few studies did not endorse this theme (Greene et al., 2023; Marais et al., 2022; McAllister et al., 2001) as they did not focus on participants' treatment experiences.

Participants described mental healthcare as ill-equipped to recognise dissociation as clinicians often lacked knowledge and expertise (Fox et al., 2013; Zeligman et al., 2017). Therefore, misdiagnosis was common, with participants receiving labels for conditions such as bipolar disorder, schizophrenia and borderline personality disorder (Fox et al., 2013; Sagan, 2019; Zeligan et al., 2017). This delayed access to appropriate treatment but also heightened internal confusion and mistrust in services:

> *"How can I exist if they don't think I [DID] exist?" -(Parry et al., 2018)*

Participants found that the burden of advocating and formulating their dissociative experiences lay with them, exacerbating crisis periods and leaving participants feeling unsupported (McAllister et al., 2000; Parry et al., 2018). Floris & McPherson (2014) found that accessing specialist DID care required a formal diagnosis, but it was met with scepticism from referrers. However, when participants successfully accessed treatment for DID, they often experienced rupture in therapeutic relationships or were forced to give up trusted therapists to follow service protocols (Floris & McPherson, 2014; Fox et al., 2013). Notably, one participant (Sagan, 2019) instead turned to artmaking as a more effective means of understanding and processing her dissociative experiences. Furthermore, participants themselves reported difficulties accepting the diagnosis, as they grappled with internalised stigma and self-doubt, compounded by professional scepticism (Chametzky, 2022; Floris & McPherson, 2014; Somer & Nave, 2001; Tomlinson & Baker, 2017; Zeligman et al., 2017):

"It's quite difficult to hold onto a diagnosis yourself... if somebody seeing you is questioning it, then I mustn't have it" -(Floris & McPherson, 2014).

Despite these challenges, many participants reflected that receiving a DID diagnosis offered clarity, validation, and hope, enabling them to make sense of their experiences (Chametzky, 2022; Floris & McPherson, 2014; Fox et al., 2013; McRae et al., 2017). The diagnosis often provided a destigmatising acknowledgement of their difficulties and a framework for understanding. The diagnosis also enabled meaningful therapeutic work as the recognition of DID resembled the acknowledgement of dissociative parts and trauma (Jacobson et al., 2015). Despite its contested status, the DID diagnosis often marked a turning point towards internal compassion, cooperation and healing (Chametzky, 2022).

Together, these findings convey that despite moments of validation and clarity through diagnosis, negotiating care was frequently marked by a lack of DID-informed support and by confronting systems which at times mirrored the core of participant's early relational trauma.

Healing Journeys: Connection, Acceptance and Integration

Despite challenges in negotiating care, this theme encapsulates participants' varied and successful accounts of healing, driven by connection and acceptance from others and between parts of the self. This theme was evident across all studies but was strongly endorsed by studies which explored healing experiences directly (Floris & McPherson, 2014; Fox et al., 2013; Jacobson et al., 2015; McAllister et al., 2000; McRae et al., 2017; Sagan, 2019; Somer & Nave, 2001). Only one study (Marais et al., 2022) did not endorse this theme as they focussed on acute patients grappling with unresolved internal conflict.

For many participants, healing began with connection, whether through therapy, peer support or belonging. Specifically, many referenced the positive impact of connecting with the DID community, describing the profound importance of being understood by others and feeling empowered:

"Every day we find ourselves helping each other out in some way. Because we know what it feels like to be zoning out, afraid or switching, we can see it in others. So, we help each other get through it" – (McAllister et al., 2000)

Greene et al. (2023) illuminated how online spaces provided affirmation, solidarity and visibility, creating shared language of multiplicity and emphasising the collective nature of healing. This also extended to therapeutic support groups (Jacobson et al., 2015; McAllister et al., 2000), as compassion experienced from others could facilitate compassion within the internal system. These experiences fostered broader interpersonal openness, as being understood enabled participants to disclose their experiences to their loved ones, improving their relationships (Fox et al., 2013).

Therapy emerged as a pivotal context for healing, offering many participants a space to integrate fragmented experiences and renegotiate their sense of self. Therapy was particularly beneficial in facilitating understanding of their parts, enabling access to dissociated memories which could be processed alongside corresponding unresolved emotions (Fox et al., 2013; Sagan, 2019; Somer & Nave, 2001). Therapy also enabled participants to learn how to listen to their parts and reorganise system roles, to reduce internal conflict and system distress (Fox et al., 2013; Jacobson et al., 2015; Sagan, 2019; Somer & Nave, 2001). One participant (Sagan, 2019) developed awareness of their alters and facilitated a sense of coming together through creative expression:

"Now… this main alter communicates with the rest of them and sometimes, I think, they come together to do the art, which is good because that means that we are coming together as one." – (Sagan, 2019)

Healing was not always described as full integration of the self and becoming completely whole. Yet, healing always involved functional internal organisation along with development of internal communication and collaboration among parts (Fox et al., 2013; Jacobson et al., 2015; McAllister et al., 2000; Sagan, 2019; Somer & Nave, 2001). Somer & Nave (2001) described integration as a gradual process rather than a single event, experienced and expressed by each participant uniquely. One participant reflected how integration involved greater autonomy:

"Today I feel I am fully aware and present both as the collective of parts and as any individual part." -(Somer & Nave, 2001)

Another participant referred to their healing as creative disintegration:

After I was done with my therapy, I found out that I could use dissociation to my advantage... I go inside and I look for the part of me that is distressed." – (Somer & Nave, 2001).

Across these studies, no participants explicitly described fully eradicating their parts or eliminating multiplicity to become a singular self. Instead, integration was more commonly framed as a process of collaboration, functional cohesion, acceptance, and, in some cases, partial fusion or co-consciousness (Fox et al., 2013; Jacobson et al., 2015; Sagan, 2019; Somer & Nave, 2001).

Participants' healing journeys took diverse forms, yet they collectively emphasised the importance of connection, acceptance and collective internal growth. Participants had varying views on the effectiveness of various healing methods. However, all highlighted the urgent need for more accessible and DID-informed mental health care which provide long-term support (Chametzky, 2022; Fox et al., 2013; McRae et al., 2017; Zeligman et al., 2017).

Discussion

Summary of Findings

This narrative synthesis examined thirteen qualitative studies to explore how empirical research presents the subjective lived experience of DID. The findings offer rich, multi-layered thematic insights into living with DID, grounded in participants' first-person accounts and drawn from diverse sampling contexts. Five overarching themes were developed, framing DID as a complex, adaptive and relational way of being.

The first theme, *Bearing the Unbearable*, conveyed DID as a functional, adaptive survival response in the context of overwhelming developmental trauma and adversity, particularly in circumstances of helplessness, entrapment and absence of external protection. These findings echo long-standing empirical and theoretical literature positioning DID as a trauma-related phenomenon, enabling continued functioning despite fear without resolution (Bistas & Grewal, 2024; Dorahy et al., 2014; Fung et al., 2023). Specifically, this theme highlighted that trauma was often perpetrated by family members, supporting notions from BTT which emphasises that dissociative mechanisms alter awareness to preserve the attachment relationship with an unsafe caregiver and thus, ensure survival (Freyd, 2003; Freyd & Gleaves, 2007).

The second theme builds on this further; *Fragmentation and Multiplicity* illustrated that dissociative parts have compartmentalised knowledge and roles, which is consistent with theories which state that the mind fragments traumatic awareness when it threatens relational survival (Fung et al., 2023). Whilst BTT offers a trauma-informed explanation for the development of dissociative fragmentation, SDT (Van der Hart et al., 2006) explains how this fragmentation is organised and maintained within the personality system. According to SDT, the personality becomes divided into distinct parts as described in the introduction chapter; the apparently normal part(s) and the emotional part(s). *Fragmentation and Multiplicity* across studies is consistent with this framework, as participants described dissociative parts which held distinct roles, functions and emotional responses that were often in conflict or unaware of one another. These conflicting influences significantly shaped how participants navigated daily life, identity, perceptions, memory, coping and agency. Taken together, these two themes illuminate how dissociative parts emerge in the context of relational trauma, enabling ability to bear the unbearable. However, while this structure may have once been adaptive, the theme of *Fragmentation and Multiplicity* also highlights several unintended consequences, including internal conflict, memory disruption, loss of agency and identity confusion, consistent with previous research (ISSTD, 2011).

The third theme, *Seeking Connection*, emphasised participants' deep longing for safe, attuned interpersonal relationships amidst pervasive experiences of relational trauma and isolation. Participants described not only the isolating nature of dissociation, but also the compounding impact of societal stigma. Previous research has similarly highlighted that DID has been frequently misunderstood and viewed as implausible, with stigmatising beliefs and inaccurate media stereotypes portraying people with DID as dangerous, unpredictable, or highly suggestible (Chen, 2022; Millard, 2020). *Seeking Connection* highlights that participants' awareness of these representations led to internalised and anticipated stigma (Gleaves & Reisinger, 2023). Participants doubted the legitimacy of their own experiences and expected rejection, disbelief or invalidation from others, thereby reducing opportunities for relational intimacy and connection. The fourth theme, *Negotiating Care*, reflected how stigma extended to healthcare contexts, shaping therapeutic relationships, access to treatment and misdiagnosis. Some clinicians believe that countertransference stemming from the client's own confusion and self-doubt, may contribute to clinician disbelief regarding the legitimacy of DID, mirroring the client's own ambivalence and fragmented sense of reality (Loewenstein & Brand, 2023). Recent work has demonstrated that societal stigma and professional scepticism contribute directly to increased self-stigma, shame, delays in seeking treatment, misdiagnosis and misinformed clinical attitudes (Boysen & VanBergen, 2013; Snyder et al., 2024). Floris & McPherson (2014) argued that the contested status of DID as a diagnostic label generates a dynamic of iatrogenic doubting, whereby professional scepticism and lack of consensus foster clients' internal self-doubt. This extends classic labelling theory, highlighting that in the context of contested diagnoses, attitudes towards the label itself can contribute to further harm. However, this review also found that receiving a formal diagnosis was often experienced as a form of recognition and legitimisation, counteracting anticipated stigma, reducing self-doubt and enabling participants to feel more accepted and understood. However, internalised stigma and iatrogenic doubting continued to exacerbate internal conflict in fully accepting the diagnosis.

Despite the pervasive impact of stigma and professional scepticism, participants' accounts of healing highlighted the significance of encountering others who recognised their parts, believed their stories and affirmed their experiences. Chefetz (2000) emphasised that effective therapeutic work requires the therapist to attune sensitively to the multiple subjective realities of parts. The final theme, *Healing Journeys*, focussed on the diverse ways in which participants found growth, healing, and integration through internal and external connection. Integration was not framed as eliminating parts, nor was it universally desired. Instead, healing was conceptualised as an ongoing process of building internal cooperation, fostering communication between parts, and finding ways to meaningfully co-exist with multiplicity. These findings align with research which reflects broader shifts in the field, highlighting that fragmentation is reduced through the development of internal collaboration (Barlow & Chu, 2014; Pais, 2009). This review found that therapy, community support and artwork facilitated the process of strengthening relationships between parts, mirroring the clinical approaches outlined by Lemke (2007). These findings suggest that healing for DID is relational, both internally and externally.

Critical Reflections and Research Gaps

The field of qualitative research on DID remains relatively small, with only six additional studies identified which were excluded from this review due to focusing on aspects outside the scope of lived experience. Whilst the selected studies offered rich data, their sample sizes were often small and not demographically diverse. This reflects wider limitations in DID research regarding the use of small overlapping samples (Beker et al., 2024). Across studies, there was a clear bias towards participants from White, Western backgrounds, along with a notable gender skew towards participants who identified as female. This pattern reflects a diagnostic bias toward females and a broader limitation whereby the voices of marginalised, non-Western populations and the influence of cross-cultural contexts remain largely under-researched (Floris & McPherson, 2014; Marais et al., 2022). A notable proportion of qualitative studies relied on case studies, secondary data sources or publicly available narratives (Chametzky, 2022; Greene et al., 2023; Tomlinson & Baker, 2019), reflecting widespread apprehension in accessing and ethically engaging participants with DID, highlighting a key gap in the literature. Whilst this broadened the diversity of voices, the absence of researcher-participant interaction limited opportunities for clarification, emotional depth and contextual probing. Furthermore, it potentially reduced the clinical applicability of the sample, given that many individuals were self-identified rather than formally diagnosed. The present study directly responds to these limitations and gaps by conducting primary narrative interviews with people diagnosed with DID.

Whilst many studies acknowledged the presence and contribution of dissociative parts, very few placed parts at the centre of their analysis. Within this synthesis, dissociative parts consistently emerged across all domains of lived experience, including identity, meaning making, relationships, treatment, and coping. Dissociative parts had distinct interpersonal needs, unique relationships with others, specific roles in daily life and particular memories. Several participants highlighted the importance of hearing the stories of dissociative parts to facilitate emotional healing (Chametzky, 2022; Jacobson et al., 2015; Sagan, 2019; Somer & Nave, 2001). This supports clinical observations stating interpersonal and intrapersonal dynamics between dissociative parts can impede therapy, making parts-based language a vital tool for mindful self-observation and working through trauma-related material (Fisher, 2017; Ogden & Fisher, 2015; Sinason, 2020). However, while these insights reveal the relational and functional significance of parts, the role and influence of these intra-personal relationships within broader system functioning has rarely been explored in depth within research. The present study was specifically designed to address this gap by exploring the narratives of dissociative parts and examining how intra-system relationships shape participants' lived experiences and sense of self. This may also contribute to the ongoing professional debate about whether dissociative parts should be engaged directly in treatment or dismissed as a problematic metaphor or defence (Floris & McPherson, 2014; Merckelbach et al., 2002; Ozturk & Sar, 2016).

Thesis Rationale

This synthesis repeatedly highlighted that effective treatment, successful relationships and meaningful healing could not occur without acknowledging the role of dissociative parts in participants' experiences of themselves and the world. Despite this, a key finding of this review is that no existing primary qualitative study to date has directly examined the subjective experience of living with dissociative parts, nor how participants with DID make sense of their parts. Whilst existing studies often refer to mechanisms such as switching, amnesia or internal conflict, dissociative parts are often background features to broader aspects of lived experience (Howell, 2005; Fisher, 2017). This represents a significant research gap in the field, given that the subjective experience of fragmentation is central to understanding DID. Considering these findings, this thesis project seeks to address this critical gap by exploring how participants with DID experience and make sense of their dissociative parts, from a first-hand perspective. By spotlighting parts as active, relational and dynamic aspects of DID lived experience, this thesis aims to contribute a deeper, more nuanced understanding of the internal worlds of those with DID.

Research Aims and Objectives

Aim: To explore the subjective experiences of living with dissociative parts in participants with Dissociative Identity Disorder, from a first-person perspective.

- Therefore, this study aims to focus on how participants narrate, construct and describe their stories and experiences of their dissociative parts.

Objective 1: To investigate how participants understand the role and function of dissociative parts in various aspects of daily life, healing, identity, relationships and wellbeing.

- This includes examining how participants perceive the ways in which dissociative parts shape their sense of self, contribute to daily functioning, and manage both internal and external demands.

Objective 2: To explore how participants make sense of their experiences of living with dissociative parts over time

- This objective seeks to understand how participants' narratives of selfhood evolve, how they adapt to the needs of their dissociative parts, and how sense-making develops in response to life changes, therapeutic processes, and relational contexts.

Objective 3: To inform clinical practice by deepening understanding of the DID lived experience and enhancing therapist confidence in working therapeutically with dissociative parts.

- This study aims to contribute empirical insights that may support the development of therapeutic approaches that are specifically adapted to DID and the unique experiences of dissociative parts.

Chapter Three: Methods

Overview

This chapter outlines the methodological framework utilised to explore the subjective experiences of living with dissociative parts in DID. Grounded in a phenomenological ontology and epistemology, this study adopted narrative inquiry to privilege participant voice and meaning making. The research design integrated ethical and trauma-informed practices throughout recruitment, screening, and interviewing, with extensive attention given to participant safety and autonomy. Public and patient involvement contributed to the design, interview process, and analysis. Data were gathered through open-ended narrative interviews with twelve participants and analysed using thematic narrative analysis. Reflexive engagement, member checking, and supervision supported the co-construction and integrity of the analytic process.

Philosophical Framework

Defining the philosophical frameworks that underpin research is essential for understanding how the research process and the production of knowledge should be conducted (Creswell & Poth, 2016). Ontology addresses the nature of reality and how it is understood, while epistemology focusses on how knowledge is acquired and studied. Together, epistemology and ontology shape the research design, methodology and interpretation of data, directly influencing the conclusions drawn. By clarifying these foundational assumptions, researchers can ensure consistency, rigour and coherence in their approach, leading to contextualised and meaningful findings (Al-Ababneh, 2020).

This research adopts a phenomenological ontological stance which posits that reality is subjective, relational and context dependent. Phenomenology views reality as constructed through lived experience, individual perception and conscious engagement with the world (Van Manen, 1990). This ontological stance is particularly well-suited to exploring the subjective experiences of participants with DID as it embraces subjectivity over objectivity, multiplicity over facticity and complexity over essentialism. It recognises that participants' realities are shaped by their often hidden and uniquely organised inner worlds, wherein dissociative parts represent distinct aspects of identity and consciousness (Dorahy et al., 2021). By adopting a phenomenological ontology, this research seeks to embrace the richness of participants' unique engagement with reality, without reducing or pathologising them. This position also accommodates the notion that reality is continually constructed and reconstructed through interactions with the self and others (Creswell & Poth, 2016), recognising that participants' understanding of their internal world will evolve over time, shaped by personal growth and therapeutic processes. Concepts such as ontological insecurity (Laing, 1994) and critiques of the ideal of ontological security (Woolley, 2007) suggest that experiences of selfhood are inherently fragile, relational and culturally shaped. The philosophical stance adopted in this study accommodates the possibility that a stable, coherent sense of self may not be universally achievable or desirable. In this context, the study does not seek to represent a fixed truth or identity, instead it seeks to explore how participants narrate, construct and make meaning of their subjective experiences of selfhood and multiplicity (Merleau Ponty, 2013). Whilst qualitative methodologies offer a valuable means of exploring lived experiences that are not directly observable, their strength in capturing subjective realities places limitations on the kind of knowledge they produce. Therefore, it should be noted that this study does not aim to make generalisable claims, instead it focusses on participants' unique meaning making processes rather than external verification.

The epistemological foundation for this research is similarly grounded in a phenomenological stance, which rejects the notion that there is an objective, external 'truth' and instead, seeks to uncover the essence of experience as it is lived and understood by the individual (Van Manen, 1990). Within the context of DID, the essence of experience tends to be fragmented yet interconnected, reflecting the influences of dissociative parts on the overall experience of the self and the world (Fisher, 2017). A phenomenological position values these experiences as a valid and meaningful existence to be explored as it is, viewing narrative incoherence and fluctuations as meaningful expressions of the fragmented structures of subjective reality (Merleau-Ponty, 2013). The choice of a phenomenological lens aligns with the core research aim to explore participants' subjective and deeply personal experiences of living with dissociative parts. Phenomenology assumes knowledge is constructed through individuals' subjective experiences, positioning personal stories gathered through narrative interviews as legitimate sources of knowledge. This is particularly valuable for participants with DID, whose stories have been historically invalidated and silenced (Loewenstein & Brand, 2023).

The use of narrative methodology aligns with a phenomenological epistemology, as storytelling is one way in which participants construct, express, and make sense of their experiences (Chase, 2008). By inviting participants to share their stories, in their own words and at their own pace, this methodology honours the richness and complexity of their subjective realities. The open-ended prompts and minimal directive questioning align with phenomenology's commitment to preserve authenticity without imposing preconceived or external explanations. This approach privileges participants' voices and embraces the co-constructed nature of knowledge as an interaction between participants' realities and the researcher's interpretive engagement (Smith et al., 2021). This philosophical positioning informed the decision to prioritise participants' subjective perspectives and to treat dissociative parts as meaning-making agents in their own right. In cases where participants' parts directly communicated during the interview, their words were included with the same respect and analytic attention as any other account. This reflects a commitment to honour the experiential validity of dissociative parts, without erasing their autonomy. A phenomenological stance also aligns with a trauma-informed approach to ethical considerations, prioritising autonomy, collaboration and showing sensitivity to the contextual and relational nature of knowledge production (Creswell & Poth, 2016). Furthermore, narrative methodologies complement phenomenology by focussing on the structure, content, and context of participants' stories, highlighting the importance of exploring both what is said and how it is said. This approach allows for an exploration of dissociative parts as both individual components of participants' experiences and as interconnected elements that shape the broader sense of self and experience. By adopting a phenomenological approach, this study seeks to contribute a nuanced, rich and sensitive understanding of the subjective experiences of people with DID, grounded in their voice and perspective.

Research Design

To complement the phenomenological stance and research aims, this study employs a qualitative research design, specifically drawing upon narrative inquiry as a methodological approach. As discussed, this study adopts a phenomenological approach that values participants' subjective meaning-making over claims of generalisability, fixed truths or external verification. The research design is therefore structured to elicit rich, first-person narratives that foreground lived experience and subjective realities. The exploratory, interpretive nature of qualitative research focusses on subjective experience and individual meaning-making processes, central to the research aims of this study.

Narrative inquiry extends this focus by highlighting that knowledge and meaning is actively constructed, rather than found, through storytelling (Creswell & Poth, 2016). Storytelling is a universal form of communication and process to recall, organise and make sense of life experiences (Frank, 2010). Narrative inquiry prioritises participants' stories as central to capturing the meaning they have made from their subjective realities. Furthermore, storytelling enables participants to share unobservable personal experiences and their inner world (Frank, 2010). Dissociative parts often play distinct roles in shaping participants' experiences (Purcell et al., 2024). Narrative inquiry provides a framework for participants with DID to articulate the stories of their dissociative parts, preserving their individuality whilst exploring how their parts' roles and experiences contribute to their collective story. This approach also reflects phenomenology's emphasis on understanding the relational and evolving nature of reality, focussing on how their experiences and understanding changes over time (Gergen & Gergen, 2006). However, it is acknowledged that narrative interviews capture only a snapshot of participants' meaning making at a particular point in time.

A strength of narrative inquiry is its emphasis on participant agency and voice which fosters an ethical and trauma-informed approach to research (Clandinin & Connelly, 2000). It avoids pre-structuring or pathologising participants' stories and instead creates space for authentic participant-driven storytelling. This aligns with the phenomenological commitment to explore lived experiences as meaningful and valid as they are, which is particularly essential for participants with DID as the abuse and trauma they may have endured have likely contributed to experiences of invalidation (Aquarone & Hughes, 2013; Sinason, 2020). Furthermore, offering participants the opportunity to share their stories may have provided therapeutic benefits, as many participants reported feeling heard and finding the experience both meaningful and healing. Therefore, narrative inquiry provides a suitable methodological framework for this research.

Self-Reflexive Statement

Reflexivity about the research process and the self is a crucial practice in qualitative research, particularly when exploring deeply subjective and sensitive topics (Etherington, 2004; Finlay, 2002). *Therefore, it is vital to acknowledge how my own lived experiences influence the lens through which I approached this research. As a 27-year-old South Asian British woman who lives with disability, I have acknowledged how my own experiences of feeling marginalised or dismissed by society have deeply informed my interest in studying DID. I am aware that my personal experiences of intergenerational trauma and my own therapeutic journey have influenced my passion for adopting a trauma-informed approach to my research. My professional experiences of working with complex psychological needs has underscored my passion for conducting research which may reduce stigma for a misunderstood clinical group. My experiences of exploring my own internal parts in therapy, such as my inner child parts, have provided me with a foundational understanding of multiplicity, though my parts are connected and integrated in ways which significantly differ from those experienced in DID.*

My clinical experiences of working with clients with histories of complex trauma has exposed me to the challenges of treating dissociative experiences and DID within systems where dissociation is often overlooked. My professional experiences have also deepened my *awareness of the silencing of some narratives over others which occur in healthcare systems. As a researcher, these experiences underpin the importance of creating a space where participants' voices can be empowered and their stories can emerge authentically, without the imposition of my own biases or assumptions. In my analysis, I aimed to draw upon reflexivity and supervision to remain attentive to how my positionality and prior experiences might shape the co-construction of meaning with participants. I strived to approach participants' narratives with respect for the uniqueness of their lived experience. I also intended to critically engage with the interpretive process, ensuring that my analysis prioritises participants' perspectives whilst acknowledging the subjective nature of meaning-making.*

Public Patient Involvement

Public patient involvement (PPI) refers to the active engagement of patients, caregivers and the public as collaborators in the planning, design, execution, evaluation and dissemination of research (Hayes et al., 2012). PPI prioritises partnership and co-production to enhance applicability, quality and relevance of the research to the target population. Staley (2017) highlighted that PPI can also bolster researchers' confidence, skills and knowledge, fostering deeper engagement and improving the overall quality of qualitative research.

This study was informed by PPI guidance and principles outlined by Jennings et al. (2018), though inclusion of individuals with lived experience on the research team was not possible due to the requirements of the doctorate programme. Nevertheless, efforts were made to incorporate insights from lived experience throughout the research process. An expert by experience with a long-standing diagnosis of DID, along with two clinical experts, provided consultation for the development of the research design and methodology. The expert by experience reviewed all recruitment materials and provided feedback and amendments to ensure that language was sensitive and appropriately tailored to the needs of people with DID. Recruitment materials that were reviewed included the participant information sheet, pre-interview consent form, main consent form, demographic questionnaire and both interview schedules.

Additionally, a pilot pre-interview and main interview were conducted with the expert by experience, who offered valuable feedback which was instrumental in informing the researcher's style and approach to interviews. The expert by experience was also consulted during the data analysis process to enhance the identification and development of final themes, thereby fostering an element of collaboration in the interpretation of findings. This approach was further supplemented by member checking, which was as a collaborative and interpretive process in which participants were invited to provide contextual clarifications, reflect on thematic resonance, and offer their own interpretations to be considered in the final analysis (McKim, 2023). Loh (2013) emphasized that member checking is vital for addressing researcher bias and achieving a richer, more nuanced understanding of participant narratives, which is an essential component of narrative research. Furthermore, the researcher obtained a student membership with the European Society of Trauma and Dissociation (ESTD-UK) allowing the primary researcher access to forums, conferences, training and resources which improved the researcher's clinical skill, knowledge and confidence in working with this population.

The study findings will be disseminated through peer-reviewed publication to contribute to the broader field of trauma and dissociation research. It is intended that the final thesis will be developed into a journal article for submission to the Journal of Trauma and Dissociation.

Ethical Considerations

Ethical considerations were central to the design of this study, shaping decisions at every stage. A trauma-informed, parts-informed, and participant-led approach was prioritised to protect safety, autonomy, and dignity. These principles provided the foundation for how participants were approached, recruited, and supported, directly informing the recruitment, sampling and interview processes.

Approval and Supervision

This research project was sponsored by The University of Essex within the School of Health and Social Care. The ethical proposal was reviewed by academic staff at the University of Essex and the Research Ethics Officer. The researcher met regularly with their academic and clinical research supervisors. This research project was reviewed by Wales REC4 Research Ethics Committee (Project ID: 340547), as part of the Health Research Authority, and received a favourable ethical opinion (Appendix D).

Confidentiality and Anonymity

Protecting participants' identities was paramount, given the sensitive and personal nature of the information shared. Rigorous measures were implemented to ensure confidentiality and anonymity, prioritising participants' privacy and data security. Each participant was assigned a pseudonym to ensure anonymity when reporting findings and direct quotations. Furthermore, as the purpose of narrative inquiry is to capture significant detail from participants’ life experiences, unique information which may be identifiable were generalised, including names of parts and demographic information. All data were securely stored electronically using password-protected systems, with identifiable information maintained separately from sensitive data such as audio transcriptions. All documentation was stored in a password protected format and passwords were unique to each participant. Only the primary researcher had access to these passwords. Participants were also given the explicit choice to decline answering any interview questions they deemed too personal or sensitive, thus upholding and respecting their autonomy.

Data Storage and Privacy

Identifiable information, including email addresses, home addresses, phone numbers, and names, was stored in a distinct electronic Excel file in a secure, password-protected format. Access to this data was restricted to the primary researcher. Pseudonyms assigned to each participant were stored in a separate password-protected document to further anonymise their data. Interview recordings were encrypted and used exclusively for transcription and analysis; the recordings were deleted from the device once transcribed. All transcripts, audio files, and forms were stored securely, detached from any identifiable information.

Informed Consent and Withdrawal

Participants in this research had often experienced significant trauma, abuse and coercion. The research design recognised the potential for participants to feel obligated to participate due to their histories of disempowerment and power imbalances (Barlow, 2007). Consent was consistently referred to as voluntary and consent forms acknowledged that participants may need sufficient time to ensure that all dissociative parts had been consulted in the decision-making process. Consent was also sought at two stages (prior to the pre-interview and prior to the main interview) to encourage participants to revisit their decision and reconsider consent at different points in the process. Consent was also verified and explored within the pre-interview discussion to address the complexities of dissociative systems, including the potential for internal disagreement among dissociative parts regarding participation. If any dissociative part expressed opposition, their needs and perspectives were accounted for in the tailored distress protocol and when considering the participation of the whole system. During the pre-interview, many participants disclosed various methods they had drawn upon to ensure that all their dissociative parts had contributed their perspective in the final decision to participate. Participants reported strategies such as holding internal system meetings and inviting dissociative parts to share their perspectives through shared ‘notice boards’. Participants were informed of their right to withdraw at any stage prior to data analysis and write-up. Capacity to consent was verified during the pre-interview meeting and dynamically assessed throughout the whole research process, drawing upon the researcher’s clinical skill and guidance from the clinical research supervisor.

Safeguarding Considerations

Interviews were conducted online through Microsoft Teams videoconferencing platform. The location address from which the participant was conducting the videocall was recorded at the pre-interview stage to ensure safety protocols could be effectively enacted if needed. The primary researcher had direct access to the safeguarding team within their university for guidance and support, in addition to their supervisory team. The tailored safety protocol clearly outlined the circumstances under which emergency services would be contacted in the event of an imminent safety risk which was pre-agreed and discussed with the participant in the pre-interview. To prevent potential harm, interviews were promptly discontinued, and the established protocol was enacted if participants exhibited signs of disorientation, amnesia, or significant emotional distress.

Minimising Risk of Psychological Harm

It was anticipated that discussing past traumas and dissociative experiences could evoke distress. Recruitment documentation explicitly acknowledged that openly discussing personal experiences may elicit overwhelming emotions, which may be unavoidable. The research design adopted a trauma-informed approach to empower both participant and researcher to collaboratively anticipate, plan and manage these risks proactively (Barlow, 2007; Campbell et al. 2019). The pre-interview explored participants' emotional triggers, warning signs and effective personal coping strategies. Participants were encouraged to identify the unique emotional needs of key dissociative parts and to consider which parts may require extra support, guidance and consideration. The pre-interview also identified personal and professional support contacts whom both the participant and researcher could call upon for additional support. All this information was summarised in the tailored safety protocol. To adhere to trauma-informed principles, empowering participants was a central tenet of this study. Interview questions were provided in advance to allow for emotional preparation. Participants were regularly reminded of their right to withdraw or pause at any stage. The pre-interview process focused on building rapport, familiarity and trustworthiness and establishing a collaborative working alliance, which was considered to be particularly pertinent to people with DID (Sinason, 2002). Breaks were encouraged to mitigate emotional strain, and clinical expertise was drawn upon to respond to signs of discomfort.

The standardised rating scale system ensured all participants had access to effective social support, presented with low or managed psychological risk and that participants had demonstrated some ability to manage distress and dissociative switching independently. In two cases, an additional contingency measure was implemented for participants presenting with higher risk factors whereby, with their consent, their therapist played a more active role in supporting their participation. For instance, the researcher liaised with the therapist before and after the main interview and the main interview occurred on the same day as their scheduled therapy session. The tailored distress protocol ensured that measures implemented to reduce psychological risk were person-centred. Emergency services involvement was considered only when immediate risk of harm was identified and when other support avenues had been attempted and considered. However, there were no instances in which emergency services needed to be contacted.

Managing Researcher Psychological Safety

The emotionally demanding nature of absorbing participants' stories necessitated measures to safeguard the psychological well-being of the primary researcher. The primary researcher had access to regular research and clinical supervision. The researcher also accessed professional peer support groups and resources through their student membership with the ESTD-UK. Reflexivity was a key aspect of the research process, a self-reflexive research journal was kept, fostering emotional resilience. Regular consultation with an expert by experience provided valuable insights and reassurance throughout the design and implementation of the research. To further enhance clinical competencies, the researcher attended various ESTD-UK training programmes and courses which were funded through the research budget. Furthermore, the researcher's professional development through the Clinical Psychology Doctorate course also enabled generic development of clinical skill in working with trauma and dissociation through placements and clinically informed teaching.

Recruitment and Sampling

Participants were primarily recruited through a referral-based purposive approach facilitated by clinicians who work therapeutically with people with DID. An information sheet tailored to clinicians (Appendix E) was disseminated through therapist mailing lists associated with specialist clinics in England and the European Society for the Study of Trauma and Dissociation (ESTD-UK). The information sheet included guidance on the suitability criteria and research procedure. Clinicians were also provided with a participant information sheet and poster advert to share with clients whom they deemed potentially interested and suitable for participation (Appendix F). Subsequently, potential participants contacted the researcher directly to express interest in taking part. In some instances, clinicians contacted the researcher directly, recommending clients they believed met the inclusion criteria and had expressed an interest to participate. Following this, the researcher reached out to these clients after receiving permission to do so. Additionally, some participants were recruited through the consulting expert by experience who shared study information with their professional network of other experts by experience with DID. Participants recruited via this route approached the researcher directly after being informed about the study.

This recruitment strategy utilised both clinical and lived-experience networks, ensuring participants were introduced to the study through trusted intermediaries. This purposive strategy enabled access to people with DID who had engaged with DID-focussed therapeutic treatment and who had a formal diagnosis of DID. Participation was entirely voluntary, and potential participants retained the right to decline involvement without any impact on their therapeutic relationships or other affiliations. Confidentiality was maintained throughout the recruitment process and consent was obtained prior to any sharing of information that occurred between the potential participant and their clinician. A total of 22 individuals expressed interest to participate with the research, of which 14 participants engaged with the pre-interview, and all were deemed suitable. The remaining eight participants were not selected as they had expressed interest to participate after the data collection period had ended.

Participants

Screening

Participants were initially screened using a self-assessment questionnaire (Appendix G) designed to empower them to evaluate their own suitability and willingness to participate in the research. A second layer of screening was conducted through the pre-interview, which allowed the researcher to develop an understanding of the participant, drawing upon a person-centred approach. Screening information was quantified using rating scales completed by the primary researcher in collaboration with their clinical research supervisor (Appendix L). These scales were informed by data collected from the initial screening questionnaire and the pre-interview, which included a brief risk assessment. This step was implemented in accordance with ethical protocols specified by the Wales REC 4 Research Ethics Committee, to safeguard participant well-being by ensuring suitability for the study.

Three rating scales were utilised, assessing distress management, level of support, and risk, which corresponded closely to the inclusion and exclusion criteria (Appendix K and L). Participants were categorized as level 1, 2, or 3 on each scale. Participants rated as level 1 across all scales were deemed suitable for inclusion. Those rated level 2 for risk but level 1 for distress management and level of support were also deemed suitable. Similarly, participants rated level 2 on either distress management or level of support were deemed eligible if they achieved a level 1 rating for the remaining scale and for risk. For participants rated level 2 on support, additional measures were implemented to involve their professional support contact (typically a therapist) in the safety planning process for their research involvement. The screening process and rating scales were designed to be person-centred, inclusive and trauma-informed (Barlow, 2007). For example, the process accounted for the fact that risks such as self-harm or amnesia are common among trauma survivors (Van der Kolk, 2014) and can be effectively managed throughout the research process, depending on the participant's internal and external resources. Following the pre-interview, a safety protocol plan (Appendix M) was devised detailing the participant's unique support needs and specifying tailored measures undertaken to ensure their psychological safety throughout the process.

Inclusion Criteria

Eligible participants were formally diagnosed with DID through either NHS services or private clinics, utilising the SCID-D interview or an equivalent validated assessment tool. Participants were required to reside in the United Kingdom and have engaged in specialist therapy for DID (as defined by the criteria outlined below) for a minimum of two years. Additionally, participants were required to have access to robust personal and professional support systems that they regarded as effective and reliable. Participants were also asked to provide details for both a personal and professional contact who were aware of their participation in the research. Eligibility further required participants to demonstrate adequate distress management and coping skills in the pre-interview meeting, which enabled them to independently manage distress without requiring significant external support. Furthermore, participants were required to present as having mental capacity and present with low psychological risk or a risk that was well managed and had not necessitated recent hospitalisation.

Criteria for Specialist DID Therapy

Participants were required to have engaged in therapy which focussed on their DID-related experiences for a minimum of two years. This criterion was developed in collaboration with the consulting expert by experience and in response to ethics committee requirements, which advised a standardised benchmark while recognising that therapy length alone is not the sole indicator of suitability. ISSTD treatment guidelines suggest that DID therapy is typically long-term, often extending five years or more (ISSTD, 2011). A two-year minimum was therefore set to balance these recommendations with barriers to accessing specialist services, and to acknowledge that many participants had already undertaken therapy prior to receiving a DID diagnosis. Specialist DID therapy may have involved the following components:

- Exploration of dissociative parts: Participants must have engaged in therapeutic work aimed at understanding the presence, needs, and experiences of dissociative parts within their system.
- Development of internal cooperation: Therapy should have facilitated the development of skills for fostering internal collaboration. The participant should be able to employ these skills to reach as much internal consensus as possible regarding participation in this research, ensuring that the needs and perspectives of their system were considered to meet the requirements for informed consent.
- Strengthening of daily life functioning parts: Participants should have developed the robustness of parts responsible for daily functioning, who may safely take a lead in participating in this research. They should also have worked on their ability to soothe or manage younger or high-risk parts effectively.
- Internal communication and distress management: Therapy should have fostered strategies for managing internal communication and distress, enabling participants to

navigate switching and internal conflicts, without requiring excessive external support or experiencing a significant increase in risk.

Therapeutic engagement and readiness to participate were verified during the pre-interview stage by attuning to participants' ability to manage distress and risk and utilise social support effectively.

Exclusion Criteria

Participants were excluded if they were under the age of 18, did not speak English, or lacked an alternative method to communicate in-depth information. Participants were excluded if they did not have a diagnosis of DID. Furthermore, the development of the exclusion and inclusion criteria accounted for the fact that DID presentations exist on a spectrum of functionality, which can vary depending on an individual's stage in their therapeutic journey. Therefore, individuals identified as particularly vulnerable at the time of screening were excluded from the study. This included individuals presenting with significant risk factors, such as a lack of mental capacity, high levels of amnesia associated with substantial harm, current and known experiences of abuse, or safeguarding concerns. Participants who had been hospitalised for mental health concerns such as severe self-harm or suicidality within the past year were also excluded. Participants were additionally excluded if they had not engaged in sufficient therapeutic work (as outlined by criteria above) to develop an understanding of their dissociative parts and to manage psychological risk. Participants who lacked sufficient social support, both personal and professional were excluded. Suitability based on these risk factors was assessed using rating scales completed after the pre-interview. Finally, participants who declined to engage in the pre-interview process were also excluded.

Sample Demographics

Out of the 14 participants who engaged with the pre-interview, 12 participants engaged with the main interview and comprise the sample for this study. The 13th participant requested their therapist to be present during both interviews. They were deemed suitable with this reasonable adjustment in place. However, they withdrew their participation due to personal circumstances. The 14th participant reported that their personal circumstances had changed after completing the pre-interview and they felt they were no longer able to safely complete the main interview. To protect participants' privacy and maintain anonymity, demographic data are presented below in aggregate form rather than linked to individual participants (Table 3). This approach ensures confidentiality while still capturing the diversity of the sample. Demographic data were collected using a demographic questionnaire, which contained open text boxes to enable participants to define their identities in their own words.

Table 4

Sample Demographic Characteristics

Demographic category	Summary of 12 participants
Age range (years)	19-74 (Average: 46.5)
Gender identity	9 female/partly female; 6 with male parts; 3 genderfluid/genderqueer/non-binary. Systems included alters with varied genders.
Preferred pronouns	Varied: she/her, they/them, he/him, us/we; Multiple systems reported part-specific pronouns.

Ethnic identity	9 White British (1 self-defined as Celtic European), 1 White European, 1 White American, 1 White Polish
Country of birth	9 England, 1 Scotland, 1 USA, 1 Poland
Spiritual and religious identity	5 Christian or raised Christian (parts vary), 5 Atheist or Humanist (2 have spiritual beliefs, 1 has parts with Christian faith), 2 Ritualistic magic and Witchcraft (parts vary).
Marital and relationship status (at data collection)	5 married, 3 long-term relationship (1 engaged), 4 single (2 previously married)
Employment status	7 full-time, 2 part-time, 1 retired, 1 unemployed, 1 voluntary work only

There were significant variation and individuality in participants' gender identity. Most (N=9) participants identified as female or female in some capacity, with some participants (N=6) reporting that they had some male parts. Some (N=3) participants identified as genderfluid, genderqueer or non-binary with their parts having their own unique gender identities. Systems often had dissociative parts that vary in gender identities, including male, female, non-binary, agender, and more.

Participants expressed a broad spectrum of religious and spiritual identities. Some participants identified as Christian or were raised with Christian beliefs and traditions. Others were atheists, humanists, or have complex or evolving spiritual beliefs. Some systems have parts practicing witchcraft, ritualistic magic, or polytheistic traditions. Many systems conveyed internal variation between dissociative parts in spiritual, faith or religious beliefs. For many, spirituality was shaped by upbringing but redefined over time, with some parts maintaining inherited beliefs while others rejected or reinterpreted them.

Initial Contact and Pre-Interview

The primary researcher contacted potential participants directly via email either after they initiated contact or following the receipt of their details from their therapist. Upon invitation, participants were provided with a comprehensive version of the participant information sheet (Appendix F). Those interested in proceeding were asked to sign a consent form for participation in the pre-interview, along with the self-screening questionnaire (Appendix H).

Once the consent form and self-screening questionnaire were received, participants were invited to the pre-interview. This additional interview adhered to the recommendations and guidelines approved by the Wales REC 4 Ethics Committee, to address concerns about ensuring the psychological wellbeing of participants and management of risk. The pre-interview also adhered to the ethical principles outlined by the American Psychological Association (APA, 2017), which emphasise respect for autonomy, informed consent, and minimising potential harm to participants (Barlow, 2007). The pre-interview schedule ensured that participants had full knowledge of the study’s purpose and potential risks, in line with APA ethical recommendations. This initial virtual meeting, conducted via Microsoft Teams video conferencing software, lasted approximately 60 to 90 minutes. To ensure a transparent trauma-informed approach (Waddell-Henowitch et al., 2024), participants received a brief written summary (Appendix I) outlining the structure and expectations for the pre-interview, including information about the meeting schedule. During the session, the researcher took notes instead of recording the session to promote rapport-building and foster a sense of safety in the virtual space. The pre-interview served as an opportunity to collaboratively explore risk management and foster partnership, preparing both the participant and researcher for the main interview. Throughout the pre-interview process, participants' choice about the personal information they shared was emphasised. They were treated as experts in their own psychological needs, with their autonomy and preferences respected throughout the process.

Following the pre-interview, the primary researcher developed a tailored safety protocol based on the discussion (Appendix M). Participants were provided with a password-protected copy of this document, alongside an invitation for them to propose amendments or provide feedback to ensure the protocol was collaboratively developed and personally meaningful. This document functioned as a practical reference of both the researcher and participant's role in ensuring psychological safety during the main interview. The pre-interview schedule (Appendix J) corresponded to items on the tailored safety protocol, with the addition of some items which enabled the researcher to gain a deeper understanding of the participant's needs and suitability. The tailored safety protocol outlined key aspects relevant to the participant's unique needs, including:

- Triggering content and language.
- An introduction to their system and their parts, such as names and characteristics.
- The participant's preferred terminology such as how they preferred the interviewer to refer to their dissociative parts (e.g. 'parts' or 'alters' or 'self-states' or 'identities').
- Information about parts that may or may not participate (e.g. younger parts who may not understand the concept of taking part).

- Non-verbal and verbal indicators of increasing distress and switching. Collaborative strategies to manage distress.
- Contingency plans for managing technical interruptions and virtual disconnections.
- Contact information for additional emotional support, including identifying trusted individuals available to assist after the main interview, considering therapist availability, and collaboratively agreeing when external support is necessary.

The pre-interview also provided an opportunity to discuss the format of the main interview and address or troubleshoot any concerns participants might have at that stage. It enabled the researcher and participant to establish a collaborative working alliance and build positive rapport. To foster trustworthiness and transparency, participants were also provided with the option to ask the researcher questions about their clinical and research background (Barlow, 2007).

Many participants reported that the pre-interview process was valuable in navigating the interpersonal challenges of the main interview. For example, during the main interview, the interviewer's need to encourage participants to share their stories without offering social input could be challenging. Participants noted that the opportunity to connect with the researcher during the pre-interview fostered trust, helping them to manage anxieties associated with these challenges.

The Main Interview

Following the pre-interview, the researcher consulted their clinical research supervisor to review anonymised participant information and confirm eligibility using the standardised rating scale system (Appendix K and L). Upon confirmation of suitability, participants subsequently received an email confirming their progression to the next stage of the study, which involved preparation for the main interview.

During this preparatory phase, participants were asked to sign a second consent form for their continued participation, including the main interview (Appendix N). Participants were also requested to complete an optional demographic questionnaire, linked only to their assigned pseudonym and participant number (Appendix O). Although completion was voluntary, all participants chose to complete the questionnaire in full. Following these steps, a mutually agreed date and time for the main interview was established. A pre-briefing summary guide was then sent to participants in advance (Appendix P), enabling participants to psychologically prepare themselves, providing them with sufficient time and information to orient themselves to the process (Barlow, 2007).

The primary objective of the main interview was to explore participants' subjective experiences of living with dissociative parts and their sense-making processes within the context of their broader DID experiences. Interviews, conducted via Microsoft Teams videoconferencing platform, ranged in duration from 90 minutes to 135 minutes and were recorded using the platform's recording feature. Conducting interviews online allowed for the inclusion of participants from diverse geographical locations in the United Kingdom, thus broadening the scope of the sample.

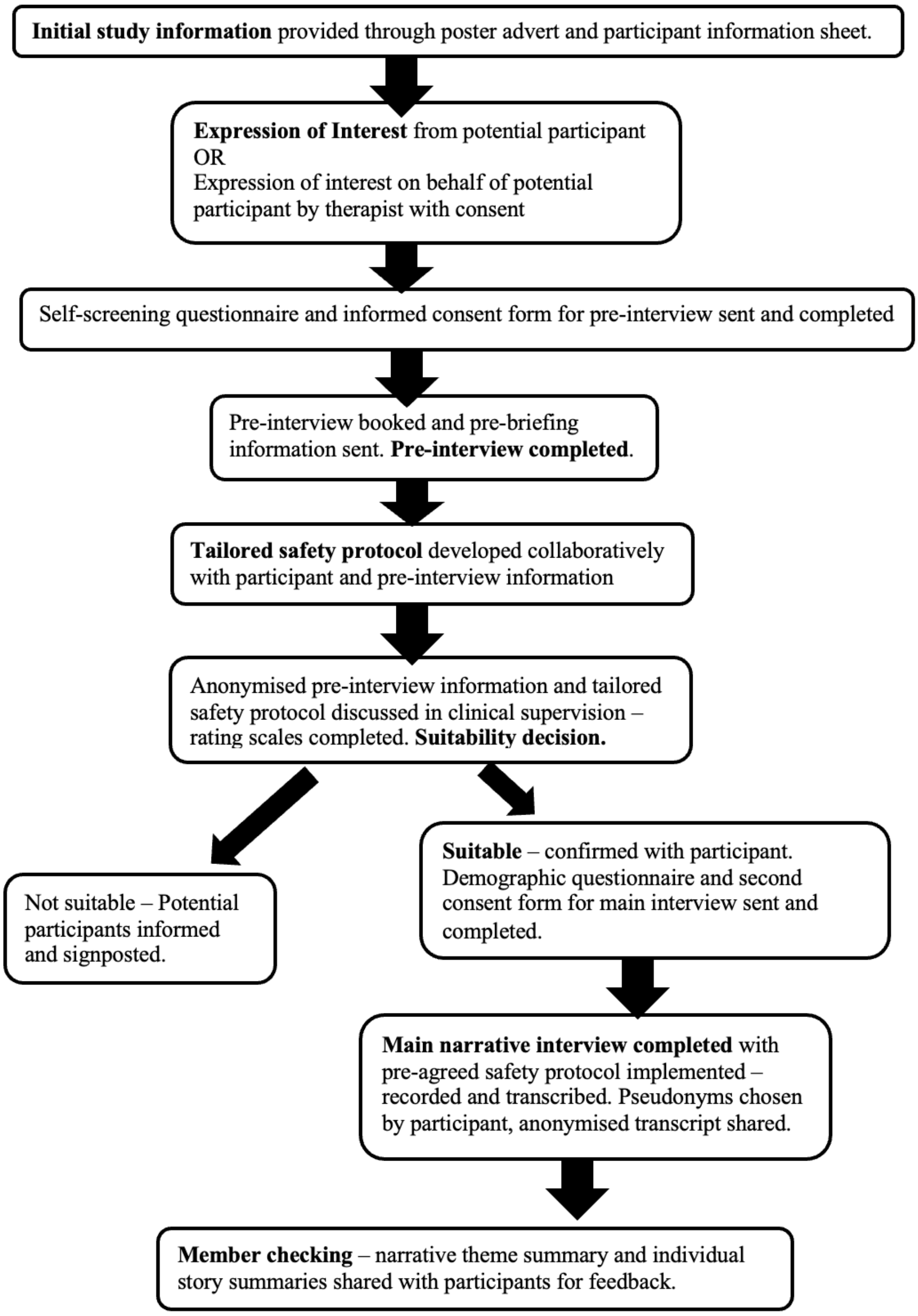
The interviews were guided by a narrative inquiry methodology (Jovchelovitch & Bauer, 2000), emphasizing the subjective perspectives and personal experiences of participants. This approach allowed participants to determine the direction, language, and pacing of the conversation. Minimal intervention was provided by the interviewer unless explicitly requested by the participant. Each session began with a pre-briefing that included a review of the tailored safety protocol. The protocol was adhered to throughout the interview to minimise the risk of psychological harm and to promote psychological safety. For instance, topics that participants had pre-identified as distressing were avoided. Participants were reminded of their autonomy, including their right to request breaks, pause or stop the interview at any time, and decline to answer specific questions without justification. The pre-interview process often included an exploration of how participants preferred switching to be managed and facilitated during the main interview. When pre-agreed, participants were supported to allow different parts to come forward and share their perspectives and stories. The pre-interview discussion established which parts were not suitable to take part in the interview and which parts had capacity to actively participate. The pre-interview usually involved a brief introduction about the main parts in the system. Therefore, the interviewer was able to draw on this understanding when interacting with parts directly in the interview, adopting a tailored approach. This approach included tailoring the interviewer’s interactions based on the presenting part’s age, cognitive ability and emotional state. The interviewer ensured that each dissociative part’s contributions were acknowledged with sensitivity, recognising the significance of each part’s voice in shaping the participant’s overall story. The interviewer maintained a trauma-informed and non-directive stance, allowing the conversation to flow naturally while ensuring that participants felt supported and respected throughout.

The interview commenced with the narrative phase, initiated by a broad, open-ended prompt: "*I am interested in how your dissociative parts/alters shape and impact your everyday life and how you came to understand them. Can you tell me about this? You can start wherever you like.*" Participants were then encouraged to share their response to this prompt in story format in as much detail as they felt comfortable, without pressure to address specific topics. Participants spoke for different lengths of time during this phase, ranging from durations of fifteen minutes to one hour. Once participants reached a natural stopping point, they were invited to progress to the follow up question phase. In this phase, participants were asked open-ended questions to elicit further elaboration on what they shared in the narrative phase in greater depth. Questions focused on "what," "how," and "when," avoiding "why" to ensure that questions did not shift focus to justification or elicit defensiveness (Jovchelovitch & Bauer, 2000). Narrative inquiry also understands that ‘why’ questions can disrupt the flow by steering the conversation in a direction that might not align with the participant’s natural storytelling. Follow-up questions explored themes such as how dissociative parts influenced therapeutic journeys, relationships, employment, health, identity, daily functioning, and participants’ evolving understanding of their dissociative parts. The duration and depth of this phase varied according to the content shared during the narrative phase and the participant’s preference.

Following the conclusion of the follow-up phase, the recording was stopped, and a debrief was conducted. This allowed participants to reflect on their experiences during the interview and provided an opportunity for the researcher to respond authentically to participants’ narratives. Many participants reported initial apprehension about how their stories were received by the researcher, which was alleviated during the debrief. Participants were also invited to select pseudonyms for themselves and their dissociative parts, ensuring their autonomy in identity representation. Finally, participants were briefed on the next steps in the research process. They were informed about an upcoming check-in email from the researcher, which would also include a small £10 Amazon voucher as a token of appreciation. Participants were also reminded of the future opportunity to review their interview transcripts, narrative summaries and final narrative themes as part of the member-checking process (Birt et al., 2016).

Figure 2

Flow diagram for recruitment, screening and interview processes



Data Analysis

Rationale

This study employed thematic narrative analysis (TNA), as outlined by Reissman (2008). The methodology aimed to explore the content of personal stories of living with dissociative parts in DID, whilst also examining how participants construct, communicate and make sense of their experiences. This methodology aligns with the research aims and is grounded in phenomenology, prioritising first-person experience, subjective reality and sense-making over time (Andrews et al., 2013).

Thematic analysis (Braun & Clarke, 2006) is a widely used qualitative approach which involves the identification of content-driven themes across datasets. TNA incorporates elements of traditional thematic analysis (Braun & Clarke, 2006), similarly focussing on content, yet it preserves the full context of each personal story. Unlike traditional thematic analysis, which fragments data into decontextualised codes following line by line coding, TNA develops codes from large chunks of texts within whole narratives, which are embedded in broader context and patterns. Grounded Theory (Charmaz, 2006) methodology aims to develop new theoretical models from data, through constant comparative analysis. Grounded Theory is less suited to studies that seek to explore subjective experience and personal meaning-making. Furthermore, it places less emphasis on participant voice and preservation of individuality. Interpretative Phenomenological Analysis (Smith et al., 2021) involves in-depth thematic coding and analysis of a small number of cases, focussing on personal lived experience. While this methodology offers valuable insights into subjective experience, it does not examine narrative construction. Frank (1995) highlights that stories must be analysed in ways that reflect the experiences of storytellers. DID narratives, influenced by the impact of trauma, are likely to be fluid, non-linear and deeply personal, requiring an analytical approach which values both individual meaning-making and shared experiences such as TNA (Staniloiu & Markowitsch, 2012). Given the complexity, richness and nuance of narratives in DID (Parry et al., 2018; Zeligman et al., 2017), it was essential to adopt a methodology that prioritised meaning-making and depth of analysis. Although other qualitative methodologies provide valuable frameworks for analysis, they often involve fragmentation of data, losing the integrity of whole personal stories (Reissman, 2008). Therefore, they do not account for the dynamic interplay between narrative structure, content, and personal meaning-making as effectively as TNA.

TNA examines the interaction between thematic content and narrative form, such as disrupted coherence, metaphorical language and temporal order, which can reveal deeper insights into lived experience (Frank 2010). Analysis of storytelling features also enables disruptions, temporal shifts or conflicting perspectives of parts to be treated as meaningful aspects of the narrative rather than as deviations. By examining 'what is said' through story content, in line with 'how it is said' through storytelling features, this study aims to uncover both explicit and implicit meanings in participants' narratives (Reissman, 2008). This is particularly relevant to individuals with DID whose internal experiences are often concealed and unobservable (Dorahy et al., 2014; Howell, 2011). TNA preserves the holistic integrity of narratives and individuality of participants' experiences, whilst extracting broader patterns which may inform clinical practice and understanding. TNA ensures that meaning-making, changes over time, and subjective experience remain central to the analysis, which is well-suited for the research aims, participant group, and epistemological position.

Thematic Narrative Analysis Methodology

The main interview was divided into two phases; the open narrative phase and the follow up question phase. Audio-recorded interview data were transcribed verbatim, adhering to Reissman's (2008) guidelines to preserve the richness of the narrative and to contextualise the process of narrative construction. This involved documenting not only the spoken content but also non-verbal elements such as pauses, utterances (e.g. 'um...') and poignant emotional states (e.g. laughter and tearfulness). The transcription process enabled the researcher to begin the process of immersing themselves in the data. Transcripts were read and re-read to deepen understanding of the context, flow and content of participants' whole stories. This immersion facilitated the identification of initial impressions regarding key themes, unique storytelling features and structural patterns, which informed subsequent stages of analysis.

The first phase of data analysis involved an examination of how each participant told their story, focussing particularly on the open narrative phase. Each interview was read as a whole, identifying story structure, emotional tone, key turning points, narrative coherence and flow, whilst examining the presence of disruptions or temporal shifts which indicated dissociative processes. The researcher took a reflexive approach when attending to whether participants' dissociative parts influenced narrative coherence or tone without problematising this storytelling. The researcher also took note of linguistic markers such as metaphors, repetition, shifts in pronouns and how the experience of dissociative parts was expressed or narrated within stories. Broader social contexts and frequently used metaphors which were included by participants were also considered. A brief narrative summary was created for each participant, to honour and preserve the integrity of their story, which are presented prior to narrative themes in the findings chapter. Brief codes were developed pertaining to these features within each story, drawing upon guidance for analysing storytelling features, outlined by Reissman (2003). Subsequently, narratives were organised into three major temporal segments, providing context for thematic codes developed later in the analysis process and informing the development of narrative themes. These segments were ‘pre-awareness’, ‘recognition and crisis’ and ‘adaptation and understanding’.

To facilitate the process of coding and theme development, this study utilised Quirkos, a qualitative data analysis software designed to support the organisation, visualisation and interpretation of qualitative data. The use of Quirkos aligned with the TNA methodological approach (Reissman, 2008; Ting et al., 2024) by enabling an interactive, intuitive means of exploring participant stories. Once each transcript had been analysed as a whole, identifying structural features and organised into narrative segments, they were then imported into Quirkos for the thematic coding phase. The software’s live colour-based coding feature enabled an immersive and dynamic engagement with the data, maintaining a visual representation of emerging patterns. To enhance reflexivity, the memo function of Quirkos was used to document the researcher’s reflections throughout the coding process.

Within each narrative segment of each transcript, the researcher developed thematic codes by identifying recurring content which emerged across participant stories, in accordance with Reissman’s guidance (Reissman, 2008). It was acknowledged that some thematic codes reoccurred in multiple narrative segments, highlighting context for the final development of narrative themes. The categories function of Quirkos enabled each code to be assigned to a narrative segment. This phase of data analysis focussed on the content of narratives. Data was coded for emergent topics which were then grouped into broader categories. Codes were developed inductively, emerging organically from the data. The researcher upheld reflexivity throughout, enhancing awareness of bias in interpretations and considering their role in shaping the data, such as how follow-up questions or interpretations may have influenced participant narratives. At this stage, the researcher examined the data for similarities and differences between participants' stories and began considering how structural features interacted with thematic content.

The final phase of analysis integrated thematic codes with storytelling features to develop six narrative themes (Appendix S). Quirkos facilitated the process of identifying thematic clusters, which enabled thematic codes to be combined in accordance with their corresponding narrative segment to form the final narrative themes. The final thematic structure conveyed a story which reflected the collective narratives of all participants, informed by narrative segments and illustrating how participants narrated their parts. Themes were refined by comparing across participants to present a holistic interpretation of the data. This involved re-examination of the data, moving between individual stories and broader themes, exploring how each person's unique journey reflected or deviated from the final narrative themes (Bamberg, 2012). This analytical approach honoured the complexity of participants' lived experiences as it identified shared experiences across participants, whilst preserving the structural and emotional integrity of each personal story (Reissman, 2008).

Furthermore, narrative research guidance recommends that participants should retain agency in the representation of their stories to ensure the research is ethical (Chase, 2008). Member checking is common practice in qualitative research but is especially pivotal in TNA as it allows participants to validate, clarify or challenge researchers' interpretations. Therefore, participants were invited to provide feedback on their narrative summaries and final narrative themes. The researcher incorporated feedback and advice from participants when consolidating themes, particularly pertaining to language sensitivity. Member checking is believed to enhance validity as it acknowledges participants' role as co-authors in shaping their own data (Bamburg, 2012).

Chapter Four: Findings

Participant Story Summaries

This section presents a brief, co-created summary of each participant’s interview narratives, honouring the individuality of their systems and stories. While the subsequent analysis identifies shared patterns across accounts, it is important to begin by highlighting the distinct internal processes, structures and dynamics that shaped each participant’s system. These introductory vignettes aim to preserve the integrity and uniqueness of each participant’s lived experience. A more detailed story summary, including descriptions of their parts, is provided in Appendix R.

Olivia’s Story

Olivia’s system comprises up to 29 parts and they are somewhat co-conscious. She experiences her parts through internal voices, emotions, and energetic shifts. Her narrative was non-linear, often shifting between past and present, and she spoke fluidly, reflecting spontaneously without pre-prepared notes. Olivia’s history includes hospitalisations, misdiagnoses, and somatic symptoms such as seizures and an eating disorder—now understood as linked to her parts and trauma. A turning point in understanding her system came when she accessed her mental health clinic notes and realised over time that her father wasn't who she thought he was, leading to a painful realisation about suppressed memories.

Emma’s Story

Emma has worked to create an egalitarian system where all parts contribute to daily life. They experience their parts through auditory and symbolic communication, often via artwork or writing. While their system was not always fully co-conscious, awareness has improved over time. Emma grew up with parents carrying their own trauma and experienced medical trauma themselves. After moving to the UK in their twenties, they described living a double life, with some parts flourishing, while others struggled. Although initially hard to accept, the DID diagnosis helped them move from denial and shame to acceptance and cooperation. Emma spoke without pre-prepared notes; her narrative was non-linear and rich with metaphors. During the interview, the part speaking on behalf of the system was referred to as Emma. However, they noted that this is the system name rather than the name of a specific part.

Riquitta's Story

Riquitta's system consists of 14 parts and is not co-conscious, meaning she does not recall what happens when parts take control. Her parts primarily communicate through journaling, each with distinct handwriting. Riquitta's storytelling was free flowing, delivered without pre-prepared notes, and loosely followed an arc from crisis and realisation to part discovery. She first became aware of her parts after finding boxes under her bed containing objects belonging to each part. A central figure in Riquitta's narrative was her care-coordinator, who modelled compassion by engaging directly with each part. Riquitta's story was marked by grief and anger over losses caused by DID, including her high-profile NHS career, memories, and relationships. Although she received five years of DID-focused therapy, funding has since been cut, leaving her feeling let down by the mental health system.

Eloise's Story

Eloise's system functions through subsystems, co-consciousness, and co-hosting, ensuring multiple parts are always present, which means they do not lose significant time or memory. Her storytelling was shaped by shifting perspectives, metaphorical language, and a non-linear structure. To stay on track, she had the interview guide and prompts printed in front of her. She frequently referenced her parts' dynamic contributions throughout the interview. Eloise spoke about past trauma related to her father's military involvement, which led her to seek therapy. However, EMDR caused flooding and overwhelmed the system. Struggling to access appropriate therapy, she focussed on piecing herself together rather than working toward integration, despite wanting to become one person.

Lauren's Story

Born into a family involved in organised crime, Lauren's system has developed co-consciousness over time, but continues to experience some amnesic barriers, particularly between organic and installed parts. Installed parts were deliberately created, named, and assigned roles by abusers, while organic parts developed naturally to support the system. Lauren described a hierarchy led by five child parts who controlled internal communication. Their system was divided, whereby organic parts managed daily life and installed parts handled abuse-related demands. Extreme abuse was used to reprogramme parts and ensure compliance. Lauren's storytelling was fluid, metaphorical, spontaneous, and non-linear, following an arc of survival, loss, and transformation. A key figure was her compassionate therapist, who treated all parts with equal respect and negotiated with installed parts to help them recognise danger and empowered them to escape abuse. With safety and therapy, the system began a journey of transformation where installed parts took on new roles, and leadership shifted toward a more democratic system.

Ellie's Story

Ellie's system comprises of over 20 parts and is structured into three clusters: daily life, trauma, and child parts. As a survivor of extreme organised abuse, Ellie recalled feeling unseen by professionals, teachers, and society. Her system is not fully co-conscious which means when one part is fronting, others are often unaware or lack memory access. Ellie experiences her parts auditorily, energetically, and through synaesthesia, allowing her to sense their emotions as colours even without direct co-consciousness. Parts mainly communicate within their clusters, with some parts bridging groups. Ellie's system has developed strategies to improve communication, including video notes, Alexa messages, and daily logs. Ellie explained how her autism influences her system's structure and sensory responses, with autistic traits and degree of masking varying across parts. Ellie's storytelling was reflective and non-linear. She often needed prompts, referred to pre-prepared notes, and took time to gather her thoughts. Her story highlights how she navigates DID through structure, transforming chaos into organisation by drawing on her neurodiversity.

Julia's Story

Julia's system is mostly co-conscious, with several parts working closely and sharing awareness. Over time, the system has undergone significant changes, including part fusions and multiple host transitions. Julia experiences her parts through auditory, energetic, and visual communication, relying heavily on her internal world. They described misdiagnoses and mental health crises, linking these to specific parts' needs. Their storytelling was metaphor-rich, perspective-shifting, and non-linear, but follows an arc of discovery, crisis, and growth. Julia spoke freely, using internal communication for prompts. Toward the end of the interview, she switched, allowing another part, Juno, to share her perspective and contributions. Key figures in Julia's life include their children and their romantic relationship with another system. Although complex dynamics arose from this romantic relationship, Julia noted how interactions with their partner's system were integral for growth and transformation within their own system.

Catherine's Story

Catherine's system is hierarchical and co-conscious, allowing multiple parts to remain aware simultaneously. She experiences her parts through auditory, energetic, and sometimes visual communication, often relying on their internal world. The interview was led by Jessica, a protector part, speaking on behalf of the system, with Cath also present and co-conscious. Jessica acknowledged other parts in real time, including Alex, who was present and watching. Their storytelling followed a structured yet non-linear arc, shaped by late system discovery, professional misdiagnosis, and internal collaboration. They described the system as covert and high functioning, having never presented to services with external crises. Catherine became aware of their system after a series of compounded bereavements and external losses which led to a breakdown in functioning. Their first therapist was supportive but lacked DID-specific knowledge. The early stages of discovery were self-directed during the COVID lockdown, later transitioning to work with a specialist therapist.

Columbia's Story

Through the process of mapping, Columbia discovered over time that their system includes over 90 parts, many of whom are not yet fully known. Her system is capable of co-consciousness, where some parts front seamlessly while others take full control, resulting in blackouts and lost time. When co-conscious, communication occurs through internal voices, energetic presence, and physical sensations. The interview was co-led by Columbia and Silas. Silas switched in, with Columbia's agreement, at moments where their leadership or perspective was most relevant. Their storytelling was fluid and vivid, following a structured yet non-linear arc shaped by confusion, discovery, and collaboration. After a series of unhelpful therapists, a turning point came with their current therapist, who built unique relationships with individual parts. A pivotal moment in their story was when Columbia disappeared into a sub-world for a year and could not be found. During this time, Silas managed their job and fought to keep them alive through ongoing trauma. This experience, though born from crisis, transformed their relationship which was once marked by conflict.

Laika's Story

Laika's system is structured and organised, made up of sub-systems focused on daily life, trauma-holding, protection, and care. Laika describes their system as both co-conscious and co-fronting, where parts witness and share in managing daily life. They experience parts through auditory thought-forms, energetic presence, and physical sensations, relying heavily on their internal world. Their internal world is vivid, with emotion-driven weather, designated safe zones and an internal social media system where parts use mobile phones to aid communication. Laika's storytelling was rich, temporally fluid and non-linear but structured around pre-prepared notes following a journey of self-discovery, acceptance, and healing. Laika is a survivor of severe organised abuse and, despite early denial, recognises that their system was overt and detectable from as early as age five. Their experience of identity is fluid and shaped by the diverse genders and sexualities of their parts. Laika identifies as a transgender man undergoing medical transition, but experiences internal gender fluidity, identifying as genderqueer when reflecting the experience of the whole system. Similarly, their sexuality has fluctuated due to host changes, affecting romantic relationships. Laika also described how their autism interacts with their DID, with parts expressing autism differently based on their unique characteristics and traits.

Rachel's Story

Rachel's system is highly fluid and energetic, rather than being made up of clearly defined, named parts. She describes two core selves, Rach and Rachel, and a surrounding "team" of parts that exist in an energetic space around her which she experiences through external emotions and bodily sensations. Rachel does not experience distinct switches but instead a seamless, continuous shifting between parts. Often unaware of who is fronting until afterward, she has experienced significant lost time at various points in her life. Her storytelling was fluid and spontaneous, following a clear narrative arc from emotional turmoil and confusion to acceptance. Rachel's story reflects late system discovery, after a lifetime of hidden dissociation. Her early life was marked by fear and neglect, growing up with a frightening mother and in a strict Catholic convent setting, compounded by the conflict between her sexuality as a gay woman and her religious background. She found success in her acting career but turned to alcoholism and anorexia to manage overwhelming emotions. After becoming sober, the continued experience of lost time led her to confront her dissociative experiences in therapy. Rachel intentionally avoided reading about other systems to focus on understanding her own internal world in her own therapy.

Rose's Story

Rose experiences her parts visually and energetically. She has always seen them around her in specific locations, referring to specific parts spatially, such as "this part over here." While she doesn't engage in full conversations with them, she senses their emotions and occasionally hears words. Rose understands her identity as intrinsically linked to her parts; she is Rose, but she functions as a group, with each part holding different aspects of her past. Sometimes she observes from the side as another part takes over and at other times, she experiences lost time and memory gaps. Her storytelling was non-linear and fluid, guided by pre-prepared notes and real-time notetaking to aid memory and structure. Her DID enabled high functioning, with different parts stepping in and allowing her to work long hours, raise three children and four grandchildren, as well as maintain a senior role in education. Her parts helped her remain consistent and composed at work, regardless of her internal state, though she relied on specific strategies to manage lost time. To mask inconsistencies, she embraced an “eccentric” persona, which deflected scrutiny or suspicion from her colleagues. After her children left home, increased lost time led her to seek professional help and discover her system. Although her parts enabled her to be skilled across many areas despite distress, it also left her feeling isolated and misunderstood by others.

Narrative Themes Overview

The following six themes emerged through thematic narrative analysis of participants' stories. In keeping with a narrative and phenomenological framework, this chapter privileges participants’ voices and perspectives, presenting their subjective accounts with minimal researcher interpretation. The researcher’s interpretative voice is more explicitly elaborated in the following discussion chapter. While the findings are grounded in participants’ accounts, it is acknowledged that the interpretive process was shaped by the researcher’s clinical and academic positioning. Reflexive awareness was maintained throughout the interpretive process to attend to how meaning was constructed in dialogue with data and context.

The themes illustrate distinct steps in how participants made sense of their subjective experiences of living with dissociative parts, thus aligning with the research aim. Collectively, these themes narrate a broader story which unfolds as participants build internal relationships, beginning with the recognition of the distinctiveness of dissociative parts, moving through processes of discovery, awareness-building, and internal negotiation, and culminating in experiences of therapeutic growth, and the ongoing process of maintaining internal cooperation. Although each participant’s story was deeply individual and unique, these themes highlight common experiences and challenges present in varying degrees across all stories, illustrating the complexity and nuanced reality of living with dissociative parts.

Table 5

Overview of narrative themes and sub-categories.

Theme	Sub-Categories
1. Acknowledging the Individual Stories of Parts: “Parts feel like they’re their own person”	• Distinct identities, characteristics, and embodied realities • Unique roles, emotions, and experiences • Divergent ways of relating to others
2. The Hidden Nature of Parts: “How can you not see the chaos?”	• The external invisibility of parts • The active concealment of parts • Memory disruption, uncertain intuition and seeking understanding • Self-doubt and denial
3. Navigating a Constantly Shifting Reality: “I feel like just a little part in the system”	• The multiple influences of fragmentation • Chaos amidst internal conflict and switching • Behavioural inconsistencies and identity confusion
4. Looking Inwards and Understanding the Internal World: “It’s a universe that you’ve created”	• Gradual system discovery and building rapport with parts • Fostering internal communication • Discovering unique system structures and internal worlds
5. Remembering Trauma and Abuse Through Parts: “This is too much for you. Let us do it.”	• Systems structured for survival and trauma adaptation • Fragmentation of traumatic experience and memory • The adaptive function of switching • The protective benefits of parts
6. Building a Home for Parts: “Forgiving each other inside”	• Living as an internal family and community • Navigating internal needs amidst external demands • Ongoing healing and grieving • Functional multiplicity

Theme One: Acknowledging the Individual Stories of Parts: *“Parts feel like they’re their own person”*

This theme illustrates the unique journeys of dissociative parts who were experienced as holding their own distinct identities, characteristics and roles within the internal system. Participants portrayed that while dissociative parts contribute to the identity and functioning of the whole system, they should also be recognised as individuals in their own right, each with their own stories, experiences, memories, emotions, perspectives, and ways of interacting with the world.

Distinct identities, characteristics and embodied realities

Participants' accounts constructed dissociative parts as not simply narrative constructs, but experientially distinct entities with separate embodied realities. Each dissociative part appeared to develop its own understanding of the world, and their identities were shaped by the knowledge and memories they held, rather than through a shared consciousness across the system:

"So I get really confused about this. [Therapist name] always says if you're Millie and you're recalling something, then it's likely that Millie was there at the time…." (Olivia)

Olivia's confusion suggests that parts' stories need to be understood and uncovered to understand memory and identity. She later implies that their ages corresponded to the age at which they emerged or the age the participant was when they endured significant events. The wide variation between parts influenced how participants described them, highlighting the complexity, fluidity and ambiguity of identity in dissociative systems:

"It is not just a matter of, oh, part of me feels this and part of me feels this. It is sometimes it is such contrasting things. Like, I mean, we would joke. We're like, oh, we're vegetarian and we eat vegetarian, but then I come along and like, give me my steak. I want my goddamn steak. Because I am not like the other parts. And I… I feel like I am me. I am my

own person and each of the other parts feel like they're their own person." (Jessica, Catherine's part)

Jessica's words suggest that parts are experienced as autonomous and have their own sense of self. In their interview, Catherine expressed strongly that although some therapies draw upon the language of parts, this alone may not be sufficient to understand dissociative parts. Catherine's account challenges the assumption that parts are merely an extension of the core self or temporary emotional states, rather there appears to be a greater degree of divergence in their values, preferences and fundamental aspects of their identity.

Although dissociative parts have distinct identities and experiences, they often related to the shared body in divergent ways, sometimes as if it were not shared at all. For example, some parts experienced embodiment more fully, while others felt alienated from the body altogether:

"And for a very long time, everyone believed they have separate bodies from each other. We didn't believe we shared a body and...And actually, even I wasn't sure whether we shared a body I couldn't. Is it- It's, It's a really hard one....people say, oh, our mind is fractured into different parts, but it just doesn't feel like that. It feels like there's lots of people, and they're all part of... um...They're all part of our family if you like, rather than us" (Lauren)

Lauren's experience highlights that the way parts inhabit the body reflects their distinctiveness and emphasises that there is a felt sense that they are not just fragments of a singular self. This was echoed by participants who expressed that some parts acted in unawareness of the limitations of their body. These embodied differences extended to sensory experience and physiological presence. For instance, Columbia observed how their body felt more energised after Silas had been fronting. In the interview, Silas described themselves as *“loud, brash, ostentatious and fun”:*

“There is a slight difference in the way the body feels when I come back after Silas has been out—it feels a little bit… lighter, a little bit more sparkly.” (Columbia)

This emphasises that each part leaves an imprint on the body, suggesting that parts do not only have distinct sense of selves, but they are embodied in a way that influences physiological state. Columbia also described how she had learnt to distinguish when Silas was fronting based on Silas’ signature physiological indicators, movements, postures and sensations. Similarly, Laika illustrated how parts could alter their sensory experience:

“Like for example, when we're eating, sometimes an alter will go from co-con to co-front. And suddenly, the taste of what we're eating has completely changed… And it’s really interesting when that happens because it’s so surreal.” (Laika)

Laika’s reflections suggest that each part processes sensory information differently and parts maintain a presence even when not fully fronting. These accounts illustrate that participants physical experience of the world is guided by which parts are present. This internal diversity creates a fluid sense of self, whereby identity is constantly evolving:

"We've struggled our whole life with who we are. We've known we're queer and trans but our actual identity has always changed. We joke that we've been across the whole rainbow because we've had so many different identities through the years, because different alters identified as different things and we've had very frequent host changes……. And as you'll notice these identities are very fluid. Um… Because our identity our whole life has always changed, some days we felt like a boy, some days we felt like a girl, some days we felt like both, sometimes neither." (Laika)

Laika’s experience highlights how dissociative identity cannot be neatly categorised within traditional societal frameworks. Consequently, their gender identity and sexuality are inherently plural, dynamic and responsive to internal shifts. Other participants portrayed how this multiplicity extends to areas such as religious or spiritual beliefs, implying that dissociative systems involve divergent worldviews co-existing within one body.

Unique roles, emotions and experiences

Analysis of structural features illuminated a range of narrative roles assigned to each dissociative part, highlighting that parts develop diverse functions. Distinct manager parts were frequently described, often responsible for managing external duties and internal system needs, making decisions on behalf of the system. Many participants described caretaking parts which frequently took on parenting responsibilities, both within the system and in their external lives. This division of responsibility within the system was further reflected by the description of fragment parts, which were defined as distinct from dissociative parts as they were not fully formed identities. Some participants defined fragment parts as highly specialised parts which carried out specific, limited functions such as handling repetitive tasks or a portion of a whole task. The existence of fragment parts for some participants suggests that management of daily life through parts is compartmentalised to promote functioning.

Some parts took on protective approaches or roles, taking on the responsibility of protecting the system from harm, often through expression of emotions such as anger or taking on aggressive relational styles. Emma's part, Mal, often expresses anger on behalf of the system when faced with interpersonal conflict or perceived threat:

"If someone was aggressive enough, what would happen would be that Mal or one of the boys would come forward and would be aggressive right back….

And, but that's just always been his way, I think, from, from childhood. It's what worked..." (Emma)

Emma's experiences convey that the fragmentation of emotions across parts contributes to individuality in their coping strategies. This concept was echoed by other participants, who frequently described how specific coping strategies and mental health symptoms were associated with specific parts, rather than shared across the system. For instance, some parts relied on self-harm, eating disorders and alcoholism as a way of managing or expressing distress and some parts experienced psychosis or autism, whilst other parts were detached from these experiences. The diversity of emotional responses within systems emphasises the complexity of developing system-wide understanding of lived experience, highlighting the importance of an approach which is informed by an understanding of parts. This structured organisation may reflect how the various roles and priorities that dissociative parts appeared to adopt may be informed by the emotions they carry and how they have learnt to respond to their environment.

Divergent ways of relating to others

Participant stories conveyed that as parts had distinct identities and roles, they related differently to the external world. Rather than experiencing external relationships uniformly, systems navigated complex and varied interpersonal dynamics, where some parts were engaged in relationships, while others remained avoidant and distrustful. These differences applied to friendships, romantic relationships, therapeutic relationships and parental relationships, demonstrating how relational engagement differs between parts. Participants often described how their parts held opposing reactions towards the same individual, suggesting that systems could be considered a collection of individual selves with differing attachment and relational patterns which can create tension and unpredictability in interpersonal interactions. Ellie described how her parts, Airiam and Tilly, employed different approaches when managing a dispute regarding the quality of the healthcare they received:

“The Trust wrote and said that it’s fine for a professional to give a false report to a tribunal, and Airiam *went absolutely ape shit [laughs] ‘She went, I don’t fucking think so!’... That’s when Tilly and* Airiam *had to work together because* Airiam *was really annoyed, and Tilly was like, ‘Yeah, you can’t say that—you need to soften it a bit.’” (Ellie)*

Airiam’s firm response contrasts with Tilly’s more measured approach, illustrating how different parts bring their own emotional responses, social abilities and communication styles when managing interpersonal dynamics. Julia emphasised this when describing her experience of being in a romantic relationship with another system:

“Intimate relationships with another system are very intense because it’s just, like, so many possible iterations, you know... Different parts having different relationships with different parts, and things get so complicated. Lots of communication required as much as we can manage.” (Julia)

This highlights the need for systems to have high levels of communication, sensitivity and negotiation when navigating external relationships as different parts have different relational and attachment needs. Many participants illustrated how this influenced parental relationships; unlike traditional parenting, dissociative parts may share parenting responsibilities between themselves or assign parenting responsibilities to a specific part(s). However, participants also described how other parts may develop unique relationships with their children. For example, Julia described how her younger parts, Nettle and Juno developed sibling-like relationships with her daughter.

Structural features in participants' narratives further illustrated the individuality of parts, such as shifting pronouns from 'I' to 'we' to 'they', perspective changes from first to third person and variations in narrative voice when exhibiting signs of switching. These linguistic and structural shifts reinforce the suggestion that each part exists as a distinct self with their own stories and experiences. This theme indicates that although this study aims to explore participants' stories, it is important to recognise that dissociative parts themselves will have their own stories and meaning making processes. Participants' self-understanding appeared to not be solely based on a cohesive personal story, rather it involves making sense of the lived experience of parts, both internally and in interactions with others.

Theme Two: The Hidden Nature of Parts: *"How can you not see the chaos?"*

This theme illustrates that the presence of dissociative parts is largely concealed from both participants and those around them. This concealment appears to not be a passive state, but an active process, shaped by dissociative mechanisms and parts themselves. The experience of not knowing, whether through memory disruption, denial, misunderstanding or unawareness, plays a pivotal role in maintaining this hidden existence. By keeping the workings of dissociative parts out of awareness, and the distress they hold, the hidden nature of parts allows individuals to continue functioning whilst maintaining a sense of normality.

The external invisibility of parts

Most participants narrated experiences of misunderstanding, misdiagnosis, and dismissal in clinical and social contexts, perceived as stemming from a lack of professional expertise. Participants reported that misdiagnosis left dissociative experiences undetected and reinforced internal unawareness, denial and self-doubt. More significantly, dissociative experiences often remained unnoticed even by loved ones or close acquaintances. Rose recounted informing her colleagues she was taking time off for her mental health:

"Nobody at work had a clue that I wasn't coping. Now I couldn't work that out. Even today, I find that hard to believe because in my head, I now know I was just switching so often and losing so much time… Everybody's thinking I'm perfectly normal. Get on with life. So that was a struggle. I felt very alone in those days." (Rose)

This highlights a disconnect between internal and external experiences, reinforcing the hidden nature of DID. Rose highlighted that high-functioning parts often took over in public spaces, concealing distress. Rachel described frustration that while parts can be deeply disruptive internally, they are often invisible externally:

"I will frequently be with family—who I love—and not remember. And I think, you know, when you feel like screaming, because you're like, how can you not see the chaos? How can you not see what's going on?" (Rachel)

These quotes emphasise a paradox whereby the survival strategy to conceal structural dissociation leaves the participant feeling unseen and alone.

The active concealment of parts

For many participants, awareness of their parts emerged after years or even decades of living without recognising the full extent of their dissociation, implying that the process of uncovering parts was often gradual and evolved over time. The hidden nature of dissociation was often conceptualised as a survival mechanism, actively concealing the legacy of trauma held by parts from themselves and the world:

"One of the problems with DID is that it's about hidden-ness. It's about hiding from… you know, the awfulness of what's happening so you can survive, but then it also hides the reality of what's happening to you." (Lauren)

Lauren's description builds on quotes from Rachel and Rose, which highlight that although the hidden nature of dissociation is intended to provide protection, it leads to unintended consequences such as a profound disconnection with one's own reality.

Participants often identified specific parts who took on an active role in hiding the existence of parts, suggesting that concealment is partially driven by parts who actively function as the gatekeepers of awareness. Lauren shared that some of their parts were deliberately formed and manipulated by their abusers to keep the nature of their trauma concealed to maintain their silence and compliance. At age 13, after being warned by their mother that revealing their multiplicity would lead to institutionalisation, Emma's part, Mara, took on the role of hiding the system, to prevent alienation and ostracisation:

"So, I think the way it worked was that she would briefly come forward to kind of interrupt…our cohesiveness of events. So, if there was something she didn't want us to know, such as that there's more than one of us…she would kind of jump in briefly and it would kind of make the memory not stick so much of that event." (Emma)

This suggests that the hidden nature of parts is not only driven by concealment and unawareness, but it is an active regulation by parts of what can and cannot be known within the system. Some participants suggested that parts had the capacity to actively mimic other parts which further concealed their existence. Participants also highlighted that parts themselves had differing levels of awareness of the existence of other parts and about the external and internal realities of their system:

"It's not even that you don't accept it… it's that you know that it's not your job to accept it. You're supposed to present, you're supposed to keep everything inside. You're supposed to make sure that whatever parts are out front have no awareness of what's going

on behind. So, it doesn't matter if you're DID… because your job is to pretend that you're not." (Eloise)

Eloise's perspective suggests that in dissociative systems day-to-day functioning must take precedence over internal truth. It appears that intentional division of awareness within dissociative systems ensures that parts who front can function without interference from trauma-related experiences. Whilst being an adaptive strategy, this delays self-recognition and acknowledgment of DID.

Memory disruption, uncertain intuition and seeking understanding

The active regulation of memory appears to ensure that dissociative processes remain hidden, preventing awareness and maintaining an illusion of continuity. Participants reported that memory in dissociative systems is not simply lost, but that it is actively regulated by which parts are present and fronting:

"The funny thing about dissociation, anyway, is, like, you don't remember anyway, you don't recall… Say you have an episode or something happens, and those parts that are there while that's happening can remember it and see it all happening like you're there with them, co-hosting. But as soon as they go, they take that with them and then you can't remember it. And then you can't even remember it happened." (Eloise)

Eloise recounted how unawareness may be distributed across parts, with each holding varying levels of awareness based on what they have retained in memory. Her reflections also highlighted the limitations of explicitly recalling amnesia as she is likely to remain unaware of what was forgotten – an experience echoed by many participants. Many participants expressed that their memory disruption was often unnoticed or unrecognised, further complicating the ability to identify dissociative processes or the existence of parts. These accounts suggest memory disruption may not be incidental, but instead functionally significant within the system. They suggest that when systems cannot remember what has been forgotten, both unawareness and functioning are preserved.

Despite system-wide efforts to conceal dissociation and distress, many participants described a lingering felt sense that something was ‘not quite right’, even if they did not initially connect their experiences to DID. This uncertain intuition often manifested as awareness of unexplained inconsistencies or a suspicion that their mind worked differently to those around them:

"Since about the age of 6, even though I’ve had trauma, I have known that I haven’t felt right alongside all the trauma. I’ve consistently been making attempts to get help… not necessarily in a really scary ‘I need help now, rescue me’ way, but just—what is going on? Something’s not feeling quite right. We need to look into this… I think I’ve always known I’ve had parts, even though I haven’t known I’ve had parts." (Olivia)

Olivia’s account reflects a simultaneous knowing and not knowing, which she lacked the language and framework to understand. For other participants, early signs of the existence of parts were mistaken for psychosis:

"At that time… we were aware of lots of... I guess we were aware of the parts, but we didn’t call them parts. We just thought that we were psychotic at that point. And we still didn’t tell anybody… because it was dangerous." (Ellie)

Despite recognising the presence of parts, Ellie framed her experiences through the lens of stigmatised mental illness, leading to silence and non-disclosure. Many participants described how their experiences did not align with mainstream understandings of identity, distress or consciousness, leading them to dismiss or reframe their own perceptions. These accounts highlight that the hidden nature of dissociation does not fully impair self-awareness but fosters a delayed, fragmented and confusing journey to understanding.

For many participants, this uncertain intuition appeared to drive a deep need to uncover what felt like a hidden truth, although the connection to DID often emerged later. Their narratives often portrayed the journey toward diagnosis as motivated by a desire to understand themselves, to make sense of internal confusion, and to validate experiences that had previously felt inexplicable or denied. Olivia described small ‘leaks’ of awareness, moments when the hidden nature of their system seemed to surface. She likened this metaphorically to the *“cat in the matrix”*, where you *“realise it is not all it’s meant to be”.* Catherine’s part, Jessica, illustrated how a moment of clarity from their previous host transformed into a pursuit for knowledge:

“Cath sort of said, it’s almost like it was another personality who took over my body. And then it was sort of—everything sort of didn’t make sense and made sense at the same time…. Right, OK, OK, let’s not panic. Let’s look into this. What does this mean? How does somebody even get multiple personalities?” (Jessica, Catherine’s part)

Participants described seeking out information through a variety of methods, including online research, joining community or online groups, seeking out specialist therapists, or a diagnosis. For some participants, the need to understand was driven by intellectual parts within the system, who took on the role of researching and making sense of their experiences. Columbia described how her parts viewed the diagnosis as imperative in proving their existence:

"In being diagnosed, they fought very, very hard for it… There was this sort of feeling that it would validate they were real to them… So they really wanted to get the diagnosis to be proved they were real…." (Columbia)

This highlights that diagnosis was not just about receiving a label, but about dismantling layers of unawareness, self-doubt and concealment which characterise DID. Columbia’s phrasing also suggests that the diagnosis served as a form of epistemic validation; an official recognition that could counteract internal doubt and external invalidation. Within a cultural and clinical context that may not always recognise multiplicity, reflexive engagement highlighted how participants' narratives conveyed a strong desire for legitimacy, reflecting a wider struggle to be believed and understood. This struggle was sometimes mirrored in the researcher's own interpretive process, where an attunement to participants' desire for legitimisation appeared to shape how meaning was constructed and represented.

Self-doubt and denial

Participants' narratives suggested that the hidden nature of dissociation, combined with memory disruption and societal misconceptions, made it difficult to accept a DID diagnosis and contributed to internal doubt. Many participants described ongoing denial and scepticism, struggling to reconcile their daily experiences with their perception of what DID "should" look like. Laika highlighted how his denial was largely shaped by his lack of awareness of their trauma history, illustrating how memory disruption can obscure the origins of dissociation and reinforce doubt:

"We often decided against having DID because of a lack of trauma [chuckles], which we would come to know was hidden behind amnesia… We have a long-standing history of extreme denial—not only of our DID, but also of our trauma." (Laika)

This captures a key psychological struggle for many participants; the belief that if they could not remember their traumatic experiences, then they must not have happened. The fragmentation of memory conflicted with their conscious understanding of their past, creating a cycle of doubt, denial, and self-dismissal, which appeared to be shaped by internalised stigma and ontological uncertainty. The societal misconception that DID is rare and only occurs in response to severe, recognisable trauma, reinforced Laika's disbelief in the legitimacy of his DID. This pattern emerged in other participants who expressed that the external stigma surrounding DID as "fake" reinforced their own fears that they were somehow fabricating their experiences:

"I just think I'm mad… And sometimes I think I've made up the degree of the abuse. If you tell somebody, you know, about the abuse, they think it's horrendous. But is it horrendous? You know what I mean? You're thinking, is it? You know, I'm here. It wasn't nice. And I wouldn't wish it on anybody… I find it hard to comprehend. Logically, I don't. I can. I can read it, and I can repeat it to you. I can write you an essay on it if you want me to. But I don't know that I buy it." (Rose)

Structural features of Rose's storytelling such as repetition, rhetorical questioning and self-correction mirror the fragmented nature of dissociative memory. Her shifting perspective highlights internal conflict which appears to arise from the hidden nature of parts, as Rose struggles to trust her own recollections. This internal conflict appears to extend beyond internalised stigma as her repeated questioning of what is 'real' or knowable highlights a deeper ontological struggle with the very coherence and credibility of her own experiences. This also highlights a wider existential dilemma; how can one trust their own perceptions and sense of reality when the very foundation of selfhood feels fragmented and discontinuous. Many participants conveyed that this internal conflict was also driven by parts who worked against the system to suppress awareness of trauma and parts, whilst others sought acceptance and understanding. Participants' storytelling process was often non-linear, including interruptions, hesitations and recalibrations mid-sentence, illustrating the active processes of navigating awareness and memory gaps. These disruptions reinforce how dissociation not only conceals experiences but also alters the way they are processed and communicated. Ultimately, these layers of memory gaps, unawareness, internalised scepticism, and stigma combined to create a profound sense of uncertainty which complicated self-acceptance. For many, it was only through gradual self-exploration and therapeutic support that they began to trust their own experiences.

This theme illustrates that participants framed the hidden nature of dissociation as an intentional feature of DID. Internally, dissociative systems regulate memory and awareness, creating conflict between parts who seek understanding and those that wish to conceal internal truth. Whilst externally, societal misconceptions and misunderstanding further obscure the existence of parts. Even storytelling features reflect the structural disruptions of dissociative memory, reinforcing how DID remains concealed, both from the individual and from the world.

Theme Three: Navigating a Constantly Shifting Reality: *"I feel like just a little part in the system"*

This theme outlines how the fragmented nature of parts, whether actively fronting or passively observing, contributes to a chaotic and confusing subjective experience. Participants described how they perceive the world through their parts, often leading to contradictory behaviour and reality distortion. The act of switching between parts frequently created confusion and internal chaos. This theme unpacks the ways in which systems operate within a fragmented, constantly shifting reality.

The multiple influences of fragmentation

Participants emphasised that parts are always present; even when not actively fronting or in control, dissociative parts were often passively observing and influencing thoughts, emotions and decisions. Analysis of structural features interpreted that parts were often listening and responding during the interview, thus signifying their ongoing engagement with the world. When answering a question about their Silver parts, Eloise voiced the answer from their perspective:

"But there's a few answers. There's a few, [refers to self] calm down! fucking hell, one at a time! Tattoo, nickname, hair, threatening, dangerous, people scared of. Mostly nickname, nickname. Hated [Eloise]." (Eloise)

Eloise's self-talk illustrates how the presence of parts can be experienced as commentating voices or feelings, which occur in parallel to external events. Some participants described that their awareness of their parts' presence varied based on whether their system was co-conscious. Contrastingly, some participants conveyed they only recognised the influence of their parts retrospectively, through habits, emotions or unexpected shifts in behaviour. Therefore, although parts are always present, dissociative systems appear to vary widely in terms of the awareness of this ongoing presence.

As parts are always present, they actively shape how participants engage with and perceive the world. Therefore, participants frequently described the duality of holding multiple, sometimes contradictory, emotions or perceptions simultaneously:

"I will never experience an emotion the same way…. Because it's also not just me feeling—having a response to the stimulus…..But they will feel something. They will have a response to the stimulus present. Which can create six different responses to the same thing, which can create a very confusing set of feelings and emotions for me to process and thoughts." (Columbia)

Columbia's reflection captures the complexity and unpredictability of experiencing multiple emotional responses simultaneously. This highlights how different parts can interpret and respond to the same situation in opposing ways, leading to internal confusion about how to process emotions effectively and how to make collective decisions. Emma expands on this further:

"So in retrospect, when I look back, I can see these two lives happening in our teenage years, in our 20s, where some of us were really spreading out and really learning to be our own people. Um…whereas others were just still struggling and there was just a kind of a gulf of a lack of awareness between us." (Emma)

Emma highlights how duality can also shape long-term perception of identity and the construction of their life story. Some parts moved forward, while others remained trapped in the past, whilst a lack of awareness further deepened the divide.

Chaos amidst internal conflict and switching

The experience of perceiving the world through parts, combined with the duality of holding multiple perspectives and reactions, often lead to internal conflict between parts, reflecting a strong theme throughout all participant stories. Eloise described an instance where two different parts clashed when attempting to front at the same time:

"They literally- it was like the eyes inside my head turning inwards smack into each other. I had the splitting lightning- and they both screamed and ran in opposite directions in my head…….We didn't go to bed that night, but I realised what happened and my head was like [gestures]- and that's when I started to notice the earthquakes." (Eloise)

Eloise's vivid and metaphorical description illustrates the physical and emotional toll of internal conflict. The imagery of splitting lightning and earthquakes conveys the significant bodily impact of conflicting parts surfacing simultaneously and consequent internal chaos. Participants reported that internal conflicts were driven by the distinct identities of parts and ranged from mundane every-day decisions such as choosing what clothes to wear, to major life decisions such as choosing a career path.

The impact of these internal conflicts often elicited confusion, distress, frustration and difficulties with emotion regulation, often creating a sense of stagnation and inaction:

"It is very frustrating because I never achieve anything in my life because it's the whole group and the whole group never agree. So, I can think I'm going to do something and cancel it and think I'm going to do something and cancel it." (Olivia)

Olivia illustrates how internal conflict can lead to a sequence of contradicting behaviours, choices and experiences. Participants often identified that these set of contradicting behaviours were underpinned by switching and a struggle for control between parts as the parts who were fronting held autonomy over the entire system:

"I guarantee we would have been trans and I am not saying all trans people have DID. I'm not saying that at all, but what I am saying is… DID presents itself in different ways, and we would absolutely be trans if Matthew were host of this body because he hated the female body and felt male completely." (Catherine)

Catherine highlights how the most frequently fronting part, the host, influenced external identity and perception of the whole system. When faced with conflicting needs or perspectives within the system, parts may actively seek to front to assert their preferences and ensure their needs are met. This was further supported by other participants who identified that switching enabled fronting parts to express, regulate and address their emotional needs:

"So a lot of alters are not able to feel their emotions without becoming dysregulated, so for example a big thing for a lot of my alters is they will come out and listen to music that relates to how they're feeling and just cry." (Laika)

Laika's reflections suggest that switching serves a self-regulatory function, allowing parts to process emotions in a way that would otherwise be inaccessible. Furthermore, parts also sought time to express themselves freely through play and hobbies. Some participants intentionally allocated time for parts to emerge safely, acknowledging that suppressing them could lead to a battle for control and internal conflict:

"So…. I would say if parts aren't being listened to, they're going to find a way for you to listen to them. End of. That's what's going to happen." (Catherine)

This suggests that when parts felt ignored, they may find disruptive ways to express their needs which could create internal tension. Furthermore, specific emotions could bring forward a relevant part, while certain postures, sensory experiences, specific times of day or social interactions were also identified as triggers for switching:

"Sometimes there are triggers… for particular parts. That I think… are related to… states of mind or body. And. So there might…be a feeling… that is very familiar to a particular part, and if we feel that feeling then the part can be triggered out....Um… Yeah, need can trigger parts to come out as well, because I guess that's kind of the point of them really." (Ellie)

Ellie's description highlights how switching occurs based on how the system has designated roles to maintain functioning. For instance, social parts may front when in social situations and work-focussed parts who manage employment may front when participants are at work.

Behavioural inconsistencies and identity confusion

The constant internal influence of parts, frequent switching, internal conflict and struggles for control, appeared to create an ever-changing sense of reality. Rather than experiencing the world as a singular, continuous self, participants' understanding and interactions with the world were shaped by the experience of switching. Consequently, participants conveyed a fluctuating sense of self, where their perceptions, choices, responses and memories shifted unpredictably. Participants also identified that parts could engage in activities outside of conscious awareness, leading to internal and external confusion:

"Some days things were really good, on form, You know, I could do everything that I was asked to do and more really. I loved learning. And another day I'd go in and I think, well, we haven't done this, you know. I just haven't done it, so you know, I'd say I, you know, I don't know what I'm doing here. Um, You know, I haven't done this before. And of course, not of course, but I now know that the teacher isn't very happy because you have done this before. And I'm thinking I haven't done this before. You have and you know exactly what to do… No, I don't. And then I'm accused of playing up and being difficult and… um… What's that word? Erratic. All those sort of things. When in actual fact I'm completely confused." (Rose)

Rose's experience depicts the challenges of maintaining consistency when different parts retain different skills, memories and abilities. As another part came forward, they would bring a unique perspective and approach which altered external behaviour. Many participants recounted moments where they struggled to explain sudden changes after appearing unrecognisable to those around them. Riquitta described how these contradictions manifested in professional relationships:

"There would be times where I would be in complete crisis or maybe one of my parts, Evil, would be in complete crisis and she'd be getting the crisis team to come and support me. And then by the time the crisis team had come to see me say maybe five hours later, I was completely somebody else, so I could be Hannah. And Hannah would be all dressed up to the nines…. But trying to explain that then to the crisis team who really didn't have a scooby-doo, they just thought… I was playing games and that I was maybe being manipulative." (Riquitta)

This example conveys how sudden behavioural and emotional shifts could be misinterpreted as manipulative or intentional when not viewed through a parts-informed lens. Other participants acknowledged how these shifts impacted close personal relationships, as they could suddenly switch from being affectionate to distant, leaving loved ones feeling confused or rejected. However, participants found that when others understood these experiences within the context of switching, interpersonal relationships improved.

Participants' own confusion about their experiences was influenced by memory disruption and lost time in relation to both daily and significant events. Some participants described feeling confused after finding themselves in unfamiliar situations or discovering objects they did not recognise. Experiences of switching, internal battles for control and lost time contributed to a sense that participants were not in control of their lives:

"A good explanation of what life with parts when you switch a lot is… Is that it's like having your life played out on a wall of CCTV monitors and each part has access to their own screen only. So we skip in and out of our screens as we switch and we have no idea what may have happened when we weren't there, what's happening when we arrive or what's happened on different screens." (Ellie)

Ellie's analogy of CCTV monitors conveys a sense of detachment, as if participants are merely watching their lives unfold rather than actively directing them which may be more common in systems without co-consciousness, like Ellie's. However, even participants that were co-conscious illustrated that they could be passive observers, comparing themselves to a passenger in a car they were not driving:

"I often so much feel like just a little part in the system. I'm not in charge. I don't know what's going on and these decisions are made like much higher up the chain sometimes I'm not even aware of them." (Olivia)

Olivia's experience of a hierarchical system was a common theme among participants, many of whom reported the presence of dominant parts occupying higher positions of power within their systems, where higher-ranking parts could override the decisions of other parts. Olivia's account suggests that such experiences may leave participants feeling powerless and disconnected from decision-making within their own lives.

Overall, this theme captures participants' experiences of navigating a constantly shifting reality due to fragmentation, switching, and the struggle for control among parts. Structural analysis illustrated how these disruptions were especially pronounced during periods of crisis and initial recognition, before participants had developed a clear understanding of their parts. These destabilising periods often coincided with difficult life events or major transitions, prompting participants to seek professional help and begin the process of making sense of their internal worlds.

Theme Four: Looking Inwards and Understanding the Internal World: *"it's a universe that you've created"*

This theme underscores how the process of looking inwards, to understand the system and internal world, supported participants to reduce confusion, internal conflict and unawareness. Turning inwards was a significant part of participants' journey, often precipitated by receiving a DID diagnosis and influenced by the pivotal role of others, especially therapists. This process involved recognising their unique system structure, learning how their parts interact and developing strategies to foster internal communication and cooperation.

Gradual system discovery and building rapport with parts

Participants recounted a gradual process of discovering their parts over time, either after receiving a diagnosis or after uncertain intuition prompted them to seek one. Participants became aware of their parts through various unique experiences and methods, through an ongoing process of discovery, with new parts continuing to emerge even after years of exploration. Some participants noted that the process of discovery was unintentional, where parts emerged unexpectedly. Some participants reported that external events precipitated the decision for parts to make themselves known. Whilst other participants reported a more intentional process:

"I have a map. Um…. with all the location names inside and then everybody who wanted to be on this map could go and put their name onto where they are and add the area if it's not there. And it's huge… And it's amazing to see! Um… So detailed. But, I don't know who most those people are. I don't know what they do, and I'm sure I'm going to learn as time goes on." (Columbia)

Columbia noted how the mapping process invited parts to come forward, whilst also recognising that some parts continued to remain unknown. This reluctance to emerge was echoed by other participants, who emphasised that parts could not be forced into awareness. Some participants found mapping to be a valuable tool for discovering parts, but its effectiveness varied widely, reflecting the highly individual nature of system exploration and discovery.

Lauren's discovery journey highlighted how the process can cause system-wide distress:

"It was in our early 30s, we suddenly discovered that other people had memories about their childhood. And we didn't have any, and that was the start I think of thinking something's not right. But it wasn't until… our early 40s when we were having therapy for something else, completely unrelated. Um, and… We started to dissociate in therapy without being aware we were and different parts started coming out in therapy. Um… And so the therapist told us… And… um… That's, you know, we sort of freaked and so on. It was a- it was a difficult time." (Lauren)

Lauren highlighted that the presence of her parts was not immediately apparent to her, but they were evident in her interactions with her therapist. Many participants also reported how their therapists facilitated system discovery, acting as an intermediary for information sharing between parts. Participants often became aware of their dissociative parts through observations and social feedback shared by friends, family and colleagues:

“Somebody was very rude to us in a lift, and I shouted at him and they were asking for elevator Olivia at work. Like so, they'd [colleagues] ask for elevator Olivia or Nice Olivia. Or and like seeing the counsellor at work. Now, if I see her, I'm either Olivia laugh a lot or Olivia cry a lot. So even when people don't know I have parts. I think it's always been intrinsic to the way I am, but I just never. I never really realised it.” (Olivia)

Even though her colleagues were unaware of her DID, their observations of her shifting states provided a foundation for which Olivia could begin to understand her parts. Lauren extended this notion further by sharing how their therapist went beyond recognising their parts, to welcoming them into the therapy:

"If we hadn't had a therapist who was willing to work with parts and be really nice to every part, you know, she had parts that were so rude to her and violent…..She was always really nice to them and welcomed them and thanked them. And she said things like, I like you all equally. None of you is more important, less important." (Lauren)

Lauren later identified that their therapist’s consistent kindness towards her parts modelled how their system could develop a sense of community and compassion for each other. Lauren and Olivia’s experiences highlighted the importance of acknowledging and recognising the existence of parts to begin the process of looking inwards.

These experiences contrasted with accounts from participants whose parts were dismissed, invalidated or ignored by others. Riquitta described an instance in which crisis services refused to acknowledge her parts, insisting that only her “adult self” was welcome:

"Because I was dissociating to different parts very regularly and the team there felt that that was inappropriate, I was kicked out… And they would, it would be this whole thing of, you know, adult Riquitta needs to be here. Well, I am more than just me. There’s fourteen others. And they also needed support." (Riquitta)

Riquitta’s experience highlighted that when parts are denied support and treated as obstacles to engagement, this leads to system-wide distress and isolation. Ellie further emphasises that all parts contribute to the whole:

“I hate to break it to you, but there is no there is no real [laughs]…There isn't really, There's no original person from before the trauma….Because the self doesn't form….under those conditions, so whoever you're talking to is always going to be a part……. If you don't talk to parts as a therapist or a clinician, then you're not going to hear about the trauma to help it heal.” (Ellie)

Ellie’s perspective suggests that without acknowledging and understanding parts, vital aspects of her story remained unheard, impeding healing progress.

To develop an understanding of parts, participants expressed that they had to engage with parts directly, building trust and rapport over time. This was also applicable to external relationships, as parts only emerged and engaged with others when they felt safe:

"There's been like initial getting to know just like you would in any relationship, there's an initial getting to know people and you kind of know the superficial stuff. And then as you really get to know them, you start to unpack sort of the deeper stuff. So, you start to

learn what they think, what they feel, why they might feel that way, what experiences they've had." (Catherine)

Catherine suggests that much like external interpersonal relationships, building trust and understanding within the system is an evolving process that requires patience, time, consistency and respect for boundaries. Building internal relationships often required active effort from the host or front-facing part to foster trust and open lines of communication:

"The fact is we are all part of one person. There is no core person. There is no only one person, one part. Cath has the name and she was made to be the face of the system, out here, but she is- she hasn't been around in some of the rest of us as long as the rest of us have been around…… Now that the system was exposed, other parts made themselves known to Cath….And, um… It was so funny because, while- there was an episode where it's sort of, Cath sort of trying to talk into the headspace because obviously communication, you build it over time." (Catherine)

Catherine highlighted that the host part is not inherently more important than other parts but serves the functional role of representing the system externally and leading on system discovery. However, this was not always applicable to participants who experienced themselves as not having a host part, where discovery came from mutual effort from a few different parts.

Fostering internal communication

Building rapport and trust between parts required participants to understand their system's unique modes of communication, actively engaging with these methods and refining them over time. Participants often relied on external tools to maintain continuity and track internal dynamics such as journalling, voice recording or note-taking and holding meetings for internal communication:

"People would pick their own colour pen… A lot of us would begin to allow others to see who's writing what, so that we could write more individually as well and say how we're feeling today. It was something that I could read back on and realise what's going on in my mind, a little bit, in our shared mind." (Emma)

Emma's experience outlines how she used an external strategy to track interactions, emotions and build an understanding of each part. This process also provided a means of reflection, as reading back through entries helped Emma piece together her internal experiences and gain insight into her system's overall state.

In contrast, some participants experienced their parts through sensory awareness which extended beyond verbal communication, such as experiencing a shift in energy:

"It's not like a conversation, but…I sensed how they were feeling and occasionally words would come…Initially, they would just pop up with their distress… and that was it. But now I'm a bit more aware. Sometimes I now know… that I'm watching from here (gestures to the left) and they're there (gestures to the right). It's always this way…. I do it thinking, well it might, but I it's, it's telepathy." (Rose)

Rose's reference to telepathy reflects how internal communication can be experienced as intuitive and non-verbal. Her gestures to the left and right suggest a consistent spatial awareness of her parts, reinforcing the embodied nature of communication between parts. Rose also described a gradual shift, where improved understanding of her internal communication developed a greater sense of awareness between parts. Similarly, strengthening internal communication not only improved connections between parts, but also facilitated memory sharing which enabled greater stability.

"So a big way we do it is obviously we invite them to like be in co-conscious or co-fronting and we showed them like oh this is our room, as you can see there's no one

dangerous here, we have all these toys you can come out and play …Um…We used to be a lot less co-conscious and co-fronting than we are now, I think as you build up relationships with different alters that like kind of unlocks that ability to be co-conscious." (Laika)

As communication strengthens and trust develops, parts may become more comfortable sharing space and awareness. Laika's experience illustrates the active role a system may take in fostering internal trust, suggesting that co-consciousness can be encouraged through safety and internal connection. Although not all systems described the ability to be fully co-conscious, all conveyed in some way that shared awareness was fostered through relationship building.

Discovering unique system structures and internal worlds

As participants turned their focus inwards, they uncovered the deeply individualised nature of their systems, recognising unique structures and internal dynamics which were shaped by their life history – as illustrated by participant story summaries. Participants' systems were articulated to vary and function in different ways and participants narrated how systems were often organised depending on the nature of relations between parts. Many participants described how parts formed alliances or deep connections, providing mutual support to one another. Julia recounted how she and another part, Jackie, developed an intimate connection:

"So, we were a couple… and that relationship brought us a huge amount of happiness and it felt very helpful, very supportive. Jackie would be in the background, co-conscious with me, always supportive and very encouraging… we were always together." (Julia)

This dynamic highlights how parts do not always function separately but can form meaningful attachments, providing internal companionship which is essential to system functioning. Silas shared their unique perspective on their evolving relationship with Columbia:

"I had to see her as not somebody ruining all the fun. You know, to me, I spent a lot of time outside partying. That's what I was good at. Life is just a big party. Um….and to her, it's not…… I had to stop being that person because I had to deal with things like…. Her job for a year and not dying and navigating mental health services, hospitals, all of that jazz and….. a very strong mutual respect came through and we communicate more and more. (Silas, Columbia's part)

The way in which their relationship changed highlighted that internal dynamics are not fixed. Silas' reflections illustrated how looking inwards can transform system structure by improving internal relationships to create a more cooperative internal environment.

Many participants described vivid and immersive internal worlds which reflected their system structures and internal relationships. Their symbolic inner landscapes contained structured environments where parts could live, interact and communicate. These ranged from houses with defined rooms for each part, to castles, forests, and even prisons where parts were confined to their own cells. The structure of these inner worlds often reflected the circumstances in which parts were formed and the system's internal structure:

"So our inner world for us is primarily a house with different rooms. We each have a room, there is also... um… recently discovered underground aspects to our inner world. And there is an outside space as well.... and that just feels like… it's like a meditation with an inner voice that's not yours …. We didn't choose for it to look the way it does, it emerged, and we just discovered it." (Julia)

This highlights how inner worlds exist independently of awareness, uncovered by the process of looking inwards. Julia's account indicated that inner worlds are not static, suggesting that as system structure evolves and participants gain cooperation between parts, their inner landscapes transform accordingly. While inner worlds often provided safety and respite from the outside world, they could also mirror external life stressors:

"If we watched a film that was violent, that would influence it. If something in life happened that was unpleasant, then we would live that out in this internal world as well. So, it was a kind of fun house mirror of what was happening in our life, and it could quite heavily influence our emotions as well." (Emma)

This suggests that inner worlds not only function as structured spaces for parts but also as psychological landscapes where emotional processing occurs. This was further corroborated by participants who described weather changes, shifting environments, or barriers forming when distress was high or emotional state shifted. For some, however, inner worlds also became deeply immersive and even isolating:

"It leads more and more into you living in a very insular world, cause your world is quite—it's a universe that you've created." (Rachel)

By referring to her inner world as a universe, Rachel accentuates its self-contained and expansive nature, illustrating how internal landscapes can become all-encompassing. She also highlights a key tension in balancing the use of the inner world for connection and escape while maintaining engagement with external reality.

Looking inwards was an ongoing process of discovery and relationship-building between parts. Participants emphasised that understanding their system structure and fostering internal communication through their vivid internal worlds were key to a felt sense of stability, awareness and internal cooperation. By acknowledging and valuing parts, participants strengthened internal trust, reduced conflict, and enhanced system-wide collaboration, ultimately beginning the process of healing.

Theme Five: Remembering Trauma and Abuse Through Parts: *"This is too much for you. Let us do it."*

This theme explores how participants understood their dissociative parts as a survival response to trauma and abuse. As participants looked inwards and awareness developed, they recognised that parts were structured for survival and shaped by trauma. Therefore, this theme is intentionally positioned later in the thematic order to reflect participants' journeys. Dissociative parts often reflected the roles, beliefs, and expectations of caregivers or perpetrators, whilst some participants reported that abusers sometimes exploited dissociation to enforce control. While parts prioritised protection and stability, this could also block access to painful truths, creating challenges in healing. Despite significant suffering, this theme reflects the strength, adaptability and extraordinary capacity of systems to bear the unbearable and survive the un-survivable.

Systems structured for survival and trauma adaptation

Many participants described their systems as meticulously structured for survival, containing a distinct division between parts that held trauma memories and responses, and parts that remained unaware, enabling functioning to continue despite debilitating past experiences:

"This major split was like… The bad side experienced all the trauma, and the good side got on with life as far as we could. We thought we had two sides—a good side with good imaginary friends and a bad side with bad imaginary friends. Except they weren't really imaginary because we couldn't, like, call them up when we wanted to. And also, they weren't really friends because they caused us a lot of difficulty as well. That cartoon we saw when we were six… it was really important, because we thought that if we were good enough, we could cancel out all the bad stuff... and make it all go away." (Ellie)

Ellie's reflections highlight that without compartmentalisation and the distinct specialisation of roles across parts; the distress of trauma would have been unbearable. This is symbolically reflected in Ellie's childhood belief that the 'good' parts managing daily life, could counteract the 'bad', parts which carried the overwhelming burden of trauma. The system's survival structure emphasises that dissociative parts are not a flaw, but a vital adaptation to deep-rooted trauma and reflective of the mind's extraordinary ability to endure and survive.

Participants conveyed that parts developed in response to the expectations and demands of their caregivers or abusers, internalising the relational dynamics that they endured. Some parts appeared to mirror abusive dynamics, internalising harmful beliefs and behaviours which were then directed inwards. Other parts shaped themselves to meet caregivers' preferences such as embodying the "perfect or good child", while others took on roles designed to ensure safety through compliance:

"I think Idris… certainly, so he dealt with things like being shouted down. He had people shout directly into his ears and he was shaken a lot, so… I think it was just overwhelming to him at the time. So, when we first reached out to him, one thing that was happening was that he felt that he was very bad, and he felt it was his responsibility to punish the rest of us because we were also bad. So, he very much felt that everything we'd ever been told about ourselves in anger was true, and he felt that he had to continue the good work of our caretakers, and we needed to be punished." (Emma)

This highlights that parts can adopt specific traits as a form of survival. Idris' role in the system extended beyond solely holding the traumatic memory of being shouted at, he believed it was his duty to enforce the same punitive methods to keep the system in line. Emma conveyed the importance of acknowledging that his resistance stemmed from the deeply ingrained messages that he had internalised to survive.

"Elio, for example… he exists as a fawn response to our main abuser, who essentially wanted a perfectly submissive sex slave. So, Elio basically took on that role and is a prey animal who just freezes… His role and identity is very heavily focused around being a rabbit. Although nowadays, as he's healed, his rabbit identity is more of that of a spoiled pet rabbit than a prey animal being hunted by a predator." (Laika)

Elio's experiences highlight how deeply trauma can shape a part's identity, not just in terms of behavioural responses but also his sense of self as a rabbit who embodies compliance. Elio's healing journey emphasised the importance of acknowledging the specific legacy of trauma and survival priorities held by each part. For Elio, understanding his use of the fawn response enabled Laika to find a creative solution, allowing Elio to be a spoiled and nurtured pet rather than a submissive and compliant animal. Laika's story also suggests that the way in which parts are shaped by abuse and trauma can extend beyond behavioural conditioning, to more deliberate and explicit manipulation by abusers:

"From a very, very young age, we used our internal world as a form of escapism. But our abusers would manipulate our internal world to place copies of themselves in there, and place copies of places where we were traumatized, and lock different alters in there. So, they'd be constantly in that state of trauma and not able to heal….So our internal world is both a mix of trauma mimicking and heavy escapism." (Laika)

Laika identified that their system was not only externally influenced by their trauma but also internally designed to ensure that trauma was not only remembered, but actively relived by parts, enforcing ongoing compliance. Lauren described how their dissociative fragmentation was weaponised and exploited by their abusers:

"Installed parts were created… through extreme trauma, you know—torture—and sort of pushed until they came out, and then they were given a name and a job to do. So, their specific job might be… um… to… let me think of one that's not too horrible… um… prevent

us from killing ourselves. So, they were trained to recognise when we'd gone too far, and that part would come out to deal with that......We had to get enough parts on board to accept that we needed to get away, because some had such loyalty and they didn't experience the abuse—they experienced what they thought were rewards." (Lauren)

In this instance, dissociative parts did not only function as a means of compartmentalisation, but also as a tool of internal deception. Lauren later described how some parts fronted to mask the presence of others who had been programmed for different purposes. This ensured that the abuse remained hidden, even from Lauren themselves. Lauren's story illustrated how some parts had been shaped to view abuse as care and were fiercely loyal to their abusers, whilst other parts worked against them to attempt to reach out for external help and safety. Therefore, internal conflict complicates the healing process, as parts often worked against each other based on their unique survival approaches.

Fragmentation of traumatic experience and memory

An integral part of surviving trauma was the distinction between parts which contained the legacy of trauma and parts which were unaware of trauma:

"We endured the culty stuff, we endured… whether it was just enduring what they were doing… watching, keeping her away from it, in any way we could… even if that was playing games with her." (Silas, Columbia's part)

Silas's repetitive use of the word "endured" suggests the immense burden of carrying trauma-related experiences. Their role was not only to experience the trauma but to act as a barrier, preventing the distress from reaching other parts of the system. Silas's reference to playing games with Columbia emphasises that whilst this role division ensured daily life functioning could be maintained, the active strategy of using distraction created unawareness. The trauma that shaped these parts also appeared to leave them trapped in the past, unable to identify that the imminent danger was no longer occurring in their external reality, distorting their experience of time:

"Different alters aren't really aware that we're no longer in trauma… um… So, it becomes like a big priority that we need to reground them in reality, as they start coming up. Otherwise, we risk like spiralling really bad" (Laika)

Laika's reflections reinforce the dual role of trauma-holding parts as both protectors and sources of distress. Although their existence ensured survival, their continued reactivity to triggers requires intentional effort to manage to keep the system safe.

Rose reflected on how her different parts responded to different phases of her traumatic experiences:

"The alters are connected to my past, I mean my alters—they each have particular memories. So, they hold, you know, she over there… she holds a particular series of like abuse… my mother went in phases of what she would do. And so this one here holds that selection of that abuse, but this one holds a different selection and significantly… the abuse had to change when we moved house… they hold different memories from that altogether, and I do trust their memories… as being accurate because there's no reason why they're not." (Rose)

Rose's description highlights the fragmented nature of traumatic memory storage, where the system compartmentalises different segments of traumatic experiences across various parts. Her statement regarding whether she trusts these memories represents a key challenge reported by many participants when processing their experiences from parts and piecing their past together. When trauma is held by specific parts to preserve unawareness, distinguishing between what is real and what is not becomes a crucial aspect of healing.

"I feel quite sad for the little ones, I think. You know, through the kind of therapeutic process, I realised how much trauma they have experienced... and how much they've… saved me from experiencing when I was a kid." (Riquitta)

Riquitta's account conveys the profound cost of survival for trauma-holding parts, expressing a deep sadness which represents a complex relationship between gratitude and grief when remembering trauma through parts. Her reflection that these parts "saved" her evokes a potential internal paradox identified by several participants; that these memories belonged to them yet were not consciously experienced.

Concurrently, participants described parts which remained completely unaware of past trauma, focussed on managing daily life. Whilst trauma-free parts maintained functioning and created an illusion of wellbeing, participants' awareness and understanding of their trauma histories fluctuated. Consequently, some participants described at times believing that they had not been affected by trauma at all:

"We were thinking that we just needed like maybe six weeks of therapy [laughs] and that we were fine! My sister was the one who'd been mentally ill her whole life. My mum was a bit… you know [laughs]. And my brother struggled, but I was the sane one. I was the one that didn't have any shit. I kept my crap together." (Eloise)

Eloise's experiences reflect how parts tasked with maintaining unawareness of trauma can reinforce denial, suggesting that the function of denial is a survival mechanism. However, Eloise's laughter suggests a retrospective awareness of the disconnect of her perceived stability and the hidden truths within her system. Trauma-free parts often embodied playful, social or high-functioning roles, enabling participants to navigate the demands of school, work and relationships without interference from distressing feelings and memories:

"Matthew came, split off, and he helped with academia. So, we went from being an average student to being an A-star student and graduated, you know, in the top 10% of high school, top 5% of uni. And we were able to do that because Matthew was able to—he didn't have any trauma. So, he was able to take in all the information and learning." (Catherine)

Catherine also noted Matthew's gender as being a key factor in his emotional and cognitive detachment from trauma. This suggests that dissociative parts are not only shaped by specific trauma-related experiences, but also by broader cultural and societal influences that shape the trauma itself. This also implies that unawareness of trauma is not merely a byproduct of dissociative systems, but an actively constructed process contributing to a part's unique identity. It also indicates that trauma-free parts are not only about forgetting trauma, but also about embodying contradictory characteristics and representing invulnerability:

"Age eight was a time where we had come from an extremely abusive and dangerous situation into something… temporarily, for the most part, a little steadier. And I think Nettle found ways to… anchor the brain in that newfound stability. So, when the rest of us are having big wobbles and things are getting unmanageable, sometimes Nettle will switch in and she's very grounding and very soothing. She's just a typical 8-year-old—she just wants to do colouring and watch Disney movies… She hasn't… she doesn't have real access to trauma or anything like that." (Julia)

Nettle's role in the system highlights that the influence of play serves as mechanisms for maintaining unawareness and protection from trauma. This was frequently echoed by other participants when describing the role and influence of their young parts.

The adaptive function of switching

In addition to trauma-free parts, switching was also described as an adaptive survival strategy to maintain perceived stability, safety and functioning. Participants described that parts would often step in at critical moments to manage distress, disrupt awareness or distract from trauma-related experiences:

> *"But it's helpful because sometimes it's just like, you need to crossover. This isn't safe. You need to get out of here. This isn't a good place to be. And I'll—9 times out of 10, I'll do as they say because they've got information clearly I don't. Whether it's just the fact actually it's bringing up trauma for them and they don't wanna deal with that… I have to respect that." (Columbia)*

Columbia's description highlights that switching for protection is often not a conscious choice, but a reflexive response to perceived danger. Her trust in her system reflects an intuitive reliance on parts that hold knowledge or awareness. She also illustrated how this process of switching enabled her to navigate challenging situations by allowing parts with specific and relevant skills to step in when needed. Similarly, Olivia explored how switching for protection could also impact memory, emotional processing and autonomy within the system:

> *"I think we must switch and then switch back. It's really, really strange. It's like someone switches in until we get to a certain point. It's like they carry you until you get to a certain point and they're like, right, I'm going to carry you because I know you're tired. I know you can't carry yourself, but also in the meantime, because it's too early and you haven't processed it, you're not allowed to speak… And I feel like the managers of the system are like parents, and they're sweeping in and saying, 'This is too much for you. Let us do it.' And it's like—but we want to do it." (Olivia)*

Olivia's experiences capture how switching can function as a protective delay, preventing difficult emotions from being experienced until the system is ready to engage with them. Unlike Columbia, Olivia conveyed a less collaborative experience of switching, illustrating how specific parts could sometimes "sweep in" without her awareness or agreement. As

Olivia moved towards actively wanting to process her trauma, she needed to negotiate with Esme, her manager part, encouraging her to step back and trust that Olivia could handle difficult feelings. Whilst Esme's intentions to protect were vital, Olivia identified that this shielding also became a barrier to healing and therapy. This illustrates how dissociative systems may require internal negotiation and compromise to enable growth and change.

When switching for protection was no longer effective, participants described shutdown as a last-resort survival strategy. Many identified specific parts responsible for initiating a shutdown response, stepping in when distress or internal conflict became unbearable. Shutdown was frequently experienced as a retreat into numbness, disconnection, unresponsiveness, or even sleep, serving as a means of temporary escape or disrupting awareness of trauma-related distress. After describing an instance of internal conflict between two parts who were fighting for control, Eloise described her experience of mental and physical collapse:

"I literally just had to go to bed. It's like my head just caved in… then I would just shut down. I had to go to bed ..... we used to have these earthquakes and it was like all the pieces came down and we kind of go down for a bit and then we'd wake up and they'd be back together in a slightly different form." (Eloise)

Eloise constructs dissociative shut down as a reflexive mechanism, aimed to reset physiological state and regain balance. The metaphorical use of an earthquake conveys the powerful and all-encompassing nature of this shutdown survival response.

The protective benefits of parts

Despite the challenges associated with dissociative fragmentation, participants consistently described their parts as a source of strength, adaptability, and companionship.

Many participants viewed their parts as an internal support network, highlighting how their parts had taught them valuable lessons, provided validation, and reinforced their sense of self-worth:

"That's only sort of half the story. The other half of the story is also a joy in life and an absolute joy in having a different way of looking at life and a different experience of life. And… I sometimes feel as though I see things more vividly, and there is something rather beautiful in that…" (Rachel)

Rachel's reflections emphasise that her parts enriched her experience of the world, adding depth, richness, and meaning to her experiences. Rather than viewing her parts as solely a coping mechanism, she described them as integral to how she experiences life itself. At the same time, she acknowledged the pragmatic benefits of dissociation:

"But equally, not remembering… Again, I'm gonna say it, but it it it's very true. Not remembering is also rather lovely. Because… it wasn't very nice…" (Rachel)

Her words highlight the dual nature of dissociation—while it can create challenges, it also provides relief from suffering. This perspective frames parts as an advantage, as many participants reflected that, without their parts, they would not have been able to navigate life as they have.

When describing how their parts protected them from the legacy of trauma, the emotional tone of participants' narratives was often marked by appreciation, awe, admiration and relief. Participants often expressed a profound sense of gratitude for how parts had enabled them to survive the un-survivable. This appreciation highlighted that although dissociative systems originated from trauma-related experiences, parts are not solely defined by suffering. This theme highlights that gaining insight into the experiences endured by parts, and understanding how the system is structured for survival, enabled participants to remember trauma and abuse through parts, serving as a crucial first step in initiating healing and grieving.

Theme Six: Building a Home for Parts: *"Forgiving each other inside"*

This theme explores the ongoing and often challenging journey of living with and caring for dissociative parts, as participants worked towards healing, adaptation and co-existence within their system. This theme highlights how participants actively built an internal home for their parts, fostering mutual respect, internal collaboration and a sense of belonging. This theme outlines ongoing complexities of managing daily life as a system, including internal and external relationships, societal stigma and emotional processing.

Living as an internal family and community

Participants consistently emphasised that creating a home for parts involved functioning as an internal family, community, or team, where parts supported, protected, and learned from one another:

"We see ourselves as one person but also as separate. I know all of my alters are me and I'm them, but we also maintain a good amount of individuality. We coexist in a way where all of us can get our needs met to live a fulfilling life. A lot of us have familial bonds with each other for example Herta is a mother figure to Elio, and honestly most of the system. Elio is a little brother to most of us. We tend to see the child alters as our little siblings and have a need to protect them from harm." (Laika)

Laika highlights how each part has a place within the system and familial bonds mirrored real-world family structures, with parts taking on parental and sibling roles. This suggests that building a home for parts is more than co-existing together, instead it is about nurturing meaningful connections between parts and fostering a sense of community.

"We've spent so much time together now that we're beginning to take on some of each other's traits. [laughs] I really like seeing it in young ones who I think, like all children, learn from the adults that they look up to and that look after them. So, I find it quite sweet when there's also kind of.... when I'm seeing traits of other adults in them that they've made their own. So, I think living together is very much a shared thing. I think as soon as we realised what was happening for us, it was important to us to find a way to live together that was as egalitarian as possible." (Emma)

Emma's reflections portray how younger parts appeared to learn from older ones, illustrating the perceived influence that parts could have on one another. Their account conveyed that parts were experienced as playing a meaningful role in each other's healing. Their laughter and warmth suggest a sense of nostalgia, highlighting the genuine love and care which has been created within their system. Their emphasis on maintaining an egalitarian environment highlighted a conscious effort to cultivate belonging within their internal world.

The internal family dynamic extended not only to protection and support but also to active parenting of little parts:

"We began to carry tiny little dolls that would fit into the palm of our hands. If we knew that someone young was struggling, we could take out this doll and treat it as a proxy for that person. It helped introduce a little bit of routine, where at a certain point in the evening, we would tuck in their doll to bed, and I would start to feel them settling down." (Emma)

Emma's use of an external object as a symbol of internal caregiving reflects a creative and practical method of soothing younger parts. Participants often devised innovative and unique ways to meet the needs of their young parts, who often required nurturing, structure, guidance and opportunities for play:

"Little ones are not allowed to touch anything sharp or hot or answer the door or do anything that's dangerous or anything that they don't know how to do because… they don't have danger perception. They don't have the knowledge that the rest of us have… So, we have to kind of limit what they do. It's hard 'cause they're around quite a lot, and I think the reason they're around is because they connect us to parts of our humanity—like creativity and awe—that's kind of important for meaning in life." (Ellie)

Ellie's description portrays that the nurturing of little parts resembles aspects of external parenting, where boundaries are developed to ensure protection. Ellie's reflections frame little parts as serving an important role in preserving creativity and joy, much like in a typical family. These narratives indicate that little parts were not solely associated with vulnerability but were also seen as contributing to the system's sense of meaning and connection.

However, maintaining harmony within the system required ongoing negotiation of internal disagreements:

"If we got angry with each other… what we ended up doing in those situations is having other parts talk—a bit like, you know, in a family, 'I'm not talking to her, so you can tell her.' [laughs] You know, because not all parts will always get along all the time. They won't. People think, 'Oh, this is great. You've got friends in your head.' No, it's not that way because we've all been formed for different reasons. We all have our own views on things. And sometimes we really just don't agree with each other… In a healthy-ish family unit, you're going to have times where you love each other, but you're just going to get on each other's nerves, or you're just not going to agree … we're all living in this one body, so we've got to try and work together as best as we can to move forward. And that means sometimes people are going to have to compromise things that they don't like." (Catherine)

Catherine’s description of their system highlights that much like any family or team, living together required constant negotiation, compromise and sacrifice. Her structural use of “we” pronouns represents the collective nature of decision making within the system and the necessity of internal cooperation, which was echoed across all participant accounts of internal negotiation. This conveys that while disagreements were inevitable, choices are not made by an individual part, but rather through collaboration between all parts, which was often an ongoing and time-consuming process.

The ability to compromise, learn, negotiate and develop internal cooperation represents that parts are not static, but are capable of growth, adaptation and personal development. Julia described how a teenage part, Juno, woke up from dormancy, leading to a period of instability due to Juno’s emotional needs. Through building meaningful external relationships with Julia’s partner and their children, Juno developed confidence and began contributing to daily life responsibilities. During their interview, Juno herself shared her perspective:

“…They [Julia] were talking about how things have changed for me… Like, since I knew about everything, and like… what it was like to not be believed before. And then to be believed and to get trusted and all that… With [partner’s system], she just believed in me so much, so it made me believe in myself more. And then like, I got a bit more confident and stuff…” (Juno, Julia’s part)

Juno’s account conveyed that growth in parts was often shaped by external factors such as validation and acceptance from others. Her narrative also suggested that part’s personal development could occur independently to other parts and often in the background. Individual changes in parts appeared to contribute to system-wide changes, with ongoing development described as a natural and evolving aspect of system life.

Navigating internal needs amidst external demands

While participants cultivated an internal sense of community and adapted to evolving system dynamics, they simultaneously grappled with societal stigma and external relationships. Participants often conveyed a deep awareness of how current and historic stigma surrounding DID shaped their internal world:

"There are more subtle things about…. um… identity and not… being allowed kind of socially or… to just be who you are. So, there is… some parts feel that they're not allowed to be because they're not what's expected from other people… and so…. it's not really like… trying to fit in, it's, it's more the opposite. It's like trying to… not be who you are rather than trying to fit in…. and I think that has a massive effect on… self and identity that is very difficult to manage." (Ellie)

Ellie's reflections highlight the tension between internal acceptance and external rejection, illustrating the ongoing difficulty of building an internal home for parts when the external world dictates that parts are unacceptable. The expectation to suppress certain parts for external acceptance contradicts the goal of creating a space where all parts are valued, posing a barrier for internal cooperation. Similarly, Rose described how societal misunderstanding shaped her self-worth:

"I didn't have the confidence to say very much, in those days because I wasn't, I didn't feel, I still don't, I think is the problem. How can anybody love me? Because they don't know me. If they don't know me. They can't love me. They don't understand me. They can't love me. And anyway, I'm not particularly likeable, you know what I mean, so there's always that there." (Rose)

Rose's words convey how societal stigma and misunderstanding can be internalised, leading to self-doubt which impacts both the relationships between parts and the ability to engage authentically with others. The stigma surrounding DID created a barrier between their internal worlds and external relationships. As internal relationships strengthened, tension between internal authenticity and external conformity due to stigma appeared to reinforce social isolation and disintegration, impeding the process of building a home for parts. Participants disclosed that these barriers to being authentic greatly impacted their ability to form relationships and explore intimacy:

"I haven't been intimate with my husband for years because the Littles are scared. I think because of trauma. The older ones don't worry about it because they're dissociating. Nobody's thought about speaking to him about it." (Olivia)

Olivia's reflections illustrate how the internal needs of parts can clash with the external demands of romantic relationships, suggesting that systems may have to make sacrifices for internal stability. An unintended consequence is that participants continued to be disconnected and isolated from meaningful external relationships altogether, leading to a deep sense of loss.

Ongoing healing and grieving

Whilst it was common for participants to express deep appreciation for their internal team of parts, they also described ongoing moments of resentment, frustration and grief over sacrifices made to maintain system stability. Managing the complexities of an internal community meant making choices which were often accompanied by loss of time, memories, opportunities, relationships and autonomy. When recounting these aspects of their narratives, participants often became tearful or emotional, conveying the depth of their ongoing grief when building a home for parts:

"I guess I feel very angry towards my parts and the diagnosis itself because it's taken so much away from me. So, it's taken away my, my work, I don't work anywhere near the

level that I was working at before… and I kind of think… and I'm angry that, that was taken away from me because of my parts and my DID diagnosis…. You feel really robbed. And then it's like… you're angry at the parts. But then you actually when you, you start pulling it back, you go, actually, I'm angry at what happened to me as a kid." (Riquitta)

Riquitta's use of the word 'robbed' conveys the depth of her loss, suggesting that fundamental aspects of her identity and aspirations felt taken from her. Her reflections construct an ongoing tension between gratitude and resentment; whilst parts were understood as protective, their actions were also experienced as limiting their opportunities. Her realisation that her anger is ultimately directed at her past trauma conceptualises the complex process of grieving and reconciling loss with understanding, emphasising the ongoing emotional labour of building a home for parts.

At the heart of this process was the recognition that every part mattered. This commitment extended even to parts that were difficult for the system to coexist with, emphasising that no part should be left behind or ostracised. Lauren described how a pivotal experience occurred when writing about their experiences:

"[therapist name] said, talked to us about forgiveness, which of course we completely freaked out because we thought she meant forgiving abusers and she went no, I mean forgiving each other inside…We started to look at the Desmond Tutu model of forgiveness … And he talked about the first part of that process of forgiveness is telling the story. And so, we were doing this, writing this book, telling this story and different parts were having their say, and others were listening to their story. And that meant it was- They saw the different perspectives. And that helped us so much in terms of acceptance of our past wasn't what each of us thought it was. It was amalgamation of all of it, and also it brought up massive grief. Because the denial was no longer able to be as strong. So, then we went through a huge

grieving process, which actually is part of the Desmond Tutu thing anyway. That once you've told your story and you've been heard, grieving can lead to forgiveness. And so, it has started this process of….forgiving each other. We're not there by any means. But yeah, that was significant….. parts are- they needed healing themselves for us to heal as a person.” (Lauren)

Lauren’s experiences underscore how the process of bearing witness to each part’s life story was a fundamental step towards healing. Her reflections also imply that the reduction of denial enabled her system to begin the process of grieving. Storytelling enabled Lauren’s system to acknowledge harm, validate pain, reconcile differences and reframe collective experiences, with every part playing an integral role in this process. The recognition that each part’s individual journey was important for the whole system’s journey reflects the significance of taking a parts-informed approach to healing. Lauren conveyed that this process of collective grieving and forgiveness enabled parts to reclaim autonomy and rewrite internal roles, building a sense of community:

“There used to be like a barbed wire fence between the two sides, and there isn’t anymore.” (Lauren)

The metaphor of a barbed-wire fence being removed powerfully illustrates the shift from a system divided by trauma to one rooted in mutual support and a shared sense of purpose and compassion for each other. Healing, grieving, and growth were described as ongoing processes that required continuous therapeutic support.

Functional multiplicity

Participants narrated that the goal of healing was not integration or eradication of parts, but coexistence, internal cooperation and *“functional multiplicity”*. Some participants reported fusions in which two or more parts came together to integrate, becoming one part:

"I think sometimes there's choice about it very, um, deliberate choice, you know explicitly. We want a fusion. This is a fusion we want and hope for it. Um…Sometimes it seems to be spontaneous. Umm and sometimes it seems to be kind of happening over a long period of time where parts grow closer and closer together, share more and more, and then just naturally the brain goes, oh, we can do this….When we first, Julia and Jackie first- we fused together. I think we were together for about a week and then there was something, I don't remember what it was, but I think there was something that knocked the system and we came apart again for a few days." (Julia)

Julia's reflections highlight the varied and fluid nature of fusion, illustrating how it can occur through intentional effort or spontaneously. Her description challenges the notion that fusion is a permanent event, instead presenting fusion as a dynamic process which is associated with relationships between parts. Although some participants experienced fusions, none reported full internal integration, and most expressed a preference to remain as they were:

"You've got older as a multiple of people… and so losing…those people is an unbearable thought because they have been with you for 60 years. And so, they feel like another essence of who you are. And so… to get rid of them… it feels like you would be killing yourself. And therefore, it is unbearable to think of losing a fundamental part of yourself." (Rachel)

Rachel's reflections illustrate that integration for her would not be experienced as healing, instead it would be experienced as a threat and an unbearable loss. This conveys how participants could perceive it as potentially harmful to view dissociative parts solely as a response to trauma that must be resolved. Participants consistently emphasised that parts are a core feature of identity and personhood, as their selves cannot be experienced or understood without parts.

Reflexive engagement highlighted that the tone of this theme could stand in sharp contrast to the fragmentation, chaos and self-doubt explored in earlier themes. This narrative shift may partly reflect the structuring influence of the narrative research process itself. The act of thematically organising participants' stories together, and of writing a thesis that seeks to make sense of complex and ongoing processes, may risk imposing a sense of resolution that may not fully reflect the lived, non-linear nature of healing in DID. Despite years of progress, participants acknowledged their healing was incomplete. Narrative structural analysis reflected this ongoing journey, as stories about parts remained unfinished, with new parts emerging, previously inaccessible memories still surfacing, and system structures continuously adapting. Participants emphasised that long-term, consistent therapeutic support was not optional but essential, enabling them to navigate these ongoing internal demands.

Throughout all narratives, participants often used plural pronouns such as “we” or “our”, linguistically reinforcing their system's collective nature. Therefore, building a home for parts was a dynamic process of negotiation, compassion, care, sacrifice and collective healing. This process was often complicated by ongoing grieving and loss, in addition to societal stigma and social isolation, creating barriers to internal acceptance. Healing was not characterised by integration, but by strengthening internal relationships and fostering a sense of community. Living with dissociative parts was often not framed as an illness or a disorder, but rather as a way of existing which is tied to personal meaning, lived experience and identity.

Chapter Five: Discussion

Overview

This discussion chapter revisits the central research aim: to explore participants' subjective experiences of living with dissociative parts through storytelling, and to examine how they make sense of the roles and functions their parts play in daily life. Rooted in a phenomenological and narrative framework, this research study intended to prioritise participants' language and meaning-making processes regarding their often-unobservable internal worlds (Calland, 2022). Through thematic narrative analysis of twelve in-depth narrative interviews, six themes were developed. These captured both the uniqueness of each participant's journey and shared patterns across stories, illustrating both the ongoing challenges and benefits of living with dissociative parts. These themes highlight the distinct nature of parts and convey an overarching narrative structure which was evident across participants' stories; from the hidden nature of parts, initial denial and unawareness, to processes of system discovery, relational navigation and meaning making through looking inwards, toward the ongoing process of healing and maintaining the complex and dynamic needs of an internal community.

Whilst the results chapter privileged participants' voices and prioritised their subjective experiences and meaning making (Chandler et al., 2015; Coburn, 2025), this chapter adopts a more interpretative and analytical stance (Kim, 2015). While participants' perspectives remain central, this chapter takes a more evaluative and reflexive position. The researcher's voice is brought forward to critically engage with the data, synthesise findings, and situate them within relevant empirical, theoretical, clinical, and cultural frameworks. Some reflexive commentary is presented later in the chapter in italics and first person to illustrate the researcher’s interpretative presence. This shift reflects the dual commitment of this research; to honour lived experience while also contributing to conceptual understanding and while developing an empirical basis in an under researched area. Furthermore, it is acknowledged that the nuance and depth of participants’ experiences cannot be fully captured or honoured within the constraints of the thesis word limit.

Summary and Integration of Findings

This section synthesises and integrates the six narrative themes, identifying key findings and drawing connections between participant experiences and wider clinical and conceptual frameworks. While each theme captured a distinct aspect of living with dissociative parts, together they narrated a shared journey and overarching trajectory of participants’ sense making processes.

The Narrative Lives of Parts and the Legacy of Trauma

Participants consistently described their dissociative parts not as abstract or metaphorical constructs, but as experientially real, embodied and emotionally distinct. Their first-hand perspectives illustrated a felt sense that each part held its own unique memories, emotions, preferences, traits, functional roles, core beliefs, sensory perceptions and relational responses, affirming the lived experience findings synthesised in the introduction chapter (Chametzky, 2022; Marais et al., 2022; Sagan, 2019; Zeligman et al., 2017). This rich individuality was rooted in the unique stories and life experiences carried by each part, with parts even holding their own gender and spiritual identities. These accounts strongly resonate with Öztürk & Sar’s (2016) framework, which positions dissociative parts as purposeful and internally coherent identities, each formed around a specific “mission” or subjective role within the system. These roles are not arbitrary or merely reactive, but they are experienced as deeply meaningful and intentional responses to different aspects of lived experience. Participants perceived their parts as caregivers, advocates, protectors, friends and organisers, each with distinct motivations and internal logic. Consequently, no two participants' systems were alike, as each was shaped by the deeply personal configuration and relational dynamics of their unique parts. Participants even described that parts operated independently in the background, contributing to perception or observing and waiting until their presence was needed. The internal coherence of parts reflects a phenomenological understanding in which the meaning and agency of each part cannot be solely reduced to fragmented experience (Howell, 2011).

Theme one illustrated that parts were experienced as internal companions, each with their own versions of reality. Theme five conveyed how their individuality was shaped by the specific traumas they had endured and the distinct functional roles they developed in response to unresolvable danger, relational betrayal and compartmentalised traumatic memory (Van der Hart & Steele, 2022). These roles reflected the motivational systems outlined by Action Systems Theory; whereby dissociative parts embody systems focussed on different domains, such as caregiving, defence, attachment, exploration, and emotional regulation (Loewenstein & Putnam, 2022). Participants frequently described how younger parts were integral to exploration, creativity, and play; caregiving parts provided internal structure and nurturance; and protective parts emerged to express anger or set boundaries on behalf of the system, thus providing evidence for these theoretical conceptualisations. The study findings also empirically and experientially bring Structural Dissociation Theory (SDT) to life by illustrating how dissociative parts appear to emerge from structural division of action systems and roles, either oriented around survival or daily functioning (Van der Hart et al., 2006). Study participants described parts that remained emotionally and temporally anchored to traumatic experiences in present time, whilst other parts were entirely unaware and removed from this trauma. These descriptions align with SDT's distinction between emotional parts (EPs) and apparently normal parts (ANPs), where EPs contain traumatic awareness away from ANPs to ensure everyday functioning can continue (Van der Hart & Steele, 2022). However, participants also described exceptions, noting that some parts simultaneously held trauma memories and engaged in daily functioning, suggesting a more fluid overlap between roles than the theory originally defines.

Furthermore, theme five conveyed that trauma was not only compartmentalised across parts, but preserved and re-enacted internally, sustained by the functional structures that had once contributed to survival. Whether intentionally manipulated or organically formed, parts were often described to have internalised the voices and demands of their caregivers and the relational dynamics of the abuse they experienced. Theme five illustrated that this internalisation often manifested as parts who enforced silence, directed blame or punishment inward, maintained unawareness or actively concealed the reality of the trauma. Some described parts which appeared as shadowy figures or presences that shut the system down to regulate awareness. Theme five highlighted that these installed or organically formed parts mirrored the logic, desires or voices of the perpetrator. These parts were often powerful, feared or disavowed within the system, reflecting what Okano (2019) referred to as "shadowy personalities", which are dissociative parts formed through varying processes of identification with the aggressor or emerging as controlling internal figures to ensure system order. Okano defines identification with the aggressor as a defensive process in which the perpetrator's voice, power, perspectives and needs are internalised, forming parts that either adopt the abuser's role, prioritise the abuser's needs, embody their contempt or emulate the protection they did not receive. These re-enactments and approaches could also be understood as structural expressions of Betrayal Trauma Theory (BTT), representing the range of strategies held by different parts to preserve attachment in the aftermath of relational betrayal (Lawson & Akay-Sullivan, 2020). BTT offers a compelling framework for understanding that participants' systems tended to privilege denial, loyalty and compliance to preserve relational attachment, often at the cost of system wellbeing and understanding. This suggests that parts do not only hold trauma, but absorb, deflect and distort traumatic awareness to prevent relational rupture, especially as this trauma is often perpetrated by caregivers whom participants also relied upon for survival (Bistas & Grewal, 2024).

Whilst BTT accounts for the need to preserve attachment in the face of interpersonal betrayal, an emerging concept of Trauma-Coerced Attachment (TCA) offers an extended framework. TCA outlines how prolonged coercion, relational entrapment and psychological captivity can fundamentally alter identity and attachment (Doychak & Raghavan, 2023). Although TCA has not yet been explicitly applied to DID, the present study's findings suggest its relevance. Participants described conditions such as coercive control, mind control, ritual abuse, and sexual abuse, often perpetrated by individuals they depended on for survival. Under these circumstances, their dissociative systems appeared to be structured around preserving the attachment bond through psychological submission, self-silencing, and identification with the abuser (Doychak & Raghavan, 2023; Miller, 2024). This suggests that the trauma underpinning how and why dissociative systems form may not be solely defined by the type or severity of abuse, but by developmental conditions of chronic entrapment, inescapability, and psychological captivity, especially by caregivers. In such conditions, dissociative fragmentation is an adaptive solution in which attachment and functioning are maintained across dissociative parts. Taken together, these theoretical interpretations have important clinical relevance, as it suggests that it is not simply the type or existence of trauma which contributes to DID, but the specific nature of the trauma and the interpersonal context in which it occurs. It also highlights that some parts may resist or disrupt the therapeutic process due to the perceived threat of fully recognising the extent of relational betrayal, particularly when the caregiver remains idealised or emotionally needed (Sachs, 2017). This dynamic was vividly illustrated by participants whose systems often worked to maintain unawareness or disengage from therapy to preserve a sense of internal safety.

Overall, the findings demonstrated that the legacy of trauma was not simply stored in memory but embedded in the relational and functional organisation of the system. The current findings strongly illustrate that parts are not simply differentiated by content, role and affect, but by story. Participants reported a felt sense that each part holds a piece of their life, often completely isolated from the rest of the system. Parts were not static identities but evolving selves with their own developmental journeys. It was only through understanding these individual stories that participants could begin to make sense of their collective experiences and move toward a more cohesive understanding of themselves as a system.

Active Regulation of Awareness and the Hidden Nature of Parts

Themes two and three highlighted a central paradox in living with dissociative parts; that despite profound internal distress, confusion, and fragmentation, participants reported that this suffering was often invisible to others. Previous research has similarly found that DID systems can be highly functional whilst remaining covert, as dissociative parts and internal distress are often not externally distinguishable to others (Calland, 2022; Reinders et al., 2012). The present analysis highlighted that participants' felt sense of internal chaos was often driven by switching and memory disruption processes, which were most impactful during periods of crisis and initial system recognition. This aligns with Chametzky's (2022) findings, which suggest that an initial period of destabilisation and confusion, arising from increased switching, often signals the beginning of a process of ‘discovering and uncovering’ the internal world, even as an outward façade of stability was maintained.

Participants highlighted that this external concealment was closely linked to the intentional hidden nature of parts, often maintained by specific parts who actively disrupted both internal and external awareness of the dissociative system. Several participants defined this concealment as a survival strategy which kept trauma-related information and distress outside of conscious awareness to preserve a sense of normality. This supports the core propositions of SDT, and BTT’s concept of adaptive unawareness, which posits that internal denial and altered memory operate to preserve attachment to unsafe or abusive caregivers and maintain external functioning (Goldsmith et al., 2004). These internal processes of concealment fostered denial, disavowal and self-doubt about the legitimacy of one’s own experiences, which were mirrored and reinforced by social processes of denial and scepticism surrounding the legitimacy of DID and the underlying abuse (Boysen & VanBergen, 2013).

The present study offers a unique empirical contribution by illustrating how dissociative parts are experienced as playing a central role in the active regulation of memory, knowledge, and awareness. This underpins and sustains the mechanisms of concealment that are central to DID. As participants described, memory in dissociative systems is not simply lost or forgotten. Instead, it is functionally compartmentalised through dissociative fragmentation, where specific memories are held by specific parts, often in accordance with the unique aspects of lived experience that those parts carry. Some parts were described as taking on gatekeeping roles, deliberately disrupting awareness or sense-making through switching, temporarily fronting to interfere with consciousness, thus influencing which parts came forward or by shutting down the system entirely. These findings highlight that switching processes may serve an active regulatory function which influences memory disruption, as memory access is contingent upon which part(s) is present. As memory access is mediated by dissociative parts, participants were often unaware of what they had forgotten. Many described how this dynamic made it difficult to trust the veracity of their memories or their understanding of past experiences, maintaining unawareness, ontological insecurity and self-doubt.

Moreover, participants conveyed that the regulation of memory and awareness often interacted with internal conflict (Marais et al., 2022). As systems moved closer toward system recognition, participants described how certain parts responded with increased opposition, often fronting to protect their own priorities or battling for control. This frequently resulted in increased switching, contradictory behaviours, heightened memory disruption, and constantly shifting subjective realities, as competing internal agendas pulled participants in conflicting directions. Previous studies have similarly highlighted how internal opposition is a common barrier to awareness (Calland, 2022; Marais et al., 2022). Participants reported that developing co-consciousness, through fostering internal cooperation between parts, helped to reduce memory disruption, amnesia and internal conflict, as parts became more able and willing to share information across the system. This suggests that the regulation of memory is an intentional feature of DID which maintains internal unawareness and enables external functionality, yet it is also a dynamic process which can evolve and improve over time. These findings raise important questions about how dissociative amnesia is assessed within current diagnostic frameworks, which often presume a passive or static loss of memory (Dorahy et al., 2014). If memory disruption is actively mediated by parts and can shift through relational and therapeutic processes, then standardised assessments may not fully capture the complexity, fluidity and nuance of amnesia in DID.

This active regulation of what can and cannot be known is supported by Öztürk & Sar's (2019) theory of alter formation, which conceptualises dissociative processes in DID as a form of reality modulation which shifts attention and memory through dissociative parts. They propose that, to cope with overwhelming trauma, the mind disidentifies with the traumatic experience, mentally separating it from the self. This process activates the mechanism of auto-reparation, in which dissociative parts are formed as 'copies' that hold and manage traumatic material. They theorise that these parts retain trauma in active memory while remaining isolated from broader consciousness, gradually becoming autonomous and narratively coherent over time. Öztürk & Sar (2019) suggest that healing involves building bridges between these isolated internal states. Similarly, Chametzky's (2022) stage of 'opening up' captures how internal trust facilitates the discovery of hidden truths, marking a shift towards greater self-knowledge and memory access. Notably, Chametzky states that this stage is often preceded by increased internal conflict, as the system begins to develop initial awareness. The flexibility and non-linearity of this process, as emphasised by Chametzky, was echoed in participant's narratives which similarly emphasised that DID is a dynamic and relational process of self-discovery (theme four) which can arise from increased internal chaos (theme three).

These findings challenge the assumption that DID can be reliably identified through conventional assessment processes or overt clinical presentation. As DID is often internally concealed and not externally observable, this may explain why misdiagnosis is common and prevalence rates are significantly underestimated (Atilan Fedai & Asoğlu, 2022). These findings suggest that DID may be more common than believed. These findings also challenge conventional diagnostic understandings of dissociative amnesia, which often frame memory loss as passive, static or incidental. The findings highlight that memory is not reliably self-reported due to the hidden nature of parts and covert systems. Instead, memories are selectively held and managed by distinct parts, each with varying access to autobiographical memory. Participants' stories revealed a dynamic and active process in which access to memory is constantly mediated, regulated, and negotiated through the actions of dissociative parts.

Vivid Internal Worlds and Systems

Study participants described vivid and immersive internal worlds such as houses with rooms, castles, forests and prisons. Participants conveyed that these were not just symbolic metaphors, but they were experientially real and meaningful psychological landscapes in which dissociative parts could live, interact and even evolve over time. Relationships between parts were experienced as central to this internal world, with many participants describing close alliances, intimate dynamics, hierarchies, rivalries and familial bonds between parts. These relationships were often reflected spatially within the internal world; for instance, parts who shared rooms or internal spaces often represented emotionally significant internal relationships.

These immersive landscapes resonate with Öztürk & Sar's (2019) theory of dissociation as a form of reality modulation, in which dissociative systems shift between internal zones of reality (e.g. fantasy, dream, imagination and utopia) in response to trauma. According to their model, these internal zones of consciousness become subjectively real, sensory and relational spaces, rather than metaphorical or purely imagined constructs.

Participants' descriptions of discrete internal spaces, such as individual rooms or castles, mirror the structural organisation of identity and consciousness into functionally autonomous spaces. For instance, some participants described dungeons or basements where trauma-based parts existed. The immersive worlds described by participants provided a narrative demonstration of Öztürk & Sar's process, depicting how dissociative parts exist and operate across different layers of reality.

Importantly, these internal landscapes were not static. Participants frequently noted that their internal worlds changed over time in response to shifts in intra-system relational safety, therapeutic progress, and increased internal cooperation. For some participants, these changes symbolised healing and increased internal harmony, for instance a 'barbed wire fence' came down signifying two sides of the system beginning to work together. Participants also described reaching out to parts or discovering them through these internal landscapes. Internal landscapes were not only spaces for containment and communication, but also for relational negotiation and healing. These accounts align with Sagan's (2019) concept of narrative coherence as a process of building an 'internal home' for parts. They emphasised that this was not just a metaphorical exercise; it was an embodied, relational process rooted in sensory experience and active creation.

These internal worlds were individualised, reflecting the structures, needs and rules of each participant's system. Participants described features such as 'fronting rooms,' 'internal noticeboards,' or 'internal social media' as mechanisms through which parts communicated or managed system coordination. Communication within these spaces often occurred in accordance with system specific methods, ranging from internal voices, energetic shifts or visual imagery, indicating the value of internal worlds in fostering and establishing intra-system communication. These internal environments also mirrored and buffered against external adversity, demonstrating how these spaces held dual functions in providing sanctuary whilst also containing re-enactments of trauma. Internal weather systems or environmental shifts within the inner world reflected shifts in internal states and external events. These findings similarly emerged in Somer & Nave's (2001) study where participants' inner worlds provided emotional refuge, relational enactments and psychological escapism. These worlds often blurred the boundaries of reality, indicating that fantasy in DID could be experienced as living a parallel reality.

These findings challenge binary distinctions between fantasy and reality, illustrating that in DID these dimensions are deeply intertwined (Somer & Nave, 2001). The findings also revealed that these inner spaces could both enhance and interfere with external functioning, highlighting a tension between immersion and isolation from the external world. This study conveys that vivid internal worlds are active psychological landscapes in which internal communication, memory access, emotional processing and regulation can occur. The narrative data in this study provides empirical grounding for understanding internal worlds as lived expressions of reality modulation in DID (Öztürk & Sar, 2019). The findings underscore the importance of attending to internal worlds to understand the subjective experience of living with dissociative parts.

Rethinking Multiplicity and Selfhood

The findings in this study contribute to the ongoing debate regarding whether DID represents an extreme on a continuum of dissociative experiences and plural identity or whether multiplicity in DID is categorically distinct. Continuum models (Gentile et al., 2013; Lynn et al., 2012; Lyssenko et al., 2018) propose that dissociative experiences exist on a spectrum, with trauma histories mediating the severity of dissociative disorders further along the spectrum. Furthermore, some theorists believe that the self is inherently disintegrated during early life and becomes gradually somewhat integrated when children experience healthy development, thus implying that dissociative fragmentation arises from disruption to the processes of normative development (Loewenstein & Putnam, 2022). This perspective denotes that many individuals, such as those with DID, remain disintegrated, particularly when there is an unresolved paranoid-schizoid position and unintegrated internal object relations according to a psychoanalytic perspective (Sar, 2023; Segal, 2018). From these perspectives, DID may represent an elaboration and intensification of dissociative capacities and multiplicity that are present to varying degrees in all humans, cautioning against the pathologisation of DID. In contrast, some scholars (Spiegel et al., 2011) have advocated for a categorical distinction, refuting continuum models. They suggest that diagnosable dissociative disorders, particularly DID, are not simply more severe but are qualitatively, neurologically and functionally different. Dell (2006) proposed that DID represents a separate class of psychopathology, which extends beyond normative and reactive dissociation, legitimising DID as a distinct and valid phenomena which warrants recognition. Neuroimaging studies have demonstrated that those with DID exhibit both reduced hippocampal volumes and distinct neural activation patterns across dissociative parts, marking structural and functional differences between DID and those without DID (Lebois et al., 2022; Reinders et al., 2014).

The present study contributes to both positions and advocates for a ‘both-and’ perspective rather than an ‘either-or’, not seeking to resolve this debate but to spotlight its complexity. Importantly, as the present study is grounded in subjective experience, the nature of inner selfhood remains ultimately unknowable to others. Therefore, comparisons between normative and dissociative experiences of multiplicity can only be explored tentatively, recognising the epistemological limits of understanding subjective experience. Theme three described experiences that echo normative internal fragmentation such as experiencing multiple and simultaneous emotional responses, shifting perspectives, contradictory states, inner dialogues and the capacity to adopt different social roles. These experiences align with psychoanalytic and existential views that a unified self is an idealised construct, and that inner division and self-estrangement are inherent to human existence (Miller, 2009; Winnicott, 2018). However, participants also described phenomena that clearly distinguish DID from normative multiplicity and disintegration, such as memory alteration, loss of time, distinct embodied states, internal hierarchies and the lack of an experiential core self. This was further supported by those participants in this study who did not report a host or core identity, highlighting the fluid and decentralised organisation of selfhood within dissociative systems. Dissociative parts were experienced not as facets of a shared personality, but as distinct individuals with divergent and often conflicting identities and bodily experiences. For many participants, this fragmentation was accompanied by a felt sense of unreality, self-doubt and difficulty trusting the legitimacy of their own experiences. This existential uncertainty about the self resonates with Laing's (1994) concept of ontological insecurity; referring to a state in which the very experience of being a coherent and real self in the world feels fragile or threatened. These findings suggests that the subjective experience of DID may extend beyond structural fragmentation, encompassing deeper disturbance in how secure or coherent the experience of being a self can feel. This may represent another layer of difference that contributes to the distinctiveness of DID.

Additionally, a common experience reported by participants was discovering actions, memories or thoughts that they had no recollection of performing or owning, highlighting a level of discontinuity which is not typically present in normative shifts of mood or perspective (Eve et al., 2024). In particular, the active regulation of memory and awareness through dissociative parts underscores the structural organisation and defensive purpose of dissociative fragmentation in DID, marking it as qualitatively distinct from everyday multiplicity and supporting Dell's (2006) propositions. Moreover, vivid and dynamic inner worlds reflected how dissociative parts are experienced to live, grow and interact as independent selves, whose existence and agency extended beyond normative parts of the self that are observed in the general population (Pais, 2009). Therefore, the study findings suggest that DID may be best understood as a trauma-specific version of human multiplicity, one that shares elements with normative experiences of selfhood whilst being functionally distinct.

Participants reflected critically on the concept of integration or fusion, questioning whether becoming a singular, whole and coherent self was either possible or desirable. Not all systems identified a host identity, and all participants rejected the idea that there had been an original, undivided self which existed prior to their trauma. Instead, participants expressed a preference for remaining functionally multiple, resonating with literature which redefines integration as fostering internal collaboration rather than becoming whole (Barlow & Chu, 2014; Clayton, 2005; ISSTD, 2011). This challenges the therapeutic aim of final fusion and raises broader questions about whether an integrated self is a psychologically realistic goal. *My own therapeutic engagement with my inner parts and fluctuating internal states driven by my own multiplicity shaped the lens through which I made sense of participant narratives and enhanced my sensitivity to their experiences. Yet, reflexive engagement helped me to recognise that my own disintegrated states were held together by a core sense of self which did not disrupt functioning or coherence in the way participants described. This potentially implies that multiplicity alone does not define DID. Instead, dissociative parts in DID are* *characterised by how the system has been shaped by trauma and how it uniquely relates to domains such as awareness, internal structure, memory and embodied internal worlds.*

From psychoanalytic, existential and cross-cultural theories of the mind, the self has long been understood to be inherently fractured and context-dependent (Altman & Coe, 2013; Markus & Kitayama, 1991; Woolley, 2007). Furthermore, cross-cultural literature emphasises that in many non-Western cultures, multiplicity is often normalised because the self is assumed to be relational, interdependent and contextually fluid (Seligman & Kirmayer, 2008). Within this framework, shifts in consciousness, identity and memory due to unknown forces are common experiences, which are even culturally and spiritually sanctioned. What is understood in Western cultures as split off parts of the self, is instead understood in non-Western cultures as spirit possession, ancestral communication or trance which are linked to individual capabilities (Hollan, 2000; Seligman & Kirmayer, 2008). In both cultural contexts, a distinct phenomenon is occurring in response to specific circumstances, suggesting that multiplicity is not only a phenomenological concept but also culturally constructed. These interpretations are underpinned by the study's phenomenological philosophical framework, which recognises the self as defined through subjective experience rather than as a pre-determined or universal concept (Van Manen, 2016; Zahavi, 2003, 2008). From this perspective, the reality of multiplicity is not dependent on whether dissociative parts are objectively 'real' or verifiable, but on how they are subjectively experienced, narrated, and understood by participants themselves. As a predominantly White British sample, participants in the present study likely struggled for legitimacy within a dominant cultural context that pathologises plurality.

These reflections suggest that although DID is functionally distinct, it reflects a universal human capacity of the mind to adapt and respond to extraordinary circumstances. The findings of this study overall suggest that DID may be best understood not necessarily through the presence of multiplicity, but as a trauma-mediated and enhanced form of multiplicity which is distinct and functionally unique.

Clinical and Practical Implications: A Parts-Informed Approach

Drawing on the study's findings and key clinical literature, this study proposes a parts-informed approach to DID clinical practice and research (Boon, 2011; Fisher, 2017; Howell, 2011; ISSTD, 2011; Mosquera, 2019, 2020; Sinason, 2002). A parts-informed approach recognises dissociative parts as experientially real, embodied and central to survival and functioning, rather than as metaphorical or defensive constructs (Howell, 2011). A parts-informed approach builds on trauma-informed principles (Reeves, 2015) and can be integrated into a range of therapeutic frameworks and modalities. The study defines this approach as a clinical stance that explicitly appreciates the meaningful presence, influence, and relational dynamics of dissociative parts.

This stance highlights the importance of adapting clinical and research practices to engage directly and respectfully with parts as integral to supporting the whole person, recognising internal worlds and the unique needs of dissociative parts as central to therapeutic work. This approach invites clinicians to listen across multiple internal voices and to work relationally with the entire system. It includes meeting systems as they are and respecting functional multiplicity as a valid and meaningful way of being. Participants in this study highlighted that when parts were acknowledged and respected in this manner, they felt more understood, empowered, and better able to move towards internal cooperation on their own terms. This study demonstrates that a parts-informed approach holds the potential to enhance therapeutic attunement, increase engagement, reduce misdiagnosis, and more effectively support complex dissociative presentations (Fisher, 2017; ISSTD, 2011).

Parts-Informed Diagnosis

The study findings raise critical considerations for how DID is diagnosed, particularly in relation to memory and awareness. Participants consistently described systems that were not only concealed from others but often hidden from themselves, consistent with existing literature (Calland, 2022; Howell, 2011; Neves & Conceição, 2025). For most participants, system discovery was gradual and implicit. Many described extended periods in which they were unaware of the existence of their parts, which was frequently maintained by parts who actively disrupted memory, knowledge and internal awareness. This has important implications for diagnostic practices, especially when assessing for amnesia through structured tools such as the SCID-D (Dorahy et al., 2014; Sar, 2011). Participants were often unaware of what they had forgotten, highlighting the inherent limitations of relying solely on self-report to accurately recognise dissociative amnesia. Therefore, a parts-informed approach to diagnosis acknowledges that the hidden nature of parts, and the system's capacity to obscure its own internal reality, may make DID difficult to identify through conventional assessment processes. The findings suggest that the active regulation of memory and awareness in DID is not incidental but rooted in survival. Dissociative systems are designed to keep distressing knowledge out of consciousness to maintain psychological functioning and relational attachment (Howell, 2011; Van der Hart et al., 2006; Van der Hart & Steele, 2022). From this perspective, unawareness is not a barrier to diagnosis, instead it is an inherent part of the lived experience of DID itself (Loewenstein & Brand, 2023). Therefore, diagnostic processes that rely too heavily on self-disclosure, observable switching, or brief clinical assessments may risk overlooking covert systems, particularly those that function through co-consciousness, subtle switching, or denial.

The study also highlighted that participants' understanding of their internal world developed gradually through processes of relational safety and internal discovery. Participants described how turning inwards, often initiated by receiving a DID diagnosis, was a transformative process that enabled them to explore their system structure and build internal relationships. This suggests that receiving a DID diagnosis marked the beginning of a slow dismantling of unawareness, creating space for previously hidden truths to emerge and fostering more meaningful internal communication (Chametzky, 2022; Floris & McPherson, 2014; Tomlinson & Baker, 2019). Therefore, a parts-informed approach to diagnosis challenges the assumption that awareness of multiplicity must precede diagnosis. Instead, a parts-informed approach recognises that the diagnostic process itself can facilitate awareness and initiate the development of an internal community. However, it is noted that this introduces a diagnostic paradox for some; while dissociative systems may have limited awareness of their own multiplicity or amnesia prior to diagnosis, current diagnostic tools often require this very awareness to be demonstratable for the diagnosis to be made (Howell, 2011; Loewenstein & Brand, 2023).

Therapeutic Relationships and Dissociative Parts

Although some concerns have been raised that engaging with parts could risk iatrogenic harm by reinforcing fragmentation (Merckelbach et al., 2002), the present study findings suggest otherwise. Participants emphasised the pivotal role of therapists who acknowledged and welcomed dissociative parts, without fear, scepticism, or reductionism. Participants stated that therapists modelled internal acceptance, validated the existence of parts and supported participants' journeys in building internal relationships and a sense of community (Turkus & Kahler, 2006). Conversely, therapeutic relationships in which parts were dismissed, denied or invalidated, or where participants were expected to present with a specific or singular self often exacerbated internal conflict, heightened perceived relational threat and deepened self-stigma. Furthermore, participants described that parts frequently observed from the background or maintained some external awareness, often only emerging when relational safety was established. This supports findings from Brand et al. (2014), whose longitudinal research demonstrated that direct engagement with parts within therapeutic work improved engagement and reduced symptomatic distress over time. Crucially, therapists who refused to engage with parts missed vital opportunities to witness and understand their client's life histories, which was echoed by study participants (Fisher, 2017; Van der Hart et al., 2006).

Participants highlighted that each part had unique attachment needs and relational styles, emphasising the importance of supportive personal and professional relationships where others took time and additional consideration to build rapport with each part. From this parts-informed perspective, therapists should actively seek to develop distinct relationships with dissociative parts, recognising each part's distinct traits and relational needs. This research itself employed a parts-informed approach which supported engagement, in which the researcher actively invited systems to share the relational needs of their parts, introduced themselves directly to those parts who chose to engage, and met each part at their current relational level - endeavouring to ensure all parts felt acknowledged and accepted.

This approach also recognises that therapists may encounter fragmented, often contradictory transferences and counter-transferences within the same therapeutic relationship (Loewenstein & Brand, 2023). As multiple parts emerge throughout the work, the therapist's emotional responses and perceptions of the client may continuously shift depending on which part is present (Kluft, 2000). This may help to explain why clinicians commonly report feelings of confusion or ambivalence when working with DID clients. It is also possible that the therapist's countertransference may echo the client's own internal denial and disbelief, particularly in relation to the reality of dissociative experiences (Loewenstein & Brand, 2023; Stubley, 2014). This mirroring may help to explain why participants described encountering scepticism and invalidation both within themselves and in clinical settings. However, when therapists can attune to these relational fluctuations, they gain valuable insight into the internal dynamics of the system itself (Kluft, 2000). This highlights the importance of ongoing reflective practice and supervision in supporting clinicians to remain grounded, responsive, and relationally attuned within a parts-informed framework.

Parts-Informed Therapeutic Intervention

The findings of this study offer key implications for psychological intervention with DID clients, particularly in advocating for a parts-informed approach to therapy. Healing was not framed as eliminating multiplicity, but as a dynamic process of negotiation and an ongoing journey of building an internal home for parts through internal collaboration. Participants described parts-informed therapeutic interventions as pivotal in facilitating this internal change, highlighting the need for therapeutic models that are flexible and responsive to dissociative parts. However, the study findings also caution against the use of some parts-informed therapeutic models, such as IFS without DID-specific adaptations, as dissociative systems may operate through distributed relational governance rather than a consistent, authoritative core self which is assumed in IFS (Loewenstein & Putnam, 2022; Pais, 2009). The findings suggest a therapeutic trajectory which closely aligns with the ISSTD's phase-oriented treatment model (2011), while also extending and adapting it by offering lived experience insights into how dissociative parts actively shape and participate in each therapy phase, as presented below.

Phase 1: Negotiating internal conflict, navigating unawareness and building internal communication

Participants described the early stages of their therapeutic journeys as marked by unawareness and internal confusion. The presence of parts was often obscured by active processes of memory disruption and internal concealment (Dorahy et al., 2014; Loewenstein & Brand, 2023). Distress was frequently experienced as internal chaos and disorientation, particularly during periods of stress, life transitions, or the initial discovery of the system. This distress was characterised by increased switching, shifting realities, and competing internal needs, often underpinned by internal conflict between parts. This study found that this turmoil could be reduced by establishing communication between parts, gradually increasing internal awareness and negotiating internal conflict with compassion and curiosity, both internally and within therapeutic work. This reinforces previous treatment guidelines stating that stabilisation and symptom reduction should acknowledge the presence of parts, consider their relational needs and foster internal trust (Boon et al., 2011; Fisher, 2021; ISSTD, 2011; Pais, 2009). Participants engaged in a range of system-specific strategies to support this process, including journalling, internal meetings, symbolic imagery, and attention to energetic shifts. This facilitated communication and information sharing, strengthened co-consciousness and fostered awareness of system-dynamics. Therefore, a parts-informed approach to crisis planning would collaboratively identify triggers for switching and create space for parts to express themselves, recognising that switching often serves a regulatory function (Chametzky, 2022). This phase should involve connection with the inner world, which functioned as sites of refuge, memory, emotional processing and internal connection. These findings are supported by Fraser's (2014) dissociative table technique, which framed early therapeutic work as establishing an internal meeting space where parts can facilitate a dialogue to reduce internal conflict, thus establishing a shared foundation for healing and therapy.

From a parts-informed perspective, this phase is crucial for considering all parts of the system and building internal consensus for therapeutic work. Participants described how some parts held priorities for maintaining internal safety that were in direct conflict with therapy. These parts often disrupted awareness, concealed inner truths and disengaged to maintain silence. In these cases, interference was not sabotage but a relational defence, rooted in protecting the system from unbearable truths. This dynamic reflects cautions offered by Sachs (2017), who argued against assuming internal readiness in clients with 'active DID', referring to those still embedded in unsafe or coercive relational contexts. Sachs's theory draws parallels with the notions of Trauma-Coerced Attachment (Doychak & Raghavan, 2023), emphasising that some parts align with perpetrators or are invested in maintaining attachment and thus resist therapeutic exploration to preserve internal order. Therefore, clinicians are encouraged to view this resistance through a parts-informed lens, acknowledging the system's survival logic in the context of therapeutic work which threatens to dismantle protective unawareness or challenge idealised relational bonds. This foundational work may encourage parts to begin stepping forward, negotiating roles, sharing their stories and participating in healing on their own terms.

Phase 2: Remembering trauma through parts and facilitating shared understanding across the system

From a parts-informed stance, this phase of therapeutic work should focus on how systems can begin to access, share and process traumatic experiences held by dissociative parts. In this study, theme five, which focussed on trauma and survival, was intentionally placed later in the thematic chronology, reflecting how memory integration only became possible once internal awareness and connection was developed (Cronin et al., 2014; ISSTD, 2011). As internal relationships and communication strengthened, parts became more willing to share their stories and bear witness to one another. Participants described that remembering was a gradual and emotionally charged process of fragmented pieces of their story coming together through parts. Some parts withheld traumatic knowledge, others questioned its reality, and some feared the impact of awareness (Raison & Andrea, 2023). These complexities emphasised the need for relational safety, trust and attunement for parts to share their stories and facilitate remembering, not only within the therapeutic relationship but across the internal system. A parts-informed approach to phase two recognises that trauma processing must proceed through careful pacing, active internal negotiation and respect for the readiness of the whole system. These findings may provide an explanation for previous research and clinical literature which indicate that premature EMDR therapy or other trauma processing can lead to destabilisation when systems are not internally coordinated (Gonzalez-Vazquez et al., 2018; Steele et al., 2016).

The findings also revealed the emotional complexity and labour of uncovering trauma in this phase. Many participants expressed deep appreciation for the protection their parts had provided. However, these feelings often co-existed with denial, grief, anger and resentment regarding limited opportunities, missing memories and a disrupted sense of autonomy. These tensions reflected the profound emotional reconciliation required to manage an internal community during this stage of healing (Fisher, 2021; Steele et al., 2017). Participants conveyed that this reconciliation could emerge through internal forgiveness and compassion, grounded in the act of witnessing each other's truths. Although remembering trauma through parts also brought grief, participants emphasised that it was also a turning point which allowed them to make sense of their history and honour the pain carried by their parts. A parts-informed approach to trauma processing recognises that accessing traumatic memory requires more than readiness; it demands internal consent and teamwork, laying the groundwork for shared understanding and system-wide collaboration (Fisher 2017; 2021).

Phase 3: Building a home for parts and thriving as an internal family

In the later stages of healing, participants described ongoing adaptation and the intentional implementation of strategies to support functioning as an internal family or community. Meaningful integration was described not as becoming one, but as building an internal home, functioning together as a team and co-regulating as a system. Therefore, this phase involves fostering and maintaining internal relationships through compassion, sacrifice, collective responsibility and negotiation, echoing Sagan's (2019) framing of healing as the co-creation of a shared internal home. Internal stability was not defined as eliminating multiplicity, but through cooperation, mutual care and the nurturing of an internal community. A central focus of this phase was balancing internal needs with external dynamics and navigating relationships both within and beyond the system in ways that fostered overall connection. As systems faced daily life and external changes, their internal dynamics and structures remained active and evolving. Parts endured their own development journeys and personal growth, re-negotiating roles and locating their place within the system. Participants' internal worlds played a vital role in facilitating this cohesion, offering spaces for connection and belonging, aligning with Lemke's (2004) findings on the function of structured internal imagery. From a parts-informed perspective, this phase is not a fixed endpoint, but an ongoing and non-linear process of relational maintenance, reflecting ISSTD's (2011) guidance that phases are often revisited throughout the therapy. In this phase, clinicians can work collaboratively with systems to define what healing means for each part, supporting each system's unique and ongoing journey toward building an internal home where every part can belong. In this way, the study also contributes to bridging the gap between clinical understanding and the lived experiences of a socially marginalised population, supporting more collaborative and responsive approaches to therapeutic care.

Critical Evaluation and Reflexivity

Reflexivity and Researcher Positionality

I was drawn to a narrative methodology after learning the extent of how systemically silenced and pathologised the voices of people with DID have been, both within clinical settings and research (Boysen & VanBergsen, 2013). This methodology enabled me to privilege participants' perspectives and honour their stories in their own terms, thus resisting oppressive structures and systems which have previously silenced their voices. This aligns with my own personal and professional values and my passion of working therapeutically with marginalised communities. However, in choosing a participant-led approach, I also found that it became more difficult to engage critically and evaluatively with the data. As the research progressed, I became aware of a tension between wanting to amplify participants' voices and needing to bring my own voice into the interpretive process. The weight I placed on protecting and preserving participants' words, particularly in the findings chapter, created an internal resistance to stepping into a more critical role within the present chapter.

I realised that I feared that interpreting participants' narratives too assertively might replicate the oppression and systemic silencing that my participants had experienced. Through reflexive journalling and supervision, I uncovered how this priority was heightened by my own personal experiences of being silenced as a racially minoritised individual with my own health difficulties and other marginalised identities. Over time, this commitment was further heightened by my experience of conducting the interviews, after participants often described that the interview process was healing as they were heard without interrogation, disbelief or dismissal. Their reflections deepened my awareness of how powerful the simple act of listening is and how rare that this experience can be for people with DID.

Through learning about the history of DID, I also learnt that much of the systemic silencing of DID voices is rooted in a pervasive fear of the reality and extent of childhood abuse and trauma (Aquarone & Hughes, 2013). The interpretive process illuminated not just what participants shared, but also what society often resists knowing. I noticed how this fear of hearing and knowing the reality of abuse is reflected both in wider societal denial and in the internal dynamics described by participants. Therefore, the silencing of DID voices is not just a matter of misunderstanding or ignorance, but a deep-seated defence and denial against unbearable realities. Throughout this project, I became increasingly aware of my own positionality, and I developed a deep respect for the complexity and coherence of dissociative systems which represented a form of knowledge which is fundamentally different from my own experience of myself. This realisation provided context as to why participants were transformed by the experience of being heard and why it felt so vital to honour their stories as they were.

It was only through both clinical and research supervision, ongoing reflexive journalling and repeated re-engagement with the data that I began to regain my interpretive voice. Through this process, I came to view interpretation as another way of honouring their stories, placing their experiences in dialogue with broader theory and practice in ways that might improve understanding and recognition of DID. Thinking this through reflexively helped me to strike a balance, advocating for participants' perspectives whilst also contributing to a more nuanced and detailed conceptualisation of DID, which is perhaps the most valuable aspect of my research. This is particularly significant because the study itself focusses on the concept of multiple voices, not just mine and those of my participants, but also the voices and stories of their dissociative parts. The interpretive and reflexive process thus reflected the practice of listening across multiplicity, creating space where multiple truths could exist.

Strengths

A key strength of this study is its use of member checking as a participatory and reflexive strategy to enhance the credibility, interpretive validity and trustworthiness of the findings (Birt et al., 2016). Following thematic development, participants were invited to review their narrative summaries and the final write-up on a voluntary basis. Eleven out of twelve participants engaged with this process. They were encouraged to reflect on whether the findings resonated with their internal realities, what might be missing, and if anything should be revised or removed (McKim, 2023). This advocated for participants' active involvement not only in reviewing transcripts, but in collaboratively shaping the interpretation of findings.

Participant responses were overwhelmingly affirming. Many described the experience of reading the findings as validating, emotionally resonant and even transformative. One participant wrote *"I feel that you have understood DID…the language you used represents my viewed world"*, whilst another shared that it offered *"a new framework and a sense of not being quite so alone"*. Many shared that the synthesised data helped them to understand their own systems more deeply. Another stated; "*Thank you for seeing us. It is like we have been invisible all our lives and you have just shown us we are visible to some people".* These reflections speak to the rigour of the analysis and the ethical and relational responsibility of representing complex subjective experiences (Vella, 2024).

These responses also suggest the themes hold relational credibility by confirming that participants' experiences had been accurately and meaningfully interpreted (Birt et al., 2016). Participants also provided clarifications and corrections which were respectfully incorporated, including preferred pronouns for their parts and conceptual nuances around system dynamics. For instance, some participants refined how their co-consciousness was described, emphasising it as a variable, individualised and dynamic process. These processes of co-construction align with Motulsky's (2021) reframing of member checking as 'reflexive participant collaboration', whereby feedback is not just used to confirm accuracy but to empower participants as epistemic contributors. Furthermore, the use of member checking in this study reflects what Vella (2024) described as epistemologically congruent practice as the process was grounded in a phenomenological framework which honoured participants' perspectives as the primary source of meaning and acknowledged the evolving nature of meaning making.

The study's commitment to credibility and trustworthiness aligns with established qualitative principles (Yardley, 2024, 2000), whilst also drawing on more recent trauma-informed and participatory approaches (e.g. Birt et al., 2016; Vella, 2024). In keeping with these values, the research process also incorporated public patient involvement (PPI), with an expert by experience consulted across multiple stages, including the design of research protocols, piloting of interviews and thematic development. Rose (2013) indicates that PPI can strengthen the study’s ethical and epistemological integrity by embedding lived experience at the heart of knowledge production. She argues that collaboration with those who live the realities being studied generates more contextualised, situated and meaningful knowledge. Therefore, this study addresses a gap in the literature by prioritising lived experience, trauma-informed principles and participatory knowledge production - an approach that is particularly important when investigating a traumatised and historically silenced population, whose perspectives have been marginalised within mainstream public discourse (Loewenstein & Brand, 2023).

Furthermore, this study developed a novel, multi-layered screening process that was both person-centred and methodologically flexible, designed to ensure that participants were emotionally safe to engage with the research. The pre-interview built and fostered the researcher-participant relationship to enhance relational safety. This process also included the development of a tailored safety protocol for each participant to meet their unique needs and manage any risks. Specific adaptations for working with DID invited participants to consider the needs and perspectives of all parts when providing informed consent. This overall parts-informed approach was guided by the principle of inclusion wherever possible, rather than exclusion. These practices reflected trauma-informed principles of choice, collaboration, and safety (Barlow, 2007; Waddell-Henowitch et al., 2024) and are rarely described in detail within published studies with dissociative populations. Therefore, this study offers novel contributions to the field by demonstrating how a trauma-informed research methodology can enable safe, meaningful and ethically attuned participation from DID participants (Barlow, 2007; Boysen & VanBergsen, 2013).

In addition, several models and frameworks that inform current understanding of DID, such as Öztürk & Sar's (2016) theory of alter formation and Structural Dissociation Theory (Van der Hart & Steele, 2022), are primarily grounded in clinical observation and theoretical synthesis. However, these frameworks have not yet been widely supported by first-person qualitative research. This study contributes to addressing that gap by providing empirical support for these models, rooted in rich lived experience narratives.

Limitations

Despite the strengths outlined above, this study is not without limitations and methodological boundaries in which the findings were produced. The sample size of twelve participants, while appropriate for narrative inquiry, reflects a specific and non-representative subgroup. The inclusion criteria limited the sample to those who had undertaken significant therapeutic work, those presenting without acute risk or crisis and those with sufficient internal communication. Although the study's multi-layered screening process was intentionally designed to be inclusive, it was nonetheless biased towards participants with a degree of psychological stability, internal cohesion and robustness to safely engage. Consequently, the findings may not capture the experiences of those who are earlier in their system discovery, those who disengaged from services, those who sought healing through non-therapeutic means such as spiritual practice, or those who experience unresolvable internal conflict which exacerbates risk. This also reflects broader ethical challenges when researching complex trauma populations, where the requirement for psychological safety can conflict with inclusive representation (Newman et al., 2001).

Furthermore, specialist DID therapy is often informed by frameworks such as SDT, which use language and theoretical models which are already represented in the evidence-base. Therapy is itself a process of narrative construction and collaborative meaning-making (Angus & McLeod, 2004). Therefore, the way in which these theories shaped participants' therapeutic experiences will have influenced the way in which they narrated their stories. Whilst this does not diminish the validity of their perspectives, it does warrant caution in drawing direct associations between the research findings and theoretical frameworks, as participants' narratives may have been directly shaped by prior therapeutic exposure to those very models.

The criteria also limited the sample to only those who had received a formal diagnosis of DID through Western clinical frameworks. As explored in earlier sections, this reflects a broader issue relating to an overreliance on Western psychiatric models, which do not account for how dissociation, multiplicity and the self are conceptualised in non-Western contexts (Kruger, 2020; Markus & Kitayama, 1991; Sar, 2022). Moreover, the sample in this study consisted exclusively of White participants from Western societies, limiting the transferability of findings to culturally diverse populations. This may also reflect how the criteria used to verify DID may exclude culturally diverse manifestations of dissociative parts, which might go unrecognised when relying on Western diagnostic frameworks (Lewis-Fernández et al., 2007). Participants' accounts of their subjective realities of living with dissociative parts are thus shaped by an understanding of the self as singular and independent. Therefore, this study reflects an epistemological stance which is rooted in Western psychological discourse. As with all qualitative research (Polit & Beck, 2010), the aim of this study was not to produce generalisable findings but to deepen understanding of lived experience within the unique context of study participants. Whilst the study offers rich insights into the subjective realities and internal worlds of DID, it may not reflect the full diversity of multiplicity experience, particularly those not shaped by diagnostic or clinical frameworks.

DID is a dynamic and evolving condition, and participants shared that their system structures, internal relationships and overall understanding continues to shift over time. Therefore, the study findings only represent a snapshot of meaning-making which is specific to the present period in participants' life journeys. Furthermore, the specific meaning and content conveyed in each participant's interview will have been shaped by the specific parts which were leading interview participation. This is particularly pertinent as participants shared that dissociative parts often held opposing views and subjective realities. While every effort was made to honour the story of the whole system, including inviting contributions from varying dissociative parts where possible, some internal voices may remain absent or only partially represented, thus replicating the marginalisation of dissociative parts present in clinical settings. This may be more impactful for parts who do not possess the capacity to communicate verbally, which highlights the need for diverse and creative data collection methods when conducting qualitative research on DID.

As explored in the reflexivity section, the participant-led nature of this methodology introduced both strengths and limitations. While conscious efforts were made to balance critical engagement with a commitment to prioritise participants' voices, the interpretive process will have been shaped by researcher bias. The researcher's personal and professional positioning, particularly relating to identification with trauma-informed stances and passion for social justice, will have inevitably influenced how participant stories were heard, understood and represented. Whilst these commitments fostered a compassionate and sensitive approach, they may have contributed to specific blind spots. For instance, data that challenged dominant trauma frameworks may have been under-explored, and clinical concepts or language may have been unintentionally imposed on participants' more metaphorical or idiosyncratic expressions. The strong desire to privilege participants' voices may have led to more descriptive than evaluative interpretations, especially in cases where deeper critical engagement may have enriched understanding. Additionally, the pre-interview process, which fostered relational safety, involved prior contact and a degree of familiarity with participants' narratives prior to the main interview. This may have subtly influenced the flow and direction of the main interview. Although reflexive journalling and supervision enabled ongoing examination of these biases, the study findings should be viewed as co-constructed and meaningfully shaped by the researcher's positionality, values and interpretive lens.

Recommendations for Future Research

Based on the findings and methodological reflections of this study, several key directions are recommended for future research which could extend and deepen understanding of living with dissociative parts in DID, outlined below.

This study was limited to a White sample, shaped by Western clinical conceptions of selfhood and dissociative phenomena (Kruger, 2020). As this chapter highlighted, cultural frameworks significantly influenced how multiplicity is interpreted and experienced. Future research could examine how dissociative parts are understood in non-Western cultures where plural selfhood may be culturally or spiritually sanctioned, to explore how cultural context shapes subjective experience. Furthermore, this study underscores the value of qualitative research in offering insight into aspects of lived experiences that may be unobservable or inaccessible through other methodologies (Frank, 2010). It highlights the need for future research to continue spotlighting the voices of those with lived experience, prioritising first-person accounts rather than interpretations offered by therapists or theorists speaking on their behalf. Expanding qualitative inquiry in this way is essential to building a more nuanced and sensitive understanding of what it means to live with DID.

The study findings highlighted that dissociative parts were not only shaped by trauma but often appeared to internalise abuse dynamics and embody roles which were organised around their abusers or caregivers. These findings provided empirical support to theories which suggest that the legacy of trauma may be structurally embedded within dissociative systems (Doychak & Raghavan, 2023; Okano, 2019). As this study is not able to make causal inferences, future research could examine how the specific relational contexts surrounding the trauma influence the formation of dissociative parts, deepening understanding of the structural organisation of dissociative systems and extending current theoretical conceptualisations. This research could help to challenge clinical misinterpretations of dissociative parts as resistant, defensive, or problematic, reframing them instead as survival-driven responses to situations of chronic entrapment, perceived inescapability, and psychological captivity (Fisher, 2017; Howell, 2011).

The study acknowledges that not all parts may be able or willing to participate through verbal storytelling within a narrative methodology. Future studies could use multimodal or system-led data collection methods that allow for alternative forms of expression such as visual mapping, journalling with parts across time, sensory-based expression or digital co-construction (Piedade et al., 2022; Sagan, 2019). These approaches could include DID participants as co-researchers into their own internal worlds. Furthermore, participants described dissociative parts not only as inner voices, but as psycho-physiological states, embodied selves, energetic shifts, visual and sensory experiences. The study limitations highlight that narrative interviews which rely on verbal information may be limited in their ability to fully capture the embodied nature of dissociative parts. Therefore, future studies could consider creative and somatic methodologies such as embodied or sensory ethnography (Ribeiro, 2017; Sunderland et al., 2012) or arts-based participatory research (Phillips et al., 2022) to capture more holistic representations of dissociative parts. These approaches may offer deeper insights into how parts are felt, sensed, and lived, extending beyond narrative accounts. When combined with more flexible inclusion criteria, such as engaging participants without a formal DID diagnosis, these methods may support more inclusive explorations of dissociative parts in non-Western contexts where verbal articulation may be limited by cultural or linguistic differences (Lenette, 2022; Salma et al., 2024).

Whilst this study supports the ISSTD's (2011) phased-oriented model and raises caution against the unmodified application of therapeutic models such as IFS or EMDR for clients with DID, further research is needed into how a parts-informed approach can be sensitively and flexibly embedded within existing therapeutic frameworks. This research could also assess the effectiveness, applicability, and limitations of parts-informed adaptations across a range of clinical contexts, including different service settings and client populations. It may also be valuable to investigate how the parts-informed adaptations proposed in this study apply to individuals earlier in their healing journeys, such as those newly discovering their systems or to clients with presentations such as Other Specified Dissociative Disorder (OSDD).

Conclusions

This doctoral thesis study explored the deeply subjective experiences of living with dissociative parts in participants with DID, capturing and honouring their voices through storytelling and narrative analysis. The findings demonstrated that dissociative parts are experienced as embodied, meaningful and purposeful elements of lived experience which hold an aspect of the participants' life story. Participants' narratives illustrated how trauma is not only remembered but actively re-enacted and preserved within dissociative systems, highlighting the complex interplay between attachment, survival and structural dissociation. The active regulation of memory and awareness by dissociative parts emerged as a central dynamic which contributed to the hidden nature of parts and the maintenance of external functioning, despite the influence of trauma. The study findings also invited a rethinking of multiplicity, suggesting that dissociative parts in DID represent both a functionally distinct phenomena and a trauma-mediated capacity of the mind to adapt to extraordinary circumstances. This research reinforced the importance of recognising the existence of dissociative parts as an adaptive, relational and dynamic response to chronic entrapment, inescapability and psychological captivity. Therefore, participants' healing journeys were characterised by ongoing processes of fostering internal communication and cooperation between parts, ultimately maintaining an internal home where parts could function together. Participants' vivid internal worlds were narrated as meaningful psychological landscapes for emotional and relational processing between parts, which evolved alongside therapeutic growth and internal cooperation. In response, the study proposed a parts-informed approach to therapeutic intervention and diagnosis which advocates for direct relational engagement with parts as central to enhancing therapeutic engagement, attunement and effectiveness.

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Appendices

Appendix A. CASP Qualitative Appraisal Assessment for Included Studies

	Chametzky (2022)	**Floris & McPherson (2014)**	**Fox et al. (2013)**	**Greene et al., (2023)**	**Jacobson et al. (2015)**	**Marais et al. (2022)**	**McAllister et al. (2001)**	**McRae et al. (2017)**	**Parry et al. (2018)**	**Sagan (2019)**	**Somer & Nave (2001)**	**Tomlinson & Baker (2019)**	**Zeligman et al. (2017)**
Total score /20:	**16**	**17**	**18**	**17**	**16**	**18**	**18**	**17**	**17**	**18**	**19**	**18**	**19**
1. Clear statement of the aims of the research	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2
2. Qualitative methodology is appropriate	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2
3. Research design was appropriate to match aims	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2
4. Recruitment strategy suited aims	Partial 1	Yes 2	Partial 1	Partial 1	Partial 1	Yes 2	Partial 1	Yes 2	Yes 2	Partial 1	Yes 2	Partial 1	Yes 2
5. Data collection addressed research question	Yes 2	Yes 2	Yes 2	Yes 2	Partial 1	Yes 2	Yes 2	Partial 1	Partial 1	Yes 2	Yes 2	Partial 1	Yes 2
6. Relationship between	Partial 1	No 0	Partial 1	Partial 1	Partial 1	No 0	Yes 2	Partial 1	No 0	Partial 1	Partial 1	Yes 2	Partial 1

researcher and participant/data has been considered													
7. Ethical issues have been taken into consideration	Can’t tell 0	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Partial 1	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2
8. Data analysis was sufficiently rigorous	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2
9. Clear statement of findings	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2
10. The research was valuable and relevant in answering the review research question	Yes 2	Partial 1	Yes 2	Partial 1	Partial 1	Yes 2	Partial 1	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2	Yes 2
gender ratio	Unclear	Biased to females	One female	Unclear	Unclear	Biased to females	Unclear	Unclear	All female	One female	All female	All females	All male

Appendix B. Data Extraction Table for Literature Review

Author(s) and year of publication	Country	Peer-reviewed Journal or organisation	Sample information	Research question or focus	Data collection and research design	Type of qualitative analysis	Key findings
Chametzky, B. (2022)	Possibly USA	The Grounded Theory Review	Secondary data - sources containing accounts and discussions from individuals who self-identified as living with DID	Grand tour question: What is it like living with a dissociative disorder, specifically DID?	Collected data from 20 public online sources – from forums such as Facebook, YouTube, and Reddit. – data collection based on grand tour question.	Classic Grounded theory	• Proposes a new theory of "discovering and uncovering" to explain the internal and external experiences of people living with DID. • The theory identifies three stages: destabilizing (denial, disbelief, confusion, dissociative imposter syndrome), opening up (frequent switching leading to emotion processing, improved understanding), and accepting (accepting DID, functional understanding, tolerating, seeking help) - emphasizing the non-linear and flexible nature of DID's manifestation. • The study also stresses the importance of societal understanding and acceptance.
Floris, J., & McPherson, S. (2015).	United Kingdom	Journal of Trauma and Dissociation	7 participants: 5f, 2m. Age range 22-48 yrs. All	How do participants experience the diagnosis and treatment of	Semi-structured interviews – recorded and	Framework analysis	• Diagnosis cross-examined: fear of being perceived as mad due to stigma, DID felt to be an extreme diagnosis, concerns about judgement or rejection from others, internalised stigma – self-doubt. Sense of

			White British. Formal diagnosis of DID in past 5 yrs.	DID, and how does the experience of this diagnosis affect them	transcribed verbatim.		hope, validating experience, linking to trauma, language to describe experiences. • Navigating care systems: difficulties accessing treatment, professionals lacked knowledge and understanding, invalidating and inadequate care, misinterpretations of behaviour, treatment was superficial or unhelpful and specialised treatment hard to access, professionals not engaging with parts and only engaging with host was deemed unhelpful.
Fox, J., Bell, H., Jacobson, L., & Hundley, G. (2013).	USA	Journal of Mental Health Counselling	One participant – 35yr old white female with DID	What is the experience of recovery for a female survivor of DID, how does dissociation affect her life and what meaning has she made from her experiences.	Semi-structured narrative interview conducted through three separate sessions, focussing on past, present and future in chronological succession	Thematic analysis	• Therapeutic outcomes: self-esteem, empowerment, normalisation of symptoms, sharing experience with others, disclosing diagnosis fostered deeper connections. Fear of disclosing diagnosis due to stigma, difficulties establishing relationships, desperation to be believed and understood • Chronology of DID: symptoms surfaced in early childhood as a coping mechanism against abuse, amnesia and presence of alters, mood swings, shame and isolation. Effective therapy helped to understand and manage DID, organise alters, process trauma and recognise situational trigger. Receiving diagnosis– validation and understanding brought hope and aided recovery. • Misperceptions: media portrayals perpetuate inaccurate and stigmatising stereotypes, sensationalised and fail to represent day to

							day lives, discouraging individuals from seeking help.
Greene, A. K., Maloul, E. K., Norling, H. N., Palazzolo, L. P., & Brownstone, L. M. (2023).	USA	Qualitative Psychology	Secondary data – Social media signatures from 325 TikTok users who self-identified as having DID. Average age:20.9 yrs.	How is DID portrayed and discussed on TikTok, and what does this reveal about the social experience of DID	Authors used TikTok's scraper tool to collect public TikTok posts using a pre-selected hashtags between 2020-2022.	Combination of codebook thematic analysis and reflexive thematic analysis – complemented by content analysis	• The findings suggest that social media (TikTok) may serve as a source of community and connection for DID. • People with DID actively engage in identity work by describing their system architectures to communicate their experience to others and to signal belonging to the DID community. Desire to challenge normative structures and find acceptance for experiences that may be stigmatised in offline settings. • Diagnosis status was used to gain credibility and acceptance within the group. • Presence of maladaptive daydreaming and the influence of this on the complexity of the system. Reality shifting: Social media platforms may blur the lines between online personas and lived experiences.
Jacobson, L., Fox, J., Bell, H., Zeligman, M., & Graham, J. (2015).	Possibly USA	Journal of Mental Health Counselling	13 survivors with diagnosed DID who had experiences with counselling or	What are the perspectives and experiences of survivors with DID on the therapeutic process and their therapists.	Semi-structured interviews – in two focus groups	Classical Content Analysis	• Effective Techniques –Challenge of managing dissociative symptoms during therapy, therapists had to learn to recognise and respond. How alters might either engage or disengage from therapy impacted the overall process. • Effective Relationship-Building – A strong therapeutic alliance was key. Establishing

			psychotherapy				trust was crucial. Many reported difficulties in trusting therapists. • Ineffective Approaches – Abrupt termination, lack of safety, over-reliance technique without rapport, and rigid approaches. Therapist Qualities – Importance of empathy, genuineness, experience or willingness to learn about DID. The importance of having a therapist who understood DID and the unique needs of alters.
Marais, L., Bezuidenhout, M., & Krüger, C. (2022).	South Africa	Journal of Trauma and Dissociation	15 participants: adult psychiatric inpatients, 19-54 yrs old, 10f and 5m.	How do patients diagnosed with DID experience internal conflict, and how does this affect their sense of self	In-depth semi-structured interview which had been previously conducted and transcribed for a different study- some in Afrikaans and some in English	Thematic analysis	• Theme 1- Conflicting worldviews: varying and conflicting ways of making sense of DID. Unaware of conflicts too. Shaped by social and cultural contexts. • Theme 2 - Conflict between dissociative identities: Conflict between parts on: actions, goals, emotions, values, information – battle for control. • Identities withholding information from others. • Conflict is pervasive and a complex aspect of the DID experience • Culture and personal background influence how individuals with DID understand their condition. • Level of awareness between identities plays a significant role in the experience and intensity of conflict. • Irresolvable conflict, mediated by differing levels of awareness, hinders integration.

McAllister, M., Higson, D., McIntosh, W., O'Leary, S., Hargreaves, L., Murrell, L., ... & O'Brien, J. (2001).	Australia	Australian and New Zealand Journal of Mental Health Nursing	Post-acute patients with DID, alongside nurses, in an acute care setting. Specific demographics and number not reported.	Deepen understanding of how nurses and healthcare staff interact with patients diagnosed with DID in acute care settings, and what challenges do they face	Action research: Focus group interviews and narrative construction from verbal and written correspondence	Thematic analysis followed by narrative construction	• Recovering from trauma: Body as a battleground and a healing site. Struggle for control between alters • Making connections: challenges of trust and abandonment. patients may test relationships, the importance of effective communication and connection, need for nurses to provide consistent support without falling into rescuer or victim roles. • Building resilience: Finding safer places, both internal and external, problem-solving to manage internal conflict, using group support to build connections and share experiences, and learning to accept the self as multiple.
McRae, L., Hundley, G., Bell, H., & Fox, J. (2017).	USA	The American Counselling Association	12 participants with DID. Mean age: 39. All White.	What are the lived experiences of survivors with DID, particularly in relation to symptoms, stigma, interpersonal and intrapersonal experiences	phenomenology-based interview strategy focussed broadly on lived experience – semi-structured focus group	Classical content analysis – using a code book and triangulation	• Missing time, body dissociation, fluctuating emotions, multiple identities, lack of central identity or no identity, history of abuse, unhealthy coping strategies, amnesia, relationship difficulties. • Symptom onset occurred during childhood or adolescence. Some noticed symptoms later triggered by major life events. • Sexual and gender discrepancies between alters • Societal misconceptions and lack of understanding surrounding DID further contribute to the challenges faced by individuals with this diagnosis. Negative

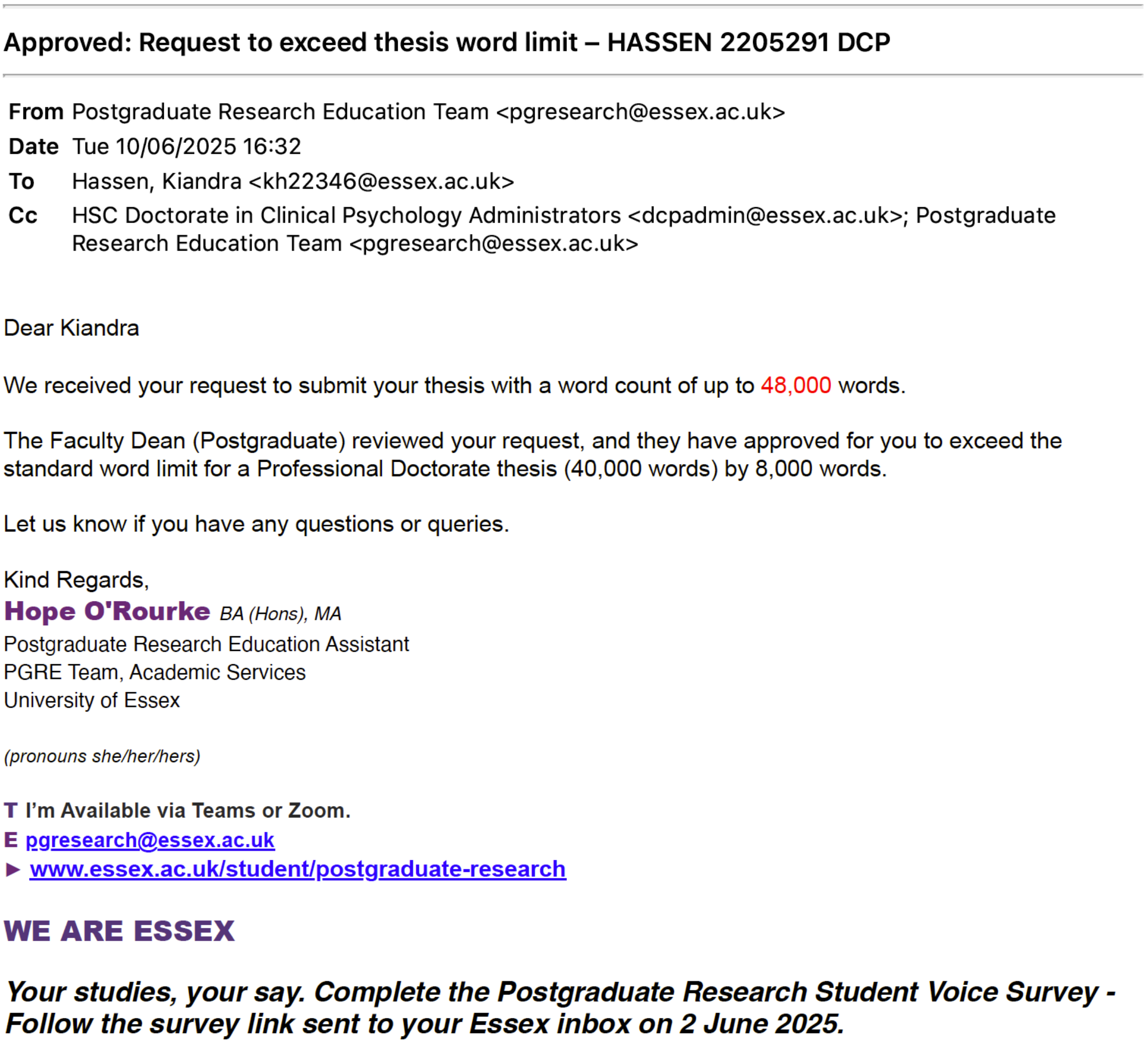
							impact on self-esteem – fears of rejection, desire for acceptance and self-acceptance. • DID viewed as a coping mechanism developed to survive –a 'gift' allowing them to function
Parry, S., Lloyd, M., & Simpson, J. (2018).	United Kingdom	European Journal of Trauma and Dissociation	5 participants with DID, all female – history of being an inpatient.	What are the lived experiences of individuals with DID, particularly in relation to time perception, emotional regulation, and the explanation of DID to others	Secondary analysis of previously collected from open ended semi-structured interview	Interpretive Phenomenological Analysis – double hermeneutic approach	• Recognising who I am and when I am in time: Alters have specific life times and contain unique information, impacting time perception and responses to situations. Younger alters not aware of key life events of the adult parts – confusion and distress. • Understand the needs of internal systems: alters have diverse needs, sometimes overlooked by others, causing distrust. • Help others understand what the self does not understand: difficulty communicating experiences with DID to others, feel misunderstood, others lack awareness. • Authors stress the importance of acknowledging needs of alters, practicing compassionate acceptance of alters – to build relationships with people with DID.
Sagan, O. (2019).	United Kingdom	Journal of Creativity in Mental Health	One female participant with DID, White British.	how art-making serves as a means of communication and exploration for	3 telephone open unstructured interviews – 4.5 hours in total	Thematic analysis - Narrative phenomenological approach	• Art helped the participant to recognise and differentiate her alters/parts, providing insight into how they work. Themes: The experience of dissociative states, early childhood, journey towards diagnosis and role of therapy.

				understanding the personal experiences of living with DID.			• Alters used art to express their experiences, related to childhood trauma – insights into their experiences and helped to process trauma memories. • Sense of coming together through art, integrating alters and traumatic experiences • Words sometimes distorted or obscured experiences. Greater clarity and authenticity in non-verbal art making process. • Importance for people with DID to explore and understand their inner world.
Somer, E., & Nave, O. (2001).	Israel	Psychology and Psychotherapy: Theory, research and practice	5 former DID patients – considered to be 'healed', by themselves and their therapists.	How do former DID patients experience their identity and memory following therapy	Ethnographic research method with semi-structed interviews – in collaboration with participant's therapists who conducted the interview	Cross case–ethnographic analysis	• The deep absorption from spirituality, fantasy and imagination were integral for everyday coping. • Transition to integration: distinct identities merged into a more cohesive and unified self gradually over time. Integration did not mean renouncing dissociative capacities completely and was experienced individually, there was no clear definition of integration across all participants. • Post recovery experiences: challenges relating to adjusting to a single identity, loss of coping mechanisms for stress management. Memories often intertwined with fantasy. • Change in self-perception and identity, shifts in relationships and daily functioning. Re-learn life skills and social interactions.

							• Experience of integration unique to each part, dissociative parts were focus of treatment.
Tomlinson, K., & Baker, C. (2019).	United Kingdom	Journal of Medical Humanities	Secondary data – five published books on females personal experiences of DID	How do women's autobiographies and biographies reflect the lived experiences of individuals with DID	Literary narrative inquiry - Published texts were used as a source of data	Thematic analysis	• Process of dissociation: memory loss, detachment from core self, presence of distinct alters with varying characteristics and levels of awareness. • Experience of abuse/trauma: severe prolonged abuse by family members or others. DID is a coping mechanism for dealing with trauma. • Social elements of abuse: abuse was ignored or denied, individuals unprotected by those who could have intervened. • Healthcare and diagnosis: challenges with misdiagnosis, building trust barriers. Receiving diagnosis was a turning point. • Increased awareness and sensitivity is needed.
Zeligman, M., Greene, J. H., Hundley, G., Graham Jr, J. M., Spann, S., Bickley, E., & Bloom, Z. (2017).	USA	Adultspan Journal	5 men with DID. Ave age: 56 yo. 4 White.	What are the lived experiences of men with DID	Semi structured interviews via phone.	Phenomenological analysis using Colaizzi's method	• All participants reported extensive abuse and trauma histories, multiple misdiagnosis and wide range of symptoms. Themes: History, alters, male gender expectations/identity, challenges and roadblocks, strengths and support. • Different roles that alters play (protector, aggressor, gatekeeper) and how they communicate with each other. Differing genders of alters.

- Male gender expectations influenced stigma experienced in relation to diagnosis and trauma. Alters influenced gender identity and presentation.
- Representation of DID and resulting stigma, difficulties maintaining significant relationships and roadblocks to treatment.

Appendix C. Approval for Word Count Extension



Approved: Request to exceed thesis word limit – HASSEN 2205291 DCP

From Postgraduate Research Education Team <pgresearch@essex.ac.uk>
Date Tue 10/06/2025 16:32
To Hassen, Kiandra <kh22346@essex.ac.uk>
Cc HSC Doctorate in Clinical Psychology Administrators <dcpadmin@essex.ac.uk>; Postgraduate Research Education Team <pgresearch@essex.ac.uk>

Dear Kiandra

We received your request to submit your thesis with a word count of up to 48,000 words.

The Faculty Dean (Postgraduate) reviewed your request, and they have approved for you to exceed the standard word limit for a Professional Doctorate thesis (40,000 words) by 8,000 words.

Let us know if you have any questions or queries.

Kind Regards,
Hope O'Rourke *BA (Hons), MA*
Postgraduate Research Education Assistant
PGRE Team, Academic Services
University of Essex

(pronouns she/her/hers)

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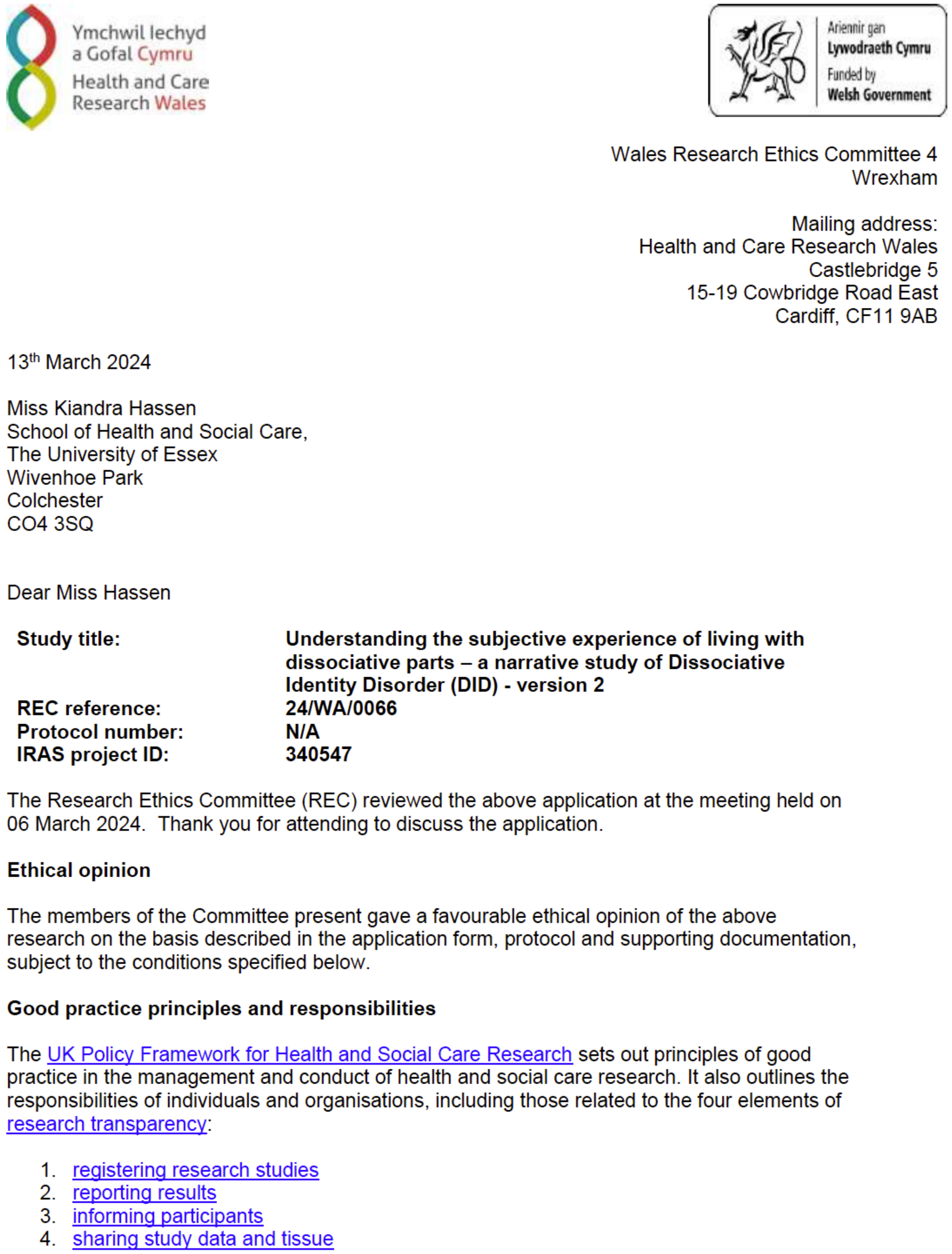
Appendix D. Ethics Approvals

NHS Research Ethics Committee 4 and University of Essex Research Governance



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

Ariennir gan
Lywodraeth Cymru
Funded by
Welsh Government

Wales Research Ethics Committee 4
Wrexham

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13th March 2024

Miss Kiandra Hassen
School of Health and Social Care,
The University of Essex
Wivenhoe Park
Colchester
CO4 3SQ

Dear Miss Hassen

Study title:	**Understanding the subjective experience of living with dissociative parts – a narrative study of Dissociative Identity Disorder (DID) - version 2**
REC reference:	**24/WA/0066**
Protocol number:	**N/A**
IRAS project ID:	**340547**

The Research Ethics Committee (REC) reviewed the above application at the meeting held on 06 March 2024. Thank you for attending to discuss the application.

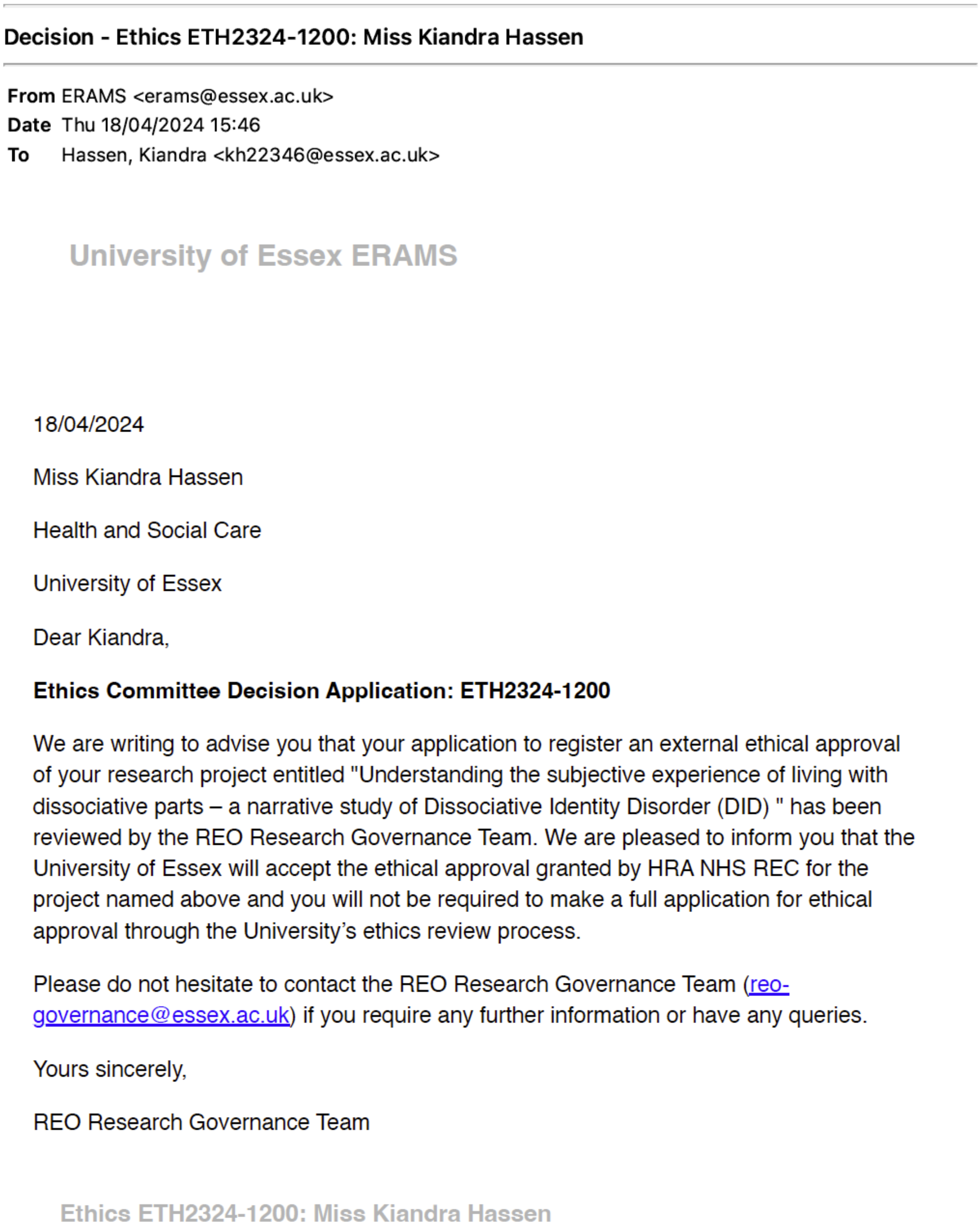
Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue



Decision - Ethics ETH2324-1200: Miss Kiandra Hassen

From ERAMS <erams@essex.ac.uk>
Date Thu 18/04/2024 15:46
To Hassen, Kiandra <kh22346@essex.ac.uk>

University of Essex ERAMS

18/04/2024

Miss Kiandra Hassen

Health and Social Care

University of Essex

Dear Kiandra,

Ethics Committee Decision Application: ETH2324-1200

We are writing to advise you that your application to register an external ethical approval of your research project entitled "Understanding the subjective experience of living with dissociative parts – a narrative study of Dissociative Identity Disorder (DID) " has been reviewed by the REO Research Governance Team. We are pleased to inform you that the University of Essex will accept the ethical approval granted by HRA NHS REC for the project named above and you will not be required to make a full application for ethical approval through the University's ethics review process.

Please do not hesitate to contact the REO Research Governance Team (reo-governance@essex.ac.uk) if you require any further information or have any queries.

Yours sincerely,

REO Research Governance Team

Ethics ETH2324-1200: Miss Kiandra Hassen

Appendix E. Information Sheet for Recruiting Clinicians

Study information for Clinicians

Study information

Thank you for your interest in my doctoral thesis research project into subjective experiences of Dissociative Identity Disorder (DID). I am interested in the experience of living with dissociative parts/alters, in participant's own words, within the context of their story. This study aims to understand the role and function that dissociative parts play in daily life and recovery through the process of a narrative interview, informed by narrative inquiry methodology. It will also explore how participants have made sense of their dissociative parts and how they might describe their experiences to others. It is hoped that this may contribute to a deeper understanding of the DID experience, which may improve effectiveness of therapeutic work and may improve therapist confidence in treating DID. It may be personally meaningful for a participant to share their story and it is hoped that this study may provide a platform for them to do this.

Participants will be invited to a pre-interview initial meeting (where we will collaboratively develop a brief tailored support plan) with the primary researcher and to a narrative interview, held on different dates, both of which will last approximately one hour. They will also be invited to fill out a demographic questionnaire asking for anonymised personal information (e.g. age, gender, occupation). Participation is voluntary and participant safety is prioritised throughout this process. Wales REC 4 (from the NHS Health Research Authority) has reviewed the study and given a favourable ethical opinion.

I am looking for individuals who meet specific inclusion criteria. These were identified to highlight individuals who have worked therapeutically to develop skills and understanding to safely participate in an open conversation about their personal experiences:

- A formal diagnosis of Dissociative Identity Disorder (DID), given by a mental health professional using the SCID-D interview (or alternative measure) for dissociative disorders.
- They are over 18 years of age, live in the UK and can communicate fluently in English.
- They have access to robust and effective personal and professional social support.
- They are not a high risk to themselves or others and have the capacity to consent. They can take a lead on stabilising themselves and their parts and independently manage switching during instances of distress.
- They have engaged with DID focussed therapy, where they have worked on…:
    - Strengthening internal relationships between parts in their system and explored conflicting needs. Their parts have some capacity to function together as a team.
    - Developing the agency of adult/daily life/core parts, who would be able to represent other parts, as well as reassure and support.
    - The development of internal communication strategies to manage distress.
    - The ability to seek internal cooperation to reach an agreement which accounts for perspectives of the whole system, to fulfil the quota of informed consent.

If you believe that a past or present client of yours may be eligible and interested in this study, please discuss this with them and pass on study information. If they prefer to be approached by myself, please fill out the form below, with consent from them for you to share their information.

Appendix F. Participant Information Sheet

Trigger warnings: References to: DID, parts/alters, emotions and feelings, DID stigma, therapy, and therapists.

Title of the study: Understanding the subjective experience of living with dissociative parts – a narrative study of Dissociative Identity Disorder (DID)

Invitation paragraph:

My name is Kiki Hassen, and I am the chief investigator for this project. I am a Trainee Clinical Psychologist studying on the Clinical Psychology Doctorate Programme at the University of Essex. Following the completion of this course, I will be a qualified Clinical Psychologist. As part of my training, I have chosen to research the experiences of those with DID, under the supervision of Dr Danny Taggart, Dr Andy Sluckin and Dr Esther Kiehl.

Thank you for expressing an interest to participate in my research study. I am aware that language used to define aspects of DID experience is unique and personal. For the purpose of this information sheet, I will use the language of parts to describe alters/identities, and the term "system" to describe the whole individual. However, if you choose to take part, I will use language which most suits you. I invite you to read all the information provided here to ensure you are fully informed before consenting to participate.

I truly believe that providing a platform where DID survivors can voice their experiences, in their words, is hugely important work. Throughout my professional journey, I've seen first-hand how the voices of those with DID have been silenced, both in research and in clinical settings. Through conversations with DID survivors and extensive reading, I've come to realize the crucial role that dissociative parts play in shaping lived experiences and guiding therapeutic interventions. Understanding in this area is sparce but essential for comprehending the profound impact of DID and for fostering meaningful progress in therapeutic journeys.

What is the purpose of the study and how would your contributions benefit others:

I am aware that references to parts can sometimes be dysregulating and distressing. It seems that for some people, their parts mirror aspects of their life experiences and speaking about parts can feel like speaking about trauma or abuse. This study is NOT interested in explicit details about trauma or abuse. I am interested in your experience of living with dissociative parts, in your own words, within the context of your story. Every person with DID is unique and different systems have different needs which vary over time. I want to understand the role and function your parts play in your daily life and your healing journey. I am also interested in the story of your whole system, without divulging information which may make you feel uncomfortable or unsafe. This study will focus on how you have made sense of your dissociative parts and how you might describe your experiences to others. In the long-term, I hope this understanding will de-stigmatise therapy which focuses on parts which may increase the effectiveness of therapy and the quality of support offered to individuals with DID, especially in the NHS.

Do I have to take part:
No. All participation is voluntary, and you can choose not to participate in part or all the study. Your decision to participate in this research is confidential and will not impact your therapeutic care. Whether you decide to take part or decline to take part, this information will not be shared with the clinician who shared the study information with you. This research is not affiliated with third party organisations involved in your care (e.g. ESTD-UK, CDS, RAMS, NHS). You may avoid answering questions which are felt to be too personal or intrusive and you may withdraw at any stage without being penalised or disadvantaged in any way. If you do decide to take part, you will be asked to sign a consent form. You are also free to withdraw at any time during the interview stage, without giving a reason. You can also withdraw after the data has been collected and prior to the study being published. You can withdraw your participation by emailing the chief investigator, Kiki Hassen, and their academic supervisor, Dr Danny Taggart, using the contact emails provided below.

Why have you been invited to take part:
You have been invited to take part in this study because you have expressed an interest, and you believe you meet the study's inclusion criteria. These specific criteria were chosen to highlight individuals who have worked therapeutically to develop the skills and understanding to safely participate in an open conversation about their experiences. Alongside the consent form, there is a self-screening questionnaire for you to fill out, which details these criteria, which will help us to work out whether you would be suitable to participate in this study.

What will participation involve:
If you decide to take part, you will be invited to the following:

- You will be sent a screening questionnaire and consent form for our initial meeting to fill out and sign.
- A pre-interview to meet myself online, Kiki Hassen, the researcher. We will meet to review the information provided here and answer any questions you may have. We will also collaboratively create a contingency plan to ensure we both understand our roles in keeping you safe during the interview and at what point we should seek external and emergency support if this were to occur. I will ask you to nominate a personal and professional emergency contact for the unlikely event that I will need to seek additional support for you. This meeting also allows me to ask you the language you prefer I use. With all information in mind, we can decide, together, if it is in your best interest to participate with the main interview.
- Prior to the main interview, you will be sent a second consent form and an anonymous demographic questionnaire, which collects anonymous personal information (e.g. age, gender identity, ethnicity, number of years in therapy).
- Finally, you will be invited to the main interview, held online, via Microsoft Teams and recorded for transcription. The duration of this interview will be tailored to your needs, allowing you to set the pace. During this meeting, you will be given a few broad topics which will guide the stories you tell me about living with dissociative parts. A copy of the interview guide will be sent to you in advance, allowing you time

to prepare, if you wish to do so. I will interrupt as little as I can, as I am interested in your experiences in your own words.

- After the interview, you will be invited to review your interview transcript and I will check in to see if you need any additional support. You can also opt in to review the themes, summaries, and conclusions I have made from all your stories. I value your perspective when deciding the final themes.
- You will be given a small gratuity of £10 Amazon voucher for taking the time and resources out to participate in this study.

What is important for you to consider when taking part:

It is possible that openly discussing your internal experiences can cause negative feelings such as upset, anger, sadness. These feelings, especially when linked to previous trauma, can be distressing and triggering. Although we will develop a collaborative plan to manage triggering content and distress, there may be some evoked feelings that we cannot predict. It is important that you feel confident and supported enough to manage these feelings and that your risk of harming yourself is low. During the pre-interview, we will identify signs we can both look out for and who to call in the event of you becoming distressed. Although, I will ask questions to guide the discussion, you can take a lead in terms of what you share, and your choices will be honoured throughout this process.

How will we use information about you:

The information you share throughout your participation in this research is confidential. I will only share *relevant* and *specific* information if I am concerned for your immediate safety. The answers which you provide will be audio recorded and I may take handwritten notes. I will only collect personal information that is relevant to the research process, such as your email/mobile number to contact you, as well as personal emergency contact details. I will also collect the address you are calling from and your General Practitioner (GP) or local authority information in case I am concerned for your immediate safety, however it is your choice whether you would like to keep your GP updated about your participation. Personal, identifiable information will be kept separate to interview data. All information collected will be kept securely and will only be accessible by myself and my supervisor. If I am concerned that yourself or somebody else is *currently* at risk of serious harm, this may be escalated to the named service/individual that you identify and/or local authority services. You will be informed and involved throughout this process.

All published data will be anonymised and non-identifiable, including interview transcripts prior to publication. The findings of the study may include direct quotations, but pseudonyms will be used. A list may be kept linking pseudonyms to names, but this will be kept separately and securely. A copy of the information which we record about you, but not other participants, will be provided, free of charge, on request.

The main publication of the findings will be written up into a report, which will be uploaded to an electronic database publishing doctoral thesis. The study may also be submitted for subsequent publication to an academic journal such as the Journal of Trauma and Dissociation. A summary of the study findings may also be disseminated, in an accessible format, through forums such as the ESTD-UK newsletter. You can choose to be sent a copy of the publication once the study is completed and submitted.

If you have any concerns regarding the use of your data, please contact the Data Protection Officer at the University of Essex via email to dpo@essex.ac.uk.

Concerns and complaints

If you have any concerns about any aspect of the study or have a complaint, in the first instance please contact the primary researcher (Kiki Hassen) or their research supervisor (Dr Danny Taggart), using contact details provided below. If are unsatisfied with the response or you feel that you cannot approach the investigators, please contact the University of Essex Research Integrity Manager, Mantalena Sotiriadou (email: ms21994@essex.ac.uk).

Approval and funding

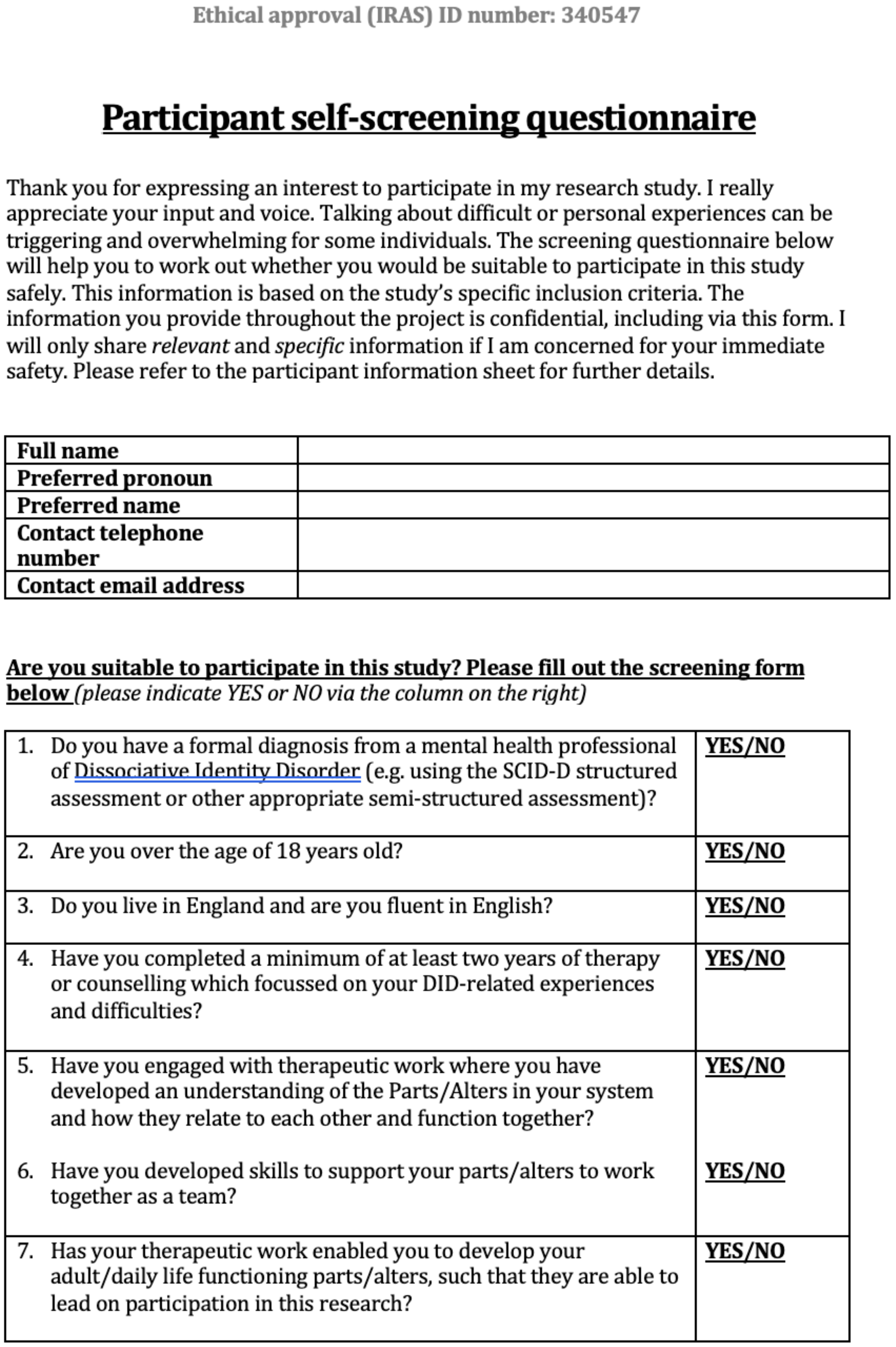
This research project is sponsored by The University of Essex within the School of Health and Social Care. This project is not affiliated, sponsored, or funded by any clinic which may be treating you or any supportive charity. Reference to "we" refers to the research team at the University of Essex, not treating clinics or charities. This research project has been reviewed by Wales REC4 Research Ethics Committee (as part of the NHS Health Research Authority) and received a favourable ethical opinion.

Thank you for taking the time to read this information sheet. I would be very grateful for your participation in this study, and I am excited to embark on this journey with you. If you are happy to proceed, please fill out the consent form for the pre-interview and the self-screening questionnaire and return this back to me by email. Following this, we will arrange a time to meet for the pre-interview meeting.

If you need to contact us or ask questions, please contact myself, Kiki via kh22346@essex.ac.uk , or Dr Danny Taggart via dtaggart@essex.ac.uk.

Warm regards,
Kiki Hassen

Appendix G. Participant Self-Screening Questionnaire



Ethical approval (IRAS) ID number: 340547

Participant self-screening questionnaire

Thank you for expressing an interest to participate in my research study. I really appreciate your input and voice. Talking about difficult or personal experiences can be triggering and overwhelming for some individuals. The screening questionnaire below will help you to work out whether you would be suitable to participate in this study safely. This information is based on the study's specific inclusion criteria. The information you provide throughout the project is confidential, including via this form. I will only share *relevant* and *specific* information if I am concerned for your immediate safety. Please refer to the participant information sheet for further details.

Full name	
Preferred pronoun	
Preferred name	
Contact telephone number	
Contact email address	

Are you suitable to participate in this study? Please fill out the screening form below *(please indicate YES or NO via the column on the right)*

1. Do you have a formal diagnosis from a mental health professional of Dissociative Identity Disorder (e.g. using the SCID-D structured assessment or other appropriate semi-structured assessment)?	**YES/NO**
2. Are you over the age of 18 years old?	**YES/NO**
3. Do you live in England and are you fluent in English?	**YES/NO**
4. Have you completed a minimum of at least two years of therapy or counselling which focussed on your DID-related experiences and difficulties?	**YES/NO**
5. Have you engaged with therapeutic work where you have developed an understanding of the Parts/Alters in your system and how they relate to each other and function together? 6. Have you developed skills to support your parts/alters to work together as a team?	**YES/NO** **YES/NO**
7. Has your therapeutic work enabled you to develop your adult/daily life functioning parts/alters, such that they are able to lead on participation in this research?	**YES/NO**

8. In your healing journey thus far, have you developed strategies for distress management, whereby you can cope with switching and internal conflict between parts?	**YES/NO**
9. Do you feel you are able to reach an internal consensus that takes into account as much as possible the needs and perspectives of your whole system, such that you can provide informed consent for taking part in this research?	**YES/NO**
10. In the unlikely event of a crisis or emergency, will you be able to provide a personal and/or professional contact who can provide appropriate and timely support?	**YES/NO**
11. Have you been hospitalised in the last year due to a mental health crisis or emergency, whereby you or a part/alter has caused significant physical harm to you?	**YES/NO** *Reverse score*
12. You will meet twice with the primary researcher, Kiki Hassen. Prior to the main interview, we will initially meet to create a collaborative plan to manage any potential issues that may arise in the main interview. This will involve a discussion around how you manage distress in your daily life, how we can keep you safe and what we can do in the unlikely event of a crisis. Do all your parts feel comfortable with your participation in this conversation?	**YES/NO**

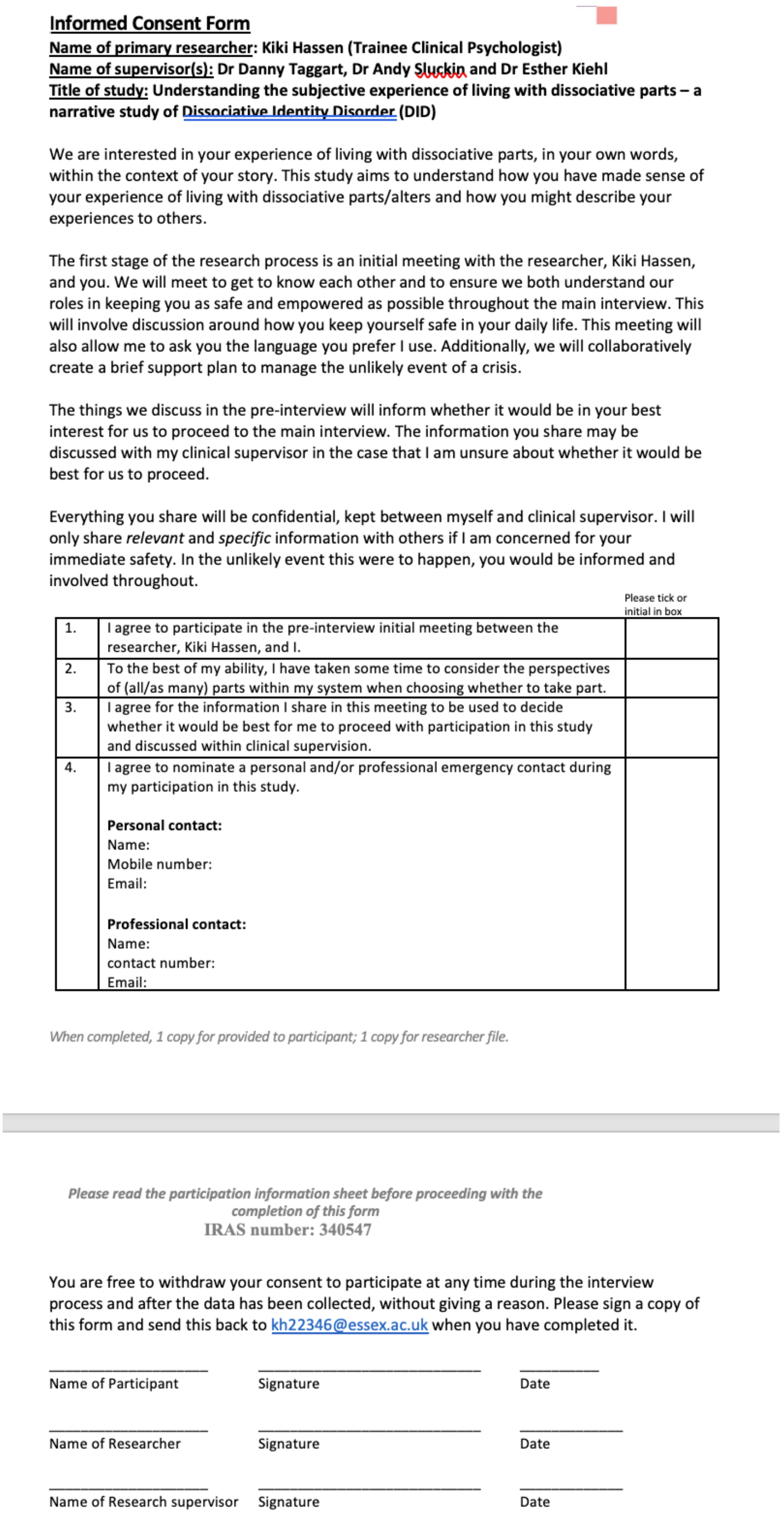
Once this has been returned to me, I will get in touch with you to provide further information and/or arrange our pre-interview initial meeting. Thank you so much for your time.

Name: ……………………………………………………………………………

Date: …………………………………………………

Signature: ……………………………………………

Appendix H. Informed Consent Form for Pre-Interview



Informed Consent Form

Name of primary researcher: Kiki Hassen (Trainee Clinical Psychologist)
Name of supervisor(s): Dr Danny Taggart, Dr Andy Sluckin and Dr Esther Kiehl
Title of study: Understanding the subjective experience of living with dissociative parts – a narrative study of Dissociative Identity Disorder (DID)

We are interested in your experience of living with dissociative parts, in your own words, within the context of your story. This study aims to understand how you have made sense of your experience of living with dissociative parts/alters and how you might describe your experiences to others.

The first stage of the research process is an initial meeting with the researcher, Kiki Hassen, and you. We will meet to get to know each other and to ensure we both understand our roles in keeping you as safe and empowered as possible throughout the main interview. This will involve discussion around how you keep yourself safe in your daily life. This meeting will also allow me to ask you the language you prefer I use. Additionally, we will collaboratively create a brief support plan to manage the unlikely event of a crisis.

The things we discuss in the pre-interview will inform whether it would be in your best interest for us to proceed to the main interview. The information you share may be discussed with my clinical supervisor in the case that I am unsure about whether it would be best for us to proceed.

Everything you share will be confidential, kept between myself and clinical supervisor. I will only share *relevant* and *specific* information with others if I am concerned for your immediate safety. In the unlikely event this were to happen, you would be informed and involved throughout.

		Please tick or initial in box
1.	I agree to participate in the pre-interview initial meeting between the researcher, Kiki Hassen, and I.	
2.	To the best of my ability, I have taken some time to consider the perspectives of (all/as many) parts within my system when choosing whether to take part.	
3.	I agree for the information I share in this meeting to be used to decide whether it would be best for me to proceed with participation in this study and discussed within clinical supervision.	
4.	I agree to nominate a personal and/or professional emergency contact during my participation in this study. **Personal contact:** Name: Mobile number: Email: **Professional contact:** Name: contact number: Email:	

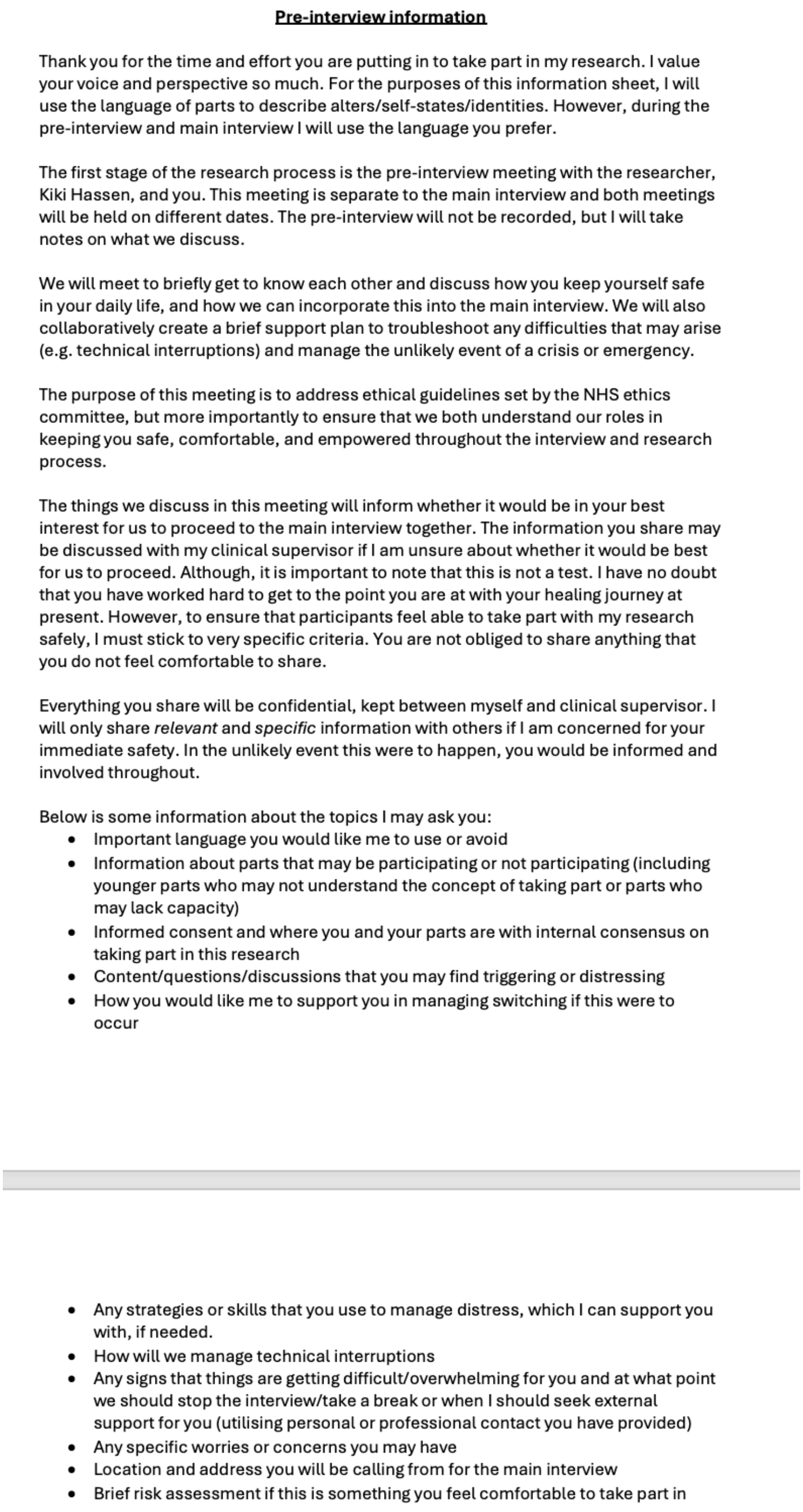
When completed, 1 copy for provided to participant; 1 copy for researcher file.

Please read the participation information sheet before proceeding with the completion of this form
IRAS number: 340547

You are free to withdraw your consent to participate at any time during the interview process and after the data has been collected, without giving a reason. Please sign a copy of this form and send this back to kh22346@essex.ac.uk when you have completed it.

____________________	____________________________	__________
Name of Participant	Signature	Date
____________________	____________________________	_____________
Name of Researcher	Signature	Date
____________________	____________________________	_____________
Name of Research supervisor	Signature	Date

Appendix I. Participant Pre-briefing Information for Pre-Interview



Pre-interview information

Thank you for the time and effort you are putting in to take part in my research. I value your voice and perspective so much. For the purposes of this information sheet, I will use the language of parts to describe alters/self-states/identities. However, during the pre-interview and main interview I will use the language you prefer.

The first stage of the research process is the pre-interview meeting with the researcher, Kiki Hassen, and you. This meeting is separate to the main interview and both meetings will be held on different dates. The pre-interview will not be recorded, but I will take notes on what we discuss.

We will meet to briefly get to know each other and discuss how you keep yourself safe in your daily life, and how we can incorporate this into the main interview. We will also collaboratively create a brief support plan to troubleshoot any difficulties that may arise (e.g. technical interruptions) and manage the unlikely event of a crisis or emergency.

The purpose of this meeting is to address ethical guidelines set by the NHS ethics committee, but more importantly to ensure that we both understand our roles in keeping you safe, comfortable, and empowered throughout the interview and research process.

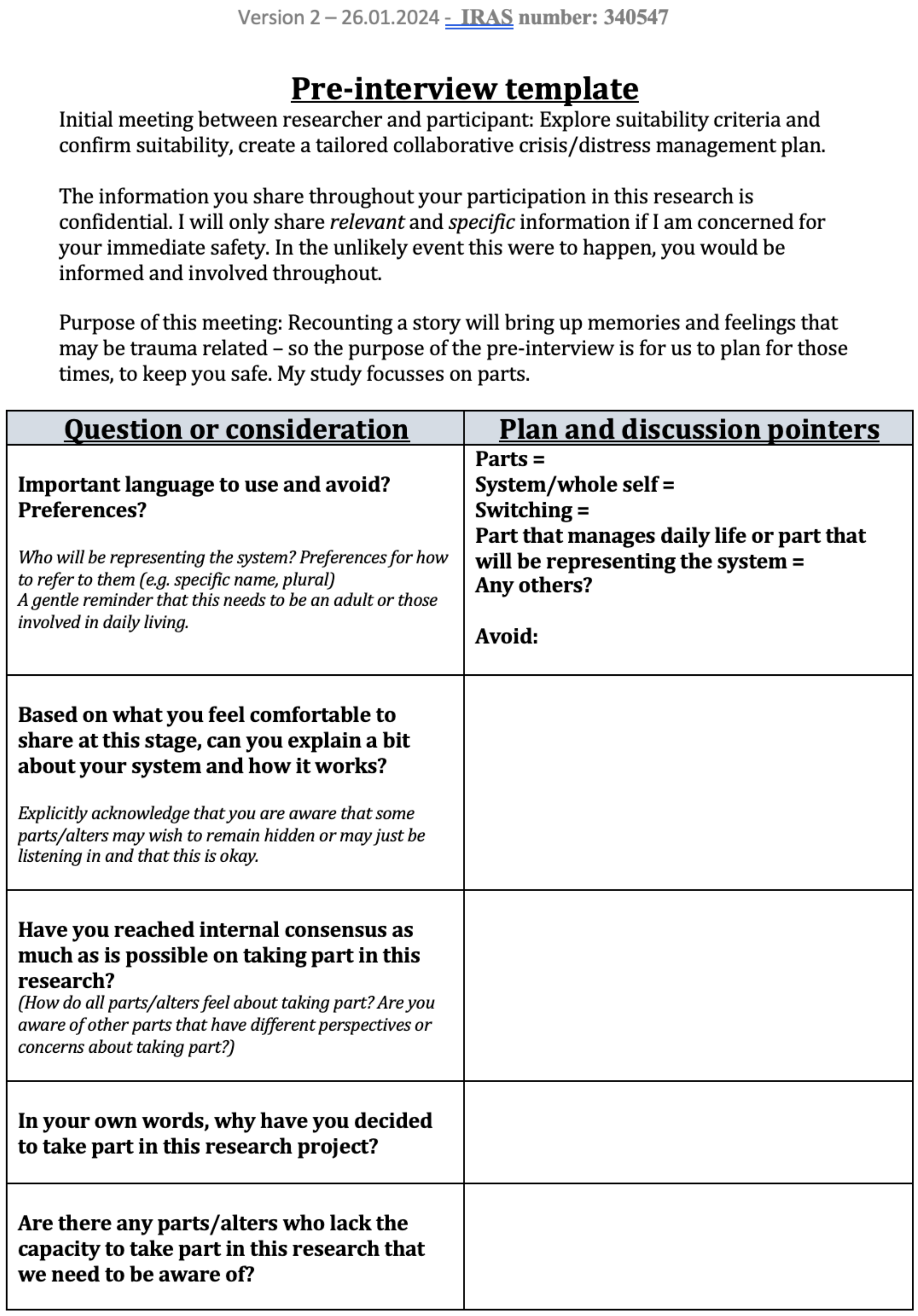
The things we discuss in this meeting will inform whether it would be in your best interest for us to proceed to the main interview together. The information you share may be discussed with my clinical supervisor if I am unsure about whether it would be best for us to proceed. Although, it is important to note that this is not a test. I have no doubt that you have worked hard to get to the point you are at with your healing journey at present. However, to ensure that participants feel able to take part with my research safely, I must stick to very specific criteria. You are not obliged to share anything that you do not feel comfortable to share.

Everything you share will be confidential, kept between myself and clinical supervisor. I will only share *relevant* and *specific* information with others if I am concerned for your immediate safety. In the unlikely event this were to happen, you would be informed and involved throughout.

Below is some information about the topics I may ask you:

- Important language you would like me to use or avoid
- Information about parts that may be participating or not participating (including younger parts who may not understand the concept of taking part or parts who may lack capacity)
- Informed consent and where you and your parts are with internal consensus on taking part in this research
- Content/questions/discussions that you may find triggering or distressing
- How you would like me to support you in managing switching if this were to occur
- Any strategies or skills that you use to manage distress, which I can support you with, if needed.
- How will we manage technical interruptions
- Any signs that things are getting difficult/overwhelming for you and at what point we should stop the interview/take a break or when I should seek external support for you (utilising personal or professional contact you have provided)
- Any specific worries or concerns you may have
- Location and address you will be calling from for the main interview
- Brief risk assessment if this is something you feel comfortable to take part in

Appendix J. Pre-Interview Schedule



Version 2 – 26.01.2024 - IRAS number: 340547

Pre-interview template

Initial meeting between researcher and participant: Explore suitability criteria and confirm suitability, create a tailored collaborative crisis/distress management plan.

The information you share throughout your participation in this research is confidential. I will only share *relevant* and *specific* information if I am concerned for your immediate safety. In the unlikely event this were to happen, you would be informed and involved throughout.

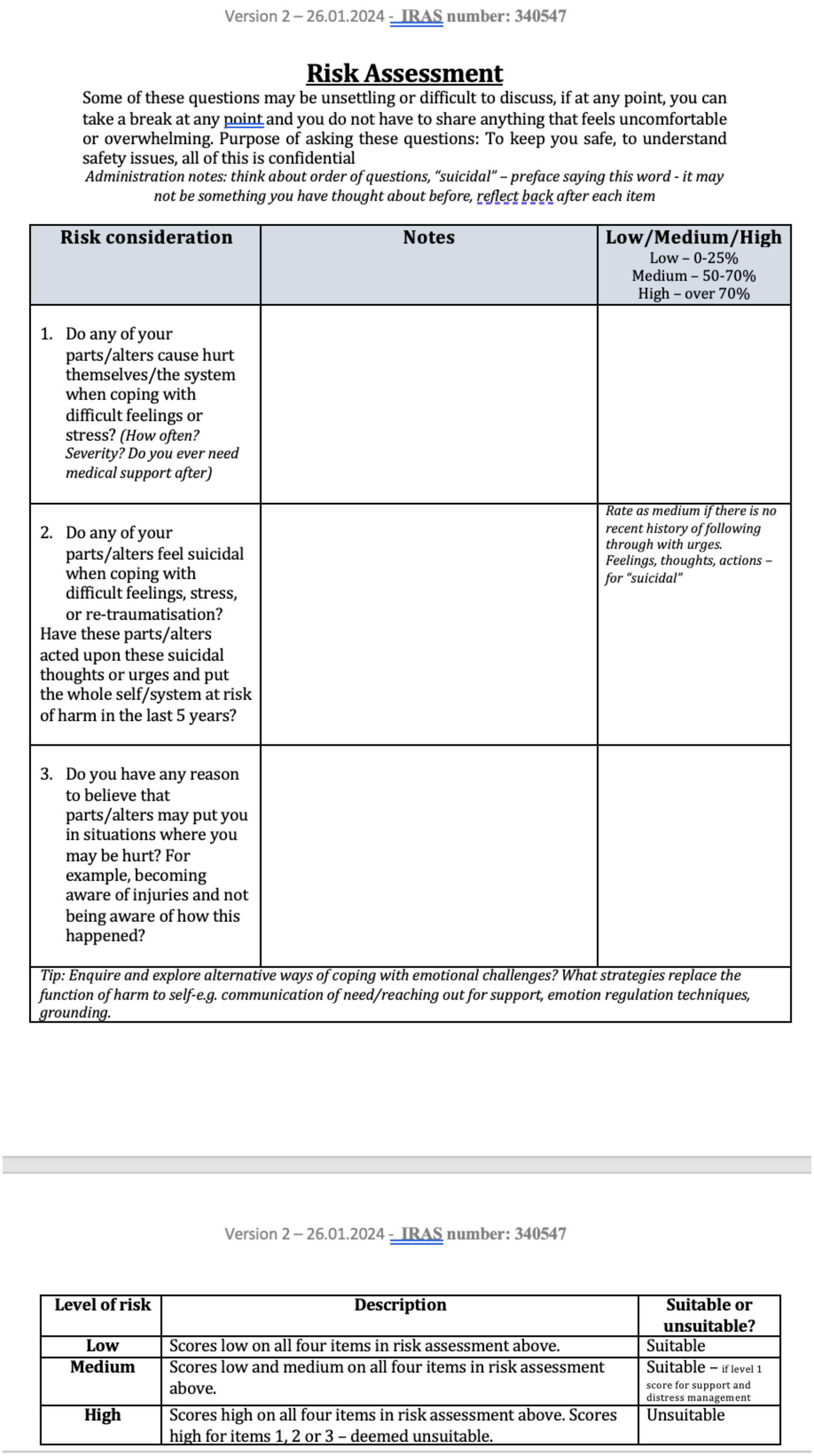
Purpose of this meeting: Recounting a story will bring up memories and feelings that may be trauma related – so the purpose of the pre-interview is for us to plan for those times, to keep you safe. My study focusses on parts.

Question or consideration	Plan and discussion pointers
Important language to use and avoid? Preferences? *Who will be representing the system? Preferences for how to refer to them (e.g. specific name, plural)* *A gentle reminder that this needs to be an adult or those involved in daily living.*	**Parts =** **System/whole self =** **Switching =** **Part that manages daily life or part that will be representing the system =** **Any others?** **Avoid:**
Based on what you feel comfortable to share at this stage, can you explain a bit about your system and how it works? *Explicitly acknowledge that you are aware that some parts/alters may wish to remain hidden or may just be listening in and that this is okay.*	
Have you reached internal consensus as much as is possible on taking part in this research? *(How do all parts/alters feel about taking part? Are you aware of other parts that have different perspectives or concerns about taking part?)*	
In your own words, why have you decided to take part in this research project?	
Are there any parts/alters who lack the capacity to take part in this research that we need to be aware of?	

What content/questions/discussions might you find distressing or triggering, and may increase risk? *For example, talking about a specific topic or part, an event that happened when you were X years old etc.*	
Can you share with me, and can we think together about how we can make this a good experience for you. For example, if you switch how would you like me to respond. How might I be able to tell if you are feeling overwhelmed or unsafe?	
How would you let me know when you need a break? *Is there something that works for all parts/alters? What options do we have available - consider non-verbal communication e.g. using a card or a symbol.*	
What techniques and strategies do you use to keep yourself safe as well as manage distress and switching? How can I support you with these? Is there something helpful I can say or do to help you to invite adult functioning parts back?	
How can you let me know that the interview is going badly for you and what do we need to do at that point? *The interview can be stopped at any time and if I am concerned, I may check in to see if you are ok to continue. You have control of this process, is there anything that might be helpful for us to discuss regarding this?*	
How might we manage technical interruptions during the research interview?	

Do you have any specific worries about the research interview which we could discuss in advance?	
External Support **Do you have external support you can access after the interview or I can contact to provide immediate support to you? If it feels okay to share more e.g. :** Which individuals will be in close proximity to you during the research interview? Do you feel able to turn to them for support? Who would you turn to for emotional support after your research interview? Do you feel able to discuss your experiences in the interview with your current therapist? Would it be helpful to have someone present for the interview or a trusted person nearby (someone to support and not engage in the discussion)? Would this impact your ability to speak freely?	
Local authority to contact if a safeguarding concern were to arise *(to look up before pre-interview meeting and to ask if needed)*	
My hope is that the planning and preparation we have put in place will help you to stay stable and connected throughout the interview. However, as a last resort, do you feel you are aware of external services you could reach out to if you needed additional crisis or emotional support? (e.g. NHS 111, Samaritans)	
What is the location of address of where you will be videoconference calling from during the main interview? **Is your personal support contact aware of when the interview is happening?** **Briefly explain the format of the main interview.**	

Appendix K. Risk Assessment Schedule and Risk Rating Scale



Version 2 – 26.01.2024 - IRAS number: 340547

Risk Assessment

Some of these questions may be unsettling or difficult to discuss, if at any point, you can take a break at any point and you do not have to share anything that feels uncomfortable or overwhelming. Purpose of asking these questions: To keep you safe, to understand safety issues, all of this is confidential

Administration notes: think about order of questions, "suicidal" – preface saying this word - it may not be something you have thought about before, reflect back after each item

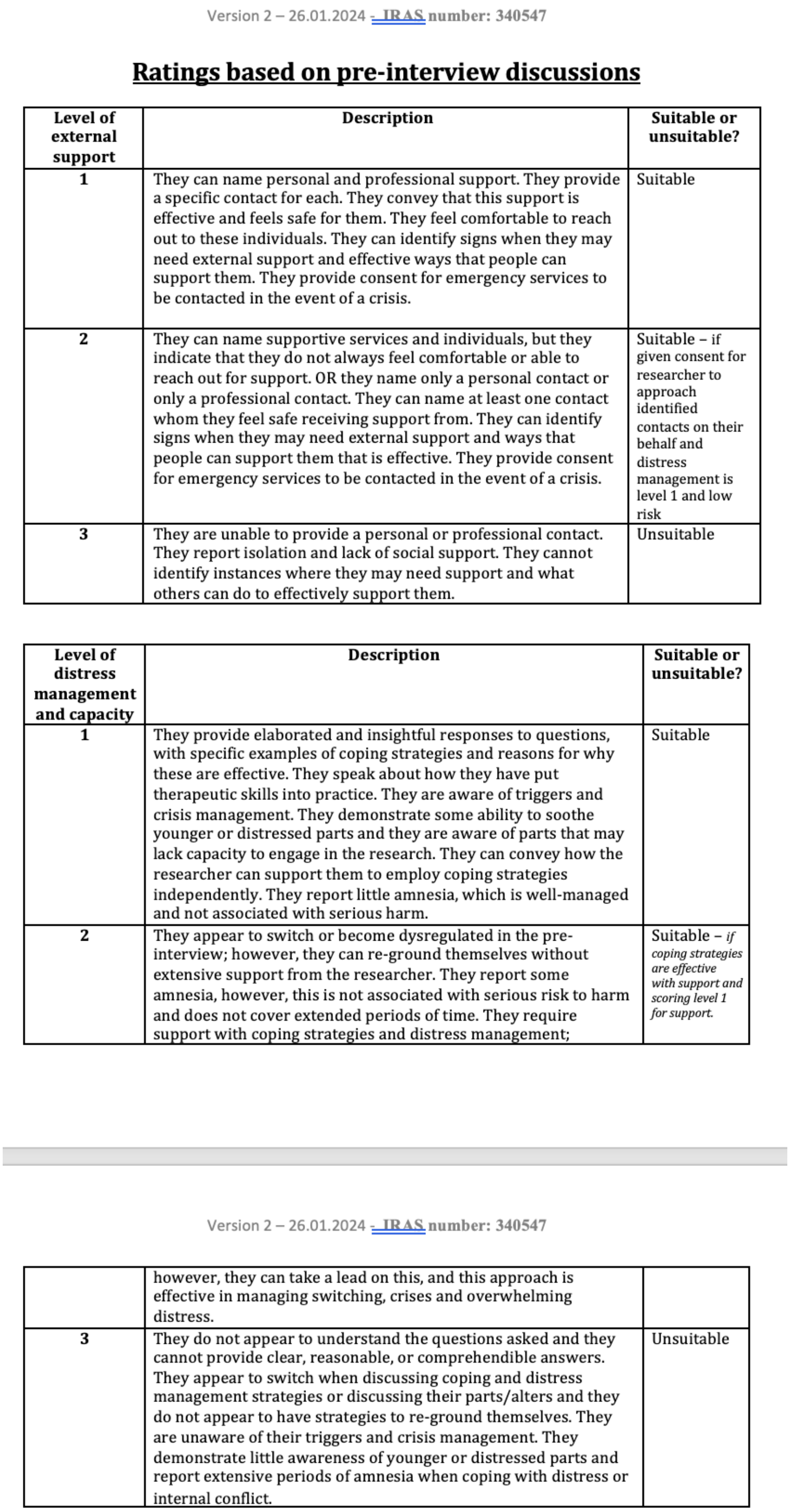
Risk consideration	Notes	Low/Medium/High Low – 0-25% Medium – 50-70% High – over 70%
1. Do any of your parts/alters cause hurt themselves/the system when coping with difficult feelings or stress? *(How often? Severity? Do you ever need medical support after)*		
2. Do any of your parts/alters feel suicidal when coping with difficult feelings, stress, or re-traumatisation? Have these parts/alters acted upon these suicidal thoughts or urges and put the whole self/system at risk of harm in the last 5 years?		*Rate as medium if there is no recent history of following through with urges. Feelings, thoughts, actions – for "suicidal"*
3. Do you have any reason to believe that parts/alters may put you in situations where you may be hurt? For example, becoming aware of injuries and not being aware of how this happened?		
Tip: Enquire and explore alternative ways of coping with emotional challenges? What strategies replace the function of harm to self-e.g. communication of need/reaching out for support, emotion regulation techniques, grounding.		

Version 2 – 26.01.2024 - IRAS number: 340547

Level of risk	Description	Suitable or unsuitable?
Low	Scores low on all four items in risk assessment above.	Suitable
Medium	Scores low and medium on all four items in risk assessment above.	Suitable – if level 1 score for support and distress management
High	Scores high on all four items in risk assessment above. Scores high for items 1, 2 or 3 – deemed unsuitable.	Unsuitable

Appendix L. Suitability Rating Scales

For Level of Support and Level of Distress Management



Version 2 – 26.01.2024 - IRAS number: 340547

Ratings based on pre-interview discussions

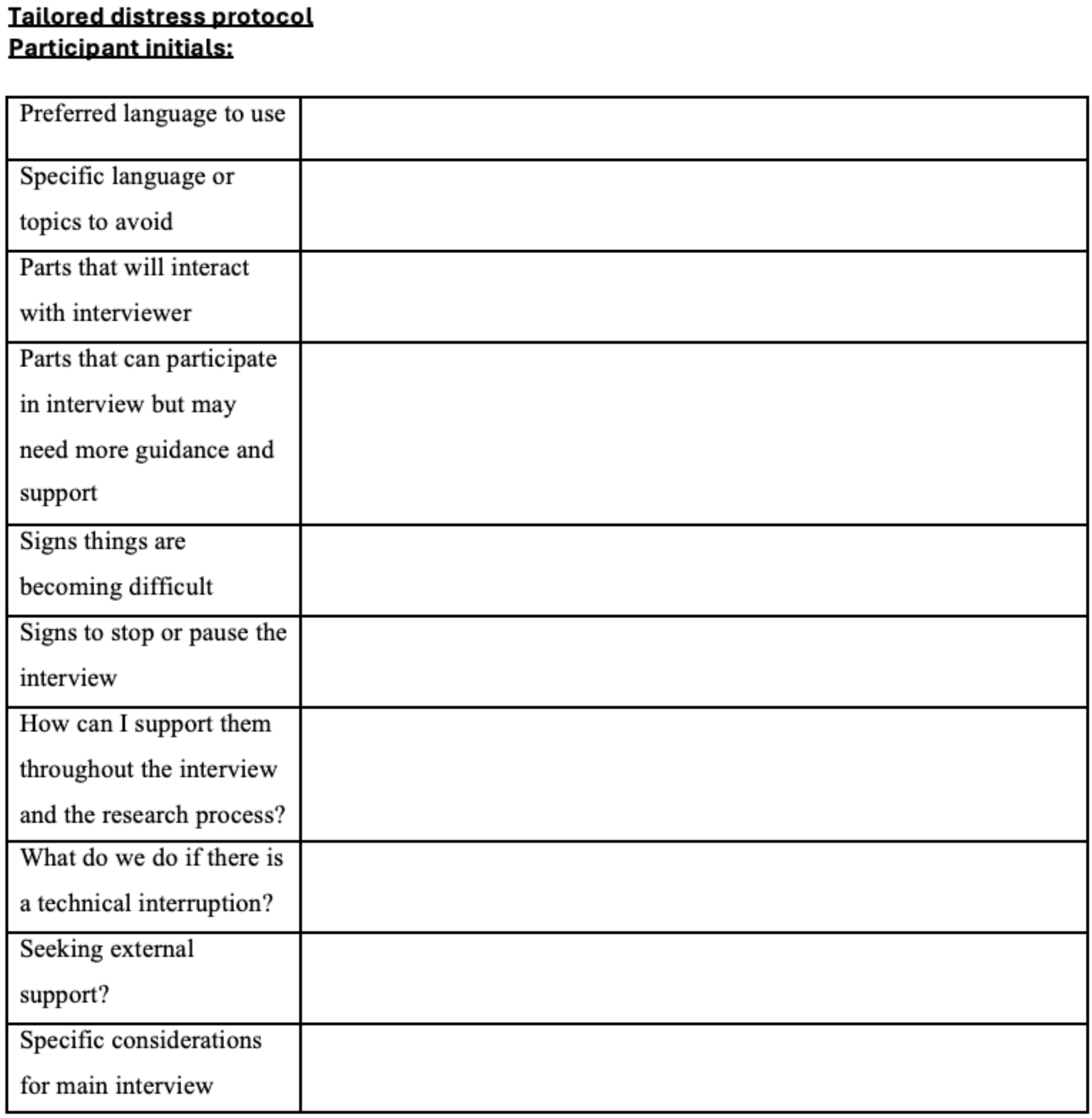
Level of external support	Description	Suitable or unsuitable?
1	They can name personal and professional support. They provide a specific contact for each. They convey that this support is effective and feels safe for them. They feel comfortable to reach out to these individuals. They can identify signs when they may need external support and effective ways that people can support them. They provide consent for emergency services to be contacted in the event of a crisis.	Suitable
2	They can name supportive services and individuals, but they indicate that they do not always feel comfortable or able to reach out for support. OR they name only a personal contact or only a professional contact. They can name at least one contact whom they feel safe receiving support from. They can identify signs when they may need external support and ways that people can support them that is effective. They provide consent for emergency services to be contacted in the event of a crisis.	Suitable – if given consent for researcher to approach identified contacts on their behalf and distress management is level 1 and low risk
3	They are unable to provide a personal or professional contact. They report isolation and lack of social support. They cannot identify instances where they may need support and what others can do to effectively support them.	Unsuitable

Level of distress management and capacity	Description	Suitable or unsuitable?
1	They provide elaborated and insightful responses to questions, with specific examples of coping strategies and reasons for why these are effective. They speak about how they have put therapeutic skills into practice. They are aware of triggers and crisis management. They demonstrate some ability to soothe younger or distressed parts and they are aware of parts that may lack capacity to engage in the research. They can convey how the researcher can support them to employ coping strategies independently. They report little amnesia, which is well-managed and not associated with serious harm.	Suitable
2	They appear to switch or become dysregulated in the pre-interview; however, they can re-ground themselves without extensive support from the researcher. They report some amnesia, however, this is not associated with serious risk to harm and does not cover extended periods of time. They require support with coping strategies and distress management; however, they can take a lead on this, and this approach is effective in managing switching, crises and overwhelming distress.	Suitable – *if coping strategies are effective with support and scoring level 1 for support.*
3	They do not appear to understand the questions asked and they cannot provide clear, reasonable, or comprehendible answers. They appear to switch when discussing coping and distress management strategies or discussing their parts/alters and they do not appear to have strategies to re-ground themselves. They are unaware of their triggers and crisis management. They demonstrate little awareness of younger or distressed parts and report extensive periods of amnesia when coping with distress or internal conflict.	Unsuitable

Version 2 – 26.01.2024 - IRAS number: 340547

Appendix M. Generic Tailored Distress Protocol Template

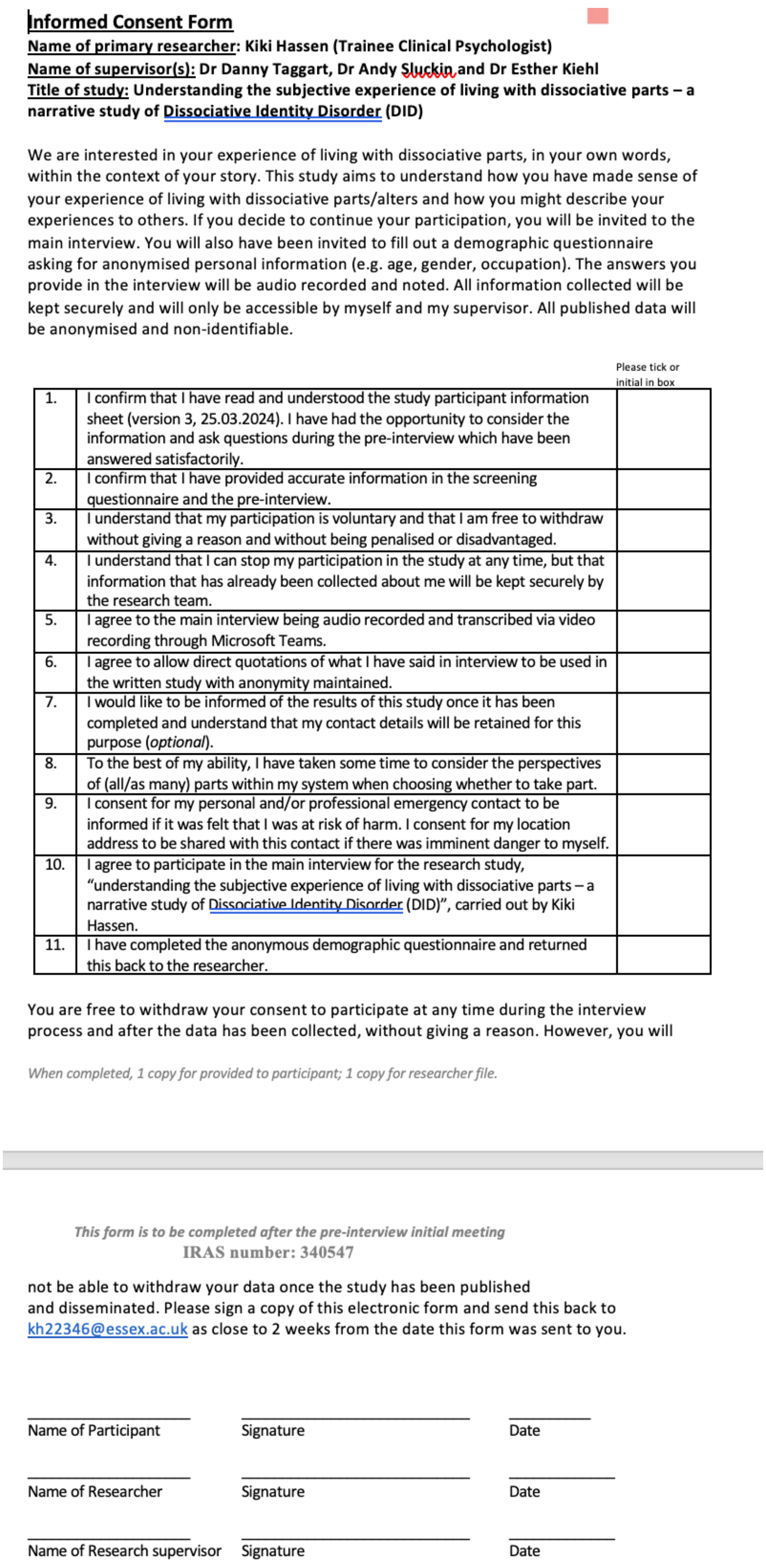
Headings often adapted uniquely to each participant



Tailored distress protocol
Participant initials:

Preferred language to use	
Specific language or topics to avoid	
Parts that will interact with interviewer	
Parts that can participate in interview but may need more guidance and support	
Signs things are becoming difficult	
Signs to stop or pause the interview	
How can I support them throughout the interview and the research process?	
What do we do if there is a technical interruption?	
Seeking external support?	
Specific considerations for main interview	

Appendix N. Main Consent Form



Informed Consent Form

Name of primary researcher: Kiki Hassen (Trainee Clinical Psychologist)
Name of supervisor(s): Dr Danny Taggart, Dr Andy Sluckin and Dr Esther Kiehl
Title of study: Understanding the subjective experience of living with dissociative parts – a narrative study of Dissociative Identity Disorder (DID)

We are interested in your experience of living with dissociative parts, in your own words, within the context of your story. This study aims to understand how you have made sense of your experience of living with dissociative parts/alters and how you might describe your experiences to others. If you decide to continue your participation, you will be invited to the main interview. You will also have been invited to fill out a demographic questionnaire asking for anonymised personal information (e.g. age, gender, occupation). The answers you provide in the interview will be audio recorded and noted. All information collected will be kept securely and will only be accessible by myself and my supervisor. All published data will be anonymised and non-identifiable.

		Please tick or initial in box
1.	I confirm that I have read and understood the study participant information sheet (version 3, 25.03.2024). I have had the opportunity to consider the information and ask questions during the pre-interview which have been answered satisfactorily.	
2.	I confirm that I have provided accurate information in the screening questionnaire and the pre-interview.	
3.	I understand that my participation is voluntary and that I am free to withdraw without giving a reason and without being penalised or disadvantaged.	
4.	I understand that I can stop my participation in the study at any time, but that information that has already been collected about me will be kept securely by the research team.	
5.	I agree to the main interview being audio recorded and transcribed via video recording through Microsoft Teams.	
6.	I agree to allow direct quotations of what I have said in interview to be used in the written study with anonymity maintained.	
7.	I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose (*optional*).	
8.	To the best of my ability, I have taken some time to consider the perspectives of (all/as many) parts within my system when choosing whether to take part.	
9.	I consent for my personal and/or professional emergency contact to be informed if it was felt that I was at risk of harm. I consent for my location address to be shared with this contact if there was imminent danger to myself.	
10.	I agree to participate in the main interview for the research study, "understanding the subjective experience of living with dissociative parts – a narrative study of Dissociative Identity Disorder (DID)", carried out by Kiki Hassen.	
11.	I have completed the anonymous demographic questionnaire and returned this back to the researcher.	

You are free to withdraw your consent to participate at any time during the interview process and after the data has been collected, without giving a reason. However, you will not be able to withdraw your data once the study has been published and disseminated. Please sign a copy of this electronic form and send this back to kh22346@essex.ac.uk as close to 2 weeks from the date this form was sent to you.

When completed, 1 copy for provided to participant; 1 copy for researcher file.

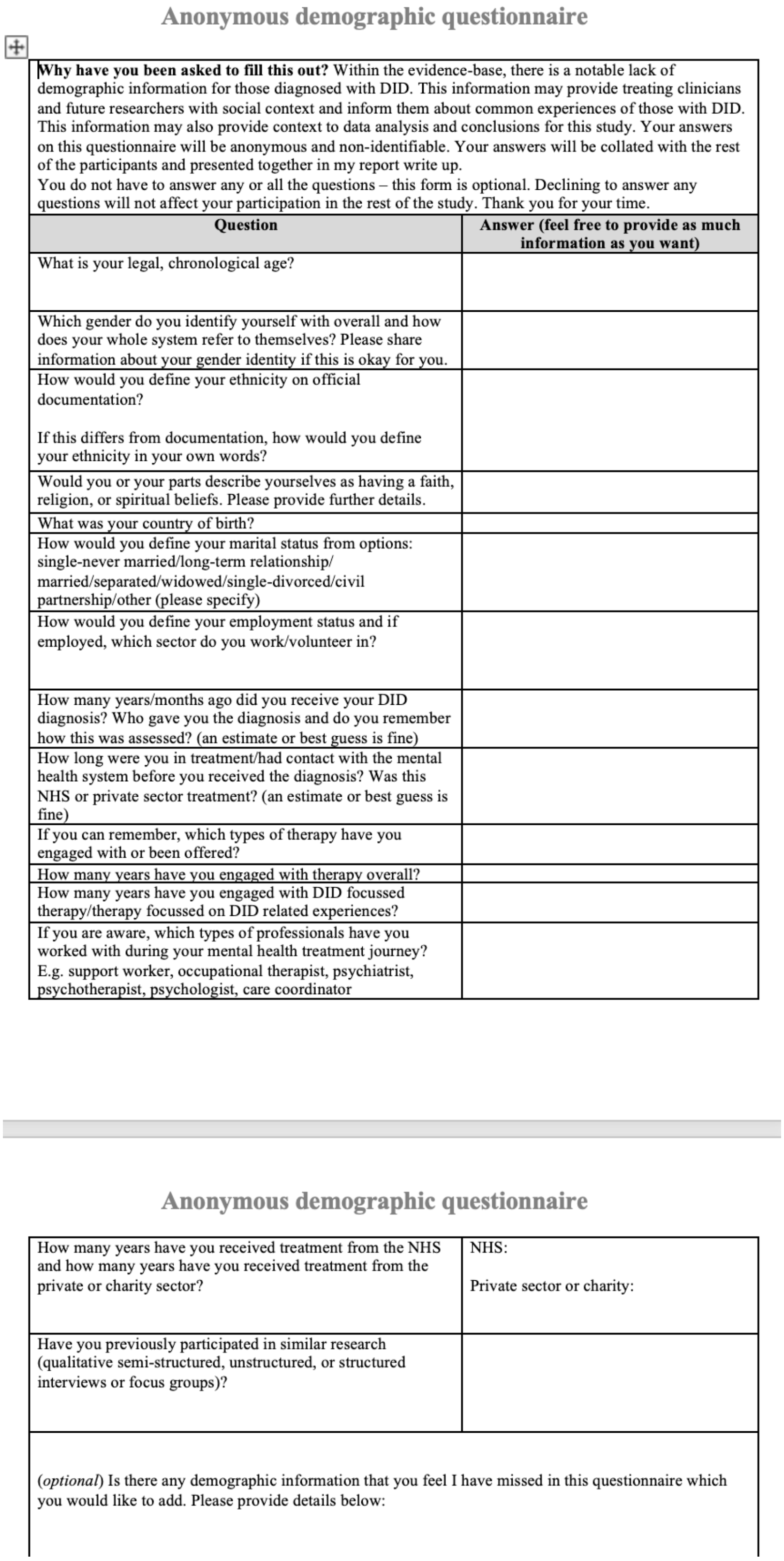
This form is to be completed after the pre-interview initial meeting
IRAS number: 340547

Name of Participant ____________ Signature ____________ Date ____________

Name of Researcher ____________ Signature ____________ Date ____________

Name of Research supervisor ____________ Signature ____________ Date ____________

Appendix O. Anonymous Demographic Questionnaire



Anonymous demographic questionnaire

Why have you been asked to fill this out? Within the evidence-base, there is a notable lack of demographic information for those diagnosed with DID. This information may provide treating clinicians and future researchers with social context and inform them about common experiences of those with DID. This information may also provide context to data analysis and conclusions for this study. Your answers on this questionnaire will be anonymous and non-identifiable. Your answers will be collated with the rest of the participants and presented together in my report write up.
You do not have to answer any or all the questions – this form is optional. Declining to answer any questions will not affect your participation in the rest of the study. Thank you for your time.

Question	**Answer (feel free to provide as much information as you want)**
What is your legal, chronological age?	
Which gender do you identify yourself with overall and how does your whole system refer to themselves? Please share information about your gender identity if this is okay for you.	
How would you define your ethnicity on official documentation? If this differs from documentation, how would you define your ethnicity in your own words?	
Would you or your parts describe yourselves as having a faith, religion, or spiritual beliefs. Please provide further details.	
What was your country of birth?	
How would you define your marital status from options: single-never married/long-term relationship/ married/separated/widowed/single-divorced/civil partnership/other (please specify)	
How would you define your employment status and if employed, which sector do you work/volunteer in?	
How many years/months ago did you receive your DID diagnosis? Who gave you the diagnosis and do you remember how this was assessed? (an estimate or best guess is fine)	
How long were you in treatment/had contact with the mental health system before you received the diagnosis? Was this NHS or private sector treatment? (an estimate or best guess is fine)	
If you can remember, which types of therapy have you engaged with or been offered?	
How many years have you engaged with therapy overall?	
How many years have you engaged with DID focussed therapy/therapy focussed on DID related experiences?	
If you are aware, which types of professionals have you worked with during your mental health treatment journey? E.g. support worker, occupational therapist, psychiatrist, psychotherapist, psychologist, care coordinator	

Anonymous demographic questionnaire

How many years have you received treatment from the NHS and how many years have you received treatment from the private or charity sector?	NHS: Private sector or charity:
Have you previously participated in similar research (qualitative semi-structured, unstructured, or structured interviews or focus groups)?	

(*optional*) Is there any demographic information that you feel I have missed in this questionnaire which you would like to add. Please provide details below:

Appendix P. Participant Pre-briefing Information for Main Interview

IRAS number: 340547

Narrative interview on your personal experiences of living with dissociative parts/alters

Preparation briefing:

You are the expert in your personal and subjective experiences and your story is best told in your own words and your way. This interview is informed by the qualitative research method of narrative inquiry, which means that the interview structure is not pre-determined or prescriptive. Therefore, this interview may differ from your previous experience of interviews. It does not take the generic question-answer format of other interviews because it is important that you choose the direction, language, pace, and format of how your story is told. Instead, you will be given a broad question/prompt, and you will be invited to tell your story in the way you would like to. I am aware you will have told your story many times in the past, to various professionals, including other psychologists. I am not interested in the story you have felt obliged to tell professionals previously. Instead, I am interested in the story you want me to know, the story which represents your personal perspective and experience.

To ensure that this interview is led by you, I will interrupt or guide you as little as possible, although I will be present and actively listening. If you require more prompting or guidance to keep you on track, I can provide this as we go. You can also keep this guide with you for reference during the interview. As you tell your story, I will jot down some further questions or clarifications to ask you once you have come to a natural 'end'. These questions will elicit further ideas and thoughts from you, which I will invite you to share freely. If there is anything you feel you have missed or a topic/question you would like to come back to, you can do so at any point in the interview.

There continues to be no pressure or requirement to share more than what feels comfortable for you. The whole interview will be recorded to make sure I capture your exact words and so I can understand your experiences from your perspective.

Following this, I will turn off the audio recorder and we will have a short debrief. The interview should not last longer than an hour, however, this time limit is flexible should you require breaks or more time. We can speak about what this was like for both of us and I will share what happens next.

During the interview, we will implement measures we identified in the pre-interview to keep you safe should any difficult feelings or memories arise. If you feel you need a break, you can take this at any point. If you switch between parts/alters during the interview, we will follow our pre-agreed plan on how to manage this.

I will contact you by telephone, following the interview, to check in. I will also offer you the opportunity to review your transcript to ensure that what I have recorded is what you intended to share and that it captures the story you wanted to tell.

IRAS number: 340547

Thank you so much for your time. I feel grateful and privileged to have the opportunity to hear your story.

Pre-brief at the start of the interview:

You can tell me about as little or as much as you feel comfortable to, you do not have to cover every topic listed below. You can convey the story of specific parts or your whole system. I will not directly enquire about trauma or abuse. Instead, I will be interested in how you have made sense of your dissociative parts in the context of your life, rather than the events themselves. It is up to you how much you choose to share.

The prompt below is how I will open the interview, following the introductory briefing:

I am interested in how your dissociative parts/alters shape and impact your everyday life and how you came to understand them, can you tell me about this? You can start wherever you would like to.

Other topics I *may* be interested in throughout the interview:

- Has the way your dissociative parts influenced your daily life changed over time? If so, what has influenced this change over time?
- How did you realise or come to know your dissociative parts exist?
- What do you understand to be the roles and functions of your dissociative parts?
- How do your dissociative parts relate to each other?
- How have your dissociative parts impacted:
    - Daily functioning
    - Therapy
    - Healing/recovery and mental health challenges
    - Relationships with others (including intimate), identity and social situations
    - Work/education
    - Health and sleep
    - Play, hobbies and interests

What is my study seeking to understand overall:

- What are some people's subjective experience of living with dissociative parts – what is it like?
- What is your experience and understanding of your dissociative parts?
- How do you make sense of your dissociative parts, within your DID experiences in general?
- Why have people made sense of it in this way?

Appendix Q. Anonymous Summary of Participant's Clinical Histories

Category	**Summary**
Time since DID diagnosis	Range: 10 months – 23 years (Mean not calculated; 3 diagnosed within past 3 years)
Diagnostic process	9 SCID-D, 2 Psychiatrist-led, 1 Clinical Psychologist
Years in mental health care (pre-diagnosis)	Range: 2 – 36 years; often long-term (5+ years in most cases)
Therapies previously engaged with	Common: EMDR, CBT, DBT, person-centred, integrative, psycho-synthesis, IFS, drama/art therapies
Years in therapy (any type)	Range: 4 – 40 years; most had 8+ years total therapy experience
Years in DID-Focussed therapy	Range: 2 – 22 years; majority had 3+ years of DID-specialist therapy
Treatment setting	7 had private therapy, 5 had NHS care (some accessed both); 2 received all care outside the UK system
Professionals involved	Wide range: psychotherapists, psychiatrists, psychologists, OTs, support workers, nurses, GPs

Category	**Summary**
Previous participation in DID research	3 participants

Appendix R. Summary of Participant Stories – Full Version

Olivia's story

Olivia's system comprises up to 29 parts and they are somewhat co-conscious. She experiences her parts through internal voices, emotions, and energetic shifts. Her narrative was non-linear, often shifting between past and present, and she spoke fluidly, reflecting spontaneously without pre-prepared notes. Olivia's history includes hospitalisations, misdiagnoses, and somatic symptoms such as seizures and an eating disorder—now understood as linked to her parts and trauma. A turning point in understanding her system came when she accessed her mental health clinic notes and realised over time that her father wasn't who she thought he was, leading to a painful realisation about suppressed memories. Key parts Olivia spoke about include:

Esme: the system manager who takes control in stressful situations.

Rachel: highly competent at work, especially with service-users.

Liv: drives system discovery and organisation, panics when life feels chaotic.

Winter: admires their parents despite traumatic attachment and is deeply connected to grief as their have parents have aged and become ill.

Beth: influential in therapy, holds trauma, and struggles with stealing and binge eating, which distresses the system.

Maria and Eliza: both trauma-holding; Eliza resurfaced in 2019 after being dormant, and Maria conflicts with Olivia's father's political views.

Lily: around six years old, her influence led to the system being misdiagnosed with a learning disability on one occasion.

Millie and Tara: joyful child parts who often front to distract from distress.

Emma and Emily: ruminate over daily events, chattering in the background.

Emma's story

Emma has worked to create an egalitarian system where all parts contribute to daily life. They experience their parts through auditory and symbolic communication, often via artwork or writing. While their system is not fully co-conscious, awareness has improved over time. Emma grew up with parents carrying their own trauma and experienced medical trauma themselves. After moving to the UK in their twenties, they described living a double life, with some parts flourishing while others sabotaged awareness due to their own struggles. Although initially hard to accept, the DID diagnosis helped them move from denial and shame to acceptance and cooperation. Emma spoke without pre-prepared notes; her narrative was non-linear and rich with metaphors. During the interview, the specific part which represented Emma's system was referred to with the system name, Emma. However, their experience is that all parts are Emma, whilst also none of them are. Key parts that Emma spoke about included:

Mara: Actively suppressed system awareness, believing they were "crazy" after their mother caught them talking to themselves and warned them never to share this with the world. The system had to negotiate with Mara to enable internal recognition.

Mal: A protective, verbally aggressive part who intervenes when he perceives Emma to be mistreated. His outbursts led them to seek therapy. Mal pushed for system recognition and initially opposed Mara.

Idris: Holder of traumatic memories of being punished, who internalised and directed this inward toward other parts. Over time, he grew to become more supportive.

Ray: A nurturing internal caretaker, who was crucial in integrating Idris through insistence on kindness and connection.

Ray Ray: Uses humour to cope and defuse tension.

Riquitta's story

Riquitta's system consists of 14 parts and is not co-conscious, meaning she does not recall what happens when parts take control. Her parts primarily communicate through journaling, each with distinct handwriting. Riquitta's storytelling was free flowing, delivered without pre-prepared notes, and vaguely followed an arc from crisis and realisation to part discovery. She first became aware of her parts after finding boxes under her bed containing objects belonging to each part. A central figure in Riquitta's narrative was her care-coordinator, who modelled compassion by engaging directly with each part, unlike other professionals. Riquitta's story was marked by grief and anger over losses caused by DID, including her high-profile NHS career, memories, and relationships. Although she received five years of DID-focused therapy, funding has since been cut, leaving her feeling let down by the system. Key parts Riquitta spoke about included:

Evil: A teenage part who self-harms to manage trauma and anger. Recently revealed to be homosexual, which is at odds with Riquitta's sexuality, causing internal conflict. Evil often presents to crisis services.

Hannah: The system manager, aware of all parts' needs and difficulties. She handled responsibilities in Riquitta's NHS role.

Rachel: Carries and expresses the system's eating disorder. She was dominant during Riquitta's hospitalisation for anorexia as a young adult.

Mark: The only male part, around nine years old. Active and sporty, he represents an archetypal boy figure, offering protection from trauma, as "bad things don't happen to boys."

Little Riquitta and Lucy Loo: Child parts who carry significant trauma and extreme vulnerability. Riquitta also described an 18-month-old part who is incontinent.

Sarah: A highly promiscuous part whose behaviour often causes Riquitta distress.

Black, Blue, and Green: Persecutory introject parts who emerge in crisis and communicate via auditory hallucinations. Black appears as a hooded figure and may be experienced as physically assaulting Riquitta.

Eloise's story

Eloise's system functions through subsystems, co-consciousness, and co-hosting, ensuring multiple parts are always present, which means she does not lose significant time or memory. Her storytelling is shaped by shifting perspectives, metaphorical language, and a non-linear structure. To stay on track, she had the interview guide and prompts printed in front of her. She frequently referenced her parts' dynamic contributions throughout the interview. Eloise spoke about past trauma related to her father's military involvement, which led her to seek therapy. However, EMDR caused flooding and overwhelm in the system. Struggling to access appropriate therapy, she found herself piecing herself together rather than working toward integration, despite wanting to become one person. Key parts in Eloise's story include:

The Silvers: A group of playful, spontaneous, and mischievous teenage parts who were the most influential in her story. They play a key role in emotional well-being and relationships, shaping her interactions with close friends.

Mum Part: Whose identity revolves around caring for Eloise's children and ensuring their safety.

Work Heads: Parts who manage professional responsibilities but can be rebellious toward system rules.

Tom: A protector part who asserts Eloise's needs and expresses anger when she feels mistreated.

Sky: A young part who holds a lot of emotion. Always in the backseat, peering in and plays an active role in daily life.

Other young Parts: Who communicate through play, often using a dollhouse and toys to express their needs.

Lauren's story

Born into a family involved in organised crime, Lauren's system is not co-conscious and experiences clear amnesic barriers, especially between organic and installed parts. Installed parts were deliberately created, named, and assigned roles by abusers, while organic parts developed naturally to support the system and assist specific installed parts. Lauren described a hierarchy led by five child parts who controlled internal communication. Their system was divided, whereby organic parts managed daily life, while installed parts handled abuse-related demands. Abusers used extreme abuse to reprogramme parts and ensure compliance. Lauren's storytelling was fluid, metaphorical, spontaneous, and non-linear, following an arc of survival, loss, and transformation. A key figure was her compassionate therapist, who treated all parts with equal respect and negotiated with installed parts to help them recognise danger and empowered them to escape abuse. With safety and therapy, the system began a journey of transformation where installed parts took on new roles, and leadership shifted toward a more democratic system. Key parts Lauren spoke about included:

Bexley: An installed part who was system host, managing adult life while concealing abuse. She disappeared in 2019 after another part disclosed the truth, causing chaos in the system and prompting Lauren to step in as host, which she continues to do.

Tess (formerly the High Priestess): An installed, high-ranking child part who initially enforced internal control. Through therapy, she softened and became a leader in system-wide conferences, bringing other parts forward in a helpful way.

Phoebe (formerly the Blood Lady): An installed part fiercely loyal to abusers. After witnessing abuse that she wasn't meant to see, her changed allegiance influenced wider system awareness.

Tiger Boy (formerly the High Priest): A child leader among the top five, who only wanted to play and draw tigers. Renaming him supported his shift away from power dynamics.

Other parts included one installed to deceive medical professionals, now more helpful in medical appointments and another who maintained alcohol addiction as a control method, now choosing healthier drinks.

The Wolf Protector: A giant childhood creation Lauren could hug for safety. Not fully separate part, but symbolic of protection during early trauma and the role of organic parts.

Ellie’s story

Ellie's system comprises of over 20 parts and is structured into three clusters: daily life parts, trauma parts, and child parts. As a survivor of extreme organised abuse, Ellie recalled feeling unseen by professionals, teachers, and society. Her system is not fully co-conscious which means when one part is fronting others are often unaware or lack memory access. Ellie experiences her parts auditorily, energetically, and through synaesthesia, where emotions manifest as colours. This allows her to sense how a part feels even without direct co-consciousness. Parts mainly communicate within their clusters, with some parts bridging groups. Ellie’s system has developed strategies to improve communication, including video notes, Alexa messages, and daily logs with sections for each part. Ellie explained how her autism influences her system's structure and sensory responses, with autistic traits and degree of masking varying across parts. Ellie’s storytelling was reflective and non-linear. She often needed prompts, referred to pre-prepared notes, and took time to gather her thoughts. Her story highlights how she navigates DID through structure, transforming chaos into organisation by drawing on her neurodiversity. Key parts Ellie spoke about included:

Cara: A trauma and daily life part who shields the system. She holds her own trauma and influences access to other trauma parts. Once associated mainly with trauma, the system has come to value her broader contributions. She was central in Ellie's legal battle against the NHS and an influential part in Ellie’s story.

Poppy: Once a child part, now supports Sage in the management of daily life through creative distraction and a caregiver for younger parts.

Sage: The front to show the world -The ‘pretend Alice’. The only part who regularly interacts with others.

Lottie: A circuit breaker part for Cara’s intense emotions such as anger. When Cara is overwhelmed, Lottie acts as a sensory reminder to prevent harm.

Morgana: A part named and created by Ellie's abusers to carry out their wishes, whom Ellie believes should be renamed.

Elodie and Hope: Supportive parts who help regulate Morgana's emotions.

Fragment parts: Carry out specific tasks (e.g. putting away shopping) and are not self-aware as separate identities.

Julia’s story

Julia’s system is mostly co-conscious, with several parts working closely and sharing awareness. Over time, the system has undergone significant changes, including part fusions and multiple host transitions. Julia experiences her parts through auditory, energetic, and visual communication, relying heavily on her internal world. They described misdiagnoses and mental health crises, linking these to specific parts' needs. Their storytelling is metaphor-rich, perspective-shifting, and non-linear, but follows an arc of discovery, crisis, and growth. Julia spoke freely, using internal communication for prompts. Toward the end of the interview, she switched, allowing Juno to share her perspective and contributions. Key figures in Julia's life include their children and their romantic relationship with another system. Although complex dynamics arose from this romantic relationship, Julia noted how interactions with their partner's system were integral for growth and transformation within their own. Key parts in Julia's story included:

Julia: The current host, newly created for this role. She previously fused with Steph, gaining her memories and later fused with Jackie, forming the current host. Julia is considered to be the primary mother to their daughter.

Jackie: Co-host, previously focused on adult intimate relationships. Resistant to therapy at first, she became more open over time. She and Julia had a romantic internal relationship which precipitated their fusion.

Annie: A former long-term host, highly functional but anxious. She tried to lead a "normal" life and struggled to accept the system. Annie was considered to be the primary mother to their son as she was the host during their son's early childhood.

Joseph: A spiritual, philosophical part who briefly hosted in 2020 following Iris's crisis. He initially rejected diagnoses and trauma but changed through dialogue with their partner's system. He insisted a neutral part take over hosting, leading to the creation of the Julia part.

Juno: A teenage part who shared her own story during the interview. Juno was described as creative and rebellious and identified as holding trauma. After waking from dormancy, which caused system instability, she experienced the most growth, transitioning from self-harm and overwhelm, to contributing to daily life and parenting responsibilities. Juno credits her growth to being believed in by a part in their partner's system.

Iris: A vulnerable part who struggles with psychosis and schizophrenia. She may be the system's gatekeeper. Her crises led to multiple hospitalisations, and she is now stabilised through anti-psychotic medication and internal teamwork.

Nettle: An 8-year-old part not associated with trauma, who brings grounding and joy to the system.

Flora: The youngest part. She holds trauma memories and expresses emotions and experiences somatically through the body.

Catherine’s story

Catherine's system is hierarchical and co-conscious, allowing multiple parts to remain aware simultaneously. She experiences her parts through auditory, energetic, and sometimes visual communication, often relying on their internal world. The interview was led by Jessica, a protector part, speaking on behalf of the system, with Cath also present and co-conscious. Jessica acknowledged other parts in real time, including Alex, who was present and watching. Their storytelling followed a structured yet non-linear arc, shaped by late system discovery, professional misdiagnosis, and internal collaboration. They described the system as covert and high-functioning, having never presented to services with external crises. Catherine became aware of their system after a series of compounded bereavements and external losses which led to a breakdown in functioning. Her first therapist was supportive but lacked DID-specific knowledge. The early stages of discovery were self-directed during the COVID lockdown, later transitioning to work with a specialist therapist. Key parts in Catherine's story included:

Cath: The face of the system, created to manage work, parenting, and social responsibilities. She struggled most with internal awareness. Cath usually fronts to the world, but in high-pressure situations, Jessica takes over.

Jessica: Physical protector who supports Cath in daily life and who is assertive, sarcastic, and distrusting of others. Jessica uses a "tough love" approach and now directs her anger outward to protect the system.

Layla: Internal caretaker and maternal figure who mediates conflict and tension between parts. Jessica trusted only Layla early on.

Matthew: An intellectual helper part formed to meet academic demands and who enabled the system to achieve high academic attainment. As Matthew is male, he experiences gender dysphoria when fronting in a female body. Recently fused with Alex.

Alex: A flamboyant, extroverted entertainer who thrives socially. Creative and open, he has often clashed with Jessica due to their opposing traits.

Daisy: A young, mostly mute trauma holder who rarely fronts unless in extreme distress. She requires significant care and protection.

Cassie: A primary trauma holder who lives in the "basement" of the system's internal house. She rarely fronts, and the system is working together to help her process trauma.

DJ: A shadowy gatekeeper figure who blocks access to certain memories and shuts down the system when needed. Resistant to trauma work in therapy.

Columbia’s story

Columbia's system includes over 90 parts, many of whom are not yet fully known. Her system is capable of co-consciousness, where some parts front seamlessly while others take full control, resulting in blackouts and lost time. When co-conscious, communication occurs through internal voices, energetic presence, and physical sensations. The interview was co-led by Columbia and Silas. Silas switched in, with Columbia's agreement, at moments where his leadership or perspective was most relevant. Their storytelling was fluid and vivid, following a structured yet non-linear arc shaped by confusion, discovery, and collaboration. After a series of unhelpful therapists, a turning point came with their current therapist, who built unique relationships with individual parts. A pivotal moment in their story was when Columbia disappeared into a sub-world for a year and could not be found. During this time, Silas managed their job and fought to keep them alive through ongoing trauma. This experience, though born from crisis, transformed their relationship which was once marked by conflict. Key parts discussed included:

Columbia: The primary daily-life part who is calm, introspective, and kind. Initially struggled to accept their parts, but after spending a year in the internal sub-world, gained deep empathy for their experiences.

Silas: System protector, who is analytical, distrustful, and fiercely advocates for diagnosis and treatment. He is charismatic and often uses sarcasm and energy to lead.

Aires: Another protector part, who is defensive and uncompromising, quick to act when the system is threatened.

Kitty and Mistress: Parts who front during intimacy; their roles were shaped by early trauma and survival needs.

Carly: A nurturing part who comforts the system through food and soothing.

Laika’s story

Laika’s system is structured and organised, made up of sub-systems focused on daily life, trauma-holding, protection, and care. Laika describes their system as both co-conscious and co-fronting, where parts witness and share in managing daily life. They experience parts through auditory thought-forms, energetic presence, and physical sensations, relying heavily on their internal world. Their internal world is vivid, with emotion-driven weather, designated safe zones and an internal social media system where parts use mobile phones to aid communication. Laika’s storytelling was rich, temporally fluid and non-linear but structured around pre-prepared notes following a journey of self-discovery, acceptance, and healing. Laika is a survivor of severe organised abuse and, despite early denial, recognises that their system was overt and detectable from as early as age five. Their experience of identity is fluid and shaped by the diverse genders and sexualities of their parts. Laika identifies as a transgender man undergoing medical transition, but experiences internal gender fluidity, identifying as genderqueer when reflecting the experience of the whole system. Similarly, their sexuality has fluctuated due to host changes, affecting romantic relationships. Laika also described how their autism interacts with their DID, with parts expressing autism differently based on their unique characteristics and traits. Key parts in Laika's story include:

Laika: Current host, responsible for daily life. Often disconnects from the body to function due to chronic illness and trauma. Coordinates coping strategies and supports others. Holds the most external awareness.

Yosano: Internal leader and strong protector. Initially developed a narcissistic shell to mimic their abuser for survival, later revealed to have deep empathy. Holds anger and enforces the rule that trauma must not be denied.

Elio: A young pink rabbit part representing the fawn/freeze trauma response. Created to submit to abuse, later reimagined as a spoiled pet rabbit. Sensitive to trauma denial, often hides and sleeps in unusual places in their inner world, bringing joy to the system.

Laika also described aggressive protector parts who misdirect rage by fighting internally, caretaker alters who take on parental roles, and fragment parts that manage specific daily tasks.

Rachel's story

Rachel's system is highly fluid and energetic, rather than being made up of clearly defined, named parts. She describes two core selves, Rach and Rachel, and a surrounding "team" of parts that exist in an energetic space around her which she experiences through external emotions and bodily sensations. Rachel does not experience distinct switches but instead a seamless, continuous shifting between parts. Often unaware of who is fronting until afterward, she has experienced significant lost time at various points in her life. Her storytelling was fluid and spontaneous, following a clear narrative arc from emotional turmoil and confusion to acceptance. Rachel's story reflects late system discovery, after a lifetime of hidden dissociation. Her early life was marked by fear and neglect, growing up with a frightening mother and in a strict Catholic convent setting, compounded by the conflict between her sexuality as a gay woman and her religious background. She found success in her acting career but turned to alcoholism and anorexia to manage overwhelming emotions. After becoming sober, the continued experience of lost time led her to confront her dissociative experiences in therapy. Rachel intentionally avoided reading about other systems to focus on understanding her own internal world in her own therapy. Key parts in Rachel's story:

Rachel: A more mature, emotionally regulated, and socially functional self. She ensures compliance, structure, and social survival.

Rach: A younger, softer, playful, and vulnerable self, described as Rachel's "true self," embodying traits she was never allowed to express in her childhood. Rach can be impulsive and reckless, often requiring Rachel to intervene. Rachel longs to stay in Rach's world but needs Rachel's structure to function.

Little People: Pre-verbal or non-verbal younger parts who can make simple tasks overwhelming but bring joy through playful activities like cycling and running.

Rachel also described parts tied to specific emotions or memories, including a powerful internal critic who perpetuates cycles of internal punishment.

Rose's story

Rose experiences her parts visually and energetically. She has always seen them around her in specific locations, referring to specific parts spatially, such as "this part over here." While she doesn't engage in full conversations with them, she senses their emotions and occasionally hears words. Rose understands her identity as intrinsically linked to her parts; she is Rose, but she functions as a group, with each part holding different aspects of her past. At times, she observes from the side as another part takes over and at other times, she experiences lost time and memory gaps. Her storytelling was non-linear and fluid, guided by pre-prepared notes and real-time notetaking to aid memory and structure. Her DID enabled high functioning, with different parts stepping in and allowing her to work long hours, raise two children, and maintain a senior role in education. Her parts helped her remain consistent and composed at work, regardless of her internal state, though she relied on specific strategies to manage lost time. To mask inconsistencies, she embraced an "eccentric" persona, which deflected scrutiny or suspicion from her colleagues. After her children left home, increased lost time led her to seek professional help and discover her system. Although her parts enabled her to be skilled across many areas despite distress, it also left her feeling isolated and misunderstood by others. Key parts Rose spoke about:

A strong mother part: Who ensures she is present and capable of caring for her children, no matter her internal state.

A work-focused group of parts: Maintain high-level and consistent professional functioning, driven by strong principles and strict standards.

A very angry part (gestured to the left): Holds her anger and frustration, often expressing verbal aggression.

An artistic part (positioned back left): Holds her creative ability but can be uncooperative. Discovered when Rose was in a mental health hospital; this part surprised Rose, who hadn’t seen herself as possessing artistic abilities prior to this.

Appendix S. Breakdown of Coding Process and Theme Development

Narrative Theme	Thematic Codes	Narrative Segment	Structural Features
Theme one: Individual Stories of Parts	Parts hold key information, Diverse and distinct identities, Emotional complexity in parts, Varied social dynamics across parts, Roles and abilities of parts, Embodied experiences in parts, Sensory experience of parts, Physiological indicators of switching	All three segments – mostly adaptation and understanding	Key characters: manager parts, caretaker/caregiver parts, protector parts, trauma holding parts. Pronoun and perspective shifts. Reference to parts contributions and switching during the interview – shifting narrative voice.
Theme two: The hidden nature of parts	Hidden nature of dissociation - out of awareness, Societal and institutional misconceptions, Loss of memory and time, Questioning past and present, Uncertain intuition, Seeking acceptance and understanding	Mostly pre-awareness, some codes overlap into recognition and crisis	Repetition, self-correction, and disrupted storytelling. Key Characters: parts who keep the system hidden or disrupt awareness
Theme three: Navigating confusion and chaos	Perceiving the world through parts, Parts are always present, Triggers for switching, Fronting for regulation and needs, Internal conflict and conflicting needs, Fronting parts have control, Duality, Navigating inconsistencies and confusion, Contradictions due to switching, Lack of control and agency, Loss of memory and time	Mainly Recognition and Crisis (Some codes present across all three segments)	Time distortions and non-linear narratives. Repetition, self-correction, and disrupted storytelling. Metaphor: Splitting lightning and earthquakes. Metaphor: watching your life through CCTV monitors
Theme four: Understanding the system and internal world	Unique system structure, Vivid internal worlds, Co-consciousness, Understanding the host role, The discovery of parts, Understanding parts through social feedback,	Mixture of adaptation and understanding; and Recognition and crisis	Key event: associated with receiving a diagnosis. Key characters: good therapist and bad therapist. Metaphor: Internal social

	Acknowledging and valuing parts, Building trust and rapport with parts, Internal relationships between parts, Unique internal communication, Strategies for remembering		media. Metaphor: A universe I've created. Metaphor: A house with many rooms
Theme five: Remembering trauma and abuse through parts	The system is set up for survival, Exploitation of dissociation by abusers, Parts hold childhood trauma away, Internalisation of trauma and abuse, Parts stuck in time, Trauma free parts and unawareness of trauma, The adaptive function of switching, Disconnection and shut down, The benefit of having parts	All three segments (mainly adaptation and understanding)	Key characters: trauma holding parts, vulnerable little parts, shut down parts. Emotional tone: gratitude, awe, relief, appreciation. Metaphor: Barbed wire between parts
Theme six: Building a home for parts	Living as an internal family or team, Nurturing and caring for little parts, Negotiation and sacrifice, Collective decision making, Every part matters, Healing for parts, Growth and development for parts, Dynamic system changes, Internal and external stigma, Difficulties sharing experiences, Social isolation, Navigating intimacy with parts, Resentment and grief, Functional multiplicity, Lifelong healing	Adaptation and understanding (some codes across all three segments)	Metaphor: Walking Beside Each Other. Journey is not over yet – ongoing and incomplete narrative. Emotional tone: anger, resentment, grief, loss, emotional pain, sadness