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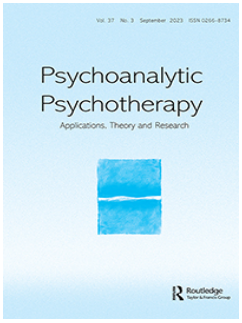

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# Dissociative identity disorder: a disorder of diagnostic and therapeutic paradoxes

Richard J. Loewenstein & Bethany Brand

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# Dissociative identity disorder: a disorder of diagnostic and therapeutic paradoxes

Richard J. Loewenstein[a]* and Bethany Brand[b]

[a]*Psychiatry, University of Maryland School of Medicine, Baltimore, MD, USA;*
[b]*Psychology, Towson University, Towson, MD, USA*

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Dissociative identity disorder (DID) is life-long, childhood-onset, posttraumatic developmental disorder where chronic early-life maltreatment and attachment disturbances prevents the child's development of a continuous sense of self across emotional states, relationships, and social contexts. As development proceeds, these self-states acquire a sense of themselves, a capacity for information processing, memory, emotion, and behavior. Conceptualizing DID involves paradoxes and apparent contradictions. DID has been categorized as a severe mental illness with major psychiatric comorbidities. Studies show that DID individuals have a unique personality organization with repeated, often covert posttraumatic reactivity, especially in relationships (e.g., therapy). Paradoxically, research shows that, during development, DID individuals preserve psychological resiliencies consistent with responsivity to long-term, psychodynamically informed treatment. These include, when not stressed, capacities for therapeutic alliance, reality testing, and observing ego.

**Keywords:** Dissociative identity disorder; trauma; posttraumatic stress disorder; transference; countertransference; psychoanalysis; developmental trauma; psychological organization

## Introduction

Dissociative identity disorder (DID) is a potentially life-long, childhood-onset, posttraumatic developmental disorder where chronic early life maltreatment, trauma, and attachment disturbances prevent the child's consolidation of a continuous sense of self across emotional states, relationships, and social contexts. As development proceeds, these dissociative self-states acquire a sense of themselves, a capacity for information processing, memory, emotion, and behavior. This paper is an introduction to dissociative identity disorder (DID) and its conceptual and clinical links to psychoanalytic[1] thinking. We argue that successful treatment of DID requires a psychodynamically informed psychotherapy and DID should be of major interest to psychoanalysts.

The relationship between dissociation, dissociative disorders (DD), dissociative identity disorder (DID), and psychoanalysis is long, fraught, and mostly conspicuous by its absence. DID is a condition of multiple clinical

*Corresponding author. Email: rjloewensteinmd@gmail.com

and theoretical ambiguities, paradoxes, and even apparent contradictions, and these must be held in one's mind to make sense of the disorder, or to at least to accept a level of ongoing cognitive dissonance. Among these is that, despite its classification as a severe mental illness with significant co-morbidities and disability (Johnson et al., 2006; Loewenstein, 2018; Loewenstein et al., 2017; Mueller-Pfeiffer et al., 2012), psychoanalytic concepts (therapeutic alliance, therapeutic frame, conflict, defense, transference, countertransference, observing ego, intersubjectivity, projective identification, negative therapeutic reaction, regression in the service of the ego, etc.) are foundational in informing successful DID treatment. However, at the same time, in order to accurately conceptualize and work effectively with DID, psychoanalysts must incorporate domains of knowledge from several literatures outside virtually all schools of psychoanalysis, such as non-psychoanalytic views of the mind, hypnosis/hypnotherapy, developmental traumatology, as well as approaches to the therapy that may feel alien, uncomfortable, and even heterodox.

Very few graduate mental health programs provide any training in dissociation/DD. In the authors' experience, there is usually *minimal training in PTSD in these programs*, despite the ubiquity of celebrity 'tell all' accounts, plays, novels, TV series, and movies where trauma (child maltreatment, rape, trafficking, combat trauma, etc.) is central to the story. Also, there is a burgeoning money-making industry of 'trauma experts' giving in-person and online trainings – and even offering 'certification' typically in their own copyrighted, non-academically studied methods – for diagnosis and treatment trauma-and-stressor-related disorders, including DID.

This is unfortunate as the US lifetime prevalence of PTSD is about 6–7% (3.6% in men, 9.7% in women), with rape, sexual assault, and physically violent attacks the most likely to produce PTSD (Kessler et al., 2005). International, general population epidemiological studies show that the 1-year prevalence of DID is 1.5%, with a lifetime prevalence possibly as high as 3.5% (Loewenstein, 2018). The US National Comorbidity Study Replication (NCS-R) found that the one-month prevalence of pathological dissociation (PD), severe dissociative symptoms consistent with diagnoses of DID, dissociative amnesia (DA), and severe forms of depersonalization/derealization disorder (DDD), was about 4.8%; this is consistent with a large, prospective Finnish general population study that found about 3.5% prevalence for PD both at baseline and 3 year follow-up (Simeon & Putnam, 2022). In the NCS-R study of PD, multiple forms of childhood maltreatment (physical, sexual, and emotional abuse, neglect), suicidality, and psychiatric hospitalizations strongly correlated with PD, but not with other diagnoses in the NCS-R. Also, it is unfortunate that, with the ascendance of behavioral and psychopharmacological models in psychology and psychiatry, few mental health training programs give more than cursory attention to psychoanalytic concepts, typically as part of a 'survey' of different treatment models (CBT, psychodynamic, etc.).

## Brief introduction to other domains of knowledge important to understand dissociation and DID

### *Discrete Behavioral States Theory (DBST), development, and dissociation*

DBST is a transtheoretical, translational *theory of human consciousness*. DBST elucidates human experience across myriad normal and pathological domains. DBST helps align many apparently different conceptual domains (e.g., understanding human development, mind/brain/body relationships, and psychopathology, and is particularly helpful in understanding DID). For extensive discussions, the reader is referred to Putnam (1997, 2016), and Loewenstein and Putnam (2022). DBST can unify understanding of many aspects of normal and pathological human functioning [e.g., emotional states; daydreaming; eating; toileting; artistic states; work states; private states; group states (e.g., at a concert; peak experiences, etc.)]. Psychoanalyst Mardi Horowitz (1979) has written about the process of psychotherapy using a behavioral states model. Transdiagnostically, most psychiatric disorders can be conceptualized as 'state-change' disorders (e.g., mood disorders, anxiety disorders, substance use disorders) as well as self-destructive, suicidal, and high-risk behaviors that attempt to modulate negative states. In particular, DBST synthesizes theoretical and clinical conceptualization of psychological trauma, dissociation, and trauma-and-stressor related (TSRD) and dissociative disorders (DD) as paradigmatic state-change disorders.

The study of infant states, the child's development of more complex states, and the co-regulation of caregiver and infant/child states is a transtheoretical model to account for normal and pathological development. DBST underlies a developmentally informed model of DID as a posttraumatic developmental disorder where extreme, malevolent, unpredictable early life traumatic states and attachment pathology interfere with the development of a unified sense of self across states, relationships, and contexts.

### *Hypnotic capacity and hypnotizability*

'Hypnosis' is a 19th century misnomer for a partially genetically determined capacity for inner focused attention, reduced peripheral awareness, and responsivity to hypnotic suggestion (Elkins et al., 2015). Hypnotic states are a subset of DBS. Kluft (2018a, 2018b, 2018c, 2019) has written the definitive psychoanalytic and intellectual history of Freud's views of hypnosis and recommends a rapprochement between psychoanalysis and the hypnosis field. There is a non-normal distribution of hypnotizability in the general population, with a small group of high hypnotizables in the 'tail' of the distribution. DID individuals naturalistically manifest the highest hypnotic capacity of any clinical group. They shift in and out of auto-hypnotic states in their daily lives (Loewenstein, 1991). The expert consensus guidelines for treating DID indicate that, because of this, *no* treatment of DID occurs without hypnosis (Chu et al., 2011). Training in hypnosis can be immensely helpful for clinicians to track auto-hypnotic

phenomena during therapy, and to provide psychoeducation about what DID patients may experience as distressing dyscontrol.[2] Therapeutic hypnosis is not a treatment, but a set of techniques that facilitate treatment. Hypnotic interventions for DID can be used throughout treatment to facilitate symptom reduction, both in therapy and by the patient using self-hypnosis to manage symptoms outside of therapy; improved internal cooperation, communication, collaboration, and empathy among self-states; to facilitate safe, paced processing of trauma memories, and for assistance with unification of self-states (Kluft, 1989, 1992, 2018a, 2018b, 2018c, 2019).

### *Trance logic*

'Trance logic' is characteristic of highly hypnotizable people in deep trance. The person limits cognitive dissonance by acknowledging both outer reality as well as their hypnotic reality. In DID, the trance logic concept can clarify how the DID individual tolerates logical contradictions between profoundly divergent beliefs, as well as imaginative, secondary structuring of self-state systems, that logically could not coexist in a single human being. It is best illustrated by example; a DID patient presented in therapy as a self-state insisting it was 20 years earlier. When told the correct date, she said, 'Oh Wow! We're in the future!'

## ***Betrayal trauma theory***

Betrayal Trauma Theory (BTT) and attachment theory, particularly of Type D attachment patterns, are related ideas and inform the work with DID patients. Type D attachment patterns (disoriented- disorganized) in infants are associated with maternal dissociation and abusiveness, and result in adolescent and adult dissociation, as well as other behavioral problems (Putnam, 1997, 2016). To briefly summarize type D attachment theory, infants may experience a type of 'fight-flight' responses to an unpredictably 'frightening' and/or 'frightened' ('hostile-helpless') caregiver. In the Strange Situation paradigm, type D babies exhibit contradictory attachment responses/relational states or dazed trance states in response to reunion with the mother. This has been called 'fright' or 'fear without solution'; the child desperately needs the parent yet pulls away in fear or goes into a trance state to tolerate connection with the mother. Primate survival requires attachment; infants will produce attachment behavior most likely to be successful with disturbed caregivers (Putnam, 2016). Attachment requires dissociation of the attachment schema from those with awareness of the dangerous parent.

A DID patient captured these conflicted attachment demands, 'It was really hard to attach to people who were trying to kill me'.

Originally, BTT was developed to assess whether delayed recall of childhood maltreatment was not only related to the extremity of the trauma, but to other

factors. BTT is a cognitive developmental analogue to Type D attachment. Here, due to frightened/frightening abusive caregivers, the developing child must separate schemas for attachment from schemas for betrayal (maltreatment). BTT is associated with higher dissociation, higher rates of dissociative amnesia, and more physical symptoms in trauma survivors (Loewenstein et al., 2017).

### *Shame and the psychotherapy of DID*

Therapists should develop competence in recognizing, understanding, and working with shame as it is universal in all patients, but is particularly endemic and pervasive in posttraumatic disorders, and is a dominant, profound presence in all aspects of DID treatment (Kluft, 2007, 2016; Nathanson, 1992). Shame is typically universally conveyed with eyes averted, head and body bowed, body slumped, and/or hands over the eyes, hair over the eyes; there may be halting speech, nervous laughter, and almost all forms of negative self-talk are shame based (e.g., stupid, weird, freaky, a mutant, a coward, horrible, needy – often the most shame-filled term; Herman, 2011; Loewenstein, 2022). Nathanson follows the model of Tomkins (see Nathanson, 1992) that there are 9 universal, biologically and genetically based affects that can be cross-culturally observed. These include interest-excitement; enjoyment-joy (related to pride); a 'neutral' state, surprise-startle that ablates the current affect and orients the person towards a stimulus that may require a different response; fear-terror; distress-anguish; anger-rage; disgust; dissmell[3]; and shame-humiliation. To briefly summarize a complex discussion, by the time we are adults, these basic physiological affects have become organized around myriad past experiences with each of these organized into 'emotions'. For example, a patient described shame as a 'magnet'. When he experienced it, it brought up an excruciating multi-sensory library of past shame experiences. Nathanson proposed the existence of defensive 'scripts' that attempt to moderate adverse emotions, in particular, shame. Nathanson describes a 'compass of shame' scripts including self-attack (self-shaming); avoidance (including cognitive avoidance, but particularly drug and alcohol use, nonsuicidal self-injury, high-risk behaviors, etc.); withdrawal (related to avoidance, but a literal or psychological 'leaving' from the shaming situation), and attack the other (bullying, intimate partner violence, sexual violence, etc., where humiliation/mortification is the delivery system for power, dominance, and control).

## Dissociative identity disorder (DID)

DID is the most severe, chronic DD, and, in addition to self-state formation manifests symptoms of all other DDs (e.g., dissociative amnesia, depersonalization/derealization, as well as spontaneous trance and auto-hypnotic symptoms, among others).

### *DID and trauma*

Multiple studies show that individuals with DID have the highest rates of childhood maltreatment of any clinical group in psychiatry, typically exceeding 90% for all types of abuse (Loewenstein et al., 2017). In general, maltreatment includes multiple episodes of physical, sexual, emotional abuse; often accompanied by emotional, physical, and medical neglect. Substantiation of trauma reports in DID includes a study of DID children that documented over 90% substantiation of maltreatment by social and medical services (Hornstein & Putnam, 1992); Also, detailed documentation of trauma was found in a forensic case series including documentation in school, medical, and social service records of extreme, often nearly homicidal maltreatment, by caregivers; adult scars that correlated with specific childhood maltreatment events; and evidence of severe childhood dissociative symptoms that had been misdiagnosed or ignored throughout life (D. O. Lewis et al., 1997). Case series have documented relatives' later-life admissions of being aware of and/or witnessing previously denied maltreatment in their DID-diagnosed family members (Kluft, 1998).

### *What DID is NOT*

DID is not a splitting or shattering of some stable aspect of a person's psyche, which breaks down into other 'parts' as a protection against the impact of trauma. Our language about the mind is *metaphorical*, and these metaphors can implicitly determine our theories of mind, and, in turn, our understanding of patients (e.g., terms like 'sequestration' or 'compartmentalization' of trauma in DID does not refer to little structures with doors in the DID brain where trauma memories are stored). Talking about the mind and DID inevitably requires physical *metaphors* that some of which concretize and reify the mind, e.g., 'splitting', 'compartmentalization', 'structure', etc. Kluft conceptualizes DID self-states as 'structured defensive processes'.

In psychoanalysis, the conflation of 'splitting' mental 'structures' in dissociation may have been pre-figured in Freud's paper on 'the Ego and the Id' referencing 'splitting of the ego' (Freud, 1923). There is a similar use of the splitting metaphor for dissociation/DID in writings in the hypnosis and other psychological literatures as well as the popular media ('split personality'). This metaphor contributes to a persistent, concretized, reified, and fundamentally misleading way of conceptualizing DID. Because we think or feel that DID individuals are 'split', or they say the 'feel fragmented, split up', we have reified the mind as if these metaphors are conceptually correct.

A tenacious hold on the splitting metaphor makes it harder to shift paradigms. Clinicians should open their minds to a different view, rather than trying to stuff dissociation/DID into the splitting concept, where it does not fit (block that metaphor!). Process metaphors better approximate DID phenomenology (e.g., division, disconnection, discontinuity, detachment, distancing, duplication/reduplication, polarization, systemization,

etc.). Some structure metaphors are inevitable (e.g., compartmentalization, sequestration, layering) but notice these metaphors are not those of 'horizontal or vertical splitting' or that the DID mind is made up of 'parts', another physical, reified, mechanistic metaphor. This term has been widely promulgated by the neo-Janetian *structural* dissociation theorists (Van der Hart et al., 2006; italics added) with DID self-states defined as 'dissociative parts of the personality'.

*Reification of DID as 'separate people in one body'*

For more than 40 years experts in the field (e.g., the authors of this paper, Richard P. Kluft, M.D., Ph.D, Frank Putnam, M.D., David Spiegel, M.D., all editions of the International Society for the Study of Trauma and Dissociation (ISSTD) Treatment Guidelines for Adults with DID, the DSM-5-TR, et al.) have explicitly written that DID is *not* a condition of separate 'people', but a disorder of subjective self-division that may be more, *or typically less*, secondarily personified and elaborated with different names, descriptors, etc. (Brand et al., 2016; Chu et al., 2011; Kluft, 1992; Loewenstein, 2020; Loewenstein et al., 2017; Loewenstein & Ross, 1992; Putnam, 1992; Spiegel et al., 2011). For example, Kluft (1992) states that 'It often is difficult to keep in mind that although the alters are not separate people, *they do embody different personified adaptive strategies and are guided by and express very different attitudes toward one another, significant objects, the treatment, and the therapist*' (p.149, italics added).

Further, all of the above, as well as the DSM-5-TR definitively state that these elaborations and personifications are *not essential to the diagnosis of DID, and are related to myriad complex socio-cultural, psychodynamic, defensive, and other processes*. These secondary elaborations can be conceptualized as the 'identity' aspects of DID (e.g., age, gender identity, sex, religion, ethnicity, profession, etc.). The expert consensus is that the DID human being/person is held responsible for all behavior, even when disavowed by amnesia, lack of control, or the agency of another self-state. Also, the consensus is that holding the DID person responsible for behavior is crucial for therapeutic progress, and to do otherwise invites regression and therapeutic impasse (Beahrs, 1994; Kluft, 1993; Loewenstein, 2020).

It is the critics of the trauma/dissociation concept that have focused on these media-based stereotypes, often to caricature the DID concept, as well as that of delayed recall of trauma memories (P. McHugh, 1995). Some have been outspoken, hostile critics of psychoanalysis throughout their careers and have specifically blamed 'Freudian' theories of 'repression' for 'the epidemic' of supposed therapeutically confabulated trauma memories and 'iatrogenic' DID (Crews, 1995; P. R. McHugh, 2008).

***OK, so what is DID, already?***

Lose the picture of the shattered, split mirror.

Instead, picture a never-put-together jigsaw puzzle with all those clearly formed and boundaried pieces – often shaped and colored subtly differently from one another – lying on top of each other in the box, with the box completely full of pieces. That is a more realistic image to get the diagnostic, clinical, and psychodynamic 'feel' of DID.

When Dr Loewenstein lectures on DID, he uses (with permission) artwork by DID patients. We wish the reader could see these, as they illustrate the psychological organization of DID in ways that transcend words. Whether the artist has formal training or not, the pictures are highly complex, often filling the entire paper with myriad forms. Frequently, the art depicts subtly overlapping, but carefully *boundaried* human faces, mouths, eyes, sometimes partly hidden bodies, hands, feet, words, shapes, as if all these human entities were flowing across, overlapping around, behind, below, and above one another.

Sometimes, the art is not representational but depicts multi-colored shapes, often with similar complex relationships, again, drawn with careful boundaries around each shape. Other art works may depict multiple personified representations, also organized beside, above, below, around one another, talking with one another, with larger beings looming in the corner, etc. The clarity of the boundaries, even with all the apparent overlap of the images is striking.

These images evoke striking aspects of the paradoxical nature of DID. DID patients produce these highly complex, often obsessionally detailed, strikingly boundaried artistic creations, even when overwhelmed, decompensated and hospitalized with severe PTSD symptoms (e.g., flashbacks in multiple sensory modalities, nightmares disrupting sleep; confusion of past/present, disorientation to the present); dissociative symptoms (e.g., rapid, dysfunctional shifting/shifting of self-states, ongoing dissociative amnesia, confusion, dissociative hallucinosis of self-state voices); and in acute safety crises (e.g., struggling with nonsuicidal self-injury; suicidal impulses, urges, and plans; eating disorders). Data from studies using structured diagnostic instruments show that when DID patients meet BPD diagnostic criteria, they are typically decompensated, and most no longer meet BPD criteria when stabilized (Ross et al., 2014; Sar et al., 2017).

Conversely, there is a literature on a subgroup of BPD with high dissociation scores on self-report screening measures (Schmahl et al., 2013). They differ from non-dissociative BPD patients in a number of ways, including poorer response to standard BPD treatment models (Kleindienst et al., 2016). Studying BPD patients with diagnostic measures for DD finds a substantial subgroup (50% or more) that meet diagnostic criteria for DID or DA (Korzekwa et al., 2009; Sar et al., 2014). Rather than DID being a variant of BPD, DID is a categorically different disorder with (discussed below) a significantly different personality organization. Indeed, the data suggest that BPD patients, especially those with dissociative features, should be screened with diagnostic inventories for DD/DID.

### *DID and developmental trauma: an etiological discussion*

DID is most accurately described as a childhood-onset posttraumatic developmental disorder where the traumatized child – with a genetic predisposition to dissociate (Becker-Blease et al, 2004; Yaylaci, 2017) – cannot complete the normal developmental processes that establish a unitary subjective sense of self that typically occur before the age of 5–6 (Putnam, 1997, 2016). Traumatic experiences – particularly repeated, malevolent, unpredictable maltreatment perpetrated by caregivers produce extreme, overwhelming states. Also, abusive parents usually provide little or highly inconsistent soothing and restorative experiences. Thus, the child is left to attempt to recover from these states, typically by a global dissociative shut-down.

Repetitive extreme traumas and dissociative shutdown states are compounded by targeted betrayal, blame, double binds, and attacks on the child's sense of self, if not the child's entire reality. Typically, these parents (and/or other perpetrators) blame, mock, and humiliate the child for being distressed, hurt, helpless. Almost universally, they blame the child for causing the maltreatment, often for contradictory reasons: punishment for being 'bad', or a reward for being 'good'; the child is 'seduced' by the adult; the act was done to clean the dirty child; the child wanted it, needed it, asked for it, etc. Abusers may insist that the child's distress should be suppressed, and/or the child cannot be distressed since 'nothing happened', and/or the child needs 'to forget' what happened – sometimes actually (with and without awareness) using hypnotic commands for amnesia.

Mostly, DID children are not 'abused'. They are tortured, often with extreme, systematic, sadistic calculation.

Some DID individuals report an early childhood history of multiple painful medical/surgical procedures that they endured with little or no comfort (e.g., repeated genital surgeries). These patients typically report being left for long periods of time in the hospital without their parents. Others describe maltreatment by staff in addition to the medical/surgical issues, including sexual, physical, and emotional cruelty (e.g., a nurse saying, 'if you don't stop crying, you'll never see your parents again!'). Others have been described as experiencing extreme wartime/terrorism-related trauma, including kidnapping by armed groups, and being forced to act as child 'soldiers' or sex-slaves, etc. (Draijer & Van Zon, 2013; Kelly et al., 2016).

These myriad assaults, and the attachment disturbances these produce (typically consistent with type D attachment pathology), interfere with development of normal metacognitive processes (typically during ages 1–6) that assist with the consolidation of a unified sense of self across different relational (e.g., with parents, siblings, others); social (e.g., at school, at home, with peers); and emotional states (e.g., excited, humiliated, enraged). The DID child often experiences further discontinuities between the reality of a chronically dangerous, unpredictably violent, sadistic home life and the insistence that the family appear to be 'perfect' in the outside world (e.g., at church, school, public

events). There may be additional disconnected realities: with friends and friends' families, where sometimes the DID child is amazed to experience a 'normal', non-violent, actually caring family environment. As the child gets older, there may be more disconnected 'realities' at camp, athletics, etc.

### *Type D Attachment and Betrayal Trauma*

Data on type D attachment and BTT help with additional understanding of self-state formation. Faced with the problem of attaching to caregivers who are at times profoundly abusive (typically *both* frightening and frightened), DID patients develop self-states that can experience attachment by dissociating betrayal, as well as self-states that experience and recall trauma by caregivers, and eschew attachment (Freyd, 1996). Maltreatment in DID often begins before the development of object constancy. The DID child may experience the nighttime abusive daddy as literally a different daddy from the daddy during the daytime – with self-states developing congruent with the 'different' parents (Putnam, 1997). DID patients report, as do most male and female childhood sexual abuse survivors, that males, particularly father figures were their most common 'primary' abuser. However, a substantial minority will report that maternal figures or other older females were the 'primary' perpetrator.

As described later, many different people, both male and female, may be perpetrators within the DID family, and/or outside it. In modal DID families with a male 'primary' abuser, the maternal figure is ultimately understood to be complicit in some way – from complete emotional or physical absence to active, ongoing involvement. Different self-states may already have developed to adapt to disturbed early attachment patterns with the maternal caregiver. Developmentally, additional self-states may arise in response to the ongoing experience of different 'mommies'. Sometimes one or both parents may also suffer with DID leading the child to develop self-states to attempt to congruently mirror the parents' self-states.

These patterns often continue into adulthood and can help understand how deeply attached some DID patients are to perpetrator caregivers, with some even continuing to experience incestuous abuse well into adulthood (Middleton, 2013). From a developmental point of view, the deeply attached self-states are life-saving. Normal human development cannot occur without some attachment experiences (Putnam, 2016). However, recovery requires that the DID patient live safely in the present. This means safety from dangerous relationships, including from members of the family or origin. This may involve a complex, grueling therapy process, with many attachment-based twists and turns.

### *Affect theory, shame, and DID*

In DID, and in other survivors of childhood maltreatment, attachment and humiliation can be experienced as literally simultaneous as attempts by the child to seek warmth, nurturance and comfort is responded to with emotional,

physical, and/or sexual violence; in its simplest form, 'I'll give you something to cry about'. Herman (2011) describes another aspect of the unwinnable predicament for the abused child in seeking attachment and comfort from cruel caregivers. Here there is a primal humiliation that fuses with attachment needs. Due to this bind of necessarily needing a caregiver for survival who is also endangering one's physical or mental survival, self-states may offer a solution. That is, self-states that dissociate betrayal are a tolerable method for being with the caregiver, typically in a humiliated, passive manner. Some perpetrators humiliate the child for being helpless. These states may become utterly convinced that they are all bad, so evil that they deserve nothing other than defilement, abuse, and punishment.

### *Self-states and self-state systems*

The basic developmental disturbance in DID is located in the self-systems, in varying discrete behavioral states of being where our 'selves' are organized. Thus, we posit that dissociative 'self-state' is conceptually, developmentally, and clinically far more accurate for the subjective self-divisions in DID than 'identity',[4] 'personality', 'alter', 'part', etc. Also, this counters the notion that there is a core mental structure in DID that is shattered, split into 'parts' or 'pieces'. DID patients will present with a central self/identity state usually with the legal name of the person. Even so, the above developmental model avoids the notion of the 'real person' and their 'parts'. Clinicians who hold the notion of 'the real person and their parts' miss that self-states are a complex, dynamic adaptation, not just symptoms. This may lead to a treatment focused on suppression or ablation of the parts (symptoms), with psychic hegemony by the 'real person' (Yalom, 1989). Usually, this results in a compliant outcome, patient flight, treatment stalemate, or a massive decompensation, as self-states fight against being ignored or 'killed off' by creating crises, engaging in unsafe behavior, etc., which in turn leads to more suppressive 'treatment'. DID patients commonly say things like, 'She *thinks* she's the "real one". Ha! We created her when we started high school, cuz we needed someone to function there'.

More accurately, our imagination can envision infinite possible 'selves' – a far more helpful notion for conceptualization, diagnosis, and treatment of DID. Sometimes, self-states' qualities, descriptors, and psychodynamic shaping have a childlike imaginative playfulness, yet simultaneously have grimly serious psychodynamic content based in surviving childhood torture.

In addition to malevolent people in the DID child's life, there may be positive people with whom the DID child can identify, if only briefly. This can include other caring, loving, supportive relatives, nannies, teachers, other children's parents, caregivers, neighbors, etc., as well as positive experiences with the parents (e.g., a DID parent with both abusive and fun-loving, seemingly compassionate self-states). These may be introjected and secondarily personified as benevolent, supportive self-states. The development of self-states/systems are adaptations to these many issues, not only 'trauma', but the relational and

emotionally tortuous ways the abuse is represented to the child. As Sullivan (1953) posited, self-state systems start to develop that reflect the myriad relational patterns of the DID individual's caregivers. Concisely, self-states develop that are congruent to the different 'multiple realities' with which the child interacts.

### *Later development*

Over time, the child's developing internal senses of self may come to reflect the dangerousness, disorganization, and conflict evident across the various relationships and environments with which they are involved. Some self-states may become subjectively personified and organize along independent developmental trajectories. In adolescence, the issues of separation and individuation, identity formation, sexuality, and autonomy from family are major developmental tasks. Dissociative adolescents have major difficulties with these, as well as attempts to move on from traumatic experiences (Kluft, 2000). These tasks may be complicated by ongoing intrafamilial violence, exploitation outside the home, as well as more positive and nurturing experiences (finding a safe friend with whose family the teen can stay). They may develop more complex and elaborated self-states and self-states systems to attempt to manage these challenges. Many of these may begin to manifest marked internal conflict, for example, self-states that deny that anything 'bad' happens in the family, and those who 'know'. This process can involve creation of self-states with different roles that may become more complex as these expand (e.g., 'school', 'home', 'church', 'friends'/different 'friend groups', et al.); intrapsychic and emotional functions (e.g., 'detached observer', 'angry one'); relationships to trauma (e.g., ones who 'know', ones who have no memory), relationship to ongoing abuse ('the sexy little boy', 'the whore'), and secondary elaborations (e.g., names, accents, wardrobe, hair style, behaviors).

DID may also be shaped by later traumatic experiences. DID patients report high rates of severe, multi-year, peer bullying, sometimes involving physical or sexual assaults. Bullying increases the DID child's trauma burden and often leads to more disconnection from others. Also, child abuse victims are more vulnerable to extrafamilial perpetrators who will preferentially seek out vulnerable children for sexual abuse. Thus, the typical adult DID patient reports additional extrafamilial sexual abuse with perpetrators including male and female teachers, coaches, guidance counselors, physicians, therapists, priests, nuns, ministers, rabbis, imams, deacons, et al. Some DID patients describe being trafficked in their families, and/or by organized criminal pedophile groups among extrafamilial perpetrators. Criminological research indicates three types of often overlapping organized abuse groups: in the community, in institutions (schools, religious institutions, etc.), and within families (Salter, 2013). DID individuals continue to be vulnerable to abuse and exploitation in adult life, including high rates of multiple sexual assaults, intimate partner violence, trafficking, etc. (see Loewenstein et al., 2017).

### *Self-state development and dynamics*

In the clinical examples that follow, we illustrate the complex nature the development of self-states/systems. There is no 'one' way to understand their psychodynamic organization. For example, one view is that DID is solely based in attachment disturbances; that self-states *only* represent aspects of highly changeable attachment patterns (Brown & Elliott, 2016).

Self-state formation represents myriad attempts to adapt, to survive, to live in 'multiple realities' at home and in the world, to manage relationships, and to try to manage to hold on to attachments to dangerous people. Some self-states are described as having limited, but important progressive developmental qualities; even so, these are tinged with themes of abuse and neglect. A DID patient reported that, starting when she was very little, she experienced self-states that 'came' to assist with developmental tasks that were interfered with by parental malevolence and neglect. One came to help her stop wetting the bed (she was beaten, made to stand outside for hours in her wet night clothes for enuresis). Similarly, she was tormented for sucking her thumb; another 'older one' came and helped her stop that. Another 'one' was described as coming to school to teach her how to tie her shoes (her parents ignored needs like this, and she already felt 'different' at school).

### *Trauma is not 'optional' for the DID individual*

The developmental life experience of the DID child is that it is not optional to experience humiliating danger, malevolence, cruelty, neglect, and betrayal from those on whom the child depends. *It is not whether the child is harmed, only when and how badly.* A major aspect of the life-long adaptation of the DID individual is the impossibility of avoiding being hurt, but 'making the least worst' of degrading, mortifying maltreatment, accompanied by betrayal at the deepest personal, social, institutional, and cultural levels. The core trauma/dissociation psychodynamics of the DID individual is to organize self-states and self-state systems around this postulate. Clinicians working with DID are more successful when they can decode this paradoxical 'logic' that explains symptoms, and most effectively leads to their resolution, by shifting 'survival' adaptations to 'recovery' adaptations. Seemingly intractable, dangerous, self-destructive behavior may be based on mitigating the effects of murderous childhood violence. One patient said, 'Hurting myself when I was a kid made my mother hurt me less, cuz I had "taken care of it" for her.' Clinicians who can think in terms of family-systems theory, general systems theory, etc. may find this a more comfortable way of thinking about DID. One DID patient's creative resilience is shown in the following. As long as she could remember, her icy, narcissistic mother repeatedly told her that 'nobody loves you' and 'nowhere is safe'. The patient created two self-states: 'nobody' who loved her; and 'nowhere' who was safe.

Observers have characterized the senior author's work with DID as, 'eclectic, psychodynamically oriented group and family therapy for one person'.

Similarly, Kluft (2000, 2007), following Kris (1982), describes that DID patients' dissociative amnesia is not based in memories being 'unconscious'. Rather, as in Janetian theory, the mind is made up of self-systems with distributed, conscious, state-dependent memory. Thus, as Kluft suggests, there is conscious withholding, 'reluctance' to share what is known, often due to shame, to 'protect' other self-states, and/or to perpetrator threats to maintain silence, etc. Accordingly, a clinician can struggle futilely to help an amnestic self-state recall what is missing (e.g., who went to Atlantic City last week and won $1000.00). Instead, one asks for those in the mind who know what occurred, even agreeing to the continuation of the protective amnesia (hypnotic trance-logical amnesia suggestion) for self-states who cannot tolerate knowing yet.

### *State transitions in DID: state switching; state shifting*

In the model of DID as highly elaborated 'separate people' in a split mind, another stereotype is dramatic switching with strikingly different presentations, like a parade of single people emerging from a revolving door. Marked switching to highly different self-state presentations does occur. However, it is often associated with poorer life adaptation, life problems, disability, and/or is a symptom of decompensation. In general, DID is characterized by subtle state shifting, where minimal overt changes occur in the person's demeanor, and to the extent this is recognized by others, it is primarily with the designation that the person is 'changeable', 'moody', 'bipolar', etc. The person's dissociative amnesia is often dismissed as being 'forgetful', 'getting dementia', 'being absent minded', etc. Actually, in many DID patients, most of the DID self-states *manifest intrapsychically*, and not in direct behavioral role enactments.

The neurobiological, developmental, phenomenological, clinical, and treatment outcome data all support a model of DID as the 'state of multiple, simultaneous states', organized as an overall self-state system, made up of multiple self-state (sub) systems. Phenomenologically, these are characterized by overlap, interference, influence, intrusion, as well as cooperation and coordination among self-states/systems; the latter to better manage life functioning. Dissociative amnesia during therapy is often related to subtle state shifting (sometimes called 'microdissociations'), and/or impingement on the surface self-states from the self-states 'behind them'. Much of the clinical presentation can be metaphorically described as the moment-to-moment summation of self-state 'vectors' that at a point in time in therapy result in a particular configuration of self-states/systems that are manifested intrapsychically.

One can conceptualize interventions at the level of self-states that present directly in 'person-like' ways: most often as interventions by 'talking over', that is, by asking for input from self-states/systems not on the dissociative surface (Kluft, 2005, 2006), as well as by directing comments to 'the whole mind', 'the whole human being'. Observers have characterized the senior author's work with DID as, "eclectic, psychodynamically oriented group and family therapy

for one person".The entire mind of the DID individual is not sub-divided. There are many functions, capacities and behavior that occur in a unified way. Kluft has metaphorically termed this a psychological 'double-entry bookkeeping system' (as cited in (Loewenstein, 2022, p. 774)). For example, in therapy, a DID patient was experiencing defensively motivated, continual anterograde dissociative amnesia, forgetting everything discussed in therapy as it occurred. This process was unresponsive to any clarification, confrontation, interpretation, etc. When, in frustration, her therapist asked, 'if you are unable to remember anything, how are you going to find your car in the parking lot when you leave?' She answered breezily and trance-logically, 'Oh, that's different'.

Also, there are issues that are unconscious in the classic sense, 'across the whole mind', often about global transference issues, that require interpretation of a number of different dissociated transference elements that lead to understanding of a broader transference pattern and its origins. Medications are not effective in DID patients if they do not treat psychopharmacological target symptoms experienced across the whole human being's mind.

***Clinicians often ask, 'Why would you work with self-states?' Based on the foregoing, the question really is: 'Why wouldn't you work with self-states?'.***

## More DID paradoxes, complexity, and ambiguity: the psychological organization of DID as viewed through psychological assessment

Our understanding of the psychological organization of DID originated in our collaboration with Judith Armstrong, Ph.D., and her pioneering methodology for psychological assessment of this population. She decided to study DID as a self-system, rather than following previous testing studies. She began by inviting, using the patient's own terminology, all 'divergent self-aspects' to participate in the testing (Armstrong, 1991, p. 536). Also, she asked to debrief the person afterwards to explore their responses to testing. This approach demonstrates why it is so important (and commonsensical) to work with all aspects of the DID person's mind in therapy. As with any other person, accurate assessment (or psychotherapy) is unlikely to be successful without the full psychological participation of the patient.

### *Traumatic content on the Rorschach*

Armstrong found that DID patients gave responses on the Rorschach that were filled with malevolent associations – imagery of aggression, blood, sex, and anatomy as well as morbid, damaged objects and people. Classically, this response pattern would have been interpreted as indicative of psychotic thought disorder. Armstrong realized that, to survive, the DID child had always to be alert for possible predictors of threat. These fear-based responses represented *accurate, survival-based reality testing*. She developed the Trauma Content score (sum of percepts of aggression, blood, sex, anatomy, and morbid divided

by the number of response; Armstrong & Loewenstein, 1990). Across studies, DID patients show an *average* of 50% of their Rorschach percepts contain Trauma Content (Brand et al., 2006). Trauma responses can also occur with other assessments. A bright patient performed well on the WAIS except for the block design. In the debriefing, she recalled being locked repeatedly by her mother in a toy box containing blocks.

### *Paradoxical resilience*

The trauma content on the testing was not the only new finding. Paradoxically, the psychological assessment research showed that DID is simultaneously a resilient adaptation that preserves and allows more normal development of important psychological capacities. We hypothesized that extreme forms of state-dependent learning might be at least a partial explanation linked to 'sequestration' of traumatic experiences that permits more normal development of adaptive, mind/brain capacities.

The psychological organization of DID is *highly complex and multi-faceted*. DID patients show higher cognitive complexity scores on the Rorschach than clinical and non-clinical subjects, including psychotic and borderline patients (B. Brand et al., 2009). This can become problematic when DID patients' defenses against continual profound trauma include elaboration of and overinvolvement in their inner worlds, a psychological withdrawal based on the belief that to 'be' in the world is too dangerous and toxic. Other differences include that DID patients have preservation of a capacity for good reality testing, when not posttraumatically activated/stressed; the ability to take distance on posttraumatic cognitive distortions; a capability to see relationships as possibly supportive, despite being exposed to extreme levels of betrayal and violence; a survival instinct and stubborn hopefulness; preserved creativity; and a highly developed capability to observe their psychological processes – observing ego capacity. In our data, the latter was significantly better in DID even compared to normal, non-clinical controls (Armstrong, 1991; Armstrong & Loewenstein, 1990; Brand et al., 2009; Brand et al., 2006). Some authors postulate that DID individuals lack the capacity for mentalization (Steele, 2009). However, this capacity can be observed in therapy, when the DID patient is not overwhelmed by posttraumatic responding. These adaptive and resilient capacities make it feasible for DID patients to develop a therapeutic alliance, and engage in insight-oriented, psychodynamically informed psychotherapy. Also, these capacities indicate DID patients' ability to successfully use metaphors and similes in therapy.

Additional findings include that DID individuals have *avoidant and obsessional personality feature*s, rather than the often-assumed histrionic personality structure. DID individuals rely on intellectualization with a tendency to try to back away from emotions. Intellectualization and the attempts at 'compartmentalization' of psychological experience fits with obsessional personality features. A subgroup of DID patients has trauma-based obsessive-

compulsive symptoms (e.g., 'If I always arrange things in my room a certain way, I will be safe'). Some meet diagnostic criteria for obsessive-compulsive disorder. Survivors of childhood trauma often attempt to exert rigid, obsessional control over themselves, their minds, and other people (e.g., the clinician). DID patients frequently show this pattern, especially in their often-stubborn reluctance to explore their inner experience, and in attempts to control the therapist and the therapy (Kluft, 1994). Like other obsessionals, DID patients feel better when they make sense of things. They respond positively (overall) with psychoeducation about their disorders and treatment. They experience marked relief when they make sense of behavior that otherwise feels shamefully out of control.

A patient described that she never could go to bed before 2 A.M. Over the years, she tried all kinds of 'strategies' for good 'sleep hygiene'; she tried 'will power', alcohol, street drugs, psychiatric medications, etc. The pattern never changed. Even if she went to bed before 2 A.M., she could not fall asleep until 2 A.M. Finally, when asked to reflect on this in therapy (note the observing ego and ability to think clearly here) she realized that 'When I was growing up, I figured out that, if, by 2 A.M. my father hadn't come into my room to attack me, he wasn't coming. So, I could feel safe to go to sleep. I found out that there were [self-states] that I didn't know about who were still trying to protect me by staying up. We did some internal communication together and they found they could stop living in "trauma time". They realize he's dead, we live in a safe place now and have a safe relationship, we don't have to keep the secrets. We can talk about things in therapy. And they can help us by helping decide when we want to go to sleep'. She said, 'I didn't like remembering that, but I am so relieved that I'm not crazy. This finally makes sense!'.

### *Multi-level responding*

Another paradoxical finding in the DID assessment research is multi-level responding, illustrating the 'state of multiple simultaneous states' phenomenology. For example, when asked for the definition of 'perimeter' on the WAIS, the patient said, 'I don't know'. At the same time, seemingly without awareness, her hand traced a circle in the air (Armstrong, 1994; Armstrong & Loewenstein, 1990). In another example, when a disorganized adolescent inpatient was asked how far it was from New York to San Francisco, she said, 'I don't know, but the lady in white says it's 3000 miles'. The 'lady in white' was a visual hallucination described as persecuting the patient from the corner of the room. In the first example, the sensorimotor responding was more sophisticated than the verbal responding. In the second, it was the hallucination that held the conflict-free information. These paradoxical phenomena are common in DID treatment and the patient's daily lives.

***Posttraumatic responding, psychological resilience, and dissociative defenses***

During psychotherapy, DID individuals typically experience continual multilevel, subtle, posttraumatic reactivity that can coincide with, and at times overwhelm the capacities for logical thinking and self-observation. Psychotherapy is an important attachment relationship; accordingly, traumatic reactivity will infuse the transference (and countertransference). This is consistent with the DID child's developmental experience of continual anticipation of unpredictable danger and threat from those on whom they relied, if not loved. Thus, overtly, or covertly, the basic, dominant transference themes are based in anticipated betrayal by the therapist, who will inevitably turn to the patient to get their narcissistic needs met, often in sexual ways, defined (see below) as *traumatic transference*.

For DID patients, attachments have only two possible outcomes. If the therapist does not betray and exploit the patient, the only other possible outcome is that the 'nice' therapist will abandon the 'bad' patient, typically precipitously. DID patients have been inculcated with the belief that their badness causes maltreatment and abandonment. In the abandonment scenario, the patient's badness overwhelms and drives away the therapist. Common distorted beliefs include that the therapist will blame the patient for abuse and shun the patient because of their badness. Also, there are fears of needing 'too much' from the therapist (and also that this could lead the therapist to abuse the patient); being 'too complicated' for the therapist to 'deal with'; having had 'too many bad things happen' that the therapist cannot tolerate hearing about, and so on. Often, DID patients will report that therapists *literally* have said these things to them, increasing their immense shame burden. Problematic and frankly exploitative psychiatric and psychotherapeutic encounters are common in the history of DID patients. This will compound the traumatic transference as the setting of therapy itself is now experienced as potentially dangerous.

*Defenses against trauma intrusions*

During Rorschach testing, some DID patients become frightened of the cards because the nature of the task pulls for traumatic material, thereby overwhelming their normal tendency to avoid and disconnect from trauma via dissociation. They may briefly lose their grounding in current reality, sometimes even have flashbacks during testing. Some individuals show biphasic PTSD-like responding. Here, neutral, or even pleasant images may be followed by traumatic intrusions – a process that may parallel the DID patient's developmental experience of something neutral or good, suddenly contaminated by danger, with dissociation as the only possible response. On testing, when the attempts at dissociative distancing fail, the individual may go into flashback, lose psychological distance and reality orientation, and even view the card itself as a literal danger.

The assessment research provides a structured way to observe these processes and illuminate what occurs in therapy. As trauma intrudes during psychological assessment, DID patients may attempt to avoid it by changing topics (maybe a result of a self-state shift), emotional numbing and detachment, dissociative distancing, sudden depersonalization/derealization, and autohypnotic strategies, or mixtures of these. Autohypnotic defenses can include hyperfocus[5] on tiny areas of the Rorschach card rarely noticed by other patients. Typically, this leads to highly detailed fantasy-based responses that serve to protect the individual from PTSD intrusions stimulated by the card ('that's the tiny, hidden entrance to a cave that is guarded by these two gargoyles who are making sure that no one can get inside the cave'). At another level, there are both a sexual-trauma, defensive image (small cave, no one can get inside), and multiplicity-based – and possibly scary- responses (two gargoyles). Multiplicity responses are also common in DID Rorschach protocols.

In another example, a man reported seeing a common image on the Rorschach, with good reality testing ('that's a bat flying'). This was followed by a personalized trauma content intrusion with perceptual distortions ('that's my dead cat that my dad ran over on purpose with his car'. The patient then appeared frightened to touch the card, as if it were a dangerous stimulus. He then said, 'a man's, uh, thing, going into someone's butt'), followed by an intellectualized and dissociative response in which the percept was seen from a distance, then a derealization response seeing the world at a distance, as if watching a movie ('now I see a spirit rising up into the sky, way above the clouds'). In follow-up questioning after completion of the Rorschach, the man showed some embarrassment about the 'weird, scary stuff I saw'. He shared that a traumatized child state reported the middle two percepts while non-traumatized, older self-states saw the two more benign images.

This response pattern may also occur during therapy. The patient may show good reality testing, followed by increasing flashback responding with decreasing reality orientation, then dissociative distancing (e.g., depersonalization), finally followed by an embarrassed detached disavowal. This shows some of the differences between DID and psychotic responding described in the literature and supported by data. Specifically, DID patients have distance from and are fearful of apparent psychotic or bizarre experiences (e.g., they are aware that hearing the voices of self-states is 'crazy' and they may feel shame reporting hearing voices). Similarly, the DID patient may respond with apologetic shame and distress over experiencing extreme trauma content. This contrasts with psychotic individuals who have delusional explanations for perceptual alterations and no ego distance on thought-disordered content (Laddis & Dell, 2012).

When more severely disrupted by traumatic material on testing, DID individuals lose distance and may go into full flashback. This is analogous to DID patients becoming increasingly activated by interpersonal trauma cues. They may engage the in kinds of defensive strategies as described during testing but may become increasingly unable to hold back posttraumatic intrusions. They

may enter a full flashback and lose reality awareness, and/or switch to self-states that embody trauma experiences and project these onto therapy and the therapist. Along with this, the patients lose access to their resilient capacities, including temporary lack of self-observation, poor reality testing, interpersonal reactivity, and severe trauma-based cognitive distortions.

The distortions, often about the therapist, may be so illogical that they appear delusional. Even during such times, they are 'quasi-delusional' in that there are often other self-states that can be accessed who retain intact reality testing and insight (Loewenstein, 2022). For example, when a woman with a Ph.D. was in a severely traumatized child state, she insisted that her dead perpetrator could still harm her because he threatened he would always be able to know, and 'if you tell anyone, I'll kill you'. Adult self-states retained awareness that this was manipulation intended to silence her and protect the abuser from being discovered. Nonetheless, it took repeated working through over months for the entire system of self-states to recognize she was safe from this man. This example illustrates that both the thought-disordered and reality-based thinking coexisted, but only attending to both allowed the reality oriented, insightful understanding to be integrated across self-state systems. This also exemplifies why it is crucial to work with self-states, as they are *resources* and not 'just symptoms'. Also, therapists need to learn how to help DID patients get grounded, and contain flashback material by active involvement in stabilizing the patient. A good introduction is the evidence-based, *Finding Solid Ground program* (Brand et al., 2022; Schielke et al., 2022).

### *Assessment research and differences between DID and BPD*

Based on the DID assessment research Armstrong (1991, 1994) reframed responses on the Rorschach that classically would have been conceptualized as 'borderline splitting'. Looking at the totality of the paradoxical data, she concluded that in DID, the concepts of trauma-based 'fractionation' and 'polarization' are more accurate than splitting. The DID child grew up in dramatically different realities: sometimes caregivers were nurturing and safe, yet these same caregivers unpredictably but inevitably turn vicious. This required the child to survive these incomprehensibly polarized experiences by developing self-states that could attempt to manage radically different parental behavior. Also, our neurobiological responses to danger and threat activate before the cortex – the 'thinking brain' – to provide automatic, instinctive responses without shades of grey (e.g., run immediately that way from the sabretooth tiger, don't sit and reflect on the size of the teeth). It would have been dangerous during experiences of life-threat, to perceive and think in 'shades of grey' such as 'My Mommy loves me but also chases me with a knife'.

In the Rorschach case above, the man could perceive others as collaborative and cooperative ('two women carrying a basket') yet also as malevolent and dangerous, followed by being able to step back, literally getting distance on the

trauma-based perceptions by seeing a kinder image of a spiritual figure that could 'rise above' the awful intrusions. On testing, Armstrong described how DID patients could step away from trauma-based responding, displaying some awareness of their contradictory responses. This is not typically possible for individuals with BPD.

Armstrong brilliantly captured fundamental differences between DID and BPD: 'Although the two groups share certain superficial similarities, a BPD patient can be conceptualized as one who has split outer reality into extreme polarities to protect his or her own psychic integrity. A DID patient can be understood as someone who has divided and compartmentalized his or her inner reality to maintain object-relatedness' (Personal Communication, October 1989, Baltimore, MD).

### *DID and observing ego*

The observing ego is essential for change-oriented, psychodynamic treatment. Almost all DID patients indicate they 'know' information 'intellectually', such as children are not responsible for abuse, but they will articulate, 'that doesn't change what I feel about myself' (i.e., shame and self-blame for trauma). Intellectualization can be defensive in DID treatment but worked with as a *beginning framework* from which to gradually erode entrenched trauma-based beliefs. Also, the obsessional personality features in DID make these patients responsive to using organizing concepts like this in goal setting for clinical work.

The multi-level responding patterns in DID mean that clinicians can, at times of decompensation, traumatic transference, and/or flashbacks, find self-states with observing ego and better reality testing, that may assist in making sense of what is going on and finding interventions. On the other hand, a controlling self-state may be consciously creating disruptions, e.g., 'causing the flashbacks' to 'keep her from telling secrets' which can be understood as avoidance of discussion of difficult memories and emotions. It may serve (in the traumatic transference) to prevent the patient from getting too close and being hurt by the clinician. Only by working with such self-states and identifying their paradoxical protective function, can these situations be fully resolved. For example, virtually all DID individuals report extremely dire threats to them or those they love if they 'tell'. First, one needs to make sure there are no *current, active threats* from perpetrators. If current threats are not present, then the therapist needs to carefully work through the fears before other self-states start to talk in therapy in detail about trauma experiences. In a classic psychoanalytic sense, one is working with the defenses before the genetic material. Overriding this type of protest and identifying too rapidly with 'talking about trauma is good', paves the way to more decompensation and disaster, without any useful working through of trauma.

## Phasic trauma treatment for DID

Consistent with treatment of complex trauma (Herman, 1992), treatment of DID follows a three-stage treatment model (Brand, McNary et al., 2013; Brand et al., 2019; Chu et al., 2011). The first stage emphasizes safety and stabilization and often requires years of treatment. The second stage involves the processing and grieving of trauma, although earlier in treatment, trauma is openly acknowledged and referred to, yet without detailed exploration or attempts to get to the full range of emotion and betrayal experienced. This stage often takes years due to the multitude of traumas experienced by DID patients, safety issues that arise during trauma processing, and the need to continue supporting daily functioning and managing internal cooperation among states. The third stage emphasizes greater integration within the patient as well as into the community, with less focus on trauma as issues related to relationships, career, and existential meaning take priority. In DID, some patients desire and achieve 'unification', that is, fusion of all self-states into a culturally congruent, non-dissociative self-system. 'Fusion' is a process where two or more self-states subjectively combine all their attributes, losing subjective seperateness. 'Integration', the process of undoing all forms of dissociative defenses, starts with any dissociative separateness, and continues after the last 'final fusion' (Kluft, 1988). Most patients achieve a 'resolution', that is, substantial decrease in dissociation, often with some fusions, and better functioning with more adaptive, coordinating self-systems with markedly less overt internal conflict.

### *Initial interventions and pacing of treatment (stage 1)*

DID treatment must be carefully paced so that the patient is not flooded with overwhelming emotions and dysregulated PTSD intrusions. Premature focus on detailed, affectively charged material will decompensate DID patients (Kluft, 2013). An overarching goal is working towards more cooperative functioning of self-states and more flexible control over dissociative and autohypnotic defenses. DID experts advise that attending to safety, emotion regulation, and management of dissociation and PTSD symptoms are crucial treatment targets in the first stage as well as throughout the treatment (Brand, McNary et al., 2013; Chu et al., 2011). Individuals with DDs indicate that they engage in self-injury in response to trauma-related intrusions, overwhelming emotions (most commonly shame states, as well as anger, sadness, and self-loathing), stressors, and severe symptoms including dissociation although, at treatment onset, few understand the reasons they engage in self-injury (Nester et al., 2022).

Research aligns with the expert consensus guidelines and expert surveys about the treatment of DID: treatment must address safety and guide patients in developing recovery-oriented methods for managing emotion, unsafe urges, and PTSD and dysregulated dissociative symptoms (Brand, McNary et al., 2013; Brand et al., 2019; Chu et al., 2011). Specialized inpatient or residential DID treatment that is consistent with the expert guidelines can

benefit patients, especially for major safety crises and decompensations (Brand, Classen, McNary et al., 2009; Ellason & Ross, 1997; Jepsen et al., 2014). Patients respond with significant improvement in safety and in many symptom domains to an outpatient psychotherapy combined with a dissociation-focused adjunctive psychoeducational program (Brand, Classen, Lanius et al., 2009; Brand et al., 2013; Brand et al., 2019). Patients and their therapists, who also participated in the study learn skills for managing unsafe urges, emotion regulation, and symptom management. It guides patients to learn the purposes of their self-harming and risky behavior, and to gradually identify and practice recovery-oriented self-regulation. In DID and other traumatized patients, self-destructive, high-risk, substance-abusing, and other dangerous behaviors *are used as regulators of overwhelming emotions, memories, severe symptoms, and relationship issues*. Interventions based on suppression of 'bad behavior', such as the unfortunately all-too common response from clinicians, 'I am so disappointed that you hurt yourself again', actually increases shame (and often covert anger) and will increase these behaviors.

The evidence-based program, *Finding Solid Ground*, encouraged the identification and working through trauma-based distortions about getting safer and using non-trauma-based self-regulation (e.g., shame scripts: 'I don't deserve to feel better', 'Letting down my guard is a trick and I will get hurt if I relax'; 'better to do it to myself first before I get hurt by someone else' etc.; Brand et al., 2022; Schielke et al., 2022). Books detailing this program are available (Brand et al., 2022; Schielke et al., 2022) as well as training in this model (topddstudy.com).

Among many initial interventions, clinicians can help patients develop distance from trauma. For example, when discussing trauma, clinicians can ask for trauma to be shared at the 'headline level', rather than the 'full story' with details that can cause cascading intrusive symptoms and flashbacks (Loewenstein, 2006). DID patients frequently experience 'emotional' flashbacks (Loewenstein, 1993, 2006), responding in extreme ways to a current situation, without recognizing it's posttraumatic 'supercharging'. The *Finding Solid Ground* program refers to this as a '90–10 reaction', borrowing the term from Jon Allen and colleagues: the current situation is important and giving rise to some of the emotion (often roughly 10%), yet most ("90%, give or take) of the emotionality is triggered due to similarities with a traumatic experience or relational pattern (L. Lewis et al., 2004). Both sources of emotion are important and must be validated, including if the therapist has said something inartful, blundered, etc. Due to recognizing the trauma-based source of their upsurge of emotions, patients feel 'less crazy' and more in control.

The overarching concept involves separation of past and present. Helping the DID patient use their observing ego is essential in understanding and resolving many seemingly intractable issues. For example, refractory self-injury often stems from complex layers of meaning/

dissociated experience. These may involve ablation of current emotional agony; a show of power over one's body no matter what the adults (including therapists) want; means of self-punishment (a self-attack shame and/or anger script); and reenactments of past trauma, and combinations. For example, a woman with DID vaginally and anally inserted caustic substances and sharp objects to feel power over past traumas that she could not control, to show shame/disgust/rage towards self-states and her body that 'betrayed me' by having an age-inappropriate genital 'response' to sexual assault, and to attempt to get rid of these self-states. In terms of shame/affect theory, she was enacting a mixture of avoidance, self-attack, and attack-the-other disguised as self-attack. Stabilization of these behaviors and lasting change among states can only occur after the trauma-based roots of these conflicts/behaviors are recognized and after states are empathized with for their attempts to find ways of having power, managing shame, and covertly 'telling their stories' of trauma.

The initial interventions may involve psychoeducation about the functions of self-harm, emotions and their (lack of) regulation; alexithymia; shame scripts; as well as insisting on therapeutic agreements for cessation of all forms of dangerousness to self/dangerousness to others. It is imperative for the clinician to stand up for the importance of safety of the patient and to focus on the trauma-based rationalizations that drive unsafe behaviors (Loewenstein, 1993). Simultaneously and paradoxically the clinician attempts to help the patient/whole mind to look at these behaviors as logically related to survival when maltreatment was unavoidable.[6] Even entrenched suicidal states are trying to help, although it can take considerable work to discover how they are trying to support survival. For example, one paradoxical protector state was asked about the first time 'he' attempted suicide; the first attempt involved jumping out of a second story window in an attempt to stop, via suicide, being forced to participate in being filmed while being raped by traffickers.[7] This state stopped decades-long rumination about, and ceased attempting suicide, only after being validated for suffering as well as the defiant stance he took against the pedophiles who were ruthlessly using him. Other self-states' terror of this self-state eased and their appreciation grew once they recognized this self-state 'held' memories of horrific abuse (i.e., 'protecting the others from remembering'), and was attempting to thwart what he perceived to be current day efforts to undermine his declaration of autonomy, control, and freedom from harm. The therapist guided the patient to shift the paradoxical, life-affirming survival strategies rooted in childhood to present day, life-affirming, recovery supportive strategies. The *Finding Solid Ground* program explains this method, as well as others, for 'separating past from present'.

A large subgroup of DID patients refuse to open up beyond the minimum about their self-state systems and trauma history. Theirs is a long-term stage 1 psychotherapy, where the goal is to help the patient maintain safety, reduce treatment at more restrictive levels of care, and help them manage as well as

possible in everyday life. Some may function at the level of the seriously and persistently mentally ill. There may be myriad dynamics for this, extreme intolerance of shame is often a major one. Others may not be able to tolerate seeing clearly the need to exit, from relationships with reported perpetrators. Some have retreated from reality and prefer to live as much as possible in complex, fantasized inner worlds that are more gratifying than their often-grim outside reality (e.g., subsisting on disability; estranged from their own children and family of origin; limited social supports; chronic medical problems, some related to self-destructive behavior; substance abuse, and the patients' trauma-related phobia of seeking medical care, etc.)

## Psychodynamics of phasic trauma treatment: putting it together

A complete psychoanalytic formulation of phasic treatment for DID likely would involve at minimum a long monograph. Putting together the foregoing discussions, working with DID can be conceptualized as learning a new language. DID individuals often respond positively to the metaphor that they feel they grew up in an entirely different culture, even though they look, talk, and dress like 'regular people', know the cultural touchstones, etc. However, deep down they resonate with the metaphor of growing up in a different world, with different rules, different customs. One DID patient who grew up to be a successful mental health practitioner and agency director, described how as a child and an adolescent, she and her brother would sit and 'watch the normal people, trying to figure out how to be like that'. Even with her life successes and having her own children, she still felt fundamentally that she might as well have grown up in New Guinea, for all that the 'regular world' made sense.

This is a language of the person's world, inner life, defensive structures, attachments, identifications, superego functions, etc., that is their entire life adaptation is organized around – not just trauma – but the inescapable and unpredictable inevitability of being savagely harmed and betrayed potentially by any seemingly positive attachment figure. And then blamed for it.

### *Do you believe me?*

Research shows that delayed recall of trauma memory is no less accurate than 'continuous memory'.[8] When studied with documentation of the events (e.g., delayed patient recall; trauma-based injuries; perpetrator confession), either can be essentially accurate, partially accurate, or confabulated (Dalenberg, 2006). In order to provide ongoing informed consent about this in therapy, the clinician should develop solid familiarity with the complex literatures on autobiographical memory, trauma memory; delayed recall of trauma memory; memory fallibility about trauma as well as non-trauma memory (e.g., Brown et al., 1998; Dalenberg, 2006; Dalenberg et al., 2012; Dalenberg et al., 2014, 2020; Loewenstein et al., 2017; Lynn et al., 2014). Informed consent is necessarily an ongoing process, particularly because, early in therapy, the DID patient generally thinks in trauma-based terms: 'all lies' versus 'all true'.

The clinical pragmatics are more straightforward, especially if one recalls the discussion of the development of 'multiple reality disorder' as the DID individual grows up. If the DID person, as it often happens early in therapy, with a pleading, desperate quality asks, 'do you believe me?' The clinician can answer, 'That sounds like you all feel very desperate about this. But I wasn't there. The real question is, do *you believe you?*'

In the DID patient, there is a deep conflict over belief versus disbelief about the person's own history, and, indeed, whether they actually 'have' DID. Trance-logically, different self-state groups will take opposing positions about this. The core BPD theme is often conceptualized as the defensive use of splitting into an all good versus an all-bad perception of self and other, and its impact on transference, countertransference, and projective identification. In DID treatment, there is a deep *belief/disbelief division*, that is reflected in transference, countertransference, projective identification, and, indeed in academics and the culture at large. Child abuse histories reported in psychotherapy are mostly unverifiable. Therapy is not a forensic enterprise; and therapists make poor detectives – and vice versa. Even if the person's abuser is jailed for abusing them, there may not be specific documentation for a panoply of criminal atrocities described by the patient during therapy. Sometimes relatives describe witnessing assaults on the patient that they deny recalling. The therapy-long task becomes helping the DID person make sense of their autobiography, which may include reconstruction, and may change over time. Thus, therapists should avoid closure and 'validation' or 'invalidation' of any specific memory material. Sometimes improbable material has a trauma-based reality to it. As one thoughtful DID patient said, 'It's not that I want you to believe me. I want you *to believe in me to figure it out*'.

For example, DID patients, often those who report organized sadistic abuse, sometimes doggedly insist that prominent political figures (even deceased ones) abused them. Decoding these reports typically involves perpetrator deception: wearing masks and saying they are the prominent person; making strong commands to an acutely traumatized, often drugged, sleep-deprived, highly hypnotizable dissociative child to 'see' Satan, or Lucifer, or a prominent political or media figure. The child will 'see' what is commanded, and it becomes part of autobiographical material. One patient described this as perpetrators using illusion to make what she called 'created realities'; adding another frequently bizarre dimension to the multiple realities. This, and related strategies may also be perpetrators' attempt to contaminate the child's memory so that, if they were accused of child abuse crimes, the victim's account will seem hopelessly improbable. Soon this will involve virtual reality glasses and AI, if not already.

For example, a patient who later achieved full fusion/integration of self-states had described and abreacted a memory of her baby sister being 'murdered' in an elaborate occultist ritual carried out by her family, their minister and members of their rural, fundamentalist religious sect. After substantial fusion

of self-states, she said she saw this event differently. She said, 'You know when I grew up, Satan was supposed to be everywhere. If a cow died in the field, Satan did it. I deeply resented my baby sister since she was so preferred over me. Again and again, I wished that she would die. When she actually died of an infection, they held a big service in our church. I couldn't tolerate the idea that I must have "murdered" her. So, I constructed her death as being murdered by Satan in a Satanic service'. However, whether one, or even either version, represents historical reality remains unknowable. On the other hand, many DID patients do not revise trauma reports during therapy, but they make more sense in terms of the overall history, and resolution of the conflict over multiple realities. For example, the patient in the prior example had to face another horror of her growing up: antibiotics and 'Satanic' medical care were anathema to her parents and church. Her sister was prayed over until she died. In a prosaic sense, they *did* murder her sister.

### *Multiplicity in therapy*

Kluft (1992, 2000, 2022) describes that few DID patients can tolerate a relatively unmodified psychoanalytic or intensive psychodynamic psychotherapy. DID individuals present with a broad range of functioning. Some are high functioning professionals, entrepreneurs, etc. Others function at the level of the chronically and persistently mentally ill. Most are somewhere in the middle. The vast majority struggle with major issues with safety, PTSD and mood disorder symptoms. The latter usually, at best, are mildly responsive to psychopharmacological treatments (see Loewenstein et al., 2017). Thus, the first stage of DID treatment usually requires a great deal of activity by the clinician around managing, and markedly reducing patients' reliance on self-regulation via unsafety. The Treatment of Patients with Dissociative Disorders (TOP DD) Network study showed that the stabilization model, including specifically working with self-states, led to a massive reduction in nonsuicidal self-injury in patients where this had been virtually a daily or weekly behavior (Brand et al., 2019). TOP DD data also show that working in the 3-phase treatment model *reduced* the level of dissociative symptoms, not increased them (Brand & Loewenstein, 2014; Brand et al., 2022; Schielke et al., 2022).

How does the therapist relate to the DID human being in therapy? Based on the notion that complex self-divisions are adaptive and represent major aspects of material, the therapist needs to find a way to envision the patient *as if* they are made up of a multitude of 'people'. This may require trance logic, or, as an alternative, regression in the service of the ego (Loewenstein & Ross, 1992), or similar strategy to maintain the idea of a single human mind who can show a mixture of unity and dissociatively divided processes. Kluft (1993) posits that the holding environment by the DID clinician should be a warm, engaged demeanor, as silence may feel angrily critical, and reinforces shame. The therapist must bear in mind that

all self-states are equally subjectively real, and understanding their history and psychodynamic meaning is the basic task. Typically, everyday self-states will say, 'they are all a part of me', and therapists use that phraseology. It is rare that DID self-states will agree that they are 'part' of other self-states. The narcissism of the everyday states may be affected (and the therapist needs to address that as well), but it is more helpful (and accurate) to say, 'You are all part of a single human being, with a single human mind. If some of you agree that you are "part" of someone else, then we will address you accordingly'.

In terms of dissociative amnesia, from the perspective of 'everyday self-states' who are adapted to managing the person's everyday life, there may be 'out of awareness behavior'. From the perspective of the self-states who enact the behavior, there is no amnesia, they have a first-person perspective on what occurred (e.g., nonsuicidal self-injury). Thus, without making efforts to 'find' and work with these self-destructive self-states, the chances of reducing dangerousness to self are markedly reduced. The therapist needs to ask to speak with those states by a method called talking through. Hence, the idea of group and family therapy for one person. Also, 'talking through' by self-states is much less disruptive than frank switching, and implicitly invites more collectively unified functioning. It is best to address a collectivity: 'I am asking everyone to listen' is an implicitly unifying phrase, especially when commenting on issues across different self-states/systems, as well as saying 'you all' as second person plural when addressing the patient.

As noted above, experienced therapists usually are working with self-states at the level of their dynamics, not their personified qualities (e.g., 'There are some of you [therapist may name the group] deny that anything problematic affected your childhood, others [named group] of you say the opposite. I'd like to ask everyone; how can we begin a civil discussion between these groups to address these differing perspectives?') Paradoxically, the therapist's phobia of 'reinforcing' separateness by refusing to talk like this, avoiding words like 'People' to describe self-states, actually drives separateness. If the word 'people' fits the person's subjective reality, or if a patient insists 'we are not part of her:', refusing to use the preferred vocabulary typically drives the patient to dig in their heels: 'I'll show you that I'm NOT part of her!' One DID patient divided her self-systems into 'the parts and the people', requiring exploration of the meaning of the distinction, not a struggle over vocabulary.

### *Traumatic transference and countertransference: a therapeutic road map*

Spiegel, 1986 defined traumatic transference in DID treatment as follows: *'The patient unconsciously expects that the therapist, despite overt helpfulness and concern, will exploit the patient for his or her own narcissistic gratification'* (p. 72). Similarly, the data on transference in other traumatized populations supports this view. In psychoanalytic studies of treatment of

Vietnam veterans and survivors of incest and childhood sexual abuse, the basic transference patterns were negative and posttraumatic (Lindy, 1989; Davies & Frawley, 1994). Typically, much of the traumatic transference is concealed and avoided, mimicking what the child learned to do with perpetrators: appease and be submissive and outwardly agreeable, while inwardly hiding mistrust, fear, anger, and disagreement. At other times, it is concealed in dangerousness to self/dangerousness to others, high-risk behaviors, acting in, and acting out.

Classic traumatic transference/countertransference scenarios include the following. The therapist is seen as a potential abuser. The therapist may literally be seen as a perpetrator (or someone else) from the past (flashback transference). The therapist may be perceived as the unprotective bystander who looked away while the child was being harmed, or the 'stupid', self-important 'good' person to whom the patient may have directly or indirectly disclosed the abuse but who then failed to do anything to protect the child. The therapist may be viewed as the co-abusing parent. This ranges from supposedly 'unaware' to actively involved in maltreatment. The therapist may be perceived as a good person, but who will ultimately abandon the patient, often after repeatedly promising to 'always be there'. The therapist may work hard to prove how caring they are; this can lead to taking on the role of 'rescuer' role, another transference/countertransference dynamic. The therapist may symbolically become the helpless child, unable to stop the patient's aggression, either in subtle, direct (verbal attack), and/or indirect forms (e.g., endless safety crises with the implicit message: someone can violently harm someone as much as they want, and you can't do anything about it).

These themes may shift seemingly kaleidoscopically. The therapist may need to ask 'all to listen' and enumerate the specific traumatic transference dynamics: 'Various ones of you are viewing me this way; others this other way; others this additional way. It all seems related to being in relationships with dangerous people'. The therapist might add at another process level of traumatic transference, 'I think you all are showing me that your experience growing up was so chaotic, confusing, and violent, that you never could predict how anyone was going to behave; and you never could predict whom you had to be to survive'. One patient wrote of her mother as follows, ' … [S]o I think having multiple people inside to comprehend the multiple realities of the environment makes sense. Kind of like, 'who do you need now? The person who knows you hate them? The person who you tell you love? Someone else? Who should I be now? The person that knows you rape us? Someone who doesn't know?'.

### *Mind control transference*

DID patients who report continual, concerted psychological invasion by perpetrators may perceive therapists as involved in mind control dynamics

(Loewenstein, 1993, 2022; Salter, 1995). Here, the therapist's concern and helpfulness are experienced by the patient as only serving to gain access to the patient's mind to control and enslave the patient; a 'mind-control transference'. Often this occurs when the patient has been exploited in organized sadistic abuse involving trafficking where there is an attempt to enslave the child, in order to provide a better 'product'. Thus, these patients paradoxically experience 'being known', 'being seen' in therapy as profoundly dangerous, not a relief and a validation. Sometimes, this type of sadistic psychological invasion can uncannily parallel psychotherapy. Perpetrators may use phrases similar to those used by therapists (e.g., 'I want you to share everything that comes to mind without omitting anything'). Some DID patients report having been abused by physicians or mental health professionals; this type of abuse necessarily complicates and lengthens the course of DID treatment.

To some extent, all DID treatment has something of mind-control transference. However, when mind control has been a major part of the childhood violence, its dynamics will dominate treatment, as the therapeutic task of understanding the patient is contaminated by perpetrator behavior that wanted 'information' about the patient and their mind. Also, it requires the therapist to go far outside typical psychotherapy training and learn about attempts at enslavement of human beings. This includes indoctrination techniques in totalitarian groups; coercive control tactics in intimate partner violence and by pimps and traffickers to enslave their victims; interrogation techniques; mind control in destructive cults; techniques used by authoritarian dictators; use of drugging, sleep deprivation, and destructive hypnosis on children; concentration camp experiences, etc.

Another aspect of learning the language of DID has to do with the presence of evil in the quotidian world. Seemingly 'normal', sometimes even prominent people, create for their DID children a psychological prison or concentration camp, except without barbed wire, guards, dogs. We do not have a model for this; seemingly 'good' people commit atrocities against children.[9] The patients themselves struggle with this. 'Everyone always told me how great my mom was, she was so kind and understanding. How lucky I was. Yeah, and she tormented me every day of my life. Why was she so good to other people and not me? You tell me it wasn't my fault. But I'm the common denominator for all of it [being sexually assaulted by both parents]. I must have made them that way'.

Common clinical issues have a traumatic transference dimension, without which the problem usually cannot be solved. For example, DID patients often have self-state conflicts over taking medication. Some self-states desperately seek medication as an anodyne, and other self-states eschew medication. In the former state, the patient tends to overuse medications (e.g., benzodiazepines) creating a need for the prescriber to set limits on, or discontinue the drug. Some DID patients desperately overuse almost any drug, sometimes creating problems with side effects and drug interactions. Another DID patient may fail to reliably take prescribed medication that benefits them, even alternating with overuse.

Several traumatic transference issues may be in play, especially if the patient reports being drugged during abuse. The overuse may reflect being given drugs that made the abuse more tolerable (e.g., opiates, benzodiazepines). The desperate overuse/demands for dose increases may reflect a subtle partial flashback to being assaulted, begging the perpetrators for the medications that 'knocked me out'. On the other hand, the refusal of drugs may stem from a fear of being controlled by the perpetrators' drugging; because at other times the patient would beg for medications, and the perpetrators would mockingly refuse to give them to her. This led to self-states who embodied a dogged refusal to be sedated, no matter how much the 'other' self-states took. In the hospital for surgery, one DID patient resisted 'going under' with general anesthesia to the point that surgery needed to be cancelled. Surgery went forward with the patient tolerating anesthesia after the clinician asked to speak to the drug-resisting self-states, acknowledged that drugs had been used adversely on her, and supported the self-states fundamentally positive attempts to resist being put in that position again.

Even without a history of drugging, another common trauma-based fear in DID is that, once the patient 'feels better' on the meds, then the psychiatrist will control the patient, have something over him/her; will 'want something from the patient' in order to keep prescribing. The patient will 'need' the therapist for the drugs. These patterns typically underlie illogical statements of concern about becoming 'addicted' to psychiatric medications, and/or accompanying continual misuse of street drugs.

Trauma-based, dissociation-based countertransference also occurs and can be crucial to decoding the therapeutic situation. One of the classic countertransference dynamics in DID is that clinicians may feel frustrated, irritated, exhausted, deskilled or even helpless to effect change, since many DID patients are desperate to hide their self-states, avoid and/or disavow trauma history, with the therapist feeling like they are doing all the work and carrying the treatment (Kluft, 1994). At other times, the therapist may feel overwhelmed at the extremity of the patient's trauma history, the sense that the nightmare of the patients' life will never end.

However, these can be decoded as projective identifications of the patient's experience of growing up, and often their later life: they were overwhelmed, exhausted, desperate, and helpless to change their situation, and perpetrators denied their distress and insisted that the patient tolerate 'more'. The clinician may say, 'I'd like all self-states to listen. I think you are giving me a graduate education in what your experience has been for much of your life. How helpless and overwhelmed you felt, and yet abusers kept insisting you do more'. Sometimes, this situation is associated with intractable suicidality. Often, this can reflect that there is an 'emotional' flashback, memories of what the patient *felt and thought* during past experience.

Here, the patient experiences, without conscious connection, their own childhood suicidality. This combines with the current suicidality, often with previously amnestic

self-states consciously feeling suicidal around increasing awareness of trauma memories and their attachment implications. As discussed previously, the therapeutic intervention is to work on each level separately: with the self-states that hold previously dissociated recollection of childhood suicidality, and also work with the 'everyday' self-states whose suicidality is related to decreased dissociation of trauma memories. Also, suicidality may have a paradoxical 'life-affirming' aspect. As in a previous example, DID patients report that childhood suicidality was a protest against uncontrollable adversity; it represented a 'No. I'm not doing this anymore. I die and it stops. I have the power and I am more powerful than the bad people'. Alternatively, there may be self-states that believe in an afterlife where 'God doesn't let little children get hurt and starved'; or simply being 'at peace' in the ground. Paradoxically, in childhood, contemplating death was an affirmation against maltreatment. In the present, the patient can use the same positive affirmation to shift this 'survival' strategy to the 'recovery' strategy of self-states pulling together for recovery and affirmation of life in the present.

### *Understanding self-states' functions*

How can children survive such deprivation and aloneness? DID children often use their imaginations, auto-hypnotic, and dissociative processes to survive. One patient imagined she was out in the rose garden smelling the beautiful roses during her drunken father's rapes (avoidance, withdrawal shame scripts as noted above). Others create a self-state that speaks to them with kindness or who coaches them through tasks; some create animal states that they experience as comforting and safer than humans (again shame avoidance, withdrawal). Other shame-scripts may include the development of sexualized self-states in childhood, who initiate 'sex' (rape) with perpetrators, to mitigate the accompanying violence (attack other; avoidance shame scripts; Kluft, 2017).

This type of self-state is experienced as mortifying by most other self-states and may be treated with a type of internal apartheid. For other self-states, they embody the certainty that 'I made it happen', which of course was reinforced by perpetrators. Also, these states may approach/invite all men sexually. This is often a test of the male therapist (and female therapists where there was female perpetration). The response, understanding the language of DID should be to talk to all self-states, focus on the specific protective function of these self-states (also, getting it over with, since 'waiting is the worst'), educate the patient and discuss this in compass-of-shame terms, and reframe the protective nature of these self-states. They came into existence to make the inevitable 'less worst' (there is no single worst in the development of DID; there are many 'worsts'). This will be tested repeatedly. These self-states may embody the words, gestures, and dress of women and men in prostitution, pornography, etc. It can be discomfiting for therapists to experience our societally conditioned responses to this type of overt seductiveness, and to make the appropriate trauma-dissociation-shame script interpretations.

Another intolerable emotion for many DID patients is pride in themselves ('don't say the P word!' says the patient). If they do something worthy of praise (or receive praise, including from therapists), they rapidly attempt to denigrate it. Some feel a compulsion to punish themselves if they are praised. If the patient says anything negative about an abusive or neglectful parent, they often experience internal castigation, and may feel urges to self-harm. These are typically reenactments of attachment-betrayal-humiliation scenarios. That is, normal needs and feelings of attachment, or other types of positive experiences (e.g., pride in one's accomplishment) were met with verbal humiliation or reprisal ('So you think you are better than me, your mother?') or overt punishment. Patients may report that any friendship or object, including pets, they were attached to were taken away, destroyed, or killed. And they were blamed for these losses. Often, self-states embody the abusive parent, and others embody themselves as children, frequently internally reenacting situations with the parent.

The internalized perpetrator has many paradoxically protective functions, and these can be analyzed in terms of trauma-dissociation as well as shame dynamics. This represents an internalized attack other script. Mortifying experiences are inevitable. These self-states serve as eidetic warnings to attempt to avoid being blind-sided (one more time) by attack. They take control over the inevitable, 'If I throw myself on the floor, you can kick me. But you can't throw me any lower', said one patient. Often, they are attempts to warn about betrayal/humiliation in attachment, any attachment. Especially to the therapist.

### *Negative therapeutic reaction in DID*

Another common dynamic in DID treatment is the negative therapeutic reaction (NTR; Chefetz, 2015). Freud (1923) originally defined it as a patient's unexpected symptomatic worsening, often after brief improvement, when the therapist predicts that an intervention should logically lead to symptom amelioration. A classical explanation for NTR in DID is the patient's malignant, punishing superego, their entrenched belief in their core badness interferes with anything positive to be internalized. Thus, when such a DID patient experiences improvement (e.g., by use of a helpful hypnotic technique in therapy for posttraumatic distress), there is a redoubling of symptoms and the technique no longer works, and further attempts to use it bring about escalating distress. Often paradoxical protector perpetrator 'introjects' claim responsibility for these punishments.

However, there is a more fundamental cause of NTR in DID, based on the discussion of attachment/betrayal/humiliation. Many DID perpetrators, particularly sadistic ones, appear to wait for the child to be absorbed in something positive, like reading a book or playing, to pounce on them and attack. They may promise to 'not do that again', wait for the child to relax their guard, then attack again. Anything nice, like the child getting a toy as a gift, will result in this being taken from him/her with sadistic assaults to 'prove' to the child that they will be 'gotten' any time anything positive occurs. One patient's mother thought her

little son was so 'generous' that he always gave his toys away to other children. He was attempting to avoid sadistically savage sexual and physical assaults from his older brothers and their psychopathic neighborhood friends. Whenever he felt good about something, they destroyed it, or made him destroy it. This had included torturing his new puppy almost to death, then insisting that the boy kill the puppy to put it out of its misery. Then, they continually taunted him that he had 'killed' his dog and must be a 'crazy, mad dog killer'.

In treatment as an adult, this DID man said, 'I learned to never trust anything good. Anything that was good, turned really bad'. This is an excruciatingly painful dilemma, that one's positive feelings, joy, excitement, pride becomes an immediate, extreme danger signal and must be obliterated. In this DID patient, introjects of his brothers and their confederates made sure to 'make something bad happen' to preempt 'outsiders' from doing it first. His tormentors also made him believe that they would make him kill his parents, like the dog, if he did not do what they wanted. Not surprisingly, he had introjects of his clueless, dissociated mother, and his alcoholic father who had savagely beaten his brothers, but sobered up when the patient was a small child, and, unlike his brothers, was treated kindly by his father. He had an 'insane mad dog killer' who had to be imprisoned in an imaginal dungeon. He found a secret ghost of his dog in his mind who told him that it was not his fault that it had been killed, but he should never let anyone know that the dog was there to support him. He was utterly terrified to reveal this in therapy and had a safety crisis after doing so.

This is a vital dynamic to understand in DID treatment. We have yet to treat a DID patient who does not recognize the phrase that 'the other shoe will drop' when anything feels or seems OK or calm. Generally, they experience this as a basic law of the universe. To avoid the profound mortification of, one more time, being so 'stupid' as to be blindsided by the 'other shoe', the DID patient must find to a way to expeditiously get rid of the good, the calm feeling, the enjoyment of something, etc.; 'waiting' for the unpredictably humiliating other shoe is 'the worst'.

Working on these dynamics requires education about shame and affect theory, and specifically about the compass of shame, within whose framework DID patients universally see themselves. In addition, it is helpful for the therapist to observe that all of us have our own compass of shame, and that human beings in general utterly despise experiencing shame/humiliation and make major efforts to defend against them. Nathanson (1992) observes that recognition of our own shame experiences is essential in empathically assisting patients with theirs. DID therapists, especially early on, may feel their own shame at the difficulties in conducting these therapies. In interventions around shame, it is helpful to recognize when there is projective identification of the patient's shame, and what is our own shame contribution. Decoding this may also help frame one's responses to the patient's shame by recognizing the connections with our own. For example, 'it is particularly hard when we are feeling ashamed, and someone we care about not only doesn't offer us empathy, but actually reinforces the shame. I wonder if some of you felt that I was doing that when I said … '

Further, one educates the patient about the NTR and the form that it takes in DID. How fundamentally cruel it is to rob someone of their ability to tolerate anything good, safe, calm. The patient can then be invited to risk tolerating and testing feeling OK, even a few seconds, with the invitation to paradoxical protectors, and others who may have thoughts about this to talk with the clinician about what they observe. Typically, this is experienced as becoming tense, then agitated, then frantic. So, it is important to not go beyond the stage of tension, to pull back and gently empathize with this predicament. As this is slowly, repeatedly worked on, at many levels, other emotions come up. For example, attack self/internal attack other scripts get activated, often combined with anger. Under the anger, there is usually sadness and grieving. These are often experienced as more intolerable than the shame or the anger. The NTR may be a defense against the sadness and the grief, as never-ending trauma memories may conceal this. It comes with the recognition that the DID patient's loved ones treated them as a hated, objectified thing, not a human. Not only was the hatred repeatedly and aggressively directed into the DID individual. There was fundamentally a hate-filled, targeted neglect of the most basic human needs.

One patient said, weeping, 'I was an orphan! Everyone hated me! I was utterly alone and under attack. And our family looked perfectly wonderful. And I could not have known that and survived as a kid. I barely can think about it now'.

In conclusion, DID is a developmental adaptation to profoundly chaotic and abusive childhood experiences. DID individuals have a unique personality organization based on dissociative self-states that include psychological resiliencies such as observing ego and an ability to develop a therapeutic alliance, alongside trauma-based reactivity, beliefs, and traumatic transference reactions. Research illustrates that long-term, psychodynamically informed treatment that focuses on improving safety and stabilization, understanding and working through traumatic transference and traumatic experiences, and acknowledging and working with self-states results in considerable benefits for patients.

## Notes

1. For simplicity, we will use the terms "psychoanalytic' interchangeably with 'psychodynamic' in this paper, albeit not all psychodynamically oriented clinicians are psychoanalysts; and there are theoretical schisms among psychoanalytic/psychodynamic schools. Also, unless specifically noted, for simplicity and space considerations, we will use the term 'clinician', 'therapist', or 'practioner' to include clinicians, researchers, academicians, theorists, et al of any background or theoretical perspective.
2. Therapists trained in hypnosis require additional training to work with trauma and dissociation in psychotherapy. Training in hypnosis for complex trauma and DDs is offered by the American Society for Clinical Hypnosis (https://www.asch.net/aws/ASCH/pt/sp/home_page).
3. Disgust is summarized by drinking spoiled milk (yuk!); dissmell is smelling the spoiled mild before drinking it (pew).
4. Self and identity are linked but distinct concepts. Self is our subjective 'I' and 'me', our moment-to-moment sense of our 'selves'. It is tied to our memory of our history, and that we can see ourselves in the future (autonoetic consciousness). Identity is

more about our longer-term descriptors, some more internalized than others: sex, gender, age, ethnicity, religion, social class, profession, and many others. Identity can be negatively used against people in racist, sexist, and similar denigration of the 'other'. In DID, the secondary elaborations of the self-states are understood as identity enactments.

5. Hypnotic inductions may begin by having the patient 'hyperfocus' on something (e.g., the place where 2 walls connect at the corner of the room). Often, this is followed by eye-closure as the patient enters hypnotic trance.
6. The clinician must ascertain if the patient is currently in an abusive contemporary relationship (e.g., violent relationships; ongoing involvement with perpetrators, etc.), as the patient will see self-destructive behavior as a life-long necessity for survival. Helping trauma survivors exit abusive relationships is usually a long, grueling process that can be painful for the therapist to endure, as the patient repeatedly returns to be hurt, and new ways of coping are overwhelmed by more humiliating, controlling perpetration.
7. It is recommended that terms like 'child pornography', 'child prostitution' be replaced by more descriptive terms as the former may imply some active involvement by exploited, trafficked child.
8. The notion of 'continuous memory' is itself problematic since we do not continually remember our autobiography. This is among the many terminological issues in this area that are outside the scope of this paper (e.g., 'recovered memory'; one can say all memories are 'recovered'). The intrapsychic process of dissociation is different from that of 'repression'; large blocks of experience are unavailable in dissociation, not relatively singular memories. The subjective experience of delayed recall is different, and is often accompanied by intense emotions at minimum, and more often frank PTSD intrusive symptoms.
9. A real-world example of this mixture of good and evil is that of Daniel Gadjusek who won the Nobel Prize for medicine for his work on what are now called prion diseases. However, he used his research site in New Guinea to bring back and adopt over 50 young boys, many of whom he sexually abused and trafficked among his friends. Goudsmit (2009). Daniel Carleton Gajdusek (1923–2008). *Nature, 457* (7228), 394–394. https://doi.org/10.1038/457394a

## Disclosure statement

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