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CONCEPTUAL FOUNDATIONS FOR LONG-TERM PSYCHOTHERAPY OF DISSOCIATIVE IDENTITY DISORDER

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This chapter discusses a conceptual framework for phasic treatment of dissociative identity disorder (DID). It is informed by 1) pioneering studies of DID's psychological structure by Judith Armstrong, Ph.D., Bethany Brand, Ph.D., and others (Armstrong, 1991, 1994; Armstrong & Loewenstein, 1990; Brand, Armstrong et al., 2009; B. L. Brand, Armstrong & Loewenstein, 2006), as well as 2) Discrete Behavioral States Theory (DBST) originally formulated by Frank W. Putnam, (1997, 2016) (for an in-depth discussion of DBST, see Chapter 16, this volume). I concur with Kluft (Chapter 43, this volume)[1] that, although more sophisticated conceptualizations of DID have been developed through the study of Complex PTSD, attachment, betrayal trauma, and affect theory, no one of these, or even all of these together, is sufficient as a complete explanatory model for DID. The goal of this chapter is to illustrate how to think and make sense of DID; therapeutics logically stems from conceptualization.

DID: A Diagnostic and Therapeutic Paradox

DID is a disorder with inherent contradictions, dialectics, and paradoxes (Loewenstein, 2020). DID is a major psychiatric disorder with substantial morbidity and mortality (Spiegel et al., 2011). Simultaneously, DID is a *resilient alternative developmental pathway* preserving important capacities for attachment, reality testing, and insight, among others (Armstrong, 1994). Throughout this chapter, I discuss important areas of knowledge for treatment of those with DID.

The principles of good psychotherapy are the same for all human beings. In trying to make sense of DID, the most well-intentioned therapist can lose sight of the human being amid the shifting, switching, chaotic presentation, the graphic enormity of the reported –then bewilderingly denied –torture and torments, and the often-horrifyingly creative forms of self-destruction.

So, What Should You Know?

Discrete Behavioral States Theory (DBST) and DID

DBST is a transtheoretical, transdiagnostic theory of human consciousness that synthesizes concepts from many domains including human development, mind/brain/body relationships, and psychopathology. DBST describes "States of Being (SoB)" as the basic DBS of human consciousness. DBST describes the importance of shared SoB between caregiver and infant as a core aspect of normal developmental attunement and attachment.

Transdiagnostically, DBST links together many different psychiatric disorders (e.g., mood disorders, trauma-and-stressor-related disorders, dissociative disorders (DD) as *"state-change disorders"*). These are characterized by "switch processes" that can result in marked change in cognition, mood, level of arousal, attention-concentration, and psychophysiological variables, among others (e.g., a sudden switch from depression into mania in a rapid-cycling bipolar patient, or an overt switch among DID self-states). Other psychopathological state changes may happen more gradually, (e.g., progressive worsening of depressive symptoms). DBST is particularly helpful in characterizing posttraumatic and dissociative disorders as state-change disorders.

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Discrete Behavioral States Theory, Self, Identity, Self-System, and Personality States

As discussed in the chapter on DBST, definitions of self, identity, and personality vary with theoretical orientation (e.g., behavioral vs psychodynamic) and field of study (e.g., anthropology vs philosophy). The terms are often used interchangeably or to define one another. They do not have firm conceptual, practical, or experiential boundaries. What follows is an attempt to more define these terms as they apply to *DID*. During normal human development, the mind becomes organized as SoB, differentiated as self-states, identity-states, and self-systems/self-state systems. Over developmental time, these organize and reorganize within more stable, partly genetic traits that become what we and others experience as our "personality." The state model defines personality as "…[T]he integration of a person's [self/identities], emotional, cognitive and other relevant states of being weighted by the history of their recurrent interactions with the person's inner and outer worlds integrated over time" (Putnam, 2016, p. 160).

For simplicity, the self – organized into many self-states –can be understood as "who" we are, subjectively experienced on a moment-to-moment basis. Identity – also organized into identity-states –is experienced subjectively, but also can be perceived by, or forced on us by, others (e.g., negative identity ascriptions about religion, ethnicity, social class, etc.). Identity states imbricate with self-states, but often have longer-term dimensions that can be conceptualized as "what" we are (e.g., straight, gay, male, female, trans, religious, atheist, physician, psychologist, African American, White, etc.). Self-states, identity-states and personality-states may be relatively unintegrated and/or in conflict.

DID: A Posttraumatic, Developmental State-Change Disorder

DID is a paradigmatic "state change disorder." DID is best conceptualized as a unique, life-long, posttraumatic, developmental disorder beginning before the age of 5-6 – an alternative developmental pathway. Due to severe, recurrent, unpredictable early-life maltreatment, and disturbed caretaker-child attachment and parenting, the dissociative child is disrupted in the normal metacognitive processes leading to development of *a subjectively unified sense of self* across different contexts, relationships, and emotional states. Through processes based on state-dependent learning and memory, unbearable memories and affects are psychobiologically sequestered. The child develops differentiated senses of self, often in conflict with one another. Later these are personified due to many different trauma-related, family, social, and cultural factors. As the DID child develops, state-dependent (relative) inaccessibility of trauma memories appears to permit more normal development in other SoB of important, adaptive psychological capacities.

DID and Self-States

DID is fundamentally a disorder of lack of integration of the *self* across states, contexts, relationships, etc. Also, theoretically, the "self" is a common, "experience-near" construct that is linked to other psychological concepts from various schools of thought, as well as everyday parlance: myself, yourself; self-psychology; self-object; self-representation; subjective self; self-esteem; self-reproach; self-awareness; self-delusion; self-consciousness; self-destruction, etc. Thus, in DID, the term "self-state" is developmentally, phenomenologically, and clinically more accurate than other terms (e.g., personality or identity state, alter, part, dissociative part of the personality). Accordingly, the terms self-state(s) and self-state system(s) will be used in this chapter.

Psychodynamic Concepts

Psychodynamic psychiatry and psychology began with dissociation (Ellenberger, 1970). Not just Janet's patients, but some of Freud's early "hysteria" patients are specifically described as displaying dual consciousness, (e.g., Anna 0) (Breuer & Freud, 1893) or had substantial dissociative symptoms (Loewenstein, 1993a). DID patients shaped the core constructs of psychoanalysis. The concepts of transference, conflict, resistance, and intrapsychic defense fit DID patients and make intuitive sense to them. DID psychotherapists should be educated in the psychoanalytic concepts of the unconscious, ego-defense, conflict, resistance, transference, countertransference, projective identification, boundaries, and treatment frame, particularly as applied to survivors of childhood maltreatment, especially sexual violence (Chefetz, 2015; Chu et al., 2011; Davies & Frawley, 1994; Kluft, 1994; Loewenstein, 1993b; Loewenstein & Ross, 1992; Steele et al., 2017). Our field has tended to polarize psychodynamic and Janetian concepts of working with dissociation. Many Janetian ideas (e.g., working with posttraumatic cognitive disortions, use of hypnotherapy, and systematic, paced work on trauma memories) are also essential to DID treatment (e.g., Van der Hart et al., 1993). It is the *synthesis* of these traditions that is most efficacious for DID treatment.

The "Older" DID Treatment Literature

In a parallel meta-dissociative process, the DD field has source amnesia for essential early works that developed the fundamental concepts of DID treatment. They are as relevant today as they were in the twentieth century. I urge DID therapists to read the classic books about dissociation and DID/MPD by Frank W. Putnam, (1989, 1997) and Colin Ross (1989, 1997); along with edited volumes by Braun (1984), Kluft (1985), Kluft & Fine (1993), Lewis & Putnam (1996), Loewenstein (1991a), and Spiegel (1991). Papers by Kluft and others on psychodynamically-informed psychotherapy of DID from the 1980s–1990s are essential reading. Many of these were published in *Dissociation*, the original journal of what is now named the International Society for the Study of Trauma and Dissociation (ISSTD), and can be accessed here: https://scholarsbank.uoregon.edu/xmlui/handle/1794/1129.

Hypnosis

Dissociation and hypnosis have been linked since the early nineteenth century (Ellenberger, 1970). DID individuals naturalistically manifest the phenomenology of deep hypnotic states (Loewenstein, 1991b). On standardized hypnotizability measures, DID patients score highest compared to other clinical groups (Frischholz et al., 1990). Theories about dissociation and DID use the construct of hypnotizability as an etiological factor (see Dell, Chapter 14, this volume). The ISSTD Treatment Guidelines for DID (Chu et al., 2011) posit that *no* treatment of DID occurs without hypnosis. Therapists who are trained in hypnosis, not only learn important interventions to help manage severe symptoms but can recognize and manage spontaneous auto-hypnotic phenomena during therapy. This can help detect state shifting/switching, overlap and interference among self-states, and defensive aspects of autohypnosis (see below).

Psychoeducation about hypnosis and use of hypnotic imagery techniques – both with and without formal trance –are important for DID patients to recognize and to allow them to gain control over autohypnotic responding. Hypnotic imagery can be highly effective in clinical management of DID: for respite, containment, distancing, internal communications, management of posttraumatic and dissociative symptoms and crises, and detoxification of traumatic memories, among many others (see Kluft, 1989). Outside of therapy, DID patients can learn to use their hypnotic gift for self-hypnotic symptom management and gain a greater sense of mastery and control over symptoms (Kluft, 2012).

Autohypnosis and trance logic are involved in the secondary structuring of DID self-states, including development of the complex inner DID worlds, and their subjective reification, as well as in DID patients' endemic reality-defying cognitive distortions and beliefs. Clinicians who understand hypnotic phenomena are less likely to be bewildered and overwhelmed by the elaborate "inscapes" found in many "complex" DID patients (Kluft, 1988). Trance logic is defined as the deeply hypnotized subject maintaining the contradictions between reality and hypnotic "reality," but minimizing cognitive dissonance (Hammond, 1990). For example, after switching between states, a DID patient reported that the date was 10 years earlier. When told the correct date, she responded, "Oh wow! We're in the future!" Another DID patient stated, "Everything you have out there in your world, we have in here in ours."

In DID treatment, countertransferential experience of hypnotic phenomena commonly occurs (for a detailed discussion, see Loewenstein, 1993b). Training in hypnosis can help therapists recognize their own auto-hypnotic responses to the shifting states of the DID patient, and they can learn how to regulate these to maintain therapeutic distance. The therapist may experience empathic, hypnotic resonance with the patient (e.g., Therapist: "I wonder if you feel like you are floating away, right now." Patient: "How did you know that?").

Abstractions, Metaphors, Reification, the Mind, and DID

Our general language about the mind is metaphorical. These metaphors can implicitly govern our conceptualization of mental phenomena. Different views of the mind among different schools of thought can determine what we see and how we see it. Kuhn (1970) posits that these differences can literally mean that what one group sees as intuitively obvious cannot be demonstrated to another.

Reification and DID

A subgroup of DID patients compellingly experience themselves as inhabited by "separate people," with the mind a seemingly physical place made up of houses, castles, tunnels, planets, stars, universes, dimensions, ad infinitum. Fueled by autohypnosis and trance logic, therapists often lose sight that these are not physically "real"; they are subjective SoB of an individual human mind, created by the singular brain of a single human being. Thus, whatever is claimed about

changes in these apparent structures (e.g., "the bad ones tore all our safe places down. They're GONE!") can be changed again by using the mind's capacity for imagery.

Reification is a foundational challenge in conceptualizing, communicating about, and treating DID. It is impossible to write about – or even think about –DID without physical *metaphors* that concretize and reify the mind (e.g., "splitting:" horizontal and vertical,[2] "compartmentalization," "detachment," "structure," "layering," "levels," "structural dissociation of the personality"). There are also process and mixed/ambiguous metaphors (e.g., "self-state system," "structured defensive processes"). "Intrapsychic defense" is a metaphor that can be understood at multiple levels of abstraction: from experience-near psychotherapist conceptualization of patients' patterns of thought, emotion, and behavior, to highly abstract theories about the mind (Bellak et al., 1973).

The term "parts" in technical and academic writing about DID too easily conflates with a reified view of the mind as a machine, a finite physical object with, by implication, finite "parts." Clinically, the term "parts" can be a useful, colloquial, descriptive term for clinicians and patients, although some DID patients respond to this term negatively (e.g., "Hey, we're important! She says we're *just* parts!"). The most recent ISSTD Guidelines for DID Treatment (Chu et al., 2011) counsels that, if possible, it is preferable for clinicians to use the DID patient's own term for self-states. Clinicians too often conflate a specific self-state or states with the "real" person with his or her "parts." Therapists should be clear that *all* self-states are aspects of *the mind of a single subjectively self-divided human being.*

Even in academic writing about DID, it is impossible, without prolix contortions, to avoid reification by using personalized pronouns and verbs in describing self-states. It is more readable and concise to write "the patient shifted to a maternal introject and said…," not "the patient shifted states, and experiencing herself as a maternal introject self-state, said…" The latter is more accurate, as the "maternal introject" is a psychological construct, not a person. Therapists can imagine an asterisk for the first formulation, to remind themselves that self-states are subjective representations, not actual people.

To reduce misunderstandings about the nature of DID, the longer form should *always* be used in notes written in hospital or other institutional charts where, for clinical, medico-legal, and/or administrative reasons, third parties can have access to the chart (e.g., clinicians and nursing staff, peer reviewers, risk management staff, insurance companies, state and federal auditors, attorneys). In the Trauma Disorders Program at Sheppard Pratt, we evolved standards for chart notes about DID to avoid reification as much as possible that, for example, eschewed patient-derived names for self-states (e.g., "Beelzebub"), unless this was essential to understand the clinical situation, and then only in quotation marks.

Conceptualizing Self-States and Self-State Systems

Self-States

Following the work of Frank W. Putnam, Richard Kluft and others (Brand & Lanius, 2014; Kluft, 1988; Putnam, 1988, 1997, 2016), DID self-states are conceptualized as relatively separate centers of information processing with their own senses of self, organized around state-dependent thoughts, emotions, and –usually a limited set of –autobiographical memories. They have the capability to initiate behavior and action directly or through influence, interference, overlap, intrusion, and/or coordination with other states. Kluft (1988) first defined that a:

> [D]isaggregate self-state functions both as a recipient, processor, and storage center for perceptions, experiences, and the processing of such in connection with past events and thoughts, and/or present and anticipated ones as well. It has a sense of its own identity and ideation, and a capacity for initiating thought processes and actions … which may be behaviorally enacted with noteworthy role-taking and role-playing dimensions and sensitive to intrapsychic, interpersonal, and environmental stimuli…
>
> *(p. 51)*

Some self-states exist only intrapsychically and do not enact roles in the world (Kluft, 1991). In DID, the construct of identity-states represents the secondary elaboration of self-state characteristics, and are often stereotyped, rigid, limited in scope, and in conflict (e.g., "We don't go to work, *they* do"). However, in DID, as in general human psychology, there is an interplay between the self-state and identity-state *systems*.

Self-State Systems

Sullivan (1953) initially described a self-state system. He proposed that different subjective and relational selves arise early in development in response to parenting, as self-systems. In Chapter 16 (this volume), we wrote: "…[A]s development

proceeds, the child begins to develop improved metacognitive, executive, observing ego capacities … [leading to better] integration of behavior; centrality and continuity of identity, and greater integration of self." Developmentally, DID self-states organize into adaptive *self-state systems* with coordination, collaboration, and cooperation between self-states for better everyday functioning.

In DID, self-state systems are adaptive, but are more in conflict and more liable to disruption. Ordinarily available metacognitive functions can be rapidly disorganized. Self-states have a sense of "themselves" and can potentially affect behavior directly or indirectly. Self-states/systems may vary markedly in capacity for reality testing. Some may literally experience themselves as separate beings (delusional separateness) with subjective characteristics different from those of the "everyday" human being (e.g., age, gender, personage/introject, cognitive set, belief systems, etc.) and/or delusional disorientation to current circumstances (e.g., experiencing themselves as existing in different times and/or places from the present). Some self-states/systems are organized around traumatic memories, and may be unpredictably activated by trauma cues with sudden intrusion of flashbacks. These may be experienced as incomprehensible intrusions/overlaps/influences; accompanied by a period of dissociative amnesia; and/or may prompt ego-dystonic, dangerous, and/or maladptive behaviors. Sometimes, dissociative amnesia is accompanied by *positive behavior* (e.g., completing one's job, doing well on a presentation, etc.). Previously well-learned skills may unpredictably disappear, reappear, and disappear again.

The overt presentation of reality testing and insight may seemingly instantly switch from sophisticated to quasi-delusional. There may be pronounced, concretized disjunctions between observing and experiencing ego: "*I* understand all that, but *I* can't do anything about the others and *their* feelings."

"Executive Control"

The notion of "executive control" by specific self-states who are "out" is not consistent with this view of dynamic self-state systems. "Control" is best understood as the ongoing, shifting, adaptational summation of self-state "vectors" at a given time in response to myriad aspects of the patient's life, psychotherapy, etc. Kluft (2005, 2006) refers to this as the "dissociative surface," the outward manifestation of the moment-to-moment complex, dynamic shifting in the self-state system in response to external and internal forces.

Kluft's "role-taking and role-playing dimensions" represent the myriad ways DID states are secondarily differentiated, often in reified inner worlds, and the self-states' presentational aspects to the outside world (Kluft, 1991). This secondary structuring is not necessarily fixed and can vary over developmental time (Kluft, 1991). Childhood DID typically is less elaborated than in most adults (Silberg, 2013), with self-states manifesting more as independently acting, autonomous imaginary companions operating through influence/intrusion, less by state shifting (See Silberg & Dallam, Chapter 27, this volume). In adolescence, where issues of sexuality, separation and individuation are central, self-states may become more elaborated and manifest more concretized forms of internal conflict (Putnam et al., 1996).

"The Whole Human Being"

Self-states and the self-state systems exist within the mind of a single human being, so we have a third level of abstraction. It is ironic that the subjective reification of DID can make it difficult for therapists to see what they have been trained to understand and treat: human beings; and we must remember that DID occurs within "whole" human beings.

DID patients can describe and display characteristics, capacities, and behavior that demonstrate unified functioning[3] (Loewenstein, 2020); that is, across the "whole mind" or the "whole human being." Kluft has described this as a "double-entry bookkeeping system" (see Chapter 43, this volume). In the psychotherapy of DID, there are important dynamics that are unconscious across all self-states. Medications are unlikely to be helpful if a medication-responsive disorder is not present across the whole human being.

Working at all three levels of analysis is essential in the psychotherapy of DID: self-states, self-state systems, the whole mind. At different times the therapist will work with the DID patient at the level of individual self-states, but always attending to indicators – that are often evanescent – of intrusion from other states. This can include subtle speech changes (e.g., suddenly child-like, teary, deeper voice, etc.); brief blocking; eyes darting to the side – almost invariably in response to voices commenting; sudden spaciness; touching the face lightly; complaints of sudden pain, typically a headache that indicates inner conflict and/or attempts to block a self-state that is coming forward. Also, sudden leg jiggling, change in eye-contact, posture, etc. Many interpretations, particularly about transference-based trauma reactivity, impact across all self-states. Simultaneously, it behooves DID therapists to recurrently do a reality check to ensure they are understanding DID as a manifestation of the entire mind, as, at times, even for experienced clinicians, the shared hyperfocused hypnotic field can lead to a compelling loss of distance.

Reification: Losing Sight of the Whole

The goal of DID therapy, as for any other patient, is improved unified functioning. Reification reinforces *separateness*. Reification may lead therapists to have difficulty when DID self-states deny responsibility for behavior ascribed to other states. Human beings, not self-states, enact behavior. Thus, if convicted of a crime, all self-states will go to prison. The "innocent" do not go free. *It is clinically disastrous to not hold the DID patient responsible for behavior, even if experienced by some self-states with amnesia or lack of subjective agency* (Beahrs, 1994; Loewenstein, 2020).

Reification can lead clinicians to practice below a standard of care that they would maintain for a "single-personality" disorder patient. This includes treating self-states as if they were separate people/patients: to "reparent" child states by literally hugging and holding the patient; to extrude (even attempt to exorcise) states as demonic embodiments of evil; to give specific self-states ongoing separate appointment times during the week, etc. Sadly, a disorder that results from a person being treated as an object, as a thing – even a very prized but defiled, detested *thing* –can result in well-intentioned therapists acting as if DID patients require a fundamentally different psychotherapy than other humans.

Self-States/Systems: Important Principles

DID is a profoundly *logical* disorder. The logic is based in posttraumatic adaptations. Most issues in working with DID are solvable by decoding which self-states/systems are involved, and what is the posttraumatic meaning of the difficulty, both currently and in the posttraumatic psychodynamic functions of the self-states/systems. The therapist must actively engage with the patient's mind to learn which self-states/systems are activated, why these states are activated – and why activated *now*, which other self-states/systems may be involved, and what is the posttraumatic meaning of the situation. These trauma-based relational dynamics also can be understood across the whole mind.

There may be – often hidden –posttraumatic reenactments: unconscious flashback narratives that have to be decoded across the mind, and relationally, frequently in the traumatic transference with the therapist. The latter may be drawn into a shared-hypnotic, countertransferential/projective identification-based enactment that may feel difficult, if not humiliating to figure out. See Loewenstein (1993a) for an extended discussion with case examples. Shame-based attachment-related dynamics across the self-state systems and the whole mind are central as well (discussed below).

Helpers, Protectors, and Problem-Solvers

Our field lacks a standardized vocabulary for types of self-states. There is a mixture of labels, mostly from the early descriptive studies of DID: child, adolescent, "host," "protectors," "helpers," "introject," "malevolent," "persecutory," "memory trace," "internal self-helper," "sexualized," "cross-gendered," "substance-abusing," etc. These are an amalgam of subjective self-state demographics and behaviors, along with intrapsychic manifestations and functions. This has not been integrated with later work postulating trauma-based, shame-based psychodynamics as the core symbolic processes of DID self-states (see Kluft, 2006, 2007).

Structural Dissociation of the Personality Theory (SDT) posits two basic types of self-states, "emotional parts of the personality" and "apparently normal parts of the personality." This is an advance in that it posits self-states as having functions related to trauma. Unfortunately, the term "emotional" does not capture core aspects of posttraumatic experience. The term "normal" cannot be defined except contextually (e.g., "normal blood-pressure," "normal distribution"). "Apparently" is not a technical term and has myriad dictionary definitions including something that is obviously visible, as well as something that may not be what it seems. The term "personality" has been eschewed in discussing DID, as it implies relatively stable, long-term, both trait and state-based manifestations of the human mind. For a more extensive critique of basic SDT concepts, see Loewenstein (2020).

Pragmatically, therapists can reframe all self-states as "problem-solvers." What problems led to their development? How are they subjectively structured to solve the problems? When patients ask me, "why are there so many?" I respond that, if one has had a lot of problems, we need as many problem-solvers as we can find to help with recovery.

"Host" Self-States

Kluft cautions against the notion of the "host personality" that often carries the legal name of the person and classically is defined as "the one who has executive control of the body the largest percentage of the time at a given time" (Loewenstein et al., 1987, p. 23, quoting Bennett Braun, M.D.). The all-too-common literal acceptance of the host-centric view leads clinicians to the developmentally inaccurate reification and conflation of the host as the "real person" – with his/her less real and important "parts." Typically, this view leads to more instability and unsafety, as

other states set out to prove that they are "not part of him/them/her." Unless all self-states agree that "*we are all part of* [name of other state]," therapists should reframe, "they are all part of *you*" as "each and all of you are aspects of *the mind of a single human being*".

Developmentally, "nominal" host states often are described as later creations to allow interaction with the outside world and/or to replace child state(s) experienced as traumatically demolished, and "put to sleep." Often emerging in latency or early adolescence, they function to engage with the outside world. They are designed to be dissociated from the trauma history and most, if not all, the other states.

Development of internal empathy is an important therapeutic task for DID patients: for all self-states to view their respective functions as adaptive. Without these surface/everyday states, the patient may never have been able to go to school, have friends, grow up, get away from home. The trauma-based meaning is that, without detachment from the trauma, the individual could not accomplish these developmental goals. It is more parsimonious and validating to reframe these often-difficult everyday states as adaptive to the overall survival of the human being. It can help therapists and other self-states better empathize with these typically depressed, amnestic, somatizing, and hyper-rigidly controlling states. It makes sense that these self-states are easily disrupted by trauma memories, and require particularly slow, careful, paced exposure to these and to internal communication.

"Malevolent," "Persecutory" "Introject" Self-States

Therapists struggle mightily with the problem of "malevolent," "persecutory" self-states, typically eidetic or symbolic versions of perpetrators. The term "introject" itself has negative connotations, although introjects can be positive people for the DID patient: a caring relative, a kind teacher, a gentle parent of a friend. "Persecutory," "malevolent" introjects can be reframed in several ways. I label them as "paradoxical protectors" and/or "underground freedom fighters." Why? The problem for the DID child is that violent torment from important attachments is inevitable, not optional. It is not a matter of "whether" it occurs, but "when" and "how bad."

These types of states protect in several ways. They are an eidetic warning system to stay alert that the dangerous people can come at any time. Sadistic perpetrators often *wait* for the DID child to be unsuspecting before attacking. The problem for the child becomes *never letting down one's guard*. Hence, the internal version of the perpetrator is like a screaming warning system. A DID patient described magical thinking, "we thought if we had him [violent father] inside, we could control him. But it didn't work." Or the child attempts to mitigate the violence by "doing it first," thus decreasing the dread; DID patients will tell you, "Waiting is the worst" (Loewenstein, 2021). Sometimes, DID patients report that hurting themselves led perpetrators to hurt them less. Kluft (2006) conceptualizes these states as identification with the aggressor: better to be the strong person harming the weak little person.

Later, Kluft (2007) formulated etiological dynamics based in defenses against extreme humiliation, "internalized attack other script[s]" (p. 308). Almost universally, the humiliated person wants to turn the tables, to retaliate; to make the attacker feel what the victim feels. This is unsafe for the developing DID child and may lead to more harm, intensifying the child's utter humiliated helplessness. Many DID individuals do not *want* to attack anyone else, especially not their parent. Thus, the DID child is thought to develop self-states that turn this wish to "attack the other" back on themselves. Typically, the structuring of these states embodies the perpetrator(s), either eidetically and/or symbolically.

Summing up these various ideas, one patient said about her vicious, icy, narcissistic mother, "I created my mother's voice to always tell me how imperfect I was. Then, it stung less when she always told me how imperfect I was."

Cruel, objectifying brutality came from the people to whom the child must attach for survival. Attachment is necessary for existence. Attachment is an existential danger. Attachment is an inevitable part of psychotherapy. One of the most common dynamics in therapy is that therapists start by encouraging connection with self-states that seem to want this: traumatized child self-states, "helper" self-states, etc. It seems "good" to connect with these "good" states.

The paradoxical protectors know only three outcomes of attachment: exploitation, abandonment, or both –and all are associated with profound humiliation. As therapy proceeds, the patient is beset with perpetrator voices filled with humiliating invective, imperatives for self-destruction, internal trauma reenactments, and delusionally separate rejections of the therapist. Typically, the therapist identifies with the victimized states and attempts to "protect" them from the "bad" states. This only drives the dynamic more. The result is psychotherapeutic chaos, stalemate, unrelenting dangerousness to self/others, a frustrated, bewildered, overwhelmed therapist often leading to ending therapy, or an endlessly crisis-ridden stalemated therapy. DID patients may create circumstances where they will be "thrown out" of therapy – taking charge of what appears inevitable: "You'll just get sick of me, get fed up with me, want to get rid of me. Just like everyone else."

The therapist should work with these dynamics from the beginning. This seemingly paradoxical stance begins to build an alliance with these paradoxical protector self-states who can become the strongest supports of recovery. Therapists can never overestimate the extent of basic mistrust of the DID patient. Therapists should repeatedly interpret the – often hidden – mistrust based on the idea that anything good will turn bad. Even so, these self-states can be hard to engage – maybe the therapist is just a more clever, trickier bad person. It is dangerous for underground freedom fighters to easily reveal their hatred of the dictator.

These self-states may report being tortured into existence by specific perpetrator terror-conditioning (e.g., to engage in forced perpetration). Protectively, they may say: "The others would have lost it. We could have been killed. That's why we had to come into existence." Over time, one often finds that hidden "behind" the perpetrator phalanx, are even more devastated child states – being protected as would a junkyard dog. "Underneath" the perpetrator "costume," one invariably finds child self-states. After considerable work, one patient's seemingly evil, "demonic" self-states said, "We're tired of being devils. We just want to be kids again."

Suicidal Self-States as Paradoxical Protectors

Intractable suicidality is profoundly difficult for DID patients and their therapists. Suicidal states often encompass what I call the "life-affirming function of suicide." For the trapped, helplessly imprisoned, tormented DID child, suicide may seem the only possible affirmation of "no," of control over one's mind and body. As one patient put it, "I was more powerful than them. I could end it, just like that!" Many DID patients conceptualize an afterlife where "God doesn't let little kids get hurt"; or simply, for the non-religious, peace and surcease from unending anguish. Eating disorder symptoms may also represent a covert "no," a refusal to have "anything bad put into me," to not have a body that can be harmed, etc. Typical psychological and psychopharmacological strategies to "eliminate" the "bad" suicidality, only increases it. Change can only occur once suicidal states are validated for their covert, defiant, anti-totalitarian stance, with empathy for their life-affirming efforts. Here, as always, the therapist frames this in terms of shifting the paradoxical, life-affirming survival strategies to life-affirming recovery strategies for safety in the present.

Also, intractable suicidality bears on emotional/unconscious flashbacks. Flashbacks are thought of as primarily somatosensory/emotional phenomena. DID patients' suicidality often begin before the age of five. As traumatic memories return, they may bring back their *childhood suicidality.* A helpful clinical solution: separate past and present. The everyday DID self-states commonly become suicidal in response to overwhelming recollections of horrific betrayal. It is often effective to separate the current suicidality from the flashback suicidality – different self-states/systems require differential approaches to intractable suicidality: paradoxical life-affirmation vs the shattering despair of recalling hate-filled objectification and indifference.

Pragmatics of Attachment and Betrayal Trauma Theory

Type D attachment (see Schimmenti, Chapter 10, this volume) and betrayal trauma theory (BTT; see Adams-Clark, Gómez, & Barlow, Chapter 7, this volume) can pragmatically be viewed together to help make sense of important issues in DID psychotherapy. In DBST terms, they can be understood as "isomorphs." Therapists, as well as genuinely concerned others connected with DID patients, often find it difficult to understand the seeming intractable attachment many DID patients have to perpetrators. Therapists tend to identify with self-states that recall abuse and view perpetrators negatively, and they struggle with the self-states that – often doggedly – insist on attachment to perpetrators and deny abuse. This is a complex and overdetermined problem. A central aspect is the inability of human primates to develop without attachment to some sort of – at least – warm and soft being (Van Rosmalen et al., 2012). Thus, the logic of type D attachment and the betrayal inherent in unpredictable frightening/frightened caregivers (DID parents are typically both), is to dissociate the betrayal from attachment (Freyd, 1996). In DID, this becomes consolidated with self-states that can experience attachment while dissociating betrayal, and visa-versa. Also, DID patients' maltreatment begins before the development of the capacity for cognitive constancy. The dissociative child may experience the nighttime rapist daddy as literally a different daddy from the daddy at breakfast – with self-states congruent with the "different" parents (Putnam, 1997). These different attachment dynamics may become more complex with DID parents. The DID child develops self-states aligned with specific parental self-states (e.g., multiple rapist fathers).

As with apparent malevolent states, therapists may find it grueling to empathize with these attached states, easier to identify with self-states that report maltreatment, who often deprecate the attached states. The attached states are deeply survival-based. Through dissociation of betrayal, these states help with critical attachment capacities, may embody hope, and, prefiguring the later everyday/surface self-states, may protect development of resilient intellectual and psychological

capacities. Unfortunately, the all-too-common enmeshment of DID patients in later abusive, coercively controlling relationships replays and reinforces these autochthonous divisions between attached and traumatized self-states.

Shame and DID Psychotherapy

DID therapists should develop competence in recognizing, understanding and working with shame (see Nathanson, 1992 for a comprehensive discussion of shame and affect theory). During psychotherapy, many common words and behaviors communicate shame (e.g., stupid, dumb, foolish, weirdo, mutant, freak). These include for example, the classic submission posture seen in humans (and other mammals) of shame mobilization: gaze averted, head and body bowed, hair covering the face, hands covering the face. Problems with eye-contact typically are based in fear of mortifying, mocking, terrifying attack by a dominant person. In extreme dominance regimes (e.g., slavery, prison gulags, organized abuse/trafficking), the lower status person is threateningly enjoined to never make eye-contact with the superior, unless told to do so. Some DID patients report extreme, tortuous double-binds around this: first, to never make eye-contact; then ordered to make eye-contact. Having done so, they are tortured for making eye-contact. If, out of frozen terror, they do not make eye-contact, they are tortured for refusing to follow an order. Without understanding these torture-based dynamics, therapists often futilely encourage DID patients that it is OK to make eye contact, sometimes precipitating seemingly incomprehensibly extreme traumatic transference-based reactivity. Always ask first: "I'd like to ask the whole mind, what would it be like if I encouraged you to make eye-contact?"

Shame and Attachment

DID psychotherapy repeatedly activates elemental shame-based conflicts about the therapist, attachment, and the safety of relationships. In DID, it can appear that attachment and humiliation are experienced as literally simultaneously entwined. Herman (2011) describes shame as "the master emotion of human life" (p. 264) originating in primary attachments that generalize to all other aspects of social life. Like other emotions, shame exists as a range of states: shy, self-conscious, feeling foolish/ridiculous, embarrassed, ashamed, humiliated, and mortified (shame unto death). Examples include "I was so embarrassed I could die" (a factor in suicidality);" "I wished the ground would swallow me up." Shame is associated with extreme social rejection: disgrace, dishonor, shunning; and, with the addition of disgust, is associated with debasement, defilement, and degradation. Extreme versions of the latter are essential to coercive control (see below), where dominance, power, and control exert their effects through humiliation. Slavery is the most extreme form of coercive control (Farley, 2013). Many DID patients, particularly with trauma involving organized sadistic abuse (OSA), describe slavery as the perpetrators' goal, including "automatic obedience" (i.e., obeying all orders, instructions & demands).

Herman (2011) describes, particularly in children with type-D attachment and severe betrayal trauma scripts, the desperate predicament for the abused child seeking attachment and comfort from unpredictably cruel and malign caregivers. The child has no choice but to seek assistance from the adults. One DID patient described this as being wordlessly, ineluctably drawn to a malevolent attachment "magnet." The adults respond by humiliating the child (e.g., "I'll give you something to cry about!"). Rejection, blame, mocking laughter, gaslit double binds all reinforce the child's shamefulness for "needing." Yet, the child cannot provide for him/herself caring, nurturance, and comfort – let alone food, clothing, shelter, warmth, and medical care. Often, the terrified DID child was threatened with complete abandonment and/or shunning. Thus, there is a – usually unachievable – attempt to be "OK" with the perpetrators to protect from literal and/or social death.

The fundamental bind: the child still must go back to the caregiver but is primally endangered in doing so. Self-states that dissociate betrayal find a way to connect to the caregiver, often in some stereotyped, debased form. Some DID patients report being savagely raped and/or physically assaulted when seeking attachment, caring, or comfort. During these assaults, perpetrators would repeat that the attacks were precipitated, or literally *caused by* the child directly or indirectly demonstrating needs. Also, adding a profound double-bind, perpetrators mock the child for being helpless, defenseless, without a shred of control.

Here again, making sense of self-states involves complex often-hidden, seemingly paradoxical trauma-based and shame-based relational schema and dynamics. Different self-states may encompass different sides of the bind: all-powerful in creating badness; completely debased and helpless with primal humiliation for their inability to control anything. Paradoxical protectors may scream in perpetrators' voices: "Never forget! Stop listening to that stupid therapist! You will be tortured more for any deviance! They know everything you are thinking!" This set of ideas in various forms reflects a near-ubiquitous threat in the history of DID patients.

In DID treatment, the fear of all-powerful "badness" that contaminates everyone, often deeply inhibiting the DID patient, manifests in the transference. Also, the child comes to believe that, if he/she caused all the badness in her family, all he/she needs is to be transformed into being "good," and magically "goodness" will come back to the parents too. Then, all will ride off into the sunset. This is a factor in DID self-states that manifest as rigidly, compulsively "good," where magical thinking involves the notion that "if I am perfect, then I can make my family OK."

Coercive Control

DID patients grow up under totalitarian coercive control regimes, an invisible gulag or concentration camp. Many continue ensnared in coercively controlling adult relationships (Snyder, 2018; Webermann et al., 2021) and/or in ongoing abusive, coercively controlling relationships with members of the family of origin (see Middleton, Chapter 13, this volume; Salter, 2017). Some DID patients are themselves perpetrators of coercively controlling intimate partner violence (Webermann et al., 2021).

Coercive control is defined in terms of power and dominance. However, *Shame is the delivery system, the rocket fuel of coercive control. Shame dynamics are the key to understanding all forms of coercive control: childhood maltreatment, intimate partner violence, trafficking, bullying, rape, torture, slavery* (Herman, 2011). DID patients struggle with making non-dissociative sense of coercively controlling attachments. It is a long-term process for DID patients to understand that psychological manipulation is the central element in coercive control, that physical violence is instrumental in the process; those periods of relative calm are part of the *cycle* of coercive control. This is a hard one for DID patients and for most abused children and adults. There is a strong, magical belief, partly based in intermittent reinforcement, that they must have "done something" to induce the hiatus. Again, this ties into the almost universal hindsight-bias-based belief that trauma survivors had some agency in the events, that they were not completely helpless (Beckham et al., 1998). If they only could get back whatever it was they did, it would make things "OK."

Power Dynamics

Therapists, no matter how egalitarian, loving, kind, altruistic, and sensitive, must be aware that therapy *always* involves power dynamics. It is inconsequential whether one uses the term patient, client, etc. Psychotherapy is a "relationship of disparity" that, like those with parents, teachers, coaches, police, religious figures, physicians (Loewenstein, 2004), is inherently unequal. The more powerful person has resources, knowledge, and abilities lacking in the less powerful. The former has a moral and ethical duty to the latter to do everything possible, notwithstanding inevitable human fallibility, to protect, teach, support, guide, and nurture them. DID therapists should be aware of and sensitive to these power dynamics – DID patients are – and should be open with their DID patients about them. They cannot be wished or denied away.

Social, Economic, Gender, and Cross-Cultural Issues

The treatment process can be affected by broader social, economic and cross-cultural issues, and their intersection with dissociation and DID, including historical trauma, racism, sexism, heterosexism, societal trauma, and institutional betrayal, among others (Gluck et al., 2021; Gómez, 2018; Holliday & Monteith, 2019). There is a substantial body of data that racism produces an analogue of PTSD, in part based on reliable and valid diagnostic interviews and self-report inventories (e.g., the UConn Racial/Ethnic Stress & Trauma Survey and the Trauma Symptoms of Discrimination Scale, Williams et al., 2018a; Williams et al., 2018b). Dissociation has not been systematically assessed in this context. The dissociative disorders field could make a major contribution by developing similar instruments to assess the presence of dissociation and dissociative disorder symptoms related to discrimination and ethnic stress and trauma.

Males with DID are an underserved group and are found throughout the mental health system. Social and cultural factors account for the failure to diagnose them, as there is a 1:1 ratio of male/female DID individuals in child/adolescent and general population samples (Loewenstein, 2018). African American males with DID may be particularly profiled as psychotic and/or antisocial (see Hohfeler, Chapter 36, this volume).

Many DID patients have suffered substantial stigmatization during their (usually) long psychiatric treatment careers, as is common for patients with (usually unrecognized) histories of past and/or current interpersonal violence and trauma. During years of misdiagnosis and mistreatment, DID patients commonly report terrifying, overwhelming, discounting, demeaning, distressing, and dehumanizing experiences, as well as physical/sexual violence and/or exploitation within a disbelieving mental health system. This adds to the difficulty for them in establishing a therapeutic alliance. Asking DID

patients about past psychotherapy and the specifics of interactions with therapists and psychiatrists that they continue to carry, often reveals profoundly humiliating experiences.

The Psychological Profile of DID from Psychological Assessment Studies[4]

The mind, the "personality" of DID individuals, is comprised of all self-states and all other dissociative and non-dissociative psychobiological capacities. Until the studies delineated here, personality assessment of DID only involved comparisons of individual self-states. Problematic results came from attempts at more general assessment. For example, a DID physicist had a WAIS full-scale IQ score of 89. When queried about this, she explained, "We had a child part do the tests." Judith Armstrong devised a multi-stage method to allow clearer understanding of DID personality patterns and cognitive processing styles. Rather than amplifying instabilities, this testing procedure had a stabilizing effect on the test subjects:

> In [a] pretest interview, the patient was informed that the testing was designed to be useful for people who feel as if they have different parts of themselves and/or who feel very divided. The patient was asked if this accurately described him/her. If so, the patient was asked to describe these parts of himself/herself. Using the patient's own terminology, the patient was invited to allow all divergent self-aspects to participate in the testing, if this was comfortable. The testee was also invited to allow the process questions as to how tasks were approached, how decisions were made, how inner information was elicited, what problems occurred in responding, and which self-aspects were involved in answering test questions. After completion of testing, all subjects had a final interview with the supervising psychologist for feedback concerning reactions to the test protocol and to discuss the process of responding to the tests.
>
> *(Armstrong & Loewenstein, 1990, p. 450)*

DID Personality Profile and Cognitive Processing Style

DID individuals are characterized by avoidant and obsessional personality features; a restrained psychological coping style, using intellectualization and internal focus, with a tendency to back away from stimuli, not affective discharge. The developmental sequestration of traumatic experiences appears to allow DID individuals to preserve state-dependent resiliency, including good reality testing about the self and others; a capacity to understand the world without cognitive distortions; a sense of humor; creativity; empathy; hope; and a capacity to see human attachments as a possibility (Armstrong, 1994; Brand et al., 2006). The latter is important in the DID patient's ability to develop a therapeutic alliance. In some patients, self-states showed idiosyncratic, covert strengths (e.g., only a "persecutory" self-state knew how to do higher mathematics).

DID patients have a state-dependent capacity for self-observation and insight (i.e., the observing ego). They can have insight and empathy – sometimes very deep empathy –towards others, even reported perpetrators, if not themselves (i.e., a capacity for mentalization). These capabilities can be substantially disrupted when DID patients are overwhelmed by posttraumatic and dissociative symptoms. They can be compromised by co-morbidities (e.g., severe, dysregulated PTSD; mood disorders; substance abuse; brain compromise due to eating disorders, head injury, and/or current or recent revictimization/retraumatization; Myrick et al., 2013). When chronically dominated by severe posttraumatic intrusions and/or major, chronic, disruptive dissociative symptoms, DID patients display impaired reality testing; volatile interpersonal reactivity; apparent loss of self-observation; and trauma-based cognitive distortions about themselves, other people and the world that can appear posttraumatically delusional (see Şar, Chapter 25, this volume). "Quasi-delusional" is more accurate, as almost always in DID one can access states that display good reality testing and insight. The symptoms of this regression, along with other factors (see below) commonly lead to a diagnosis of borderline personality disorder (BPD) (Şar et al, 2017).

The Rorschach Traumatic Content Score

During testing, DID patients frequently interpreted the Rorschach with morbid and malevolent associations – aggression, blood, violence, and violent sex – that, along with reports of hallucinations and passive influence symptoms, ordinarily would have been interpreted as indicia of psychosis. Instead, these results show that, from early childhood on, the DID patient had to be hypervigilant to possible predictors of threat in their environment. The Trauma Content (TC/R)

score indicates that automatized, fast-track fear-system responses represented *accurate, good, survival-based reality testing.* TC/R is defined as the sum of sex, blood, and anatomy scores, plus the morbid and aggressive special scores over total responses (Armstrong & Loewenstein, 1990). Across studies, DID patients show a *mean TC/R score of 50% response during psychological assessment, with a range of up to 150% responses* (i.e., multiple trauma response to each card). Sometimes the cards were literally perceived as dangerous objects, precipitating a flashback with loss of grounding and reality testing, pushing away the card, falling forward onto the card, etc.

Accordingly, DID patients had repeated idiosyncratic trauma reactivity during testing. A bright patient did well on the WAIS IQ testing, except for poor performance on block design. In debriefing, she related that, for long periods of time as a child she was locked in her toy box –with her toy blocks. Her block design performance deteriorated *due to posttraumatic disruptions*. In therapy and in their everyday lives, DID patients often have unpredictable, idiosyncratic, multi-layered posttraumatic responding to seemingly quotidian, neutral, and/or benign stimuli (Loewenstein, 1993b, 2006).

Splitting versus Polarization

Armstrong (1994) reframed responses typically viewed as "splitting," indicia of borderline personality organization/disorder. She suggested concepts of "fractionation" and "polarization" are more accurate in understanding DID patients' responses. The DID child had to internalize polarized childhood realities; responses to ongoing trauma required ongoing division of self-states (fractionation). It is maladaptive, if not hazardous during extreme danger and life-threat, to think in complex "shades of grey." At other times, Armstrong found that DID patients could step back from trauma-based responding and display insight into their contradictory responses. Polarization manifests in self-states who encompass alternative meanings, realities, and relational scripts (e.g., dissociation of betrayal). Armstrong (1994) conceptualizes DID self-states as "multiple self-languages" (p. 361).

While BPD and DID have some superficial similarities, consistent with type-D attachment and betrayal trauma theory. Armstrong stated that, "The BPD patient can be conceptualized as one who has split outer reality into extreme polarities to protect his or her own psychic integrity. The MPD patient can be understood as someone who has divided and compartmentalized his or her inner reality to maintain object-relatedness."

Complexity, Dissociative Distancing, and Auto-Hypnotic Defenses

On Rorschach measures of psychological complexity, DID participants show significantly higher scores than all clinical and non-clinical subjects. This correlated with overinvolvement and enthrallment with complexity, even to the extent of loss of interest in outside reality[5] (Brand et al., 2006). During testing, as posttraumatic symptoms intruded, DID patients attempted avoidance strategies, including dissociative distancing and cognitive avoidance, either by emotional detachment, or changing topics, and/or autohypnotic strategies. The latter included hyperfocus on tiny areas of the Rorschach card, with elaborate, sometimes fantasy-based responses. When these failed, the patients lost distance from the test stimuli with intrusive symptoms, age-regression, emotional flooding, and increasing loss of reality testing.

For example, in a recent tele-therapy appointment, a DID patient was struggling with extreme distress recalling mortification and degradation, her utter helplessness and powerlessness during years of childhood incest and trafficking. Suddenly, she stopped talking, looked down, and appeared to intently focus on something. On inquiry, she said, "Oh, I just got focused on this receipt on my desk. I don't know why. What were we just talking about?" She had deflected from her distress and shifted states through autohypnotic hyperfocus.

DID Psychological Profile and the Process of DID Psychotherapy

The psychological assessment data helps clinicians anticipate, make sense of, and devise logical interventions during all phases of DID. The psychological profile validates major aspects of the phasic trauma treatment model and clarifies how it leads to clinical improvement (Brand et al., 2012; Brand et al., 2019; Chu et al., 2011).

Delineation of a "whole human being" personality profile in DID patients supports that DID is not a disorder of "personality" fragmentation, rather one that is structured around subjectively divided self-systems. Development of DID emerges from a unique, ongoing, peritraumatic defense against continual childhood threat and maltreatment. These data support that dissociation later functions as an intrapsychic defensive process that becomes secondarily structured and shaped by myriad factors, observable during psychotherapy as autohypnotic defenses, and dissociative defenses such as depersonalization/derealization and state shifting/switching.

The finding that the personality structure of DID patients is primarily avoidant and obsessional is consistent with other studies of trauma survivors. Some DID patients are severely avoidant and deeply phobic of internal experience (Van der Hart et al., 2006). The obsessional features indicate that there will be attempts to maintain rigid control, also characteristic of other childhood sexual trauma survivors. Obsessional personality features can be found even under DID symptomatic chaos: decompensated DID patients can create detailed, organized self-state system maps with clear boundaries around self-states and/or self-state groups, with well-delineated communication pathways among states. This is consistent with the clinical studies showing BPD features in DID are related to clinical decompensation, with better functioning apparent when the DID patient is stabilized (Şar et al., 2017). Also, consistent with the testing studies, this demonstrates the simultaneous, multi-level SoB, with better reality-testing and functioning often hidden under the surface chaos. This underscores the importance of therapeutic interventions directed beyond the dissociative surface to concealed self-state systems (see below).

The obsessional personality features indicate that DID patients will do better overall with information and understanding. Typically, when DID patients make sense of the effect that specific traumatic experiences have had on them, they express relief that "things make sense," but "I wish I didn't have to know that" (Loewenstein, 2006). This is a core aspect of DID patients' improvement in psychotherapy.

Capacity for Insight

The observing ego is essential for change-oriented psychotherapy. Almost universally, DID patients will say that they "know" accurate information "intellectually," but this does not change the "feelings" about it. Some DID patients use extreme, derealized intellectualization as a global defense. However, intellectualization can also be helpful: it may be conceptualized as a *beginning*; a framework that can help the DID patient work, in a more logical and deliberate way, on intense emotions and posttraumatic beliefs that are experienced as facts.

In DID therapy, even at times of apparent complete decompensation, one can usually find observing and/or controller self-states. The former may display awareness of what is occurring; the latter may be consciously creating disruptions (e.g., "sending in flashbacks" to prevent discussion of difficult material, thwart the therapist from being able to harm the patient by knowing "too much", etc.). Early in my career, I spent much of a therapy session attempting to ground a DID patient from repeated flashbacks, confusion of past/present, and the misperception that I was a perpetrator from the flashback. Finally, increasingly grounded and oriented, she began to collect herself to go home. Suddenly, she switched. A cheery sounding voice announced, "I saw it all! Boy, did you look funny! But she's really hard to deal with. You did OK." The solution to flashback crises in DID may be with hidden states *creating* the flashbacks to disrupt therapy. Often seen as "sabotaging," instead the paradoxical protectors see danger in some aspect of the therapy and try to mitigate it. At another level, the specific flashback material may point to a particularly important posttraumatic narrative that has to do with what is being avoided.

Traumatic Transference

"The patient unconsciously expects that the therapist, despite overt helpfulness and concern, will exploit the patient for his or her own narcissistic gratification" (Spiegel, l986, p. 72). Consistent with a hypervigilant interpersonal adaptation to years of unpredictable, malevolent threat by attachment figures, the trauma-content data predicts that mistrustful, negative, traumatic transference themes will dominate much of DID treatment (Loewenstein, 1993b). One would expect long-term, multilayered, complex, severely mistrustful, often concealed, negative traumatic transference at all levels: across the whole mind, within specific self-states/self-state groups, and manifesting across the self-state systems.

Classically, there are several types of traumatic transference/countertransference scenarios. First, and easiest to conceptualize, the therapist is seen as a perpetrator. In the flashback transference, the therapist may eidetically appear as a perpetrator (or someone else) from the flashback. Next, the therapist may be perceived as the bystander who looks away; and/or the "stupid," often officiously, self-important "good" person to whom the patient may directly or indirectly attempt to disclose abuse (e.g., "Oh that's awful, dear. Let's just call your mother and ask her about what you said about your father").

Another transference role is the co-abusing parent, ranging from supposedly "unaware" to neglectfully punishing, and/or actively involved in maltreatment. Another theme is the abandoning person. Even if the therapist really is a good person, he/she will abandon the patient, typically precipitously, and typically after promising to "always be there." This scenario often occurs when the therapist or a concerned other takes on the "rescuer" role, another classic traumatic

transference/countertransference misalliance that can be damaging to the DID patient, typically when the enervated, frustrated rescuer withdraws or departs. No therapist can rescue or save any patient. Therapists may seem to know this with other patients but dissociate this understanding when working with DID.

DID patients may have an extreme reaction to something the bewildered therapist perceives as routine (e.g., changing the time or date of an appointment). However, in the power dynamics, the therapist implicitly communicates that he/she is completely in charge of whether the patient remains in treatment or not. The therapist could summarily dismiss the patient at any time. As therapists, we generally see ourselves as "on the side of the patient." However, we tend to neglect areas of potential conflict (e.g., fees, schedules, and absences). No patient gets to negotiate a time he/she prefers for the therapist to go on vacation. DID patients' lack of adherence to even helpful prescribed medication may also be based in fear that medications are a way to control the patient and/or symbolize precarious dependence on medications (or the prescriber). This theme may reflect reenactment of being drugged by perpetrators who controlled access to medications that could worsen or attenuate abuse, among others. Drugged children are different than adults who take drugs voluntarily. In general, adults have a cause-and-effect notion that ingestion leads to certain outcomes, as well as side-effects. One trafficked DID patient reported being given "fast pills" and "slow pills," while being savaged by paying perpetrators.

Finally, the therapist may symbolically become the patient, helpless to stop aggression, perpetration, and/or is subject to subtle or direct forms of abuse. DID patients' seemingly intractable safety issues often can be understood this way. In the countertransference, the therapist may experience a projective identificatory sense of helpless, overwhelmed futility at the patient ever stopping self-destructive behavior. For example, in an intervention across the whole mind, I said to a patient, "I'd like everyone to listen. I think you're giving me a Ph.D. course in what it was like when you were growing up helpless in the face of unending, unpredictable aggression. Powerless to stop someone hurting you, hurting someone else. Every time you thought things may have stopped or were not as bad, they got even worse."

Mind Control Transference

The therapist's overt helpfulness and concern is perceived by the patient as only in the interest of gaining access to the patient's mind to malevolently invade, control, and enslave the patient. This type of transference is intensely, pervasively compelling in DID patients who report long-term, calculated, sadistic perpetrator psychological invasion (Salter, 1995). It is almost ubiquitous when there is a history of OSA. It can also reflect psychologically invasive, controlling mental health professional parents and/or parents who are "shrinky," insinuating into the patients' thoughts and emotions. Typically, these involve malevolent manipulation of DID patients' high hypnotizability, self-states, and self-state systems. DID parents may deliberately manipulate and/or attempt to structure their children's self-states and systems to imitate, reflect, and or complement theirs. These different sources of mind-control transference can occur together in various combinations, and can be maginified when there is later psychological invasion and manipulation by exploitative, abusive psychotherapists and/or psychiatrists.

Patients describe mind-control tactics as uncannily like psychotherapy. Similar sounding phrases invite the mind to open, to share what comes to mind, with perpetrators frequently described as, or said to be, physicians, psychiatrists, psychologists, et al. Many DID patients describe subsequent, often sadistic, abuse by psychotherapists, who may use similar hypnotic, mind, and coercive control tactics to ensnare and dominate the patient. Introspection and "being seen" by the therapist are experienced as dangerous, not validating. Because of this, clinicians *must* embrace empathic therapeutic patience in long-term work with DID, especially where there has been a history (often hidden) of psychological invasion.

Attachment, Humiliation, and the Traumatic Transference

The DID child experiences an existential danger in the fusion of attachment-betrayal-humiliation. The word "needy" is one of the worst, if not the worst, a DID patient can say about him/herself. As a patient recently said, "You never could go and ask for anything. It was too humiliating…They treated me like I was disgusting for needing anything. I was a piece of shit, and they were holding their noses. I was so alone. I was alone in my family. I would've been less alone on a desert island." Here disgust/dissmell/degradation were added to humiliation.

Through imaginative, creative dissociative processes, the mind of the DID child structures self-states to help. One patient created specific states who assisted her to stop wetting the bed (she was savaged repeatedly for doing so); and taught her how to wash, brush her teeth, and tie her shoes. Another patient's mother told her, "nobody loves you" and "nowhere is safe." She created "Nobody," who loved her and "Nowhere," who was safe.

Therapists may respond with positive feedback to the patient for creativity in the face of malevolence. Typically, before saying something positive to a DID patient, I will ask if it "OK with everyone" if I do so. Often the answer is negative. It is important to respect this boundary. It may take years for a DID patient to accept the therapist saying something positive, let alone the "p-word" (e.g., "proud of you"). Thinking in the language of trauma, one must remember that some perpetrators may have told the child how "proud" they were of him/her concerning something heinous.

When a DID patient describes doing anything that logically would lead to a feeling of pride, they will often immediately begin to denigrate it and themselves. If there is something negative implied about a parent, almost immediately, they will deny that the parent ever did anything wrong, say how bad they are for suggesting it, and may engage in self injury as punishment. The paradoxical protectors (parental introjects) will be active here to attempt to anticipate, control and attenuate a feared shaming response by trying to "make it happen first." At the whole human being level, the patient is indirectly sharing a narrative of what happened in interactions with parents.

Understandably, the most common approach is to attempt to challenge the self-shaming, the denial of parental malevolent narcissism, and to insist that punishment is unwarranted: the patient did nothing wrong, and this is framed to reestablish safety. Instead, even during the process of reestablishing safety, I would ask the "whole mind to listen, everyone to listen;" that the patient is showing me the sequence of interactions with the parents, anticipating my responding similarly. The patient shows the powerful person his/her abject humiliation; assures this person that he/she is wonderful and the patient is the "bad one" who would not have the temerity to think otherwise; and that the person need not bother to punish the bad patient, the patient will take care of it. Here, I would talk to the introject paradoxical protectors, and interpret their caring, protective (*from me!*) intent as I detail the elements of the sequence, and the attachment-betrayal-humiliation scenarios. These self-states often will agree with all of this, except, that not only do they not "care" about the other states, they also "hate" them for being so "weak, wimpy, stupid" (shame words). I respond, that if that were so, what reason would the introjects have for bothering to intervene? Why not let the bad person do whatever to "the others"? These states may grudgingly admit that they *do* care.

To deconstruct this intervention: I identify a core trauma/attachment schema. I am expected to be a highly shame-prone narcissistic parent, who cannot tolerate the implication that I might have done something wrong; the idea that the patient has done something praiseworthy is an attack on my narcissism. The patient has already learned to be self-abasing and self-punishing to pre-empt the savage, mocking, "punishment" of this sadistic, mercurial parent: "So, you think you're so great, huh? Let's just see how great you are!"

Implications

From the beginning of therapy, I focus on, track, and attempt to deconstruct the traumatic transference themes. I prioritize engaging with the paradoxical protectors and reframing their motives. These patterns can change relatively quickly or require intensive, long-term work to establish basic safety, management of repeated safety crises, etc., especially if there are multiple paradoxical protector systems (see Loewenstein, 2006). Also, as an instantly triggering male, physician, and psychiatrist, I make the traumatic transference an open discussion almost from the moment the patient sits down for an initial appointment. Female therapists need to recognize that a substantial minority of DID patients describe women as primary perpetrators. This can lead to a similar, immediate, "hot" traumatic transference. Ultimately, for DID patients, both males and females have been destructively harmful.

Other traumatic transference themes will continue to emerge. For example, the therapist seems "so nice" but must be very "tricky" (a word almost universally used by DID patients), softening up the patient for an even better "gotcha." Alternatively, self-states will see the therapist as grandiosely, narcissistically wanting to be "in charge" of everything about the patient, displacing the protective self-states. At the human being level, this indirectly communicates about extreme perpetrator coercive control. Always pay careful attention to the words; another transference theme: "Nice" does not imply a core disposition to be moral, ethical, empathic, altruistic, humanistic, professional, etc. If you are "nice," you can easily become "mean."

In the DID mind, human interactions are negotiable, up for grabs; role-descriptions do not predict behavior. Thus, the patient tries to figure out what the therapists "wants" (how often do these patients say, "what do you want?"), and "needs" to "stay nice." Also, the DID patient must "take care" of the inadequate and/or perpetrator parent to "get" anything positive, being very careful not to have the shame-prone, retaliatory parent feel any inadequacy. In DID families role reversals are endemic, children are "parentified" to take care of parents' "sexual" needs (rape is not sex, but this is how it is constructed), cook, clean, and take care of siblings, often before age 5 to 6.

Negative Therapeutic Reaction

The negative therapeutic reaction (NTR) is endemic in DID psychotherapy (Chefetz, 2015). It has been described in the psychoanalytic literature since Freud's original definition (1923), as a patient's ongoing, unexpected symptomatic worsening, often after apparent brief symptomatic improvement, when logically the therapist anticipates that the patient should continue to improve. There have been a number of psychoanalytic formulations to understand this phenomenon. One explanation from this literature may particularly fit DID patients, a malignant, punishing superego: the patient has an extreme belief in his/her profound badness, and cannot allow anything positive to be internalized; no helpful imagery or technique for emotional regulation, etc. (Rosenfeld, 1975).

The Phobia of Feeling Good

The most common cause of NTRs in DID patients manifests as mistrust of positive experiences in a relationship, driven by attachment-betrayal-humiliation scripts. DID patients routinely describe perpetrators who find, or even sadistically cultivate, ways to attack the patient when he/she might feel OK, calm, interested in something positive. The perpetrator not only savages the patient but ridicules and mocks him/her for the audacity to think that he/she would ever be safe or OK.

No surprise then, that DID patients experience a phobia of feeling "better," safer, or relaxing their guard. As adults, DID patients may feel inhibited about finding enjoyable vocations and/or avocations, or even having fun. Perpetrators attackingly humiliate DID patients about enjoying *anything*. As a patient said, "All my father wanted to see was the look in my eyes when he betrayed me one more time." It is exceptionally cruel to torture someone to be profoundly, automatically phobic of any positive emotion. Therapists must respect how slowly this existential terror can be ameliorated; how much grueling work in the negative transference is required to move this needle even a little. Even words like "better" can have a paradoxical meaning. A perpetrator might use this word to describe the DID patient becoming seemingly more compliant to the perpetrator's demands. Simple, everyday words may be "boobytrapped". This is among the reasons that psychotherapy of DID is a *long-term* endeavor. Empathic, therapeutic patience is a quality to which DID therapists should aspire.

Early in therapy, I educate DID patients about the attachment-betrayal-humiliation dynamics, how maliciously sadistic it is to make someone dread feeling OK, relaxed, good, positive; that it becomes fused with betrayal, mortification, and self-loathing. I suggest that the patient "risk" tolerating this, even a little, and that protectors observe and talk with me about the tension that builds. A DID patient describing this reminded me, as noted above, that "waiting is the worst." It is better to "make it happen," do it to oneself, provoke the therapist to "fire" or "get rid of" the patient. Anything the patient likes or could begin to "count on" will be discovered by perpetrators and used against the patient in the most sadistic manner possible, even the therapist could be harmed – another reason to try to get rid of therapy. Far from "sabotaging," these paradoxical protectors may feel they are safeguarding the therapist from perpetrator threat, even at the patient's own expense.

Trauma-Dissociation Logic: There is *Always* a "Method in the Madness"

DID is a very logical disorder. However, it is trauma-dissociation logic. In DID psychotherapy there is a logical way to decode, deconstruct, and make sense of clinical issues, especially seemingly incomprehensible safety crises, predicaments, imbroglios, transference-countertransference difficulties, and the emergence of previously unknown self-states. The paradigmatic example of this logic was noted above in the DID patient whose WAIS block-design performance unexpectedly deteriorated, because of the repeated confinement abuse of being locked in a toy box.

I have described this as learning a language from another culture. DID patients, even those who are highly successful professionals, resonate with the metaphor of growing up in a different, clandestine culture, albeit appearing to be from the everyday culture. Often DID patients describe that, by interacting with other children and teachers at school, and/or even literally sitting and watching people, they tried to learn "how to act like regular people." Feeling so alien is a source of profound shame.

Therapists need to learn this language and this culture, as the assumptions of the everyday world, even the world of less extreme developmental trauma, may not fit with the assumptive world of DID patients. This requires therapists to think about self-states, particularly the paradoxical protectors/underground freedom fighters, from the perspective of the trauma-dissociation culture. Sometimes, it helps simply to ask the DID patient, "does this remind you of anything?" You may find that the solution to the predicament can be readily described by the patient. It is dissociated not with

amnesia, but in the fundamental sense of important psychological information that logically should be connected but is not; and this disconnection is based on comprehensible psychological processes like profound shame, making the patient reluctant to ever speak or have a voice. As one patient said, "everything that was good, was bad."

Metacognition and Mentalization

In DID, problems with metacognition are complex, multi-factorial, and paradoxical. There is no unified sense of self across SoB and contexts, nor is their adequate centrality or continuity of identity. Autobiographical memory may have complex state-dependent dynamics, as different self-states/systems loculate different autobiographical memories (e.g., multiple reality disorder). These may be differentially activated and/or in conflict. Self-states/systems may experience delusional separateness and/or delusional disorientation to current circumstances, with dereistic autobiographical memory. State shifting/switching is often accompanied by dissociative amnesia between states, although there are frequently overarching observers that may have relatively global self-observing and memory continuity. Self-states/systems may be experienced as removing memories, "sending in" memories (e.g., flashbacks, and/or providing confabulated memory to other states). Even at times of apparent complete dysregulation, controller states may describe "being in charge of" and creating or moderating psychological chaos.

Self-states may report autobiographical memory as first-hand experiences, then deny recall of these memories at a later time. Some self-states describe derealized autobiographical memory. They "know about" aspects of the life history, but do not experience these as autobiographical memories. Self-states appear to experience complex posttraumatic states, flashbacks, which may be divided among self-states/systems in terms of emotional, somatosensory, cognitive, and behavioral aspects of memory. Some appear in frank flashback, others in states similar to that of the dissociative sub-type of PTSD.

Skills and knowledge may be widely distributed or state-dependent (e.g., a DID inpatient who trance-logically denied that her "work" self-states/systems were in the hospital: "Why should *they* be here? There's nothing wrong with *them*"). Trance logic can adversely affect metacognitive capacities in some ways, yet allows for self-observation, as demonstrated in hypnosis research showing the existence of "hidden observer" states that experience or recall what had been hypnotically ablated (Hilgard, 1986). Skills and knowledge domains may be state-dependent (e.g., cooking, driving, artistic productions, areas of knowledge like mathematics or bookkeeping), but may be variably available through overlap among states, or rapid state shifts.

Strategies to improve metacognitive/executive integrative functions include increased communication, collaboration, and cooperation among self-states/systems. These are foundational, overarching therapeutic tasks in DID treatment that involves the basic integrative approach to psychotherapy. They can involve specific technical interventions (e.g., journaling, "internal meetings," self-state substitution, use of safe-place or containment imagery for subjective respite, to contain trauma memories). "Survival"-based problem-solving strategies can be replaced by "recovery-oriented" strategies (e.g., using safe-place imagery instead of non-suicidal self-injury for containment and attenuation of intolerable cognitions, affects, and memories).

These strategies begin to create a repertoire of "recovery-oriented" self-regulatory and adaptive strategies and practices to develop safety and stability. There is a hierarchy of interventions to "detoxify traumatic or distressing states of being." In the first stage of DID phasic trauma treatment, this may primarily involve using the observing ego capacities to see patterns that represent unconscious/emotional flashbacks. This results in work on separation of past/present, but without "all the details and all the feelings." The latter begins in later treatment stages after these more basic interventions have been consolidated, and the patient's and therapist's life spaces and resources permit working in a more in-depth way on trauma memories.

Conclusion

This chapter is a truncated journey through the basic theoretical, conceptual, and clinical constructs that shape how, after over 40 years and literally thousands of DID patients,[6] I think about the process of DID psychotherapy. My goal has been to give the reader a brief survey with the hope that this will provoke a deeper look at what is presented here. Most of the ideas and techniques (e.g., hypnosis, developmental traumatology) have not been systematically taught in mental health training programs. With the increasing theoretical and clinical hegemony of behaviorally-oriented concepts and treatments, psychodynamic principles – the foundation of DID treatment – are no longer taught in any real depth in most training programs. Psychodynamic principles are fundamental to DID treatment (e.g., boundaries/treatment

frame, traumatic transference/countertransference, projective identification, reenactments, and negative therapeutic reaction).

Even before I began to work with DID, through my long collaboration with Frank W. Putnam, I learned to think in terms of DBST principles, and the notion of "state-change disorders" as a possible unifying conceptualization of psychiatric disorders, and, later, as a deeper way to make sense of DID. Also, through Putnam's work on attachment and SoB, DBST informed my understanding of the developmental processes that led Judith Armstrong to characterize DID as an "alternative developmental pathway." Armstrong's brilliant work on DID psychological organization is isomorphic with DBST developmental theory of DID, illustrating the later impact of the developmental malevolence survived by DID patients. The study of affects by Donald Nathanson and Judith Herman, and particularly as synthesized by Richard Kluft in terms of DID and shame dynamics, are essential touchstones to working with DID. Jennifer Freyd's betrayal trauma theory aligns with studies of Type D attachment in traumatized children.

There is convergence between DBST treatment principles and psychodynamic views of change though psychotherapy where, despite different words, their concepts particularly fit the goals of DID therapy. These include improved continuity and accessibility of autobiographical memory, even traumatic, shame-inducing, and other distressing memories; improved access and acceptance of associational patterns of thought/emotion; more clear and consistent reality testing; improved cause and effect thinking; and more deliberative and mindful behavior. Movement towards these goals fosters integrative processing and results in greater coherence, continuity and less conflict in self/identity-states. Self-identity is more integrated across all emotions, states, and contexts and can better withstand and/or recover from overwhelming, traumatizing, and/or stressful events and experiences.

Notes

1 This chapter should be read as a companion to his.
2 Psychoanalytic writers criticize the term "splitting" as easily concretized and reified (see Lustman, 1977).
3 This is not unique to DID. Unmedicated, homeless schizophrenic patients know where and when they get their monthly disability checks.
4 I am not going to detail the specifics of the variables on test measures (e.g., the Rorschach), that show a DID profile, and that differentiates DID patients from all other clinical groups. Detailed descriptions of these variables can be found in Armstrong & Loewenstein (1990); Armstrong (1991, 1994); and Brand et al. (2006, 2009, 2019).
5 There is a subgroup of DID patients who describe an attempt at complete withdrawal from reality that has been experienced as a life-long, inescapable, nightmarish catastrophe. This is a factor in lack of, or only very slow response to treatment. It is egosyntonic to live in dissociative, auto-hypnotic complex worlds.
6 This is not an inflated number. For almost 30 years, I was an inpatient psychiatric attending, psychotherapist, or team leader for hundreds of individual inpatient admissions to the Sheppard Pratt Trauma Disorders Program, Trauma Disorder Unit and Trauma Disorders Day Hospital. At the same time I conducted 30-35 hours per week of intensive psychotherapy with DID outpatients, and performed numerous outpatient and inpatient consultations. At one point, I did at least 3 consults per week. Also, I consulted upon and/or supervised the treatment of many other trainees and attending therapists.

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