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Case Report

A novel phase-oriented treatment approach for dissociative identity disorder comorbid with major depressive disorder and somatization: A case report

Hümeýra Ergül^{a,*}, Burcu Uysal^a, Ceren Acartürk^b, Medaim Yanık^a

^a Department of Psychology, Ibn Haldun University, Istanbul, Türkiye

^b Department of Psychology, Koc University, Istanbul, Türkiye

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ABSTRACT

Background: The phase-oriented treatment approach is the widely recommended approach for Dissociative Identity Disorder (DID); however, evidence for brief, intensive outpatient delivery remains limited. This case report describes an intensive, time-limited, phase-oriented intervention in a client with DID comorbid with major depressive disorder and prominent somatic symptoms.

Methods: Following an initial clinical interview conducted according to DSM-5 diagnostic criteria and informed by information from a first-degree relative, a 41-year-old woman received an intensive outpatient phase-oriented treatment model across 17 sessions delivered over nine closely spaced days (two consecutive 50-minute sessions per treatment day; total 100 min). Symptom change was evaluated at baseline and at a 45-day follow-up using the Dissociative Experiences Scale (DES) and relevant subscales of the Dissociative Disorders Interview Schedule (DDIS). Long-term clinical follow-up was documented at 2, 3, and 8 years.

Results: Dissociative symptoms decreased substantially from baseline (DES = 31.43) to the 45-day follow-up (DES = 6.07). On the DDIS depression subscale, endorsed items decreased from 9/9 at baseline to 1/9 at 45 days; on the somatic symptoms subscale, endorsed items decreased from 20/39 at baseline to 6/39 at 45 days. The reduction in somatic complaints was considered to have occurred in parallel with the integration of alternate identities characterized by pain and bodily distress. At the 8-year follow-up, despite experiencing several significant losses and stress, the DES score went up to 25, with some increases in the DDIS depression (5/9) and somatic symptoms (14/39) subscales, but still stayed below the initial levels of dissociation, depression, and somatic symptoms.

Conclusions: This case suggests that an intensive, time-limited, phase-oriented model may be feasible and associated with clinically meaningful short-term symptom reduction in DID with depressive and somatic features. Long-term follow-up indicates that gains may be broadly maintained yet sensitive to major stressors. Further systematic research is warranted.

1. Introduction

Dissociative Identity Disorder (DID) is one of the most frequently misdiagnosed and least treated psychological disorders, often going without proper care for extended periods. DID is characterized by the presence of two or more distinct identity states, accompanied by marked discontinuities in the sense of self and behavior. These identity states may recurrently assume executive control over behavior and can also influence internal experiences, perceptions, and emotions. Collectively, these identity states constitute the individual's overall personality

organization (International Society for the Study of Trauma & Dissociation [ISSTD], 2011).

The prevalence of Dissociative Identity Disorder (DID) in the general population has been reported to range between 1% and 1.5% (Johnson et al., 2006; Ross, 1991; Şar et al., 2007; American Psychiatric Association, 2013). Epidemiological studies indicate that prevalence increases as psychiatric severity rises, with DID observed in around 2% of outpatient populations and up to 5% of inpatient psychiatric settings, with even higher rates recorded in emergency psychiatric hospitals. According to international epidemiological research, 8.6–18.3% of the

* Corresponding author.

E-mail address: humeýra.ergul@stu.ihu.edu.tr (H. Ergül).

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general population meet diagnostic criteria for any DSM-IV dissociative disorder, and 1.1–1.5% of the general population meet diagnostic criteria for DID, making it more common than is commonly believed (Dorahy et al., 2014).

Historically, somatoform disorders and dissociative disorders have been linked through the concept of hysteria and, until the DSM-III, were conceptualized as having similar underlying processes or mechanisms (Kallivayalil & Punnoose, 2010). High rates of somatization and somatoform disorders are found in DID clients. Nijenhuis (1999) has characterized many of these symptom types as somatoform dissociation. Common somatoform symptoms in DID clients are quite varied and can include abdominal pain, pelvic pain, joint pain, face and head pain, lump in the throat, back pain, non-epileptic seizures, and pseudo-asthma, among others. Somatoform dissociation may explain the high rates of childhood maltreatment, particularly sexual abuse, found in clients with somatization disorder (Briquet's Syndrome), somatoform pain disorder, hypochondriasis, and conversion disorder, particularly non-epileptic seizures (ISSTD, 2011).

1.1. Phase-oriented treatment approach

The most cited treatment model for DID is phase-oriented treatment, which involves three stages. In stage 1, clients work towards establishing safety and stability. Some DID clients may lack interest in or the psychological and practical resources for moving beyond this stage. In Stage 2, the focus shifts to maintaining stability while exploring trauma narratives and resolving trauma-related emotions, beliefs, and behaviours. In Stage 3, treatment focuses on the integration of identities and the ability to live without dependence (Dorahy et al., 2014).

Another commonly cited treatment for DID is psychodynamically aware psychotherapy, often eclectically incorporating other techniques, such as hypnosis (Putnam & Loewenstein, 1993).

Although phase-oriented treatment delivered in its conventional form is the primary framework for the treatment of dissociative identity disorder (ISSTD, 2011), its implementation often requires lengthy and resource-intensive care. This raises the clinically important question of whether more intensive, time-limited intervention formats may represent a meaningful alternative for selected patients, particularly when access to longer-term psychotherapy is limited, the financial burden is substantial, or alignment with existing care trajectories is difficult. The present case report is therefore not intended to demonstrate efficacy in any definitive sense, but rather to illustrate how an intensive outpatient format may be clinically organized and what kinds of short- and long-term outcomes such an approach may yield.

1.2. Ethical considerations

All procedures performed in this study were conducted in accordance with ethical standards. The client provided written informed consent for the use of clinical information for academic presentations and publication. Client confidentiality and anonymity were strictly maintained, and identifying details were modified where necessary to prevent recognition.

2. Case summary

Case: A 41-year-old Turkish woman (referred to as R. hereafter) with a history of complex trauma presented with DID, major depressive disorder, and somatic symptoms. She had experienced two traumatic marriages and had two children from her first marriage. She was born and raised in Türkiye, where she completed her secondary education. She had aspired to attend university but was unable to do so because of her marriage. Her father was a tradesman, and her mother was a housewife. At the time of assessment, she was residing alone in the family flat. She had a younger sister. She had no physical impairment and reported that she had excelled in business prior to the deterioration

of her quality of life due to this illness. She was unemployed while receiving therapy.

Chief Complaint: The client (R.) exhibited a prolonged history of dissociative symptoms and expressed a profound desire to attain mastery over her illness. She had persistently auditory hallucinations that she perceived as originating from her mind, which she characterised as intrusive and distressing, alongside spells of amnesia and challenges in recalling daily occurrences.

Furthermore, she affirmed the presence of dissociative somatic symptoms, such as involuntary speaking and episodic sensations of tongue expansion, primarily occurring in religious contexts. The client described enduring feelings of fear and shame, along with increased anxiety due to ongoing financial difficulties. She refuted any prior psychiatric or psychotherapy interventions but expressed a distinct desire to enhance self-acceptance and emotional regulation.

History of current disorder: R. reported long-standing experiences of internal voices and perceived loss of control over her body. There were voices in her head, and she grew tired of them. She had difficulty maintaining a relationship for a long time due to sudden emotional shifts. She would become very happy or very angry, with depressive symptoms including tearfulness, hopelessness, low energy, and worthlessness. Depression fluctuated violently, but she insisted. She had contemplated suicide but had never confessed it. She also reported frequent feelings of intense anger and restlessness toward herself, often accompanied by feelings of guilt and shame.

Medical History: R. indicated that she had no additional issues apart from fibromyalgia. She had been prescribed pregabalin (Lyrica) 150 mg and venlafaxine (Efexor) 75 mg by a rheumatologist three years prior. She was still taking them.

History of Substance Abuse: She reported no substance abuse or abuse history. She had some recreational alcohol, but she was not interested in any other form of drug abuse.

2.1. Assessment scales

2.1.1. Dissociative experiences scale (DES)

The Dissociative Experiences Scale (DES), created by Bernstein and Putnam (1986), is a widely used tool for assessing dissociative disorders (ISSTD, 2011). This 28-item self-report scale measures the frequency of dissociative experiences, such as amnesia, depersonalization, and derealization. Comprehensive meta-analyses indicate that the scale has strong internal consistency and reliability (Michelson & Ray, 1996). The cutoff score is 30, and the final score is calculated based on the average of all responses. A high DES score suggests that the individual completing the questionnaire is likely to possess a dissociative condition (Vermetten et al., 2007). The Turkish version of the Dissociative Experiences Scale (DES) was adapted and validated by Yargıç, Tutkun and Şar (1995).

2.1.2. Dissociative disorders interview schedule (DDIS)

The Dissociative Disorders Interview Schedule (DDIS), developed by Colin A. Ross and colleagues in 1989, is used after the initial screening to help clarify a diagnosis (ISSTD, 2011). The DDIS uses DSM criteria to assess dissociative disorders, somatization disorder, major depressive disorder, and borderline personality disorder; studies show that DDIS is effective for diagnosing BPD. The interrater reliability coefficient (kappa) is notably high, ranging from 0.95 to 0.96, with a sensitivity of 95% (Ross, 1997).

3. Psychotherapy approach and process

3.1. Psychotherapy approach: a novel alter-based phase model

The alter-based phase model is grounded in the ISSTD's phase-oriented treatment framework; however, rather than being applied to the entire personality system in a sequential and linear manner, it is

implemented at the level of alternate identities that emerge during therapy. Within this framework, the protocol is organized into 11 steps and comprises 35 distinct intervention techniques. In this approach, each emerging alternate identity is addressed according to its clinical readiness: first to recognize and understand its function, then to achieve stabilization, and, when clinically appropriate, to proceed toward integration.

This model assumes that therapeutic progress can be sustained without waiting for the complete stabilization of the entire system. In this way, the treatment process acquires a more flexible, dynamic, and individualized structure. At the same time, this approach is based on a cyclical therapeutic logic in which work with alternate identities strengthens the host, which in turn facilitates work with other parts of the system.

This protocol was developed over the years by the last author (M.Y., M.D., psychiatrist), and its theoretical foundations and related clinical approaches have been discussed in detail in his published work (Yanik, 2018). The detailed treatment protocol will be published separately, but a general overview of the protocol is presented in Table 1.

3.2. Initial clinical interview (intake assessment)

The initial clinical interview was carried out by the last author (MY), with the first author (HE) serving as a co-therapist. In this interview, formal clinical inquiries were conducted to facilitate differential diagnosis, and the client's self-reported experiences were assessed in conjunction with collateral information gathered from her sister. After a thorough evaluation of the data and in alignment with DSM-5 diagnostic criteria, the client was diagnosed with DID and major depressive disorder.

Observation: At the beginning of the interview, the client showed an abrupt shift in posture, facial expression, vocalization, and muscle tension. Intervention: The therapist responded by directly acknowledging the emerging state and using a containing, non-confrontational stance to maintain safety and engagement. Clinical interpretation: This sequence was later interpreted as an early indicator of alternate identity activation and informed the decision to work within an alter-based phase framework. Afterward, psychoeducation about DID was provided, and plans for future sessions were discussed. Since the client was only in the city for a short time, a focused consultation plan was made, with the next session scheduled for the following day. During this session, the therapist worked directly with the alternate identity and maintained an approach focused on acknowledgment and containment to help stabilize the client. At the end of the session, Yanik referred the client to co-therapist Ergül for continued therapy and care.

3.3. Treatment

The intensive format was selected based on both logistical considerations and clinical judgment. The client's out-of-town residence and limited availability within a restricted treatment window were among the primary logistical factors informing this decision. From a clinical perspective, this format was considered potentially appropriate based on the manageability of acute risk and the client's apparent capacity to tolerate a higher-frequency therapeutic structure, including maintaining basic grounding and functional continuity between sessions. Suitability for this level of intensity was reassessed continuously throughout the course of treatment, with ongoing attention to potential signs of destabilization and the need for clinical adjustment. Accordingly, the intensive format was conceptualized not as a routine intervention, but as a selective and individualized clinical option. Sessions were generally scheduled as two consecutive 50-minute sessions held two or three days apart; when needed, brief breaks were provided.

Whether inpatient care was needed because of suicide or homicide risk, severe disorganization that impaired independent functioning, ineffective outpatient treatment, medical complications, need for

Table 1
Alter-based phase model.

Step	Components
1. Clarifying the Diagnosis	Diagnosis and differential diagnosis, differential diagnosis of DID
2. Case Formulation	Severity of DID, degree of fragmentation, assessment of prognosis, comorbidities, need for medication, if any need for hospitalization, estimated duration of therapy, feasibility of therapy for the client, face-to-face/online or combined therapy
3. Psychoeducation	A means of coping with trauma, fictional portrayals of DID versus clinical reality, it is not a supernatural phenomenon, it is not an illness of the mind, the DID curve, untreated dissociation is self-perpetuating, DID is treatable, adjunctive pharmacotherapy for DID
4. Identifying the Most Active Alternate identities	Early identification is paramount, methods of scanning, the therapist and the alternate identity meet, navigating the unexpected
5. Emergency Stabilization	Are there any pressing issues, any possibility of suicide, any possibility of harming self or others, any risky behaviors outside the client's recollection, any self-directed hostility and critical internal dialogues, any impairment in independent daily functioning
6. Detailed Identification of the Alternate identity System (Mind Map)	Mapping the inner world: an incremental approach, the inner world may be as fantastic as a science fiction movie, conflict and hierarchy versus cooperation, finding alternate identities through mental imagery of the inner world
7. Enhancing Internal Communication and Cooperation Among Alternate identities	Introducing alternate identities to one another, communicating with the alternate identity system as a whole, forming sites where alternate identities can live and meet collectively, roundtable discussions and decision-making procedures
8. Advanced Stabilization	Functional analysis of issue-linked alternate identities, minimizing problems in interpersonal life, strategies for enhancing adaptive functioning, resolving persistent nightmares and distressing dreams, strengthening the host
9. Addressing Trauma	Orienting alternate identities to the present day and time, processing ongoing trauma within the mind, bringing traumatized alternate identities to a safe place, sending copy alternate identities out of the mind, decluttering the inner world, the rehabilitating traumatized alternate identities, bedtime strategies for some alternate identities, "Mission accomplished! You can let go!", raising the child alternate identities, integration of traumatized alternate identities into the present day and time
10. Integration	Goal: Complete integration, the disadvantages of choosing to remain dissociated
11. Follow-up	If needed integration of alternate identities that surface in the follow-up phase, coping with loneliness ("the silent mind" phenomenon), post-integration mourning, building new resilience in the face of trauma, preventing re-traumatization through self-protection skills

diagnostic observation, poor medication adherence, or substance misuse.

In the present case, the client's high motivation for treatment, the absence of current self-harm behaviour, and the absence of an active suicide plan supported an outpatient format. The fact that she was staying in her sister's home rather than living alone, together with the availability of an accessible support person, was also considered a protective factor. Her strong emotional investment in her children and her wish not to lose value in their eyes were likewise understood as factors supporting her connection to life.

Suitability for outpatient treatment was reassessed dynamically throughout treatment. Her regular attendance, observable benefit from the intensive format, and the availability of her sister as an emergency contact supported continuation of outpatient care.

Day 1 –

Session 1 (Psychometric Evaluation)

On the first day, scales were used to assess the intensity of dissociative symptoms and to apply the diagnostic framework. The client obtained a score of 31.43 on the Dissociative Experiences Scale (DES), which is above the commonly accepted cut-off score of 30 and indicates clinically significant dissociative symptomatology. In addition, according to the Dissociative Disorders Interview Schedule, she met the diagnostic criteria for Dissociative Identity Disorder (DID). The application was completed with considerable difficulty due to frequent, sudden shifts between identity states during the session. In the context of the DDIS, the client disclosed experiencing sexual abuse on several occasions during childhood; these disclosures were documented according to age range and degree of relational proximity (details were restricted at the reporting level to safeguard identity confidentiality).

Session 2 (System Mapping, Initial Stabilization)

Observation: Following the scale administration, two alternate identities, H. and Child R., emerged. H. described himself as male and bearded. The child alternate identity presented herself as six years old. During the session, the child alternate identity displayed behaviours such as tongue protrusion, mocking, and lip pursing. She also emphasized her expectation of emotional closeness from her parents. **Intervention:** In this session, the therapist worked directly with the alternate identities to support system mapping and initial stabilization. The intervention focused on helping the host develop compassion-based internal communication with the child alternate identity and inviting her to the “current home” for safety. The child alternate identity was then asked to draw a family picture in order to facilitate expression of her feelings, and the host was encouraged to continue compassion-based internal care until the next session. **Clinical interpretation:** This session was important for mapping the alternate identity system and establishing an initial relational bond between the child alternate identity and the host. The relationship formed with the child alternate identity was considered to provide a basis for subsequent stabilization.

Day 2 –

Session 3 (new alternate identities: Depressive R., A., Red, Female R.).

Observation: Four new alternate identities emerged: Depressive R., A., Red, and Female R. Depressive R. referred to school-age problems and family unrest. A., who identified as male, expressed intense disgust toward the host identity. Red introduced herself as 25 years old and as someone who had known the host identity since childhood. Female R. described herself as wearing a red dress, with blonde hair and red lipstick, and expressed marked hostility toward men. **Intervention:** Direct communication was established with the newly emerged alternate identities, and their clinical characteristics were documented. Efforts were made to facilitate their introduction to, and communication with, the host identity. **Clinical interpretation:** This session demonstrated the structure of the alternate identity system and showed that different alternate identities emerged with distinct affective and functional patterns. The identification of these new alternate identities provided a basis for planning targeted interventions in subsequent sessions.

Session 4 (Dissociative crisis and integration with “Religious R.”).

Observation: The client reported marked physical exhaustion and stated that she wished to remain lying down. During the session, an acute dissociative presentation emerged, characterized by self-directed throat-clutching behaviour and intense punitive verbalizations. This presentation was conceptualized as the activation of a persecutory alternate identity. The newly emerged alternate identity introduced itself as “Religious R.” and displayed controlling and punitive characteristics. **Intervention:** The intervention focused on recognizing the newly emerged alternate identity and understanding its function within the dissociative system. In this process, efforts were made to establish a conciliatory relationship between the host identity and the alternate identity. With the consent of both, integration between the host identity and the alternate identity was achieved, presenting itself as “Religious R.”. **Clinical interpretation:** This session demonstrates that integration may occur within the same session, depending on the readiness of the alternate identity. Strengthening the host identity was a central therapeutic aim in this process.

Day 3 –

Session 5 (Conflict with H. and depiction of somatic pain).

Observation: H. emerged abruptly, accompanied by bodily pain representations and escalating tension, and the client struck herself in the face. **Intervention:** The therapist attempted to establish contact with H., listened to the reasons he expressed, and contained the behavior, with safety subsequently re-established. **Clinical interpretation:** This episode illustrated the intensity of inter-alter conflict and suggested that H. may have served not only a punitive but also a defensive or protective function.

Session 6 (“Imprisoned Child” and externalization of copy alternate identities).

Observation: In the latter part of the session, a new alternate identity, referred to as “Imprisoned Child” emerged and stated that it was “in prison”. While exploring the internal system, two “copy alternate identities” emerged, D., representing the abusive relative, and T., representing the paternal role. When the elimination of the “prison” imagery was attempted, the client stated that she was only able to remove half of it and that she perceived a “window”. **Intervention:** It was explained that these figures were not real persons, but internal cognitive representations, and the client was assisted in expelling these representations from the mental domain. In line with the principle of stabilization, it was planned that the part she was unable to remove at that stage would be “kept for now” and revisited in the following session. **Clinical interpretation:** This session is important in that it illustrates how the inner world may be structured through traumatic representations and copy alternate identities. It also suggests that the intervention was based on addressing traumatic internal scenes gradually, within tolerable limits, rather than all at once.

Day 4 –

Session 7 (Depressive regulation and amnesia).

Observation: A marked increase in bodily control was observed in Depressive R. During these periods, the host identity exhibited complete amnesia. Depressive R. reported experiences of being forced to have her hair cut and to wear unwanted clothing. It was also reported that H. emerged in a supportive capacity, particularly during episodes of bodily “pain.” **Intervention:** Depressive R.’s narrative was attended to, and the observed changes in bodily control and amnesic transitions were made explicit to the host identity. **Clinical interpretation:** This session suggests that some alternate identities may serve not only conflictual but also supportive or regulatory functions. It is also noteworthy in making visible the relationship between somatic symptoms and alternate identity functions.

Session 8 (body correction imagery, A., and traffic accident).

Observation: Subsequently, the previously identified male alternate identity A. stated that he was the “surviving part” who experienced the traffic accident while intoxicated. R.’s actions of “rescuing” A. from the accident scene, “bringing” him home, and providing care were

acknowledged. **Intervention:** A corrective imagery intervention targeting body image was implemented. The theme of providing care to A. was therapeutically recognized, and the continuation of this care was assigned as homework. **Clinical interpretation:** This session exemplifies a non-confrontational, reparative, and compassion-focused approach to the traumatic experiences carried by the alternate identity. It also makes visible the relationship between body image, trauma, and alternate identity functioning.

Day 5 –

Session 9 (enhancement of well-being).

Observation: The client reported an improvement in her overall sense of well-being. H. shared that he recalled the client's first husband's infidelity and the lack of familial support during the divorce process. He expressed that he had felt "very angry" throughout that period. **Intervention:** H.'s narrative was actively listened to, and space was provided within the session for the expression of its emotional content. **Clinical interpretation:** This session suggests that H.'s anger may be related to past interpersonal injuries and themes of abandonment. Furthermore, the reported improvement in well-being may reflect the short-term effects of the regulatory interventions implemented in earlier sessions.

Session 10 (addressing severe somatic symptoms).

Observation: Marked somatic symptoms accompanying H.'s anger were observed. **Intervention:** Stabilization was maintained throughout the session. **Clinical interpretation:** This session suggested a close association between intense affect and bodily expression. The severity of the somatic symptoms indicated a need to contain and regulate emotional processing.

Day 6 –

Session 11 (H.'s supplementary themes and reality update).

Observation: H. articulated additional themes that were troubling him, including concerns about his weight and his inability to attend university. **Intervention:** A reality update was carried out, and space was created for H. to re-evaluate the host's current life circumstances. **Clinical interpretation:** This session suggests that reconnecting traumatic and deficiency-related themes that had remained frozen in the past with present life reality may serve a preparatory function for integration.

Session 12 (Integration with H. followed by A.).

Observation: H. consented to integration with the host identity. Subsequently, A. also expressed a desire for integration. **Intervention:** Integration of both alternate identities, H. and A., with the host identity was achieved. **Clinical interpretation:** This session suggests that prior stabilization and reality-updating interventions may have supported readiness for integration. The emergence of integration requests appears to be associated with a reduction in the functional burden carried by the alternate identities.

Day 7 –

Sessions 13–14. Integration with Red and "Imprisoned Child": Copy Alternate Identity Intervention and Completion of Internal Imagery Work

Observation: The integration process with Red was completed. During this process, a copy alternate identity representing the client's romantic partner emerged and appeared to interfere with the integration. This alternate identity stated, "R. wanted to abandon me during the sessions." On the same day, the "Imprisoned Child" reported being able to eliminate the remaining half of the prison imagery as well as the window; integration was then accepted and completed. **Intervention:**

The emerging copy alternate identity was approached as an internalized illusory representation, and the client worked to remove this image from consciousness. After several attempts, the representation was dismissed again. The internal imagery work that had remained incomplete in the previous session was then continued, and integration was carried out. **Clinical interpretation:** These sessions suggest that the integration process may be influenced not only by inter-alternate identity dynamics but also by internalized relational representations. They also indicate that the gradual transformation of traumatic inner-world imagery may serve a preparatory function for integration. In this case,

working with copy alternate identities may likewise have contributed to reducing internal barriers to integration.

Day 8 –

Sessions 15–16. Integration of Depressive R. and Work with a Maternal Copy Alternate Identity

Observation: Depressive R. reported marked improvement and expressed a desire for integration, which was subsequently achieved with the host. During the same process, a new alternate identity, V., emerged, identifying as a 55-year-old woman and speaking in a persistently critical tone. **Intervention:** Integration-focused work was conducted with Depressive R. In working with V., this representation was addressed as not belonging to present reality, and the client was assisted in externalizing it from consciousness. **Clinical interpretation:** These sessions suggest that a depressive alternate identity may become ready for integration following sufficient progress. They also indicate that internalized representations of parental figures may be organized as alternate identities, and that working with these representations may contribute to internal regulation.

Day 9 –

Session 17 (Consolidation, integration with Female R., mind scan)

Observation: Female R. stated that she "felt" that the client had become stronger and expressed a desire to become part of R. **Intervention:** Integration between Female R. and the host identity was achieved. **Clinical interpretation:** This session suggests that the perceived strengthening of the host may have supported readiness for integration. Following the integration work, the client was invited to conduct an internal scan. At that stage, no additional alternate identities or dissociative spaces were reported. Given the methodological limits of a single-case report, this finding was interpreted cautiously as a clinical indication that the alternate identities presented during the treatment period may have been integrated at that point (Tables 2 and 3).

3.4. Follow-up

Pre-treatment: The Dissociative Experiences Scale (DES) score was 31.43. On the Dissociative Disorders Interview Schedule (DDIS), the depression subscale yielded 9/9 "yes" responses, and the somatic symptoms subscale yielded 20 "yes" responses out of 39 items.

45 days post-treatment: The DES score decreased to 6.07. On the DDIS, the depression subscale yielded 1 "yes" response out of 9 items, and the somatic symptoms subscale yielded 6 "yes" responses out of 39 items.

Post-treatment: In weekly sessions following treatment, the goals were to maintain stabilization, develop new coping strategies, and enhance functioning. After 11 online sessions, the client reported significant improvement and requested a break. This request was reviewed mutually in light of the clinical course, and the sessions were paused.

2-year follow-up (2019): Approximately two years later, a single follow-up session was conducted at the therapist's initiative. The client reported good overall functioning; no psychometric assessment was administered.

3-year follow-up (2020): In 2020, the client requested a new appointment and reported increased dissociative symptoms in the context of relationship difficulties with her boyfriend. Over three sessions, re-fragmentation of the alternate identity H. was observed. Direct sessions with H. were held, with the goal of stabilization was targeted, and integration was achieved. The client once more reported significant progress and requested a cessation of sessions.

8-year follow-up (2025): Approximately eight years later, at a follow-up session initiated by the therapist showed that the DES score was 25. On the DDIS, the depression subscale yielded 5 "yes" responses out of 9 items, and the somatic symptoms subscale yielded 14 "yes" responses out of 39 items. During this session, the presence of alternate identities was not evaluated.

Table 2
Alternate identities map summarizing the characteristics of selected alternate identities.

	Persecutor Alternate Identity	Positive Alternate Identity	HOST	Flamboyant Alternate Identity	Child Alternate Identity	Male Alternate Identity
Name	Religious R.	Red	Host	Female R.	Child R.	H.
Gender	Female	Female	Female	Female	Female (child)	Male
Age	17	25	41	30	6	35
Appearance	Wears white clothing	Playful facial expression	Well-groomed, orderly	Red dress; blonde hair; red lipstick	Naked; braided hair; wears headphones	Bearded
Internal Location	Not specified	Not specified	Current living environment	Darkness	Darkness	Not specified
Time of Emergence	Not specified	Present since infancy	-	Middle school years	Not specified	Present since age 17
Trauma History	Family pressure	Not specified	Not specified	Sexual abuse	Not specified	Sexual abuse
Mood / Affect	Intensely punitive and threatening	Social, lively	Relatively stable	Irritable; agitation accompanied by laughter	Intense fear	Angry, depressive affect
Speech Pattern	Threatening, authoritarian	Fluent, social	Neutral	Expressive; accompanied by gestures and mimics	Limited, fearful, childlike	Refuses to speak / minimal verbal output
Body Control	Threats directed toward bodily harm	Bodily control preserved	Bodily control preserved	Thumb biting; tendency toward alcohol use	Poor bodily control; freezing responses	Fully takes control of the body
Conditions of Emergence	Not specified	Not specified	Predominantly present	When alone or in the presence of men	Not specified	Emerges during periods of stress

Note: The features included in the alternate identity map were organized according to the order of assessment questions used in the therapeutic techniques developed by the last author (MY).

Table 3
Scores of assessment scales across assessment time points.

Assessment Scale	Pre-treatment (2017)	45 days post-treatment	2-year follow-up (2019)	3-year follow-up (2020)	8-year follow-up (2025)
DDIS/Depression	9/9 “yes”	1/9 “yes”	Not assessed	Not assessed	5/9 “yes”
DDIS/Somatic symptoms	20/39 “yes”	6/39 “yes”	Not assessed	Not assessed	14/39 “yes”
DES	31.43	6.07	Not assessed	Not assessed	25

Note. DES = Dissociative Experiences Scale, DDIS = Dissociative Disorders Interview Schedule.

4. Discussion

The applicability of the intensive alter-based phase model was established with a thorough pre-treatment risk assessment and evaluation of the client's clinical stability. During the initial evaluation, no suicide ideation or plan was detected, self-harm actions were absent, and the client's general psychosocial functioning was deemed enough to facilitate an intensive outpatient intervention. The client's ongoing participation in therapy and the noted decrease in dissociative and depressed symptoms reinforced the clinical appropriateness of this method in this situation.

The approach used in this case was different from strictly following the traditional phase-oriented for the whole alternate identity system (ISSTD, 2011). Instead, it was based on an alter-based approach in which each emerging alter was guided through its own “alter-based-phase” process. In this setup, a novel therapy approach developed by the last author (MY) were used to help recognize, stabilize, and integrate alternate identities as they appeared during the therapy process (Yanik, 2018). This flexible structure enabled therapeutic progress without requiring full-system stabilization beforehand and enabled intensive treatment delivery.

In a case series study conducted by Uysal et al. (2025), they implemented interventions for clients diagnosed with Dissociative Identity Disorder using techniques developed by the last author (MY) and an alter-based phase approach after the earthquakes in Türkiye on February 6. Yanik trained and supervised the therapists in that setting to apply this model. The psychotherapy approach used in the present case is the

same as that used in Uysal et al. (2025), but the present intervention is a more intensive, time-limited version.

4.1. Intensive and time-limited treatment duration

The literature emphasizes that DID treatment is typically long-term, with the first phase alone often requiring months or years (Dorahy et al., 2014; ISSTD, 2011). Nevertheless, as demonstrated in the present case, a structured and intensive program may facilitate marked Phase 1 stabilization within a relatively short time frame. The intensive format was selected due to clinical and logistical considerations, including the client's out-of-town residence, the need for rapid reduction of acute instability.

Importantly, the present approach does not represent an experimental or first-time application in our clinical setting. At the Medaim Yanik Psychiatry–Psychotherapy Clinic, intensive, time-limited formats have previously been implemented for a small number of carefully selected clients once clinical suitability was established. However, this format is not routine. The therapist continuously re-evaluates treatment suitability. The client's response, level of stabilization, and safety indicators are closely monitored, and if signs emerge suggesting that the intensive format is no longer appropriate, the treatment structure may be modified or discontinued. Accordingly, this approach is applied rarely and selectively, based on dynamic clinical assessment. The present case constitutes the first systematic documentation of this ongoing clinical practice in the form of a case report.

At the 45-day follow-up, marked reductions in DES and DDIS subscale scores suggested clinically meaningful short-term improvement. Nonetheless, the observed partial symptom increases at the 8-year follow-up, subsequent to significant life stressors, suggest that treatment gains were not absolute and that dissociative symptoms may remain susceptible to stress over time.

The long-term follow-up primarily documents symptomatic and functional evolution, rather than providing direct evidence regarding the organization of dissociative identity states. Since alternate identity presence was not systematically assessed at the 8-year follow-up, interpretations of long-term integration remain necessarily tentative.

Major crises and strong stress in adulthood can put a lot of strain on the dissociative system, making it harder for the main personality to stay in control and allowing facilitating previously hidden alternate identities to come back after being inactive for a long time (Dorahy et al., 2022). International treatment guidelines state that even individuals

who have successfully integrated their identities can still see their dissociative symptoms come back, or even get worse, when they face very serious life stressors (ISSTD, 2011). This clinical framework aligns with the findings of Uysal et al. (2025), who studied with the February 6 Türkiye earthquake survivors, in which not only symptoms were worsened for individuals diagnosed with DID but it was led to the development of new alternate identities in about 25% of cases. In the present case, the changes seen during the eight-year follow-up indicate that stressors like sudden and traumatic loss of a parent, not having family support, and feeling lonely may have put pressure on the dissociative system, causing it to change. Accordingly, the clinical situation seen during long-term follow-up is better understood as a stress-related return of dissociative processes instead of a real relapse, because there are clear outside stressors and the person hasn't completely gone back to their original dissociative state before treatment.

4.2. Working with alternate identities and alter-based phases

In this case, the therapeutic process focused on direct engagement with each emerging alternate identity, with attention to its function and role within the system, and with integration pursued when clinically appropriate. Rather than imposing elimination or premature integration, alternate identities were approached at their own pace, with an emphasis on recognition and stabilization. This stance appeared to support the maintenance of the therapeutic alliance, particularly when working with persecutory alternate identities and those associated with intense bodily distress.

As described in Section 3.1 and summarized in Table 1, the model can be understood as cyclical rather than strictly linear. Different alternate identities entered different phases at different times, depending on their level of activation, functional role, and readiness. This flexibility appeared clinically useful within a brief intensive format, as it allowed the therapist to prioritize stabilization for some alternate identities while facilitating progression toward integration for others.

The alter-based phase approach may help maintain system stability during intensive therapeutic work. The observed reduction in somatic symptoms should be understood as an exploratory clinical association rather than evidence of a causal relationship.

4.3. Somatic symptoms and dissociative processes

In this case, the reduction in somatic symptoms was observed to occur alongside the integration of alternate identities associated with pain and bodily distress. This finding is consistent with the concept of somatoform dissociation (Nijenhuis, 1999) and suggests that some somatic symptoms in DID may be related to dissociative processes. Alternate identity structures may express bodily experiences associated with early trauma and maltreatment, and therapeutic engagement with these structures may contribute to changes in somatic complaints.

4.4. Copy alternate identities and internal representations

The therapeutic work with “copy alternate identities” representing abusive or significant others was a notable aspect of this case. As conceptualized by Yanık (2018), copy alternate identity function as internalized representations of traumatic relational figures. This concept shows theoretical convergence with Dorahy's (2022) discussion of “identification with the aggressor” drawing on Ferenczi's work (1949). Despite differences in terminology, both perspectives emphasize the enduring internal presence of traumatic relational representations and the clinical importance of addressing them in treatment.

4.5. Safety, stabilization, and clinical boundaries

Client safety is a central concern in intensive, time-limited treatment formats. In this case, stabilization was prioritized in light of self-harm

risk and acute dissociative crises, and inpatient admission was kept as a contingency within the treatment plan. These considerations underscore that intensive formats are feasible only within a framework of explicit safety principles, experienced clinical teams, and structured follow-up planning.

4.6. Limitations and generalizability

Accordingly, this report is best regarded as a clinical illustration rather than as definitive evidence of efficacy. It suggests hypotheses about intensive work with dissociative systems and highlights open questions regarding client selection, mechanisms of change, and long-term outcomes, all of which require systematic investigation beyond the scope of a single-case report.

Moreover, intensive treatment formats are not suitable for all clients with DID. High levels of self-harm risk, insufficient external support, severe substance use, or limited stabilization capacity may render such approaches inappropriate. Accordingly, intensive and time-limited formats should not be viewed as universal treatment models but rather as conditional options to be considered in carefully selected cases.

5. Conclusion

This case report suggests that an intensive, time-limited, phase-oriented outpatient intervention may be feasible in carefully selected cases of DID. In the present case, the alter-based phase model was associated with short-term reductions in dissociative, depressive, and somatic symptoms. Yet, as a single-case report, it does not permit strong causal inferences. Instead, it offers a clinically grounded illustration of how such a format may be organized, as well as the potential benefits and vulnerabilities that may unfold over time.

However, findings from long-term follow-up indicate that these treatment gains were not absolute or permanently fixed and that dissociative symptoms may remain sensitive to major life stressors. This illustrates the value of conceptualizing intensive, time-limited treatment formats not as stand-alone or definitive solutions, but as interventions that require dynamic responsiveness to the clinical process, flexibility for modification when indicated, and support through long-term follow-up.

In conclusion, intensive, time-limited, phase-oriented psychotherapy should not be regarded as a universal treatment model for Dissociative Identity Disorder. Rather, it should be considered a conditional option applicable to selected cases under appropriate clinical circumstances, delivered by experienced clinicians with explicit prioritization of safety and stabilization. More systematic and comparative research is necessary to more precisely define the clinical parameters, indications, and long-term outcomes of this approach.

Future considerations

Further research is needed to evaluate the feasibility and effectiveness of this intensive, time-limited format in larger samples. Future studies should clarify its clinical indications and contraindications, and use standardized long-term outcome assessments to examine the durability of treatment gains and potential relapse/recurrence patterns. The relationship between somatic symptoms and dissociative processes also warrants further investigation, particularly through the use of more specific measures of somatoform dissociation and bodily symptom change.

Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this work, the author used Grammarly and QuillBot to assist with language editing, grammar correction, and paraphrasing suggestions in academic English. After using these tools,

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CRedit authorship contribution statement

Hümeyra Ergül: Writing – review & editing, Writing – original draft, Methodology, Conceptualization. **Burcu Uysal:** Writing – review & editing, Conceptualization. **Ceren Acartürk:** Writing – review & editing. **Medaim Yanık:** Supervision, Methodology, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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