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From trauma to fragmentation. A gender perspective on the effects of childhood sexual abuse on dissociative identity disorder development

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Introduction

In recent decades, the relationship between childhood trauma and psychopathology has assumed a central place in clinical reflection and the scientific literature, particularly with regard to the long-term outcomes of early adverse experiences. Among these, child sexual abuse (CSA) represents one of the most serious and destabilizing forms of maltreatment, not only because of its intrinsic violence but also because of its capacity to undermine an individual's emotional, cognitive, and relational development.

Nonetheless, the belief that trauma necessarily equals pathology is reductive, because it risks remaining vague unless one considers the different nuances through which childhood sexual abuse translates into specific clinical outcomes. My interest is focused in particular on one such possible manifestation: dissociative identity disorder (DID).

The title of this thesis, "From Trauma to Fragmentation: A Gender Perspective on the Effects of Childhood Sexual Abuse on Dissociative Identity Disorder Development," summarizes two central lines of inquiry. The first addresses the causal and mechanistic relationship between CSA and the development of this dissociative disorder, while the second adopts a gender perspective as an interpretive lens on prevalence, presentation, recognition, and social stigma.

In this way, my objective is to investigate and highlight not only the possible connections between trauma and dissociation, but also the ways in which social, cultural, and relational variables can influence the presentation, clinical interpretation, and recognition of the disorder.

For my literature search, I identified keywords and synonyms—along with other related terms, phrases, and concepts—and then consulted Google Scholar, Scopus, and Web of Science for multidisciplinary research, as well as PubMed and PsycINFO for psychology-related searches, gradually narrowing the scope until I identified the literature most relevant to my objective.

The thesis unfolds in three main stages. The first chapter analyses the phenomenon of child sexual abuse, with particular attention to definitions, risk factors, and the multiple forms of its short- and long-term effects. In the second chapter, the psychopathological disorder is presented, with an in-depth look at its clinical features and the pitfalls that may lead to misdiagnosis or confusion with other disorders.

The third chapter links the two topics, highlighting common aspects, the consequences of sexual abuse that may overlap with the symptoms and difficulties individuals with DID live with daily, and the role that social stigma plays in shaping perceptions of both phenomena, contributing to different constructions depending on a range of variables, including the victim's gender.

Chapter 1. Child sexual abuse: when consent cannot exist

Child sexual abuse (CSA) is a form of maltreatment of children recognized worldwide as an extremely serious human rights violation and a significant public health concern. At the same time, a key unresolved issue is the lack of a globally shared definition or understanding of what constitutes CSA. Questions still open to debate within political, legal and research communities include analysing the risk factors for CSA, understanding the mental health outcomes of CSA, identifying the protective factors that make some children less likely to experience impairment following CSA exposure, and developing the most effective prevention, assessment and treatment strategies.

1.1 Definitions of abuse, its multiple forms and what we do not see

Currently, the multiplicity of existing definitions for the term CSA encompasses slight and often subtle differences between each of the various categories employed when defining it, which may moreover have political or legal implications and influence research approaches (Murray et al., 2014).

> Following the World Health Organisation (WHO, 1999) definition of CSA as:
> the involvement of a child in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violate the laws or social taboos of society (p. 15),

Murray et al. (2014, p.2) extend the definition of CSA to include:

> the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of child in prostitution or other unlawful sexual

practices; the exploitative use of children in pornographic performances and materials.

This description emphasises that the imposition of a sexual act against an individual's will constitutes an act of violence, regardless of the presence or absence of physical force, especially for those who are not fully able to give consent or to resist.

The United Nations Children's Fund (UNICEF, 2013) identifies CSA as the set of sexual activities against minors who have not reached the legal age established by national legislation, encompassing exploitation of vulnerable and fragile children, abuse of trust or influence, coercion, as well as conduct aimed at personal gain, such as the grooming of children, their prostitution, and the observation of children in sexual performances. It is important to underline that sexual abuse does not only concern penetration, but also includes voyeurism, touching a child's genitals, showing pornographic images to a child, or exposing one's own genitals (National Sexual Violence Resource Center, 2011).

UNICEF (2020a) revealed that more than 120 million people are forced into sexual acts at a young age, the majority of whom are female (89%), while males account for 11%. Child sexual abuse occurs in every corner of the world, with both short-and long-term effects (Ali et al., 2024), and despite the recognized notoriety and media resonance of this phenomenon, many of its aspects remain unclear. The WHO's 2002 World Report on Violence and Health compared it to an iceberg, in which the authorities are aware only of the smallest, most superficial portion, whilst an incalculable number of cases go unreported due to various factors (Krug et al., 2002).

Worldwide, the 2006 World Report on Violence against Children reported that in 2002, approximately 150 million girls and 73 million boys had experienced CSA, including 1.2 million victims of trafficking and 1.8 million involved in prostitution or pornography (Pinheiro, 2006; WHO, 2006; Andrews et al., 2004; International Labour Organization, 2004). Furthermore, researchers report rates of CSA of 7.9% among boys and 19.7% among girls, with a higher prevalence in Africa and lower rates in Europe (Pereda et al., 2009).

It has been calculated that 500,000 children are victims of sexual abuse every year (Young Women's Christian Association, 2017). Moreover, the phenomenon has been present throughout all historical periods (Ali et al., 2024). Indeed, in some ancient civilisations, as reported by Ali (2019), such acts toward minors were tolerated and interpreted as an educational practice, and throughout history, views ranging from acceptance to rejection of it have prevailed (DiLillo et al., 2014).

Furthermore, the COVID-19 pandemic and the resulting lockdown measures further increased children's risk, since they inadvertently promoted social isolation, parental stress, and high levels of economic instability (Lawson et al., 2020; Pereda & Diaz-Faes, 2020).

1.2 The body that screams: the neurobiology of trauma, survival responses and somatic signals

When faced with highly stressful stimuli or direct threats to one's safety, the central nervous system is instantly activated into an alarm phase and to ensure survival the brain coordinates neurobiological responses, which modulate reactions through sequential stages:

- assessment and fight/flight: the nervous system analyses the threat and available resources in the blink of an eye. If the situation allows, the sympathetic 'fight or flight' response is triggered to escape the danger;
- immobilisation and shutdown: when active defensive responses are impractical or fail, a state of terror sets in, leading to critical immobility.

The interaction between the victim and the perpetrator is asymmetrical and this constitutes a direct threat to the child's physical integrity. Lacking the appropriate means to oppose the adult, the child's nervous system becomes overloaded, and a shutdown reaction is triggered. Subsequently, the mind implements a perceptual desensitisation that reduces sensory and environmental inputs, progressing to peri-traumatic dissociation. The mind detaches itself, creating a fracture that fragments the memory of the event and separates it from its emotional component, thereby producing a deficit in the normal processing of the experience (Bakacs, 2021).

According to D'Ambrosio (2010), the type of response differs according to gender. Boys are more likely to exhibit a system of hyperarousal, whilst girls tend to display a sensitised dissociative system. The psychophysical balance is compromised, manifesting as motor hyperactivity, anxiety, impulsivity, sleep disturbances, and cardiovascular symptoms such as tachycardia and hypertension.

Finkelhor & Browne (1985) identify four emotional experiences which become specific pathogenic factors following abuse and take root in the child's inner world:

1. Feeling of helplessness, as the adult can overpower the child and satisfy their own desires at the child's expense. This perception of being unable to escape the situation intensifies the sense of defeat.
2. Feeling of betrayal. With the violation of intimacy, the adult ceases to be a figure of safety, which has consequences especially when the non-abusing caregiver,

most often the mother, fails to provide the expected protection (D'Ambrosio, 2000; Liebman Jacobs, 1994). This can later lead to depressive presentations or to hyper-dependency accompanied by chronic mistrust (Friedrich, 1990).

3. Feeling of stigmatization, as the child perceives themselves as different, permanently marked by the experience, and persistently struggles to process feelings of guilt and shame.
4. Traumatic sexualization, which fosters a premature and disordered interest in sexual matters.

Downing and colleagues (2021) suggest that stress-related changes in pro-inflammatory molecules, particularly changes in gene expression and cortisol levels, mediate both short-term and long-term effects (Ali et al., 2024).

1.3 Where the risk of abuse originates: explanatory models, risk factors and the intra-family perpetrator

One of the earliest theoretical approaches to explaining child sexual abuse is Finkelhor's (1984) Preconditions Model, based on Cohen & Felson's (1979) Routine Activities Theory, which argues that violence results from the presence of a suitable target, a motivated offender and the absence of capable guardianship. Finkelhor (1984) sets out the four preconditions that lead to the occurrence of sexual abuse:

-high motivation to commit a sexual offence;

-disinhibition of internal restraints against committing offences involving minors;

-overcoming external barriers such as parental supervision or social control;

-overcoming the child's resistance through manipulation or deception.

According to the Quadripartite Model of Hall & Hirschman (1991), however, the underlying factors in child sexual assault are:

-sexual arousal toward children;

-beliefs that justify the act itself;

-emotional dysregulation;

-personality disorders.

Moreover, perpetrators may fall into different categories, depending on which of the four factors is most predominant in each case.

In their Integrated Theory, Marshall & Barbaree (1990) argue that some people are at greater risk of committing child sexual abuse due to vulnerabilities that developed during adolescence, which hindered the acquisition of appropriate ways of managing sexual needs,

thereby fostering a link between sexual desire and aggression. Abusive behaviour is therefore thought to result from the interaction between these individual vulnerabilities and social variables such as stress and substance use.

In the Compositional Theory of Pedophilia, Gannon (2021) argues that it is the intersection of biological, psychological and environmental factors that fosters an interest in prepubescent children, whilst emphasising, however, that pedophilia does not necessarily imply the commission of the offence. Some meta-analyses show that this phenomenon is prevalent in 24% of women (Pan et al., 2021), whilst the figures are lower for men (Moody et al., 2018). However, the majority of studies highlight a much higher proportion of male perpetrators than female ones (Hunt, 2006; Seto et al., 2015), and these perpetrators are adults or adolescents known to the child (Mathews et al., 2024).

Although sexual abuse is a widespread phenomenon worldwide (Gewirtz-Meydan & Finkelhor, 2020; Pereda et al., 2024; Pereda et al., 2009), gaps in our knowledge persist (Russell et al., 2020), such as the risk and protective factors associated with this traumatic event and which interventions are effective in preventing or reducing it (Zych & Marín-López, 2024).

Risk factors provide the colours with which abuse is painted and shape the meanings attributed to it (Bakacs, 2021). Knowledge of these factors serves not only to ensure treatment for those who need it, but also to identify the measures required to reduce the risk of victimisation (Assink et al., 2019), while analysing them enables us to gain a comprehensive picture of the situation faced, its level of impairment, and the course of action to take when addressing the trauma. Understanding these factors helps to understand both the nature of the abusive experience and the extent to which it has impacted the person's life (Bakacs, 2021).

Analysis of the data in terms of absolute risk shows that the majority of perpetrators of sexual offences against children were not themselves victims of childhood sexual abuse (Marshall & Mazzucco, 1995) and that, conversely, those who experienced sexual abuse in childhood are unlikely to become child abusers themselves (Paolucci et al., 2001; Salter et al., 2003).

The literature on sexual abuse victimisation attributes a central role to various risk factors distributed across the multiple ecological contexts in which the child may live (Assink et al., 2019). According to Kraemer et al. (1997), a risk factor represents a specific type of antecedent variable correlating with a future outcome and allows individuals to be classified within different levels of risk. Thus, if a child who engages in antisocial behaviour is more

likely to be a victim of child sexual abuse, then antisocial behaviour would represent a risk factor for CSA victimisation.

Child sexual abuse often co-occurs with other forms of neglect, particularly in family environments that compromise the child's healthy development such as extreme poverty, single-parent households combined with substance abuse, domestic violence, low levels of education and emotional neglect are alarming conditions (Perez-Fuentes et al., 2013; Butler, 2013). Domestic absence, however, places the individual at even greater risk, as it is inevitable that they will be forced into sexual acts to obtain essential survival goods, such as food, money and shelter (Tyler & Johnson, 2006).

In their study, Assink et al. (2018) were able to link many risk factors not to the children's problems and difficulties, but to those of the parents, including relational, psychiatric, and physical problems, low educational attainment, substance abuse and intimate partner violence. A history of sexual abuse experienced by the parents themselves can be considered a factor in parental vulnerability, since such experience may lead to unresolved trauma and attachment-related issues. It may represent a risk factor for perpetration, and whilst an association has been found in men between past physical abuse and the commission of sexual offences, this link has not been observed in women (Widom & Massey, 2015).

Moreover, the child's upbringing in a non-nuclear family or the presence of a stepfather must also be considered, as should the impact of frequent moves or multiple family residences. The parent-child relationship is fundamental. In dysfunctional contexts, this implies low levels of attachment and consequent care, a low perception of competence, and overprotective parenting. Consequently, a poor-quality relationship between mother and daughter constitutes a risk factor, particularly for paternal sexual abuse of children (Paveza, 1988). However, this factor also applies to abuse by anyone else (Schechter et al., 2002). Children who have experienced family breakdown may have developed dysfunctional patterns as a result of exposure to conflict, aggression and violence (Finkelhor, 2008), and the literature shows that an overprotective parenting style encourages the child to adopt a dependent and passive attitude (Ladd & Ladd, 1998), compromising their ability to defend and protect themselves from potential groomers (Assink et al., 2019). In addition, the presence of a stepfather poses a particular threat to stepdaughters rather than stepsons (Finkelhor et al., 1990).

It is important to emphasize that the factors identified in parents were considered as risk factors for victimisation by CSA, not for its perpetration by the parents themselves. Undoubtedly, substance abuse, a history of CSA among caregivers and the presence of psychiatric disorders make the child an even more perfect target for perpetrators both

outside and within the family. Among individual risk factors, chronic physical and/or mental health conditions, drug use, involvement in delinquent behaviour, poor social skills and frequent internet use have been identified (Assink et al., 2019).

Stith and colleagues (2009) highlighted how parents' tendency to perceive their child as problematic and their own excessive levels of anger are among the most significant risk factors for physical abuse and neglect.

While gender plays an important role, since being female increases the risk of becoming a victim, as sexual abuse generally involves heterosexual men targeting young girls (Finkelhor, 2008), the literature has not yet reached a unanimous consensus regarding the age boundaries that distinguish childhood, adolescence and adulthood (Walker et al., 2017). Indeed, some researchers associate the concept of victimisation with children under the age of 12 (Miron & Orcutt, 2014), whilst other studies on CSA extend the age range up o 18 years (Campbell et al., 2008; Davis et al., 2006).

Protective factors are categorised into protective factors and buffering protective factors. The former are directly related to the outcome, whilst the latter serve to mitigate the negative effects of existing risk factors (Lösel & Farrington, 2012; Seto et al., 2023). Both risk and protective factors can operate at different ecological levels, including the individual, family, community and societal levels, and can differ depending on the context, the relationship between victim and perpetrator and the severity of the abuse (Zych & Marín-López, 2024). Ward & Fortune (2016) emphasise that risk factors can be predictive, but they have limitations, and more complex models incorporating multiple levels of analysis are required.

Despite the vast number of studies on this topic, it is difficult to reach definitive conclusions regarding prevention, precisely because of the variability in samples, methods and results (Younas & Morrison Gutman, 2022). For example, among mothers at risk of intergenerational child maltreatment, a systematic review found that both external resources, such as social support, and internal resources, such as self-esteem, act as risk factors for transmission to their children (Atzl et al., 2019). A study by Younas & Morrison (2022) confirmed the findings of Meng et al. (2018) that social support is a major buffering mechanism against child maltreatment.

There are two main types of abusers: the intra-family abuser, that is, a member of the family, and the extra-family abuser, that is, someone from outside the family unit. The former is the most common and involves complex dynamics that affect not only the perpetrator and the victim but the entire household system, thereby hindering disclosure because all involved

parties may fear scandal, damage to their reputation and potential social exclusion (Bakacs, 2021).

In such situations, the severity of the consequences for the child tends to increase the closer the emotional and power bond between the abuser and the victim is. Therefore, when abuse is perpetrated by a parent, it leaves deep psychological and relational scars, as a result of which the child may develop mechanisms of justification or self-blame to protect the parent's image and preserve the perceived stability of the relationship (Bakacs, 2021).

The motivations behind the abuse do not always lead to a diagnosis of pedophilia. In couples with a dysfunctional relationship dynamic, the non-abusing spouse may tolerate or normalise the child's monopolisation of their partner's attention, with the child effectively becoming an emotional surrogate (Bakacs, 2021). Extrafamilial perpetrators cover a heterogeneous range of profiles, and in such cases severity may increase, because the offender has no ties that would induce them to protect the victim or conceal their actions, and is therefore free to satisfy all their fantasies (Bakacs, 2021). They use the offer of objects or substances as a form of coercion, and children, needing attention and affection, can easily be misled by the abuser's behaviour, as the abuser uses these gestures to gain their trust and apparent consent (Bakacs, 2021).

Contact-free sexual abuse involves acts such as exhibitionism, voyeurism, sexual jokes, exposure to pornography, unwanted sexting, staking and grooming (Zych & Marín-López, 2024). According to a systematic review by Barth and colleagues (2013), non-contact sexual abuse is prevalent in 17% of males, with contact sexual abuse affecting 6% and its most severe form, forced sexual intercourse, affecting 3%. In females, the figures are 31%, 13% and 9% respectively. The settings in which the abuse can occur include the home, care facilities, sports clubs and religious organisations (Australian Government, 2013), although technological developments have increasingly introduced the internet as a new venue for grooming (Finkelhor et al., 2024).

1.4 Invisible scars: short- and long-term psychophysical consequences

The scientific literature highlights how child sexual abuse leads to a wide range of traumatic outcomes, including impaired interpersonal trust, deterioration of psychological well-being, loss of bodily autonomy and, when the perpetrator is a family member, the breakdown of fundamental emotional bonds (Arata, 1998; Berliner & Conte, 1995; Finkelhor, 1990; Finkelhor & Browne, 1985; Herman, 1992,19997; van der Kolk, 1994,1996).

Moreover, victims often describe a profound sense of otherness and a sense that their identity has been damaged, perceiving themselves as irreparably harmed and this experience, coupled with feelings of isolation and social stigma, frequently leads to processes o withdrawal that distance the child from their peers and from their community context (Finkelhor, 1990; Finkelor & Browne, 1985).

While it is recognised that a traumatic event of this kind is harmful to both physical and psychological health (Ali et al., 2024), there is no single pattern of side effects (Beltran, 2010). Various researchers have listed, amongst these, brain injuries and death (Ali et al., 2024), which Habes et al. (2022) also identified these as the most common outcomes among children, although it cannot be ruled out that a victim may experience no consequences that impair their social, emotional and cognitive abilities (Ali et al., 2024).

Furthermore, not all sexual abuses are equally traumatizing. The three most important factors relating to the severity of the trauma are:

1. The severity of the sexual abuse in terms of the invasiveness of the specific sexual acts (genital fondling as opposed to vaginal or anal penetration).
2. Whether or not the perpetrator was a father or stepfather.
3. The degree of physical force or violence used during the abuse (Russell,1986).

Among the many short- and long-term consequences are post-traumatic stress disorder (Zych & Marín-López, 2024), depression and anxiety (Lindert et al., 2014), suicide (Paolucci et al., 2001), problematic sexual behaviour (Noll et al., 2019; Paolucci et al., 2001), poor academic performance (Fry et al., 2018) and long-term poor physical health (Irish et al., 2010), as well as emotional suffering, mood alterations, and cognitive distortions. However, individual may react differently to the traumatic event, with manifestations that may change over time (Ali et al., 2024).

Short-term consequences are referred to as 'initial effects', given their emergence within approximately the first two years after the abuse (Batool & Abtahi, 2017) and it was found that 66% of children exhibited emotional disorders, 5.2% showed mild to moderate disorders, while 24% did not show significant changes (Ali et al., 2024). A study by Fontes et al. (2017) found that 13.3% experienced feelings of loneliness, 7.5% had relational difficulties, and 9.5% reported insomnia.

Long-term effects may include peer rejection, low self-esteem, confusion, conduct disorder, aggression, oppositional defiant disorder, and over time may give rise to chronic depression, substance dependence, eating disorders (Hodder & Gow, 2012), economic difficulties (Ali et al., 2024), impaired academic achievement, and revictimization (MacIntosh

& Ménard, 2021). These outcomes occur more frequently when the abuse is repetitive and interpersonal, subsequently increasing the likelihood of developing PTSD (Ali et al., 2024).

1.5 Beyond the silence: pathways of protection, support and trauma treatment

Primary prevention is generally aimed at the general population with the intention of raising awareness and bringing about a change in attitude toward CSA. Those at risk are referred for secondary prevention, such as a helpline, whilst tertiary prevention may focus on supporting victims and reducing the threat of revictimization (Kemshall & Moulden, 2016). In addition, these initiatives can take place in both community and custodial settings (Koehler & Lösel, 2024). Legislative and regulatory measures for prevention include mandatory reporting, working with children checks, reportable conduct schemes and helplines (Zych & Marín-López, 2024).

An alternative intervention would consist of reducing risk factors and increasing protective factors (Zych & Marín-López, 2024). For instance, since the Good Lives Model asserts that people commit sexual offences due to an inability to satisfy their needs in ways that are socially acceptable (Ward et al., 2007), the intervention strategy should aim to ensure that the sex offender leads a good life, rich in personal fulfilment and strengths (Zych & Marín-López, 2024). In line with this, based on the Precondition Model (Finkelhor, 1984), the individual could modify the means of emotional gratification, thereby reducing sexual motivation and arousal and promoting an approach to sexuality that is socially acceptable. To counter victimization, plans can be implemented to increase external barriers, such as supervision by caregivers and within institutions, and above all, to educate children to be aware of their autonomy and to know how to ask for help (Zych & Marín-López, 2024).

After abuse, the child can seek help from Child Protective Services (CPS), legal, medical and police teams, social services, and/or therapeutic residential facilities (Murray et al., 2014). These CPS investigate and intervene when there is a possible case of sexual abuse perpetrated by a caregiver or in situations where the person with custody of the child has failed to fulfil their protective role. Investigations should occur promptly, and, together with the victim, a series of oral interviews is conducted, and a medical examination is performed by a specialized professional (Sheela et al., 2001). Family members are also interviewed, and CPS are responsible for assessing the likelihood that abuse could recur in the future. In such cases, removal of the child is requested and placement with a relative or in foster care is arranged, or the perpetrator is directly removed from the residence.

The best approach to treatment is generally considered a biopsychosocial one. Besides the possible involvement of medical staff for physical assessment, children and caregivers are assigned case managers who coordinate the legal and mental health services necessary for the child's development (Murray et al., 2014).

A review compared different types of treatment and found that cognitive-behavioural therapy (CBT) was the most effective, due to its benefits and reduction of PTSD and depressive symptoms (Gillies et al., 2012). Furthermore, Silverman et al. (2008) also support the efficacy of trauma-focused CBT (TF-CBT) as the only intervention considered 'well-established'. Murray and colleagues (2014) define TF-CBT as an interactive model that includes aspects of cognitive-behavioural therapy, affective therapies, humanistic approaches, attachment-based work, empowerment, family therapy, and exposure techniques, developed to help children with traumatic experiences of sexual abuse. This treatment is not reserved only for the child but also involves the supporting caregiver. Components of this approach include psychoeducation, affect modulation, relaxation, cognitive processing, trauma narration, cognitive restructuring of the trauma, desensitization, joint parent/child sessions, and strengthening safety skills. The strength of this method lies in its flexibility to be adapted to different situations and needs.

Treatment of trauma in adults involves recognizing a dissociated child part that, although unconscious, influences the individual's equilibrium through distress and dysfunctional emotions. Avoiding the event is not a solution, as addressing the trauma requires a process of reintegration that situates the abuse within its proper space and time, integrating the child of the past into the adult's current identity (Bakacs, 2021).

Help-seeking also clearly emerges at the somatic level, since phobias and interpersonal difficulties are reflected in posture, muscle tension, and nonverbal language; therefore, attention to the body becomes a cornerstone of the therapeutic setting (Bakacs, 2021).

Chapter 2. A fractured identity: exploring Dissociative Identity Disorder

When speaking of dissociative disorders, reference is made to a range of psychopathological phenomena characterised by an alteration of daily functions of environmental perception, identity, memory and consciousness (Kaplan & Sadock, 2003). Dissociation can therefore be defined as a dysfunction in the physiological processes that integrate mental functions, in which a set of contents and experiences becomes separated from consciousness, thereby impairing full self-awareness. Furthermore, it is an experience that affects everyone, such as when one arrives at one's destination without actually realising one has driven along that road, because one was lost in thought (D'Ambrosio et al., 2005).

2.1 How dissociation manifests itself in a fragmented identity

The clinical presentations arising from dissociative mechanisms have their historical roots in the psychopathology of hysteria. Indeed, within the anglophone psychiatric tradition, the distinction between conversion hysteria and dissociative hysteria is well established. The manifestations of the former concern the somatic level, whereas those of the latter are characterised by their exclusively psychological nature, such as amnesia, sleepwalking, dissociative fugue and multiple personality disorder (Invernizzi, 2000).

The DSM-IV-TR identifies four dissociative disorders:

1. Dissociative amnesia
2. Dissociative fugue, previously termed 'pathogenic'
3. Dissociative Identity Disorder, formerly known as 'multiple personality'
4. Depersonalisation disorder

The most severe of these is Dissociative Identity Disorder (DID), which has a chronic course and rarely reaches complete recovery (Kaplan & Sadock, 2003).

The symptomatology comprises a complex of psychological, behavioural and somatic manifestations (Cummings, 1985). Among the specific characteristics of the disorder, the individual experiences profound distortions and temporal discontinuities, often accompanied by lacunar amnesia of which they become aware only through reports from external observers. Furthermore, their behaviour may range from adopting alternative identities and using the pronoun 'we' when speaking to being unable to recognise personal

belongings or drawings they have produced themselves. Physiologically, they tend to experience headaches and internal auditory hallucinations, which are not recognised as separate phenomena, and are found to have a history of severe emotional or physical trauma during childhood.

DID is characterised by the coexistence within the same individual of multiple distinct and mutually autonomous personality states, each of which exercises a transient yet pervasive control over the individual's modes of self-representation, attitudes and behaviour; the original identity remains completely unaware of the existence and actions of the other personalities, and the transition from one to another is sudden. Another distinctive feature of this coexistence is that some identities are aware of the others. Each has a name, characteristics and memories (D'Ambrosio et al., 2005) and may differ in terms of gender, age and ethnic origin, or may show signs of another psychiatric disorder, such as a mood or personality disorder (Kaplan & Sadock, 2003).

As regards the relationship between DID and gender, according to Dorahy & Krüger (2017) "multiple gender identities and different gender-typed behavior can coexist in a single person who has a complex DD, such as DID. Consequently, the contributing influence of social construction to, and the fragility of, gender development is displayed in disorders such as DID" (p.465). The authors also state that the reason for diagnosing a higher prevalence of dissociative disturbances in women may be due to the fact that men with such symptoms are more often not diagnosed. Moreover, men with symptoms of dissociative disturbances may be involved within the legal system rather than the health system, often as a result of being criminalized for their behaviour.

It is important to emphasise that when we speak of 'other personalities', we are referring to stereotypical and concise representations of an individual's inner conflict of emotions, memories and cognitions, arising from the process of dissociation as an attempt to cope with intolerable pain. Moreover, whilst initially created with specific functions, these may, over time, acquire a secondary autonomy, to the extent that a distinction can be made between the 'host personality'—which holds executive control for most of the time—and the 'original personality', from which the other identities have separated (D'Ambrosio et al., 2005).

The child. It is this personality that retains memories of traumatic events that occurred during childhood, which is why it tends to be frequently frightened and in a constant state of hypervigilance, although it may appear friendly for the sole purpose of

gaining affection and approval. When this aspect emerges, changes may occur in posture and the use of gestures, in the way of speaking and even in vocabulary (D'Ambrosio et al., 2005).

The protector. This persona may present itself as a friend, helper, counsellor or wise relative, displaying reassuring and mature attitudes, yet at the same time exhibiting violent and aggressive behaviour, accompanied by antisocial behaviour and substance abuse (D'Ambrosio et al., 2005).

The persecutor. This may stem from identification with the aggressor and, in children who have been victims of abuse, is associated with the belief that they are guilty or wicked and therefore deserving of punishment. This personality type is responsible for the antisocial behaviour exhibited, as well as for suicide attempts, substance abuse and attempts to inflict any kind of pain upon oneself. Even though they appear tough and impassive, they grapple with feelings of sadness, exclusion and anger at having to contain everything that is going wrong. When the personality is of the opposite sex, the behaviours exhibited may be more extravagant, as the sexual dimension is involved: although an alter of the opposite gender in women may serve a protective function, it often instead channels the expression of sexual orientations or gender identities that are repressed or not integrated into the primary identity, such as dressing as a woman and engaging in prostitution with transgender individuals (D'Ambrosio et al., 2005).

Diabolical personalities. These are often associated with the individual's cultural background; they encompass all the unacceptable aspects of the self, and there is still a belief today that they involve episodes of demonic possession (D'Ambrosio et al., 2005).

2.2 Diagnosis and critical issues: distinguishing DID from other disorders

From an epidemiological perspective, studies indicate that the prevalence of psychological dissociative conditions ranges from 2 to 6 % of the general population (Seedat et al., 2004), partly because psychiatrists rarely diagnose dissociative disorders (D'Ambrosio et al., 2005).

However, a geographical difference has been observed between the USA and Europe in terms of hospitalised patients. While in the USA the prevalence rate of dissociative disorders ranges from 14.6% to 58.3% (Ross et al., 1991; Saxe et al., 1993; Horen et al., 1995; Latz et al., 1995; Rifkin et al., 1998), in European countries it ranges between 5 and 27% (Tapio et al., 2004; Knudson et al., 1995; Modestin et al., 1996; Tutkun et al., 1998; Friedi & Draijer, 2000). These findings stem from the fact that, in Europe, these studies were linked

to another DSM Axis I disorder, whereas dissociative symptoms were interpreted in their own right in the United States (Friedl et al., 2000).

The most commonly used diagnostic tools are as follows:

1. **SCID-D**, a semi-structured interview that assesses the presence and severity of dissociative disorders across five domains, in accordance with the DSM criteria (Steinberg, 1993)

2. **DDI-S** (Dissociative Disorder Interview Schedule), a structured interview comprising 131 items used to diagnose somatoform disorders, depressive episodes, borderline personality disorder and all dissociative disorders. It is also useful in investigating childhood physical and sexual abuse and the characteristics of DID (Ross et al., 1989)

3. **DES** (Dissociative Experience Scale), a self-report scale that assesses the level and type of dissociative experience. It consists of 28 items that investigate the frequency of specific dissociative experiences in the subject's daily life, and responses are recorded on an 11-point Likert scale expressed as percentages ranging from 0% to 100% (Carlson & Putnam, 1993). This instrument was devised by the same authors as a measure of a psychological trait, in which the criterion for dissociation was the absence of the normal integration of thoughts, feelings and experiences within the flow of consciousness and memory.

The DSM-IV-TR sets out the following diagnostic criteria for dissociative identity disorder:

- the co-existence of two or more distinct personality states or identities, each characterised by distinct patterns of perception, cognition and relating to the self and the surrounding environment
- at least two of these alternate in assuming executive control over the individual's behaviour
- marked impairment of memory and an inability to recall significant personal information
-the disturbance is not due to the physiological effects of a medical condition or a substance

The ICD-10 similarly sets out the diagnostic criteria for dissociative identity disorder and defines it as Multiple Personality Disorder (D'Ambrosio et al., 2005).

In the DSM-5, however, dissociative (disintegration) disorders are identified as dissociative identity disorder (DID), dissociative amnesia, depersonalisation, derealisation, imaginative absorption/escape, other specified dissociative disorder and unspecified dissociative disorder (APA, 2013).

The limited clinical understanding of the disorder further complicates its diagnosis, particularly within the European scientific community. This may be due both to the influence of the biological model in psychiatry and to society's tendency to repress or ignore deeply painful and uncomfortable realities such as child abuse. Another obstacle stems from the presence of multiple conditions in the individual and the overlap of symptoms with other disorders, making it necessary to differentiate diagnostic criteria appropriately in order to avoid misdiagnosis (D'Ambrosio et al., 2005).

A lack of training in recognising trauma-related dissociation, limited access to reliable scientific evidence on DID, the ongoing debate regarding its aetiology, and the overlap of symptoms with other disorders only serve to exacerbate the underdiagnosis of the disorder. For this reason, misdiagnoses are common, which hinder the initiation of appropriate therapeutic interventions (Reinders et al., 2019). Indeed, in their study the authors found that, before receiving a correct diagnosis, the patients in their study had, on average, received four alternative diagnoses, had been prescribed inappropriate pharmacological treatments, and had spent several years in mental health services. In line with these findings, the most common diagnosis given is that of a depressive disorder (Şar et al., 1995; Kandemir, 2012). Despite the difficulty in making a correct diagnosis, however, a pure dissociative disorder is rare (Atilan Fedai & Asoğlu, 2022).

There is a belief that many men with dissociative disorders are more likely to end up in the criminal justice system than in the healthcare system to receive treatment, making it difficult to identify and treat them (Şar et al., 2004). In their study, Atilan Fedai & Asoğlu (2022) found that the prevalence of women diagnosed with DID was higher than that of men, but lower than the percentages of female patients reported in the literature.

Analysis by various authors suggests that amnesia is the most frequently observed symptom in patients with DID (Boon & Draijer, 1993; Putnam et al., 1986; Ross et al., 1989; Lewis, 1996; Şar et al., 1995), and the average number of alters reported ranges from 7 to 15 (Putnam et al., 1986; Ross et al., 1989; Coons et al., 1988). However, at the time of diagnosis, only two or three alters tend to be evident, whilst the others emerge during the course of treatment (Özen et al., 2018).

The differential diagnosis must consider:

1. **Temporal lobe epilepsy**. Given the possibility of episodes of depersonalisation or dissociative states, neurological examinations and an electroencephalogram help to clarify the diagnosis, in which no parallel identities are formed (Coons et al., 1988; Kapur, 1991; Mesulam, 1981; Schenk & Bear, 1981).

2. **Mood disorders**, as changes in mood are common, and mood exerts a significant influence on self-perception and memory.

3. **Eating disorders**, as the mechanism of dissociation promotes and sustains cognitive distortions and a distorted perception of the body and the self.

4. **Behavioural and self-related changes** resulting from intoxication with exogenous substances

5. **Hysteria**, which is gradually disappearing from international manuals and classification systems

6. **Schizophrenia**, one of the most common diagnoses in the medical history of individuals with DID

7. **Borderline personality disorder** (BPD), with which a 64.2% rate of comorbidity has been reported (Boon & Draijer, 1993; Van den Bosch et al., 2003)

8. **Malingering**, feigning or exaggerating symptoms for secondary gain such as avoiding legal consequences or obtaining disability benefits (Brand et al., 2006).

9. **Occasional delusional syndromes**, such as Capgras syndrome, Fregoli syndrome or subjective double syndrome (D'Ambrosio et al., 2005).

A differential diagnosis can also be made between schizophrenia and BPD in relation to DID. While schizophrenia primarily involves a process of splitting, which leads to a loss of contact with reality and consequently an impairment of relational and social functions, dissociation does not affect the perception of reality. Furthermore, in a study of DID involving 100 cases, it was found that 49% of those affected had previously been diagnosed with schizophrenia (Putnam et al., 1986). In schizophrenic patients, the voices are mostly irrational, incoherent and bizarre, and are distinguished by the fact that the individual perceives them as coming from outside, whereas in patients with DID they are consciously perceived as coming from within, from inside their own head (D'Ambrosio et al., 2005).

What fundamentally distinguishes dissociative identity disorder from schizophrenia is the absence of the typical negative symptoms of the latter, in that there is no evidence of severe cognitive, social and occupational impairment, autistic withdrawal or emotional blunting (Briere & Zaidi, 1989; Bryer et al., 1987).

With borderline personality disorder, on the other hand, comorbidity is observed due to the presence of:

-unprovoked anger;

-self-harming behaviour;

-emotional instability.

In this case, the overlap in symptoms relates to the descriptive rather than the organisational aspect of personality, and the difference between the two disorders lies in the severity of childhood trauma histories and in amnesic episodes, which are more prevalent in dissociative identity disorder (D'Ambrosio et al., 2005).

According to Kluf (1987), the clinical presentations differ in the following factors:

- **Impulsivity**. In BPD patients, impulses are pervasive, whereas in DID they are circumscribed and limited to a specific identity.
- **Interpersonal relationships**. In BPD, these are unstable and intense due to fragility and a lack of object constancy, whereas in DID they lack organisation due to amnesia and other dissociative disturbances
- **Self-harming and suicidal behaviours**. In BPD patients, these behaviours are intended to relieve tension, avoid abandonment and manipulate others; conversely, in DID there is no manipulative intent, but they merely express an internal conflict between the personalities

2.3 Dissociation and traumatic memory: how the brain fragments experience

The literature shows that the dissociation of different parts leads to a variety of brain activations and cardiovascular responses at the moment the trauma is imprinted in the memory (Van der Hart et al., 2005). Numerous studies have focused on the underlying neural processes of dissociative amnesia, identifying alterations primarily in the limbic structures, the temporal lobe and the frontal areas, but also in the cerebellum, occipital cortex and parietal cortex (Taïb et al., 2023).

Damage to brain tissue, as well as causing a complete reset of memory, can lead to amnesia, meaning the individual is no longer able to recall memories and/or form new ones. When it comes to dissociative amnesia (DA), however, all is not lost (Van der Hart & Matar, 2012). As Janet (1904) noted, whilst some brain atrial natriuretic peptide (ANP) parts cope with amnesia in response to trauma, other brain evoked potentials (EP) parts rely on hypermnesia, a process in which these memories are extremely vivid. The result is the reactivation of traumatic experiences and EP parts, which interfere with the functioning of the ANP.

Individuals with DID have been observed to engage in the process of hypermnesia even in situations unrelated to trauma. Furthermore, within their system, the ANP does not

associate traumatic memories with personal involvement, allowing each part to respond appropriately, unlike the way the EP operates (van der Hart et al, 2005)

Sternberg & Schnall (2006) describe the five typical manifestations following trauma:

Amnesia. This manifests as an inability to specifically recall an event or a period of time and does not consist of a permanent erasure of the memory, but rather a shift from the conscious to the unconscious realm.

Depersonalisation. This takes the form of a sense of detachment from the self or the experience of observing oneself from the outside, and manifests in various, often overlapping ways: emotional numbness, altered body perception, a sense of invisibility, failure to recognise oneself in the mirror, internal dialogue with imaginary people, and the perception of being both an observer and a participant at the same time.

Derealisation. This involves a detachment from the surrounding environment, as it is perceived as alien or unreal.

Identity confusion. This manifests as persistent uncertainty about one's own self, with internal conflicts and difficulty in defining a coherent identity; however, when this state persists beyond an episode linked to a stressor, it takes on clinical significance.

Identity alteration. Those who experience sexual abuse during childhood are more likely to exhibit alterations in identity or perceived sexual orientation. This alteration consists of observable changes in the person's behaviour; by using different voices, names or habits, the individual finds themselves harbouring several 'selves' within, each with their own memories, preferences and modes of expression.

2.4 Trauma, attachment and treatment pathways: from stability to integration

A vast body of psychopathological literature agrees that there is a link between traumatic experiences and alterations in cognitive functions, consciousness and identity (Grummitt et al., 2024). However, the nature of this association remains difficult to define. Exposure to trauma does not always lead to a dissociative disorder, and conversely, not all patients with dissociative disorders report a traumatic past. Clinicians' excessive conviction of this correlation has, however, at times led the patient themselves to believe they had been the victim of abuse or family maltreatment, when in reality nothing of the sort had taken place (Liotti, 2000).

Taking into account the different types of attachment that a child may form with their caregiver, Liotti (2000) points out that even if no significant evidence of abuse has been found, the presence of a post-traumatic dissociative state in the caregiver can induce a dissociative state of consciousness in the child, which manifests itself unequivocally in their relational behaviour. The process of intergenerational transmission consists of the following stages:

1. The traumatised caregiver unconsciously expresses fear, disorientation and anger as a result of the emergence of dissociated traumatic memories whilst caring for the child.
2. The child receives two conflicting messages: the comforting and nurturing embrace of the caregiver, which, by its very nature, tends to evoke feelings of protection and security in the child; and, at the same time, the threat of alarm and disorientation, which, again by its very nature, triggers fear responses.
3. The child's consciousness is unable to organise a coherent reaction to explain the caregiver's withdrawal and subsequent return, as it is unable to understand that the dissociated multiplicity of the other person's behaviour is merely a product of the interference of memories that suddenly surface in the adult's consciousness.

A child with disorganised attachment may simultaneously construct at least five representations of themselves in relation to the other person, which are mutually incompatible and cannot be integrated:

- the self as cared for by the caregiver: the child is the victim and the caregiver their saviour;
- the self as frightened by the caregiver: the adult is seen as a persecutor;
- the self as capable of instilling fear in the caregiver: the child perceives themselves as the caregiver's persecutor, whilst the caregiver becomes the victim;
- the self as capable of comforting a fragile and vulnerable caregiver;
- the self and the caregiver as both helpless victims, facing an invisible and unidentifiable danger (Liotti, 2000).

Although the triggering cause of dissociative identity disorder remains unknown, several significant risk factors have been identified:

-highly destabilising experiences or abuse during one's lifetime;

-a lack of a support network and emotional attachment figures;

-susceptibility to hypnosis and abnormalities in electroencephalographic activity (D'Ambrosio et al., 2005).

Moreover, the severity of dissociation depends on the experience of a traumatic event, often an unusual form of violence, psychological abuse or sexual abuse, which occurred during childhood and was perpetrated by one or both parents (Mulder, 1998). Liotti (1999), however, emphasises that dissociation is not necessarily an inevitable consequence of trauma.

According to Janet (1889/1973; 1907/1965), mental activity is aimed at adapting to the environment rather than at defence against intolerable internal impulses, and this occurs through the 'personal synthesis' of structures of meaning. The author points out that dissociation represents the failure of this synthetic process, caused not only by trauma but also by the concomitance of intense emotions and debilitating behaviours. When, on the other hand, dissociative mechanisms are triggered by a traumatic experience, they should not be viewed as a protective strategy against the event itself, but as a consequence of it.

Within the dissociation model, the early development of internal working models plays a crucial role in the response to trauma in adulthood. Individuals who have formed a secure attachment in childhood benefit from a significant protective factor. Conversely, those who have established an insecure or disorganised attachment are more vulnerable to dissociative symptoms (D'Ambrosio et al., 2005).

In traumatic dissociation, an individual's memories are fragmented, poorly integrated into mental schemas and often devoid of verbal content (Van der Kolk et al., 2001). Integrating these memories becomes a central aim of therapy, which simultaneously involves the ability to find the words to describe them (Miti & Onofri, 2011). These authors demonstrate how cognitive-behavioural techniques can be effective in managing outbursts of anger and anxiety or in improving interpersonal communication skills, whilst methods such as hypnotherapy and guided imagery enable access to memories and the experience of associated emotions. Furthermore, they emphasise that the treatment of dissociative disorders is a lengthy, multifaceted process requiring a fairly diverse approach, in which at least one or two sessions per week are needed to carry out intensive trauma processing, whilst maintaining a connection with the present.

Characterised by a complex prognosis and the absence of spontaneous recovery, DID remains a serious and, in many respects, enigmatic condition. Given the scarcity of effective traditional therapeutic approaches, psychiatric hospitalisation is frequently necessary (D'Ambrosio et al., 2005).

From a psychopharmacological perspective, benzodiazepines are used to facilitate the retrieval of traumatic memories, given their ability to alleviate anxiety (Loewstein et al., 1988), antidepressants are the most appropriate for those with suicidal tendencies (D'Ambrosio et al., 2005), whilst antipsychotics are recommended for the inhibition of

impulsive behaviour and in response to misdiagnoses in individuals with schizophrenia (Barkin et al., 1986; Kluft, 1984).

The use of psychotropic drugs is only one aspect of therapeutic intervention in patients with dissociative disorders (Putnam & Loewenstein, 1993), not least because there are currently no drugs capable of acting specifically on dissociative symptoms (Miti & Onofri, 2011). The specific pharmacological treatment for dissociative disorders involves drugs that have shown positive results in the treatment of PTSD (Stein et al., 2009), such as the antidepressants sertraline and paroxetine (Paneva et al., 1996; Stein et al., 2006), mirtazapine (Davidson et al., 2003), venlafaxine (Davidson et al., 2006a; 2006b), antipsychotics (Stein et al., 2006), such as olanzapine (Stein et al., 2003) and risperidone (Bartzokis et al., 2005), as well as anticonvulsants that have a mood-stabilising effect (Stein et al., 2006) .

From a psychotherapeutic perspective, however, psychoanalytic psychotherapy aims at reintegrating the traumatic experience, promoting the replacement of dissociative defences with more adaptive coping mechanisms, whilst cognitive-behavioural psychotherapy aims to bring together the various fragmented affective states, thereby helping the individual to understand that dissociative symptoms belong to the past (D'Ambrosio et al., 2005).

In some treatment plans, dissociation is at the heart of the intervention. In others, it is merely a symptom that emerges when addressing the true motivation for the intervention. In still others, it merely represents the periphery of the problem for which the patient is seeking help (Liotti, 1993).

Most of the treatments proposed for dissociative disorders are derived from those recommended for the treatment of PTSD, albeit with modifications (Miti & Onofri, 2011). Although efficacy in dissociative disorders has been observed to be similar to that seen in populations of women who were victims of CSA and have chronic PTSD (Brande et al., 2009), there remains a need for more in-depth research into the application of interventions aimed at patients with DID and complex histories, such as victims of prolonged childhood abuse (Cloitre, 2009). Scientific research shows that around two-thirds of patients with dissociative disorders improve significantly following treatment, whilst the remainder develop severe chronic conditions (Miti & Onofri, 2011).

Based on the ISST-D guidelines, the treatment model most widely used today consists of several phases, with particular emphasis placed on the therapeutic relationship (Dworkin, 2005) and the patient's unconscious belief systems, rather than on the analysis of the traumatic event (Miti & Onofri, 2011). According to the latter, the treatment involves establishing the therapeutic relationship, suppressing symptoms and stabilising the patient in preparation for the processing of traumatic memories. The integration of dissociated mental

functions and the rehabilitation of relational abilities constitute the ultimate goal. The authors emphasise, however, that "the best results are achieved in patients who make every effort to maintain control over themselves and their lives and who persist in their constant attempt to normalise their existence" (2011, p. 78).

First phase. A psychoeducational approach is also adopted, in which the patient is recommended specific reading material on the subject (Herbert & Didonna, 2006) and, to facilitate the normalisation of their experience, is provided with information and explanations designed to encourage an understanding of their distress and to work with them to define a shared treatment plan (Miti & Onofri, 2011). Moreover, the patient's psychological and physical wellbeing is promoted by encouraging them to follow a healthy diet and, above all, to stay adequately hydrated (Miti & Onofri, 2011), as well as by participating in meditation groups such as mindfulness (Didonna & Kabat Zinn, 2009).

Chu (1992b; 1998) uses the acronym SAFER to list the objectives of this stage:

- **Self-care and Symptom Control**, which involve attending to one's own needs and learning 'grounding techniques' which, by counteracting the 'numbing' effect typical of DID, help bring the patient back to reality and into the present moment, teaching them to recognise the onset of dissociative symptoms more quickly and how to increase their control over them (Chu, 2007).
- **Acknowledgement**, involving psychoeducation and the recognition of the experience of abuse, with a proper understanding of its significance and consequences
- **Functioning**, involving the effective maintenance of daily life, including suggestions for participation in partial residential groups
- **Expression**, involving gradual learning to recognise one's own feelings and to communicate them
- **Relationships**, involving issues related to trust, boundaries, and interacting with people.

It should be noted that many patients may remain in this phase for an extended period and occasionally even for the entire duration of treatment; however, although they may show improvement in personal safety and overall functioning, they are not yet ready to engage with an in-depth exploration of their traumatic history (Miti & Onofri, 2011).

Furthermore, the therapeutic relationship triggers the activation of the attachment system, such that the patient may oscillate between an abnormal dependence on the therapist or being totally independent of them. However, too early and intense activation of this system can compromise the patient's ability to regulate emotions and reflect on interpersonal

experiences; for this reason, it is best not to immediately encourage an in-depth exploration of traumatic memories, but rather to foster a cooperative relationship, without overstepping therapeutic boundaries (Miti & Onofri, 2011).

Second phase. Given the complexity and fragility of the situation, the therapist must not only listen to the spontaneous account but, as a matter of extreme caution, explore the patient's traumatic memories in depth, taking particular care not to refer to childhood abuse so as not to induce the creation of false memories (Miti & Onofri, 2011)

Third phase. "It is as if I can now see what happened, but situated in a chronologically precise time" (Miti & Onofri, 2011, p. 87). Finally, patients are able to acquire a more stable sense of identity, a greater capacity for self-care and more functional ways of relating to their former selves. The reduction in symptoms allows the patient to devote more time to their daily routine and to expand healthy interactions with the outside world (Miti & Onofri, 2011). The aim is to explore, with empathy, the dual significance attributed to both the remembered experience and the very act of remembering it (Mollon, 2002a; 2002b).

Clearly, revisiting traumatic experiences can be particularly painful. However, thanks to the work carried out previously, individuals should be able to tolerate the complex emotions that often accompany this process and avoid acting on dysfunctional impulses. Furthermore, survivors of severe traumatic experiences undergo a transformation in their internal relationship with the abusive figures. Those who once appeared as evil giants are now perceived as smaller and less powerful, and these events are situated in the past, rather than being continually relived in the present (Miti & Onofri, 2011).

Chapter 3: When trauma multiplies the self: psychopathological outcomes and comorbidity in DID among adults who survived CSA

Research has shown that CSA survivors are in no way a homogenous group and that very considerable variability exists relating to both the types and the severity of psychological outcomes and the presence of comorbidity. This chapter explores a range of the repercussions for CSA victims at all stages of their development, with particular reference to dissociative disorders.

3.1 Repercussions of abuse on processes of self-representation and identity development

Understanding an experience of sexual abuse begins with acknowledging that it profoundly alters the perception of space and time, jeopardising the usual human capacity to process what has happened. Victims of child sexual abuse themselves, once they reach adulthood, identify conflicting memory representations as they may encounter memories that are either extremely vivid or faded. Every day the mind is committed to denying the traumatic event, attempting as far as possible to distance itself from what has happened and, although the individual may be determined to leave the past behind, dissociation suppresses the conscious account, even though emotional and physical traces persist (Bakacs, 2021).

3.1.1 Deficits in narrative coherence and cohesion, and the ability to integrate experience: the three dimensions

Trauma freezes time, imposing itself violently on the victim, undermining the ability to attribute meaning to experience, the sense of control and the relational dimension. In this regard, the holistic perspective highlights the impairment of overall development due to the dysfunctional alteration of the psyche (D'Ambrosio, 2010). As argued by Herman (2005), "it is a state of primary senselessness, in which nothing exists, in which the capacity to encode

experience is for an instant rendered entirely inactive. It is an experience beyond the limit, unthinkable and eluding conceptualisation" (p.1).

A further dilemma is presented by the problem of embodiment, which is frequently overlooked or downplayed when assessing events such as sexual abuse, despite the fact that the wound left by whatever level of severeness of the trauma is undeniable. Consequently, the individual finds themself questioning the experience of 'having' and 'living within' a body. The moment physical boundaries are breached, what was external manifests itself as something that has penetrated the interior, distorting the inner self and its relationship with any external influence (D'Ambrosio, 2010).

Thus, the traumatised child will not recognise this as part of themself, but as an alien figure with whom they are forced to coexist (Bakacs, 2021). Consequently, the child's interpretation of the world undergoes a profound revision of its conceptual foundations, such as trust in goodness and dignity, the concept of invulnerability, and social and moral assumptions (Erikson, 1976; Janoff-Bulmann & Firenze, 1983; Silver et al., 1983; Wortman, 1983).

Bakacs (2021) introduces the concept of three dimensions: temporal, spatial and a third dimension involving an alteration of the perception of both space and time. Memories of the events we experience are situated in the first dimension, whereas the second dimension encompasses their physical, emotional and sensory memories, which, when then taken together, constitute the story of our lives.

Facing a traumatic event, the person is thrust into a parallel dimension, independent of the previous ones, arising from the perceptual alteration of space and time and the integrative impairment of the first two dimensions. This third dimension is characterised by the fact that even when the memory is vivid, its nuances are fragmented and disorganised, making it increasingly difficult to feel credible in the eyes of others and in one's own eyes.

Through dissociation, the memory of abuse begins to desperately wander, carrying with it the faded shadows of the victim and their abuser. As a consequence, the surrounding environment is constantly perceived as a threat due to feelings of guilt and shame. Furthermore, this dimension has the ability to unconsciously inference one's experience, as if it were constantly repeating itself, yet at the same time had never actually happened. This is why the accounts of adult victims of sexual abuse are often characterised by inconsistencies.

The narrative completeness of a story is defined as the set of relevant details that meticulously establish the credibility of the events (Bauer et al., 2014; Eisenhower et al., 2007; Leippe et al., 1991). However, when speaking of narrative coherence, we usually refer to the

way in which the parts of a text are consistent with one another, considering a logical framework (Cain, 2003; Hudson & Shapiro, 1991; Lanciano et al., 2012). For this reason, a narrative is considered coherent when the event is situated within a spatial-temporal framework by the listener (Graesser et al., 2007; Graesser et al., 2004; Miragoli et al., 2019).

From a legal perspective, the child's testimony is the cornerstone of proceedings (Cossins, 2020; Procaccia, 2016) and, as highlighted in the literature, age and the presence of post-traumatic symptoms influence the perceived credibility of the testimony and of the witness themself (Miragoli et al., 2022). In terms of narrative completeness, from the age of six, children are progressively able to integrate their own reflections on events (Stein, 1982) and secondary details (Goodman et al., 1990) into the basic information, retaining them firmly in memory (Eisen et al., 2002). Reese and colleagues (2011), in their study of narrative coherence, identify linguistic and cognitive skills as children develop. The correct sequencing of events is already present in preschool children, and the ability to contextualise emerges in mid childhood, whereas the ability to narrate in terms of past, present and future is perfected during adolescence.

The presence of post-traumatic stress disorder (PTSD) further contributes to the distortion of the narrative, of spatial and temporal information, and of the resulting chronological sequence (O'Kearney et al., 2007; Sales et al., 2005; Stallard, 2003). The child is overwhelmed by intense negative emotions, which they are unable to process correctly, and thus resorts to defence mechanisms, including dissociation, repression or avoidance, leading to misinterpretation and impaired integration of the event (Brewin, 2001; Brewin & Holmes, 2003; Caretti & Carraro, 2008; Terr, 2008). Furthermore, this difficulty is reflected in the presence of isolated, unconnected phrases, which prevents the listener from fully understanding the victim's perspective (Brewin & Holmes, 2003; Ehlers & Clark, 2000; Miragoli et al., 2019).

3.1.2 Guilt and shame as the core of trauma

From birth, the child has learnt to recognise the adult as a figure essential for their own survival, but from the moment that adult proves to be a threat, they are forced to face a path of no return, living with what has become a double-edged sword. In this way, the adult is able to share and manipulate, as they like, the relationship with the child, who is, in any case, dependent on them, while leaving no visible traces for others to see (Bakacs, 2021).

The ambivalence of guilt is a key factor. The first emotional consequence the child must face is precisely this sense of guilt, which initially places them in a punitive position for

'being wrong', the reason why the adult figure has the power to punish them. While this self-accusation is clearly unfounded, the child cannot conceive that it is the adult who is in the wrong.

At the same time, this feeling is also caused by an inability to rebel against abuse. When feeling afraid, the child probably realises that there is nothing wrong with themself, but lacks the resources needed to stand up to the adult. It is only when they recognise their own innocence, while still accepting the double-dealer, that their emotional survival hangs in the balance as they come to terms with the fact that they have been abused, rather than protected, by their own point of reference.

When they reach adulthood, the individual begins to blame their past self once more, turning old wounds over in their mind that they were unable to express, and is once again called upon to come to terms with the healthy anger felt towards the powerful figure. This emotion, which cannot be aimed directly at their abuser, finds a scapegoat, and is ultimately turned against the individual themself and/or their surroundings in a potentially vicious cycle of revenge. In particular, the greater the sense of guilt, the more intense the self-anger will be, whereas, when this anger is projected outwards, it can turn into sadism and/or a constant dissatisfaction stemming from the failure to find a scapegoat.

Moreover, shame is the ever-present feeling following sexual abuse, one that offers no escape for the child and is often carried into adulthood. The individual feels they are constantly inadequate in the eyes of others, and the deeper this sensation becomes, the harder it is to perceive oneself as conforming to others. Generally, this feeling of embarrassment stems from excessive exposure to something socially defined as negative. In such a traumatic sexual experience, the child may have experienced pleasure as a result of certain gestures or caresses, provoking an ever-greater sense of shame and inadequacy, but also both a dual perception of themself and a projection of themself through the eyes of others (Bakacs, 2021).

This gives rise to a persistent perception of the surrounding environment as a threat poised to expose one's inadequacy. The individual is thus led to become their own tormentor and begins to ruminate on not having been able to react, coming to view themself as a failure for the rest of their life. As observed by Talbot et al. (2004) and Dorado (2010), dissociation is a means to keep the intensification of shame under control. Moreover, Lee et al. (2001) emphasize the distinction between shame, associated solely with the evaluation of the self, and guilt, which involves the disrespecting of socially shared norms. Tangney (1996), on the other hand, explains how it is the latter emotion that brings individuals to engage in self-punitive behaviours.

The disclosure of having been a victim of sexual abuse is typically complex, and even more so when the persistent nature of the abuse involves a close adult figure in the child's life. For this reason, it is understandable that victims may feel ashamed to give voice to their inner distress, even many years later. Nevertheless, studies conducted on adult survivors of child sexual abuse, recruited through internet (Lamb & Edgar-Smith, 1994) and in therapeutic settings (Roesler & Wild, 1994), have found more negative reactions when the abuse was disclosed at an early age rather than in adulthood and this apparent contradiction with common assumptions may be explained by the effectiveness and functioning of support services available to victims (Ullman & Filipas, 2005).

These feelings eventually have implications in terms of alterations in self-image, as the boundaries of the self are shaped by shame and guilt, while anger contributes to an increase in self-punitive behaviours. Given the fact that these three elements fluctuate between internal and external dimensions, and that the traumatic experience involves two or more individuals, trust in others is continuously questioned and this results in the inability to address the relational dimension in a functional way (Bakacs, 2021).

Ullman & Filipas (2005) reported that, according to Coffey et al. (1996), Gibson & Leitenberg (2001) and Long & Jackson (1993), in contrast to men, women were more predisposed to experience symptoms of distress and self-awareness at the time of abuse and were also more engaged in desiring to leave the past behind through coping strategies. Andrews (1998), Lisak (1994), Talbott et al. (2004), on the other hand, argue that both sexes show equally shame and guilt, with the difference that men attribute these feelings for not taking a position, typical of male gender stereotypes, in stopping ongoing abuse (Gardner, 199; Lisak et al., 1996). Dohary (2012) found that the male gender stereotype was at odds with the perception of being devoid of values, dignity and skills, therefore branded as a failure. These findings are consistent with previous investigations focusing on male victim of sexual abuse (Bolton et al., 1989; Lew, 1988; Spiegel, 2003).

3.1.3 Alteration in the representation of the self and the other

The concept of 'sense of self' is the tool through which the person relates to the external world (Cicchetti & Beeghly, 1990). This undergoes changes when sexual abuse is involved (Briere, 1992, 2002; Murthi et al., 2006; Putnam, 2003), impacting the processes of self-regulation and impulse control (Cole & Putnam, 1992; Fonaggy et al., 2004). Research has long shown how various forms of violence have multiple negative impacts on children's psychological and physical well-being, particularly on personality development and the

delineation of self-identity (Bedi et al., 2013; Di Blasio, 2000; Feiring et al., 2010). Moreover, these two processes are most severely compromised when violence is perpetrated by a close figure and occurs repeatedly over time (Pine & Cohen, 2002; Talbott, 2000).

The presence of a functional and supportive caregiver influences positively the child's development of curiosity about the outside world and a sense of self worthy of affection and care, projecting this positivity onto their perception of others (Fonagy et al., 2002; Procaccia et al., 2013). On the contrary, experiences of maltreatment and abuse provide the child only with negativity and fragmentation, promoting low self-esteem, and the belief that they deserve nothing but the suffering they have endured (Ayoub et al., 2006; Browne & Finkelhor, 1986; Feiring et al., 2002; Saha et al., 2011; Zorning & Levy, 2011).

Those who have survived trauma often realize that they are no longer the person they once were, which is why, in addition to having to deal with various stages of the therapeutic process, they seek help specifically regarding the loss of a sense of self and their former life (Courtois, 1988; Herman, 1992). However, even today, the literature offers little data on the process of recovering a sense of self, although it emphasizes the importance of giving voice to one's pain and testimony, distancing oneself from the trauma, and strengthening one's self-perception (Phillips & Daniluk, 2004).

Defence mechanisms lead the individual to an incessant process of management of the dissociative moments and a maintenance of the fragility of the verbal self. This is responsible for the relationship between each one of us and the external word and allows others to understand our being. As a consequence, in individuals with DID, the memory and management of sensations and feelings are entrusted to 'other people', thereby alleviating the suffering caused by the trauma (Young, 1992, pp. 89-100). Moreover, the scars left by the abuse entail a constant questioning of all the certainties that had previously been constructed (Bakacs, 2021).

Both in the study by Procaccia et al. (2014) and in earlier research (Appleyard et al., 2010; van der Kolk et al., 1991), similar findings emerged. As individuals grow up, their relational investment with peers increases, yet, at the same time, only victims of sexual abuse are more cautious about trusting others' outward appearance and behaviour, fearing the possibility of deeper intimacy (Procaccia et al., 2014). When a dissociative disorder takes hold of a person, their level of trust in strangers undergoes a profound disruption, especially if the trauma was inflicted by a parent or primary caregiver. It thus becomes difficult to establish any kind of relationship with others, as the possibility that in might turn into dependent relationship with a new abuser is perceived as potentially just around the corner (McWilliams, 1994).

In this regard, Liotti (2011) introduces the concept of 'attachment phobia' as a reluctance to enter into a trusting and supporting relationship with another person, stemming from a fear of encountering dysfunctional attachment scenarios once again. This tendency towards social self-isolation is also explained by the dual representation of the self: one that is potentially harmful to the safety of others, arising from a build-up of unprocessed anger, and one that is in a constant state of alert and the hyper-vigilance towards the outside world (Talbott, 2000).

The journey of personal identity development, particularly following trauma, is characterised by two key questions:

1. How does one recognise what one is and what one is not?
2. How can one identify what one was and still is, and what one was not and still is not?

For those who have had to cope with physical abuse, this development may involve a shift in the definition of the self and one's own self. The concept of 'me' and 'mine' would no longer reside in the body, but in one's head, understood as in the mind as a separate entity. Conversely, events such as sexual experiences, which concern emotional embodiment, become alienated from the person, as if they did not belong to them.

The individual possesses a double-edged sword. While on the one hand they have the power to suppress and control such negative experiences, on the other they inevitably deprive themselves of pleasurable and relational human experiences (Young, 1992). As a consequence, a person with DID must clearly represent the self as a totality of different, intersecting elements, in order to enact mechanisms such as emotional regulation, metacognition and agency (Liotti, 1999).

3.2 How trauma alters the brain: from CSA to DID

Childhood is the stage of life characterised by the greatest vulnerability and sensitivity to environmental stimuli, and a key factor in neurobiological alterations, which, when combined with experiences of abuse, can lead to mental and physical illness, is the effect of epigenetic changes in the processes of learning and stress response regulation (Bocchio-Chiavetto & Cavallo, 2015). Being exposed to stressful situations over a long period of time can impair a child's neurological development, affecting the brain regions associated with stress and thereby putting the prefrontal cortex, hippocampus and amygdala at particular risk of damage (McEwen et al., 2015). Epidemiological studies show that at least 30% of

psychiatric disorders in adulthood are attributable to traumatic events experienced in childhood.

3.2.1 The impact of sexual abuse on brain function

In recent years, several studies have been conducted on the adverse effects of maltreatment and abuse on brain development and neuropsychological functions. (Bocchio-Chiavetto & Cavallo, 2015) highlight an increase in substances released by neuroendocrine and neurotransmitter systems in response to a stressful situation and a consequent vulnerability in brain development, particularly in the limbic system, white matter and prefrontal cortex, as well as in the executive functions regulated by the prefrontal lobes. However, memory remains unaffected, with the exception of emotional burdens relating to the abuser.

In cases of child maltreatment, the hypothalamic-pituitary-adrenal (HPA) axis plays an important role, given that exposure of the brain to excessive or insufficient levels of the axis's products, glucocorticoids, can jeopardise normal brain function and the regulation of the axis itself (Lupien et al., 2009; Chrousos, 2009).

Several studies have compared the neurological and neurocognitive differences between women who have experienced childhood sexual abuse and women who have not experienced it (De Bellis et al., 2011; Minzenberg et al., 2008). Furthermore, neuroanalytical tools have identified asymmetries in brain plasticity and structure in women with early-onset CSA, particularly in the prefrontal cortex, amygdala, cerebellum, corpus callosum, hippocampus and limbic system, including the hypothalamic-pituitary-adrenal (HPA) axis (De Bellis et al., 1999; Hart & Rubia, 2012; Heim et al., 2008; Shin et al., 1999; Teicher et al., 2003).

Once an individual comes to understand the emotional dimension, plan their cognitive behaviours, and express their identifying attributes, this signifies that the prefrontal cortex has come into play (Dubin, 2001). However, it is the orbitofrontal cortex of the prefrontal cortex that governs mechanisms such as learning, social integration and behavioural decision-making (Kringelbach, 2005). It is precisely in this part of the cortex that Bremner and colleagues (1999) found an increase in blood flow in CSA survivors with and without post-traumatic stress disorder (PTSD). However, when stories of CSA were read, this flow decreased in the medial and dorsolateral prefrontal cortex, potentially compromising the effectiveness of processes typical of this area, such as decision-making tasks (Dubin, 2001).

This argument is also supported by Shin et al. (1999), who suggest that such a reduction in blood flow in the bilateral anterior frontal regions and the left inferior frontal gyrus is also a key factor in the interpretation of emotional situations and the weighing up of alternatives (Wilson, 2003). Furthermore, Dubin (2001) observed a significant heightened sensitivity to themes such as sadness and anxiety, as well as to the surroundings environment (Shin et al., 1999), following an experience of CSA.

A study conducted by Tomoda et al. (2009), which involved the use of structural magnetic resonance imaging (MRI), revealed an 18.1% reduction in grey matter in the left visual cortex and a 12.6% reduction in the right visual cortex in women with a history of CSA. Nevertheless, this alteration is also influenced by the duration of the abuse, which occurred before the age of 12. Teicher et al. (2004), again using MRI, contributed to previous research by observing a 17% reduction in the size of the corpus callosum, associated with the presence of CSA in girls. However, this difference can be partly explained by the fact that, in the literature, it is often found that the corpus callosum is larger in women than in men, facilitating better communication between the two cerebral hemispheres (Dubin, 2001).

A reduction in the corpus callosum was also found by Andersen and colleagues (2008), highlighting how the period in which CSA occurred, 9-10 years, and its persistence between 14 and 16 years, have a negative impact on the ability to manage visual stimuli due to this impairment in grey matter volume (Blanco et al., 2015). Furthermore, using Diffusion Tensor Imaging (DTI), significantly lower white matter integrity values were found in men with a history of CSA compared to the control group (Verazov et al., 2025). Changes in white matter also affect attention and memory, functions that are often impaired in men who have experienced CSA (Kamali et al., 2014).

Regarding the amygdala, which regulates fear response and enables the individual to understand the consequences of their actions (Dubin, 2001; Wilson, 2003), no differences in amygdala volume were found in survivors of CSA (Andersen et al., 2008; Bremner et al., 1997), whether or not they had PTSD (Bremner et al., 1997). On the contrary, Teicher & Samson (2016, in their study of CSA victims, found a reduction in amygdala volume, whilst it increased in individuals with a history of neglect. Although Andersen et al. (2008) did not link amygdala alterations to the number of years of sexual abuse, Yamamoto et al. (2017) found that the intensity of sexual abuse is a key factor in hyperactivity specifically in the amygdala and, in the 14-16 age group, has a negative impact on grey matter volume (Andersen et al., 2008).

Research into the hippocampus has led to conflicting findings. Whilst one study found that the hippocampus was smaller in survivors of CSA, particularly in those aged

between 3-5 and 11-13 years (Andersen et al., 2008), Stein et al. (1997) reached the conclusion that there is no relationship between the age at which the abuse occurred and the volume of the hippocampus. Nonetheless, when using MRI, they arrived at a finding consistent with previous studies: the volume of the left hippocampus was 5% smaller than that of women without CSA, indicating a greater tendency to exhibit more intense emotional responses (Matsuoka et al., 2007).

Heim et al. (2013) also found a reduction in the thickness of the parahippocampal cortex. The outcomes of the studies by Andersen et al. (2008) and Wilson (2003) reveal several deficits in the processing of auditory stimuli and in memory management, although the authors acknowledge that further research is required. Bremner et al., (1999, 2003), found that when CSA victims with PTSD were presented with a script describing the abuse that had suffered there was a decrease in blood flow in their right hippocampus, but neural activity increased in the cerebellum. Chiasson et al. (2022) confirm that autobiographical memory is also affected in men with a history of CSA, but not of PTSD.

The repercussions of such a traumatic experience can further compromise psychological and behavioural well-being (Bailey & McCloskey, 2005), attention span and abstract reasoning (Beers & De Bellis, 2002), and may even lead to limited vocabulary and restricted academic prospects (De Bellis et al., 2011). Individuals with a history of CSA are more likely to process the trauma by adopting maladaptive coping strategies (White et al., 2007; Zwickl & Merriman, 2011), which contribute to increased anxiety and depression (Arreola et al., 2009; Mimiaga et al., 2009), and sexual dysfunction (Black & DeBlassie, 1993; Grumet, 1985; Loeb et al., 2000; Najman et al., 2005; Watkins & Bentovim, 1992) in adulthood. These changes may serve an adaptive function, as highlighted in the latent vulnerability model described by McCrory & Viding (2015). Initially, the individual uses these brain changes to respond to maltreatment and better cope with the challenges of growing up differently from their peers. However, if this persists over time, there is a greater risk of developing (psycho)pathologies.

The re-processing of inputs generated by the cortical region can be considered as a consequence of the thinning of the somatosensory genital cortex. Over time this brain adaptation may lead to the emergence of sexual dysfunctions (Teicher & Samson, 2016). Teicher & Samson also recognise that various brain alterations stem from a wide range of trauma types; consequently, it is rare for them to be adaptive in just one context. However, an adaptation to the environment could be explained by the action of glucocorticoid receptors in initiating neuroplastic rather than neurodegenerative mechanisms (Deppermann et al., 2014).

3.2.2 Neuroimaging findings: structural and functional differences in the brains of patients with DID

The persistent lack of understanding regarding the etiopathogenesis of DID can lead to questioning the very existence of the disorder (Brand et al., 2016; Merckelbach et al., 2016; Vissia et al., 2016). Therefore, such patients have often been denied access to benefits from treatment. Moreover, to avoid uncomfortable situations, they themselves prefer to conceal their symptoms (Reinders et al., 2019; Spannos, 1994). The difficulty in identifying the etiopathogenesis also lies in the fact that DID is regarded by many as the most severe form of childhood-onset post-traumatic stress disorder (PTSD), given that it is rare to find an individual with a dissociative disorder who does not also have PTSD (Chalavi, 2013; Ehling et a., 2007; Vermetten et al., 2006; Weniger et al., 2008).

There are two perspectives on the link between trauma and dissociation: the fantasy-prone model and the trauma-related model. The latter highlights how severe abuse, experienced during childhood, is more likely to lead to the onset of dissociation (Blihar et al., 2020). Although Stein et al. (1997) found a significant reduction in hippocampal volume among survivors of CSA and a correspondingly high score on the Dissociative Experiences Scale (DES), several researchers and psychiatrists remain sceptical (Irle et al., 2007; Reinders et al., 2012).

Another problematic aspect is that trauma can be fabricated or exaggerated (Elzinga et al., 1998; Şar et al., 2017). However, research has found that there is no correlation between patients with DID and fabricated trauma (Reinders et al., 2012), although the verifiability of false memories is limited, given the impossibility of clinically recreating the amnesia experienced by individuals with DID (Blihar et al., 2020). On the contrary, the fantasy-prone model attributes dissociative symptoms to fabrication and/or sociocultural influences (Reinders e al., 2012) and therefore the outbreak of the disorder may be influenced by a tendency towards fantasy (Chalavi et al., 2015a; Dalenberg et al., 2012). Indeed, the American Psychological Association (APA, 2013) also highlights how the culture, to which the patient belongs, plays a role in the form the disorder takes.

It is only in recent decades that dissociative disorders have attracted the attention of neuroimaging research, leading to the discussion of changes in glucose metabolism in areas such as the parietal, temporal and orbitofrontal vortices, as well as the hippocampus and basal ganglia (Modesti et al., 2022). However, the literature presents a variety of findings, some of which are contradictory: hyperactivation of certain brain regions (Mathew et al., 1985; Saxe et al., 1992; Elzinga et al., 2007) and/or hypoactivation of others (Tsai et al.,

1999). Schlumpf et al. (2014) observed a state of hyperactivation in the prefrontal cortex in patients with DID while at rest. Reinders et al. (2016) also linked hyperactivation, during the neutral personality state, to the utterance of words reminiscent of the trauma.

Furthermore, episodes such as anxiety and flashbacks of traumatic events can be attributes to reduced activation of the ventromedial prefrontal cortex (Vissia et al., 2022), resulting in impaired memory performance (Modesti et al., 2022). A further consequence could be a decline in mentalisation capacity, given that traumatic reenactment is linked to anxiety and sensorimotor processes (Hiser et al., 2018).

In an effort to understand whether memories linked to trauma tend to lead the mind towards a process of disorganisation or organisation, Liotti and Farina (2013) compared a group of patients with dissociative disorders with a control group of the same age and sex. In addition, using coherence electroencephalography and the Adult Attachment Interview, following a reenactment of the traumatic event, no increase in cortical connectivity as observed in the patients, unlike in the control group.

Chalavi et al. (2015) observed a decrease in cortical volume, specifically in total grey matter as well as in both the right and left hemispheres, in patients with DID when compared with healthy individuals. They also found a further reduction in grey matter volume in the left and right frontal lobes in individuals with DID and PTSD. Reinders et al. (2018, 2019) confirmed previous research by finding that cortical grey matter volume was also lower in the left and right medial frontal gyri, in the right hemisphere of the orbitofrontal cortex, and in the left and right medial orbitofrontal cortices. Cortical grey matter volume was also lower within the cingulate cortex. Smaller volumes of white matter were found in patients with DID in certain areas of the right inferior frontal gyrus, left middle frontal gyrus, right middle-superior frontal love and the left premotor, cingulate and precentral cortices (all three left cortices) (Reinders et al., 2019).

One consequence of having a smaller orbitofrontal cortex may be an increased likelihood of abnormalities in fear response (Milad & Rauch, 2007). Indeed, these individuals cope with the processing of trauma and fear in relation to the distress ing event through neurotic defence mechanisms (APA, 2013). A drop in the overall volume of the entire left parietal lobe was observed by Chalavi et al. (2015b), who demonstrated that parietal cortical volume is significantly associated with the severity of dissociative symptoms. The temporal lobe also shows variations, particularly in terms of cortical volume, which was found to be smaller in the entire temporal lobe and in both hemispheres (Chalavi et al., 2015b). The structural volumes of the temporal and parietal cortices may further explain the onset of the

host's derealisation mechanism at the moment when control is taken over by an alter (Blihar et al., 2020).

This reduction in various frontal regions clearly highlights the impact that trauma has on the frontal cortices (Blihar. Et al., 2020), particularly in the light of typical indicators such as dissociation, cognitive dissonance and the presence of multiple personalities (Siegel & Sapru, 2015). Furthermore, a significantly smaller bilateral hippocampal volume has been observed in individuals with DID (Vermetten et al., 2006), whilst Chalavi et al. (2015b) came upon the same reduced size in subjects with both DID and PTSD, compared to those with PTSD alone. Tsai et al. (1999) further validated this finding using fMRI. Vermetten et al. (2006) confirmed these findings, observing that subjects who had completed therapy or who had otherwise overcome DID once again had larger hippocampi. Ehling et al. (2007) also noticed an interesting inhibition of the parahippocampal gyri in individuals with dissociative identity disorder, although they found no differences depending on whether the patient had recovered from the disorder or not. fMRI revealed a significant reduction in the right parahippocampal gyrus, which occurred at the moment of personality switching (Tsai et al., 1999). Schlumpf et al. (2013), on the other hand, observed greater activation of this region when individuals entered a dissociative state.

On the other hand, the amygdala has also been found to have a smaller volume in individuals with DID (Vermetten et al., 2006; Ehling et al., 2007), although the severity of the trauma and the size of the amygdala are not correlated (Ehling et al., 2007). Thus, the reduction in overall brain thickness and volume, as well as in cortical and subcortical areas, may result from an excessive of trauma-related glucocorticoids (Chalavi et al., 2015b; Vermetten et al., 2006). Nevertheless, this drop is also typical of other psychological disorders, such as PTSD, BPD and DA (Weniger et al., 2008).

Hawksworth & Schwartz (1977) refer to a 'fracture of the core personality': the differing metro abilities observed between the host and the alter no longer depends on grey matter, but on the neural connection between the motor cortex and other brain areas, which are distributed unevenly. For this reason, the alters are able to manifest themselves in the various cortical regions associated with movement.

The hippocampus, which plays a key role in memory reconstruction and consolidation (Blihar et al., 2021), may, when smaller in size, be one of the causes of the various memory deficits observed in patients with DID (American Psychiatric Association, 2013; Reinders et al., 2012) and PTSD (APA, 2013; Vermetten et al., 2006; Weniger et al., 2008). Furthermore, these congruencies may also explain episodes of amnesia experienced

by hosts and alters in individuals with DID (Brand et al., 2016; Chalavi et al., 2015b; Reinders et al., 2012).

3.3 The intergenerational impact and the issue of credibility

Herman (1992, p. 51) describes trauma as "the pain of the powerless. Traumatic events disrupt the normal coping mechanisms that give human beings a sense of control, connection and meaning". According to Marinella Malacrea, traumatic experience "causes the normal defences and ordinary strategies used to cope with external events to fail" (Militello, 2011, p.13). Research contributing to the literature on early trauma has highlighted how, beyond the direct consequences experienced by the individual, trauma should be seen in terms of intergenerational transmission (Russo, 2008).

3.3.1 The intergenerational transmission of trauma

Starting from the assumption that child maltreatment is not limited to the various forms of physical violence or sexual abuse, Miller (1995) examines the broader scope of the concept of emotional neglect, whose vicious cycle of responsibility and guilt has led modern developmental psychopathology to focus on analysing and interpreting the child's psychic structure within their family context (Tambelli, 2017). In this regard, the significance of Bowlby's attachment theory is fundamental, particularly in terms of its definition as the guiding thread that accompanies individuals on their path of psychosocial adaptation (Cramer, 1989), and of Internal Working Models (Bowlby, 1973), which guide their expectations and behaviour in terms of security or insecurity (Tambelli, 2019).

At the core of the diagnostic interpretation of childhood distress lie family dynamics, which are central to intergenerational transmission to offspring and the mechanism by which violence is perpetuated. This involves two processes: the projection, by parents, of unresolved experiences from their own attachment relationships, and the intergenerational transmission of attachment itself (Tambelli, 2019). Once this projection reaches the child, through unconscious behaviours, the child will begin to externalize the distress stemming from these relational experiences and will unconsciously organize their psychic structure around violence and guilt for not having sufficiently satisfied the attachment figure (Tambelli, 2019).

Behavioural distress may manifest itself as impulsivity, aggression, anger, attention deficits, and delinquent behaviour, all recognizable as early as the start of primary school, a critical stage in which children learn principally through imitation of their caregivers (Tambelli, 2019). This distress is initially visible within the home environment where the

child lives and, over subsequent years, manifests itself in extra-familial, school, and social contexts as well. It is important to emphasize that the behavioural models learned from parents constitute the lens through which the child will view themself and the world in adulthood, including as a parent (Scapicchio & Gleijeses, 2020).

On the other hand, these dysfunctional patterns undermine the ability to cope with difficult situations, leading to the adoption of mechanisms that shut out awareness (Lyons-Ruth & Jacobvitz, 1999). However, "even if childhood wounds do not heal on their own, healing is always possible" (Tambelli, 2019, p. 83). For example, if the construction of one's self is compromised, this leads to processes of fragmentation and an inability to exercise self-control (Tambelli, 2019). Furthermore, anger leads to a continuous cycle of family tensions, which highlight parental failure to counteract the "unconscious phantoms and imaginary roles that determine not only parents' self-representation but also their conduct toward their children, in the generational sense of the term: attitude and verbal behaviours, expressions of affection, and shortcomings" (Manzano et al., 1999, p.6).

Traces of cumulative trauma are not healed by time. On the contrary, they become further concealed, to the point that they become embedded in the body (Gallinari & Paulis, 2018). Highly traumatic relational environments challenge an individual's interpersonal skills, particularly in trusting others, oscillating between the fear of an emotional yet protective closeness and attempts to control the relationship itself (Gallinari & Paulis, 2018). The following generation becomes trapped by this dual representation of the parental figure. Distorted relational patterns drive the individual to desire being a better parent yet simultaneously prevent them from doing so (Gallinari & Paulis, 2018).

Furthermore, given the caregiver's ambivalent behaviour, the individual is driven by dysfunctional assumptions, such as expressing dissent always entails danger and that it is one's duty to surrender one's body solely for the other's sexual gratification (Liotti & Farina, 2011). These beliefs also guide the choice of a partner, and even in foster care, during adolescence the child is constantly seeking emotional bonds and care that more closely resemble those provided by their own parents (Gallinari & Paulis, 2018).

Even a single trauma, which can become complex as it is passed down to the following generation, can compromise family balance (Gallinari & Paulis, 2018). However, the family must, if it able to, confront the traumatic traces and make sense of that experience (Hetherington & Kelly, 2002). The interpersonal functioning patterns transmitted across generations must then conform to the culture and personality traits of the family members of that lineage (Gallinari & Paulis, 2018). Furthermore, the process of dissociation plays a decisive role both in the transmission to the child and in the child's attempt to cope with the

trauma of abuse (Lyons-Ruth, 2012). The lack of a safe environment exposes the child to further trauma outside the family and leads to two conditions: in cases of emotional neglect, the child seeks comfort and physical contact, to the point of being defenceless if an unknown sexual abuser were to show interest in them, while the victim of domestic violence has no one to turn to for help (Tambelli, 2019).

3.3.2 The role of silence and narration

Although child sexual abuse is not uncommon, a large number of cases go unreported, which contributes to victims' silence and leads to severe emotional, physical and psychosocial repercussions (Chandran et al., 2018). Blackmail or fear of punitive consequences (Seshadri & Ramaswamy, 2017) and the interplay between social and individual factors (Malhotra & Biswas, 2005) play a significant role in the decision not to report. When a child decides to seek justice for their traumatic experience, they encounter a further obstacle: the threat of retraction by their caregivers, who do not want to publicly admit that they have failed in their role of protection and care and do not trust the child's account (Chandran et al., 2018). Another factor contributing to the decision to remain silent is that, in most cases, the child knows the perpetrator, which is why parents are even less likely to take protective measures for the child (Chandran et al., 2018). "It takes a village to break the silence" (Caprioli & Crenshaw, 2015, p. 15)

In this respect, it would be important to provide adults with professionally developed programs focused on the prevention and recognition of child abuse, while also addressing the overlapping nature of this trauma. This would also improve their ability to respond effectively when a child confides in them about the abuse they have suffered (Chandran et al., 2018). However, it is also essential to promote interventions aimed at the victims themselves, so that they learn to recognize the signs and elements that constitute abuse, with the collaboration of psychiatrists and mental health professionals (Chandran et al., 2018).

Children need to be able to report the abuse they have suffered and, at the same time, have access to easily accessible protective services, which must also be available to marginalized and overlooked segments of the population, such as ethnic minority groups or orphans (Chandran et al., 2018) who, in countries like India, in search of a better standard of living, find that resorting to crime and sexual exploitation leave them with no way out (United Nations Office on Drugs and Crime, 2006). Awareness of one's rights, gender awareness, and public awareness all contributed to the fight against this crime (Chandran et al., 2018), in particular by dismantling a major stereotype constructed by a patriarchal society, namely,

the notion that boys cannot be victims of abuse and the resulting belief that simply growing up is enough to cope with the experience (Subramaniyan et al., 2017).

The culture of silence emerges in both the dynamics of abuse and any situation involving sexual violence, but this mechanism that leads to the silencing of victims originates much earlier than is commonly thought (Caprioli & Crenshaw, 2015). In fact, perpetrators focus more on the ideal victim, that is, the one who seems most likely to remain silent (Caprioli & Crenshaw, 2015) and as accessible as possible, given that in most cases victims know their perpetrators (Lyon, 2014; Lyon & Dente, 2012). For example, emotionally needy, depressed or isolated children are a vulnerable target group (Beauregard et al., 2007; Lyon & Dente, 2012), as their isolation and resulting dependence on the adult are facilitated by their lack of an effective support and care network to rely on (Lyon & Dente, 2012). Furthermore, the scarcity or complete absence of protective relationships makes children more likely to fear that they will not be listened to and may even be accused of bringing it upon themselves (Sorsoli et al., 2008).

Grooming is the process by which the perpetrator builds a relationship of trust and deep connection with the victim (Lyon & Dente, 2012; Sorsoli et al., 2008) so indestructible that it increases the child's loyalty to the perpetrator, making the child more receptive to potential sexual requests and strengthening their relationship (Caprioli & Crenshaw, 2015). Lyon & Dente (2012) emphasize that "the most common factor that predicts delay in reporting abuse is the relationship between the perpetrator and the child: the closer the relationship, the longer the delay" (p. 1210). In addition, the child is likely to feel ashamed and blame themselves, especially when they realize that they crave the adult's attention and derive physical pleasure from physical contact with them, which consequently reduced the likelihood that they will speak up (Caprioli & Crenshaw, 2015).

In this process, the power hierarchy also plays a key role, as children are typically aware that they must obey adults (Caprioli & Crenshaw, 2015), thereby preventing the perpetrator from resorting to threats (Kaufman et al., 1998). Lister (1982) pointed out that this unspoken part was strongest when the abuser was the parent themselves, reinforcing the child's desire to protect, help, and even care for their abuser, and blurring the image of the idealized parent.

Given that there remains a high demand for child pornography in the United States (Finkelhor & Ormrod, 2004; U.S Department of Justice, 2010) and a widespread circulation of images and advertisements that sexualize children (American Psychological Association Task Force on the Sexualization of Girls, 2007; Kilbourne & Levin, 2008; Tishelman &

Geffner, 2010), Tishelman & Geffner (2010) emphasize that society itself actually participates in the sexualization of children:

> Therefore, there exists a relative discontinuity between our collectively embraced values and an underworld of sexual activity involving children. This creates risk for the children directly involved in sexual exploitation but hypothetically may indirectly contribute to the normalization of CSA. Ultimately, these mixed messages filter down to children as well as adults, possibly impacting expectations, behaviours, disclosures, and reactions to CSA (p. 613).

Furthermore, cultural constructs related to sexuality and gender play a role in this process (Caprioli & Crenshaw, 2015). Alaggia (2005) highlights how, while for women the difficulty in disclosure is linked to the fear of not being belli ed or even blaming themselves, men feared stereotypical cultural beliefs, such as being considered effeminate or homosexual (Sorsoli et al., 2008). As Caprioli & Crenshaw (2015), "How ironic that the very system we have set up to break the culture of silencing ends up mimicking the system that creates it in the first place" (p. 9). In fact, although very few of these cases ever reach the courts (Crenshaw, 2011, 2013, 2014; Crenshaw & Stella, 2015; Thoman, 2013), children find themselves once again caught up in a culture of silence, as such an environment is ride with factors that inevitably hinder their ability to testify, such as a stressful atmosphere an intimidating demands from forensic professionals (Caprioli & Crenshaw, 2015).

In addition to neurobiological changes in response to traumatic memories, when a witness takes the stand, they may experience freezing and dissociation as a means of emotionally protecting themselves from intense cross-examination, which often involves aggressive and intimidating pressure (Caprioli & Crenshaw, 2015). Selective mutism is an anxiety disorder characterized by a child's inability to speak in social settings such as school, even though they do not experience these difficulties in other environments, such as at home (APA, 2013; WHO, 2018).

Jacobsen (1995) recounts the story of a 15-year-old boy with a history of physical and sexual abuse during childhood who, from an early age, was reluctant to speak, a condition that worsened upon entering high school. "He denied that he felt discomfort in speaking at school, insisting instead that he had nothing to tell" (Jacobsen, 1995, p. 863). During therapy, depressive symptoms, social fears, and brief dissociative states were also observed, and it was only through the use of drawings that he revealed how various conflicting voices existed within his mind. His amnesia caused by his past, the emergence of multiple identities and

voices, and different ways of relating to himself and his surroundings led to a diagnosis of dissociative identity disorder. The therapeutic intervention aimed to uncover what lay behind the suppression, calming the identities, encouraging them to bring forth memories and feelings linked to past traumas, and assuring them there would be no consequences for giving voice to them. Once trust was established, the identities revealed everything and the adolescent began to make progress both in school and with his peers. Therefore, it appears that it was the identities that presented the boy from speaking, intimidating him into not revealing details about the murders he had witnessed as a child (Jacobsen, 1995)

In order to enhance interpersonal functioning, each personality voice has the right to be acknowledged and heard, even though some go to great lengths to choose the path of silence and secrecy. However, this journey toward self-awareness, collaboration, and respect among the alter egos takes time. Calland (2022) described how, during her sessions with her patient Marie, "a professional black British Caribbean woman of 40" (p. 77), she felt a desire to free a part of herself that was like a child, a part she felt was trapped, but the silent personality of this child seemed to have taken complete control of her body. It is now widely recognized that a treatment for DID that integrates body-centred and mindfulness-based approaches is effective (Ogden & Fisher, 2015; van der Kolk, 2014; Forner, 2017). It was only when Calland provided her patient with paper and pencil that she was able to give voice to themself, saying, "it feels like the boxes contain snakes, and I'm afraid to open them: they might bitte and poison me or numb me with depression" (Marie's drawing (detail), 2006, untitled, author's archives). Marie had always believed she was crazy, as she had always lived with indistinct voices in her head, and it was only after four years of weekly therapy that she began to recognize each of her alter egos' voices and talk to them, distinguishing her daily life from their past experiences (Calland, 2022).

3.3.3 Gender differences in disclosure

"To say it out loud is to kill your own childhood" (Halvorsen et al., 2020, p. 3). Although the disclosure of CSA is a topic to which both researchers and governments pay close attention, it remains a complex process in which reported incidents and those actually experienced conflict (Hillis et al., 2016; Stoltenborgh et al., 2015), to the extent that even Gries and colleagues (2000) consider it "a dynamic rather than static event" (p.33), given that the victim may be inconsistent or may retract their account at any moment (Alaggia, 2005). Approximately 70% of CSA victims do not disclosure their experiences until adulthood (Lemaigre et al., 2017), while about 28% keep them to themselves (Ruggiero et al., 2004; Smith et al., 2000; Priebe & Svedin, 2008). In fact, research focusing on the latency of

disclosure reports a time span of 3 to 18 years during which the delay in disclosure occurs (Kogan, 2004; Lamb & Edgar-Smith, 1994; Oxman-Martinez et al., 1997).

Various factors drive the delay in disclosure, such as the child's age and gender, cultural dynamics, intrafamilial dynamics, and dynamics with the perpetrator, as well as the potential for repercussions on social support (Alaggia & Turton, in press; Everson et al., 1989; Fontes, 1993; Gartner, 1999; Goodman-Brown et al., 2003; Jonzon & Lindblad, 2004; Kogan, 2004; Paine & Hansen, 2002; Wyatt & Newcomb, 1990). Abused children usually do not come into direct contact with the police or social services (Cater et al., 2016; Jernbro et al., 2017; Lemaigre et al., 2017), but prefer to confide in their peers (McElvaney, 2015; Priebe & Svedin, 2008) and then, if necessary, to a trusted adult, who assists in the disclosure process (Augusti & Myhre, 2021; Many & Collin-Vezina, 2021). Simply telling someone is not enough, the presence of a listener is required (Brennan & McElvaney, 2020; Jensen, 2005). However, as revealed by some male and female participants in Alaggia's (2005) study, verbal disclosure can also be replaced by behavioural or indirect approaches.

Nevertheless, this process does not always have positive outcomes, as it can also be experienced negatively, depending on how others react to the disclosure (Tener & Murphy, 2015). Indeed, children may be blamed, not believed, and cause their family to break down (Paine & Hansen, 2002). A female participant in the study by Alaggia (2005) stated "I was removed from my family because my sister was sexually abused by our father. Even though he had sexually abused me, while I was going through the investigation, I never admitted to it. I didn't admit to anything until I was 12 years old [3 years later]" (p. 460). On the other hand, sharing can reduce stress, mitigate the hypervigilance associated with maintaining secrecy, and lead to appropriate treatment (Kelly & McKillop, 1996; Kelly et al., 1995; Vogel & Wester, 2003)

One obstacle to disclosure is that children often do not recognise their experiences as abuse (Halvorsen et al., 2020), as they are unable to recognise that they have been exposed to something wrong and to put that experience into words (Kolko et al., 2002; van der Kolk, 2005; Schönbucher et al., 2012; Teicher et al., 2016; Nordanger & Braarud, 2017). Furthermore, if the abuse is intra-familial, the likelihood of waiting more than a year before reporting the trauma is eight times higher (Magnusson et a., 2017), particularly if the abuser uses grooming as a strategy of exploitation (Wolf & Pruitt, 2019; Plummer, 2018). In this way, "these mixed and often confusing feelings showed that sexual abuse was not black or white in the experience of the participants, and this complicated the process of disclosing sexual abuse" (Halvorsen et al., 2020, p. 16).

The combination of age and gender may also play a significant role (Halvorsen et al., 2020). Girls take less time to report CSA than boys (Lippert et al., 2009; Easton, 2013; Easton et al., 2014) and, although the risk of not reporting decreases with age (Steine et al., 2016; Lippert et al., 2009), it is more difficult for boys to speak out if they are older (Easton et al., 2014). Smith and colleagues (2000) noted that 48% of the girls in their national survey had waited five years after the abuse before speaking to anyone about it, whilst 28% had disclosed their victimization exclusively during the research interview.

Feelings of guilt and shame, and the fear of not being believed but rather stigmatised, are some of the barriers that prevent disclosure among many survivors of CSA (Hershkowitz et al., 2007; Jensen et al., 2005; McElvaney et al., 2014; Crisma et al., 2004; Schönbucher et al., 2012; Reitsema & Grietens, 2015). Since ancient times, male victims of sexual abuse have received less attention, although several studies show that men are more frequently victimised than is commonly perceived (Dhaliwal et al., 1996; Holmes & Slap, 1998; Hunter, 1990; Lisak et al., 1996). The low rate of disclosure or reporting of such incidents reflects a persistent fear of appearing weak, of revealing possible homosexuality, and of being accused of instigating the abuse themselves (Dhaliwal et al., 1996; Romano & De Luca, 2001).

Indeed, if men decide to reveal that their abuser is of the same sex, there is a real concern that they will be perceived as homosexual (Alaggia 2005), due to social heteronormativity, which dictates how one should behave based on the notion that heterosexuality is the norm (Habarth, 2014). "This idea of being a passive victim goes against hegemonic norms of masculinity, which postulate that men should be dominant an aggressive" (Guyon et al., 2021, p. 808) and, as Gardner states (1999, p. 70), "the unrealistic internalized ideal of manhood" contributes to the stereotype that men cannot be victims of sexual abuse.

Moreover, men generally do not want to be seen as victims as it is labelled as a female and undesirable experience (Alaggia, 2005). Paradoxically, the fear of repeating abusive behaviour is both a reason for remaining silent about the experience of CSA and a motivation for speaking out about it, as one male participant states: "My kids were actually the biggest fear. That was my biggest fear, sexually abusing my girls" (Alaggia, 2005, p. 462). However, when their abuser is female, victims are often regarded by other men as 'lucky' for having had the sexual opportunity (Deering & Mellor, 2011), which further undermines the credibility of male survivors of CSA (Guyon et al., 2021).

If a woman is abused, it is common not to believe her or to assume she was asking for it (Alaggia, 2005; Alaggia et al., 2019). Marylin, a participant in the study by Guyon et al. (2021), reported that her mother blamed her for what had happened simply because of the

way she was dressed. According to the mother, "It was up to you to avoid parading in front of him in your short nightgowns" (p. 815), even though she herself had chosen her daughter's clothes. Melanie, on the other hand, had to deal with her father's violent aggression. He threw her against the wall, grabbed her by the throat and accused her of talking nonsense. Furthermore, as women have always been regarded as the flow that holds any family together and are therefore responsible for maintaining family bonds (Toner & Akman, 2012), their disclosure is further compromised (Guyon et al., 2021).

Although there is considerable awareness in the literature of gender-related barriers to CSA disclosure, in practice most studies involve female participants, effectively overshadowing the experiences of the opposite gender (Guyon et al., 2021). Male victims in the study by Guyon et al. (2021) admit to having been stigmatised for failing to take action against the abuse or for not speaking out sooner. Furthermore, while women felt disempowered when pressured to take legal action against the abuser, for men this occurred when they were asked to pretend that nothing had happened and even to judge their perpetrator, by the very person to whom they had confided. 15 men and 10 women felt ignored when they opened up to people they trusted, and faced with this kind of response, they felt they could only rely on themselves.

Halvorsen et al. (2020) also found, based on participant's accounts, that factors such as religion and the historical period in which they had grown up had a particularly significant influence on disclosure. In cultures, for example, where there remains a taboo against speaking openly about sexuality and where the importance of preserving the image of the perfect family is emphasised, this process is even more complicated (Alaggia, 2001, 2005; Paine & Hansen, 2002), but factors such as poverty, migration and discrimination also act as barriers to disclosure (Fontes, 1993).

Since the literature shows limited consensus on the factors that facilitate disclosure, it is essential to focus more on what helps victims, rather than on what merely hinders their opportunity to confide their experience (Brennan & McElvaney, 2020), as "delayed disclosure of sexual trauma signals the loss of a childhood free from victimization" (Alaggia, 2005, p. 454).

3.4 Fragmented bodies, plural sexualities: diversity in sexual behaviour

Sexuality is one of the core aspects of personal development (Kools & Kennedy, 2001). During childhood and adolescence each child develops a healthy sense of identity and

sexuality through interactions with peers, a process that is fundamental for fostering personal growth, awareness of one's sexual feelings, learning socially shared modes of sexual expression, and acquiring the capacity to form intimate relationships (Bukowski et al., 1993). Finkelhor & Browne (1985) emphasize that victims of child sexual abuse confront a traumatic and inappropriate sexualization, which consequently has repercussions on their development.

3.4.1 Sexual identity development and coming out

As a consequence of abuse, both men and women experience a loss of control over their sexuality and sexual orientation (Alaggia, 2005). However, the link between CSA and the sexual domain has been studied more extensively in homosexual men compared to those who identified as heterosexual. In these studies, the traumatic event was consistently correlated with a higher number of partners, multiple unprotected sexual encounters leading to sexually transmitted infections, and sexual activity in exchange for money and other benefits (Senn et al., 2008).

Having experienced abuse by a person of the same sex led the men who participated in Alaggia's (2005) study to remain silent so as not to confront homophobic/heterosexist attitudes perpetuated by society. One participant admitted:

> But I guess it's burning us to keep our mouths shut; it's you embarrassing… Well, you're going to think I'm a F— (faggot?). And I'm not. I had never heard the word homosexual in the little community I lives in. So I was quite devastated to understand it wasn't normal when that day these guys were telling me the facts of life. So the height of the flashbacks and stuff I didn't want to, um, I almost became homophobic because I was afraid that if I went outside, um, people would know something about me that I was gay (p. 461).

Although some men were homophobic for a period or manifested prejudices following the abuse, for those who later identified as bisexual or gay:

> The trauma of child sexual victimization by a same-sex perpetrator complicated the already complex process of coming out around their sexuality and their choice of life partners. Especially for the men who were homosexual, their first sexual experience being a traumatic one later contributed to sexual dysfunction (Alaggia, 2005, p. 464).

The women in the study who later identified as lesbians acknowledged that being abused by a man had created confusion regarding their sexual orientation. Nevertheless, they expressed

frustration about how people hastily insinuated that their sexual orientation had been determined by the negative experience with that man.

3.4.2 Risky sexual behaviours, behavioural addictions and psychopathological mediators

Engaging in an interpersonal relationship or any type of bond can be compromised if one has had a background of abuse (Homma et al., 2012). When abuse is perpetrated by family members or known persons, defensive barriers are dismantled and trust disintegrates (Saewyc et al., 2004), leading to two opposing scenarios: avoidance of any relationship due to fear of renewed victimization and constant urgency to have someone nearby, even if inadequate (Kendall-Tackett, 2002).

Sexual behaviour is jeopardized by the same neurobiological dysregulation and its effects on cognitive and psychosocial growth (Homma et al., 2012). The sense of powerlessness and low self-esteem impact the ability to openly discuss contraceptive methods with partners (Saewyc et al., 2004), leading individuals to view sex as a shortcut to receive affection (Wilson & Widom, 2008) and tending toward risky sexual behaviours (Smith et al., 2004) and ephemeral relationships (Briere & Elliot, 1994). The way individuals approach their environment is compromised, favouring a distorted perception of themselves and others, while paying less attention to protective behaviours such as contraceptive use (Abajobir et al., 2017).

Greater severity of abuse is associated with a greater tendency to engage in risky sexual behaviours, such as having multiple sexual partners (Merrill et al., 2003) and engaging in sexual relationships with people they have just met, which increases vulnerability to sexually transmitted infections (Walser & Kern, 1996). According to the traumagenic dynamics model by Finkelhor and Browne (1985), traumatic sexualization leads to the belief that sex is inevitable for ensuring affection from others. A further mediator is the type of attachment developed: in interpersonal relationships, insecure attachment translates into distrust toward others and reluctance to approach them (Fraley & Shaver, 2000), leading the individual to seek numerous short-term sexual relationships (Senn & Carey, 2010). At the same time, this type of attachment can result in such a desperate need for affection and closeness the subject is willing to undertake various risks to maintain the romantic relationship (Senn & Carey, 2010).

Despite the scarcity of studies, the literature suggests that the connection between sexual behaviour and abuse experience also depends on gender (Futterman e al., 1993; Mason et al., 1998; Zierler et al., 1991). However, the correlation between CSA and risky sexual

behaviours conducted by Abajobir and colleagues (2017) did not show gender differences. Previous studies also precluded gender comparisons, as they used to include only one gender in their samples (Senn et al., 2006). In their research, Senn and colleagues found that for both genders, the involvement of force and penetration during the abusive event increased the likelihood of engaging in sex trading.

In Saewyc and colleagues' (2004) study, a greater tendency was found for boys, compared to females, to pursue risky behaviours. Shrier and colleagues (1998) also found that more sexually abused men had multiple sexual partners compared to their female counterparts. In their sample, Jinich et al. (1998) reported that men who have sex with men indicated that the level of coercion experienced during abuse led to even higher rates of unprotected anal intercourse and elevated HIV seroprevalence. Fergusson and colleagues (1997) corroborate these findings, and in their study individuals with a history of sexual abuse involving penetration reported more than five sexual partners by adulthood, without using contraceptive methods, predisposing them to unwanted pregnancies and sexually transmitted diseases.

Since boys are typically perceived as independent and competent in personal relationships (Purcell et al., 2004), in the sexual domain it is presumed that they have a guiding role (Saewyc et al., 2004). Men often attempt to avoid disclosure, particularly when the perpetrator is of the same gender. One strategy is to establish a relationship with women or even become a father to camouflage everything that occurred (Saewyc et al., 2004, 2008).

Another significant factor is pornography, which is primarily associated with harmful sexual behaviours in children and youth (McKibbin et al., 2017). Its use is significantly correlated with violent episodes in both sexes, both at a young age and adulthood (Wright et al., 2016), but it has been evidenced that the male gender makes more use of it than women (Peter & Valkenburg, 2011). Prostitution can also be associated with a traumatic past; Zierler and colleagues (1991) identified that women had a four times greater likelihood of admitting to having been prostitutes. In addition, risky sexual behaviours are also correlated with problems such as alcohol consumption (Choudhry e al., 2014), personality disorders (Baams et al., 2014), aggression and antisocial behaviours (Epstein et al., 2014), depression (Orth et al, 2008) and lack of family support (Auerbach et al., 2011).

Moreover, studies support the idea that substance use also constitutes a key factor in the link between sexual abuse and subsequent risky behaviour (Senn et al., 2006), facilitating the choice to have more partners while disregarding the risk of sexually transmitted infections (Steele & Josephs, 1990). According to some studies, female victims tend to face pregnancies

(Trickett et al., 2011) and adolescent maternity (Noll et al., 2006), preterm birth (Noll et al., 2007), and other gynaecological problems (Sickel et al., 2002) in the future.

3.4.3 Compulsivity, fantasy and the dissociative process

'Compulsive sexual behaviour' is defined as the persistent failure to regulate continuous and intense sexual impulses or urges, which results in sexual attitudes that compromise normal functioning (Kraus et al., 2018). Masturbation, frequent use of pornography and intimate relationships with multiple unknown partners are generally socially accepted, but when manifested with excessive frequency and intensity, they can interfere with the individual's personal and relational life (Kuzma & Black, 2008).

The traumatic dynamics model (Finkelhor & Browne, 1985) promotes survivors of CSA's tendency to appropriate dysfunctional sexual scripts, setting convictions and decisions about sexual behaviours (Casto et al., 2019). Gold & Heffner (1998) suggest that sex primarily serves to reclaim the sense of control lost in childhood due to CSA, and the combination of CSA with other forms of abuse during childhood only increases the possibility of compulsive sexual behaviours (Meston et al., 1999; Schloredt & Heiman, 2003). Ferree (2002) reports in their sample 81% of men and women with a history of CSA, 97% emotional abuse and 72% physical abuse.

Furthermore, CSA is linked to feelings of shame and guilt during the relationships, decreased sexual desire, and orgasm and excitement disorders in both genders (Lisak & Beszterczey, 2007; Loeb et al., 2002; Najman et al., 2005; Price, 2007; Walker et al., 1999). Consequently, compulsivity and sexual avoidance (Aaron, 2012; Colangelo & Keefe-Cooperman, 2015) can coexist, generating a situation of sexual ambivalence (Noll et al., 2003; Vaillancourt-Morel et al., 2015) with varying relevance (Herman & Hirschman, 1981).

Few studies have focused on CSA and consequent sexual behaviour in males. While some results are consistent with those produced in studies on women (Senn et al., 2008), others can be somewhat contrasting. If for some authors men experience compulsive sexual behaviours frequently, while women prefer sexual avoidance (Aaron, 2012), for Långström & Hanson (2006) CSA led to hypersexuality more in women, while for Skegg et al. (2010) in men. However, gender differences may be merely a product of studies on CSB conducted exclusively on men (Blain et al., 2012; Forouzan & Van Gijseghem, 2005; Parsons et al., 2012). Meston and colleagues (1999) highlighted that among young women, experiences of sexual abuse are positively correlated with greater frequency of intercourse, masturbation, and fantasies, as well as more liberal and less restricted sexual attitudes and behaviours.

The problematic emergence of deviant behaviours in children tends to indicate further internalizing and externalizing difficulties (Allen, 2023a; Allen et al., 2015; Friedrich et al., 2003) and impairments in social interactions and emotional and behavioural dysregulation (Allen, 2025). Dissociative symptomatology, which can manifest during sexual experiences, may constitute a mechanism through which child sexual abuse contributes to increased risky sexual behaviours and vulnerability to sexual victimization, thereby reducing the individual's ability to recognize, process, and correctly express their own desires and personal boundaries (Mazinan et al., 2024).

Furthermore, several professionals who work with sexually abused minors support the idea that they are more likely to become abusers in adulthood (Salter et al., 2003). These same authors emphasize that intrafamilial violence leads the victim to transform into a potential abuser. However, in Glasser and colleagues' (2001) study, they discovered that the tendency to become abusers was greater when the original abuser was female rather than male.

Sexual fantasy plays a fundamental role in research on human sexuality, given its private nature and independence from the surrounding environment, as well as its importance for human sexual behaviour (Leitenberg & Henning, 1995). Specific images of fantasy can represent one's lived childhood (Friedman & Downey, 2000), thereby allowing for a better understanding of certain aspects of the development of human sexuality.

Research has highlighted that although there are not significant gender differences (Jones & Barlow, 1990), men are more inclined to experience dominance and behavioural initiative, rather than submission, in sexual fantasies (Bivona & Critelli, 2009; Knafo & Jaffe, 1984; Zurbriggen & Yost, 2004). The difference lies in frequency, given that men engage in sexual fantasies in greater frequency (Baumeister et al., 2001; Ellis & Symons, 1990), but also in terms of development. Indeed, generally, boys encounter their first sexual fantasies earlier than girls (Leitenberg & Henning, 1995), despite reaching sexual maturity much later than females (Wu et al., 2015). Leitenberg & Henning (1995) highlight that males experience sexual excitement and practice masturbation at an earlier age (Knoth et al., 1988) and more frequently (Meston et al., 1996).

Regarding sexual submission fantasies, these are more frequent among women (Knafo & Jaffe, 1984; Wilson, 1987), and Leitenberg & Henning (1995) questioned why this "preference" exists. One answer may be the traditional sexual script, in which having a more passive and submissive role during sex is attributed to the female gender, while the male role is represented by active and instrumental (Byers, 1996; O'Sullivan & Byers, 1993). Alternatively, one can focus on the gender difference in the prevalence of sexual abuse during

childhood (Leitenberg & Henning, 1995), which has led individuals to experience sexual submission as a form of sexual excitement.

Nevertheless, Byers and colleagues (1998) found that female students expressed their aversion to the concept of sexual submission. As a result of conditioned excitement due to traumatic sexualization, research indicates that women with prior experiences of CSA have a higher probability of reporting submission fantasies compared to other women (Briere et al., 1994; Gold, 1991), but it is not yet clear whether these fantasies are interpreted positively or negatively.

Furthermore, there is not enough research to establish the presence or absence of a correlation between CSA in men and cognitions of sexual submission (Renaud & Byers, 2006). The results of Renaud & Byers' (2006) study suggest that, although some women may be led to be favourable toward passivity and submission, more often these are considered merely hostile; conversely, these factors were perceived pleasantly and erotically by many men.

Conclusions

The aim of this thesis is to propose an integrated account that explores the traumatic dimension with dissociation without reducing the complexity of subjective experience to a simple causal connection. It does not treat CSA and DID merely as two separate phenomena, focusing on how childhood trauma can undermine a sense of safety, emotional capacity, and identity formation. Most specifically, when trauma occurs within a dysfunctional relational context, it can promote dissociative processes that, in some cases, contribute to the development of a psychopathological disorder.

In this view, dissociation appears as an extreme adaptive mechanism through which the individual attempts to survive an experience that cannot be integrated. Consequently, identity fragmentation should not be read only as a symptom, but also as a response to the profound disorganization produced by the traumatic experience.

A gendered perspective makes it possible to capture aspects often overlooked. Gender influences not only prevalence and the ways the experience is lived, but also its social representation, the courage to disclose, and clinical recognition.

The analysis across the chapters reveals a plausible and coherent relationship between CSA and DID. However, the shift from trauma to fragmentation is neither automatic nor uniform, and the work demonstrates that not all individuals exposed to CSA develop DID.

The importance of this subject lies both in its clinical relevance—improving diagnostic formulation and therapeutic intervention—and in its social and preventive impact. Fully understanding the traumatic history and individual factors in a comprehensive way underscores how essential it is to enhance early identification and protective policies.

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