European Journal of Trauma & Dissociation 3 (2019) 95–102

Available online at
ScienceDirect
www.sciencedirect.com

Elsevier Masson France
EM|consulte
www.em-consulte.com

Original article

The origin of so-called "shadowy personalities" in patients with dissociative identity disorder

Kenichiro Okano

Kyoto University Yoshida-honmachi, Sakyo-ku, Kyoto Shi 606-8501, Japan

ARTICLE INFO

Article history:
Received 22 March 2018
Received in revised form 14 July 2018
Accepted 24 July 2018

Keywords:
Dissociative identity disorder
Shadowy personality
S. Ferenczi

ABSTRACT

Introduction. – In this study, the author presents ideas about what he calls "shadowy personalities" (SPs), that is, destructive and aggressive, often masterminding, parts of personality among patients with dissociative identity disorder (DID).
Objective. – This study demonstrates how these SPs manifest themselves, how they can be dealt with in various clinical settings, and how this notion adds to the understanding and treatment of DID.
Method. – The author seeks to conceptualize several types of SPs, which manifest themselves differently in various clinical settings. The review of literature demonstrates how this notion could be related to, and different from, notions such as "persecutory parts of the personality" and "controlling emotional part (EP of the personality)" proposed by past authors. Then, case material is presented, and the implications of some psychotherapeutic approaches are further discussed.
Results. – SPs have been demonstrated to have the following features: anger/aggressiveness, difficulty in identification, temporary appearance in critical situations, and an almost physically felt presence. The author demonstrates some prototypical SPs, such as SPs with aggressors' voices, depressive and self-destructive SPs, SPs asserting themselves on behalf of the host personality, and competitive SPs. A hypothesis of the way SPs are formed is presented, primarily based on Ferenczi's theory of identification with the aggressor (IWA). Three types of situations leading to IWA are proposed: 1. A child identifies with the aggressive aspect of the aggressor (i.e., "becoming" an aggressor); 2. A child identifies with the internal image of him/herself in the aggressor's mind (i.e., aggression is directed inward); and 3. A child identifies with a bystander (both in reality and fantasy) and aggression is used in support of him/herself.
Conclusion. – The notion of SPs describes not only their nature but also the way they are perceived by other parts of personality. It was found that SPs are formed through different types of IWA, but their clinical manifestation can be a mixture of features reflecting all of them. The notion of SPs is experience-near for patients and can be used as a communication resource for the therapeutic pair to better understand one another and focus on the therapeutic orientation and goals.

> . . . In the other state she hallucinated and was 'naughty'—that is to say, she was abusive, used to throw the cushions at people, so far as the contractures at various times allowed, tore buttons off her bedclothes and linen with those of her fingers which she could move, and so on.
> Fräulein Anna O, Case Histories from Studies on Hysteria. Josef Breuer (1895, p. 24)

1. Introduction

Dissociative identity disorder (DID) is no longer considered a rare condition. In some studies, its prevalence among the general population is estimated to be around 1–3% (Johnson, Cohen, Kasen, & Brook, 2006; Murphy, 1994; Ross, 1991), which should be giving many psychiatrists and psychotherapists the opportunity to be in contact with patients with this condition in their clinical settings, whether they are aware of it or not.

While treating patients with DID, clinicians often encounter types of personality states that display negative emotion and behaviors, such as aggressiveness or self-destructiveness. These personality states tend to evade our clinical approach, but their

E-mail address: kenokano@gmail.com

https://doi.org/10.1016/j.ejtd.2018.07.003
2468-7499/

existence often threatens and overshadows that of the patient because of their unpredictable and intrusive nature. Although these types of personality states have been described or referred to by multiple authors in the past, I would like to single out and discuss in detail one type because of its huge clinical impact and significance.

In this study, I call these personality states "shadowy personalities" (SPs). In fact, the expression "SP" has been used for quite some time in my clinical practice, both by my patients and therapists involved in their treatment. The name was derived rather spontaneously, probably from my patients as this is often how they describe these personality states—namely, that they are not easy to grasp and often take the form of a shadow or grayish figure in their minds. Some patients call SPs "shadows" or "shadow-like", while others refer to them as dark or black figures that lack a clear countenance or discernable facial expressions (see examples of a patient's depictions of the SPs).

Naming parts of personality might not be altogether beneficial for patients with DID. In my clinical practice, I leave it to the patients how their different parts are to be addressed. However, SPs quite often lack any specific name. In that case, I suggest to the patient that we call them "SPs", at least temporarily, among ourselves (unless the patient proposes otherwise). Some patients might modify the expression into what they prefer, such as "the dark fellow", "that black guy", and the like. Thus, SPs can be used as communication resources among therapeutic couples to facilitate communication regarding what is going on in the patient's intra- and extra-psychic experiences. However, when SPs are active and present in the clinical setting, the clinician should ask them how they want to be addressed.

In general, SPs can be readily distinguished from other personality states in DID. Other personality states are usually more "elaborated" (Van der Hart, Nijenhuis, & Steele, 2006), with their own names and distinct profiles, including ages, first memories, and typical situations where they appear. They often exchange or share information among themselves about their daily life events or salient histories. In contrast, SPs tend to be excluded from the circle of other personality states and prefer living isolated lives. Some of them are dormant and give no indication of their presence for extended periods, although their presence is given a legend-like status in the patient's mind.

The term "SP" also depicts the way they visually appear. When patients are asked to draw their internal world, SPs are drawn quite roughly, often entirely shaded with gray and with no facial parts while other personality states have distinct body contours and facial features. Usually, patients try to avoid being contacted by SPs because of the latter's dark and sinister nature. Some SPs are perceived as very arrogant and condescending. "Shadow" not only connotes something negative and aggressive but also carries a nuance of some mastermind-like influence behind the scenes. Calling them "SPs" seems to make sense as when SPs themselves realize that is what they are called, instead of feeling offended or denigrated, they feel they are being paid the respect and awe they deserve.

Although the term "SP" developed rather spontaneously among clinicians and patients in a way quite independent from any academic influence, "shadow" obviously has Jungian connotations. In this context it is relevant to quote R. Noll (1989), whose description of "shadow" in the context of DID coincides very well with the idea of SPs presented here, as follows:

> The shadow is violently represented by the frequent presence of "persecutor" alternate personalities. These persecutors torment the afflicted individual, often committing acts of internal violence toward other personalities, violence toward other people (including homicide), or attempting self-mutilating or suicidal actions towards the "host" body. Sometimes—reflecting the strong resurgence of the archetypal strata—these shadow-like personalities actually claim to be demons or the Devil himself. These persecutors compulsively repeat the painful abuses suffered at the hands of adults by the victimized child, forever recreating the initial sadistic situation that splintered the young mind into a multitude of identities (p. 365).

2. A review of literature and theoretical formulation

The nature and characteristics of aggressive parts of personality in DID have been described and discussed by major authors. In his classical work, Richard Kluft (1984) touched upon the aggressive and destructive parts often observed in DID patients. Frank Putnam (1989), in his classification of different "alter personalities", mentioned "persecutor personalities which sabotage the patient's life and may inflict injury upon the body and can be suicidal" (p. 109). As for its origin, Putnam states that "[s]ome persecutor personalities can be recognized as 'introjects' of the original abuser(s); others have evolved from original helper personalities into current persecutors" (p. 109). Putnam also describes that that personality "strikes a contemptuous or condescending attitude toward the therapist and often actively seek undermine treatment" (p. 109), which is the nature of SPs that I described above.

Colin Ross (1997) also mentioned "persecutor personalities", which he describes as "often responsible for suicide attempts, 'accidents', self-destructive and self-defeating behavior, and outwardly directed aggression as well... They often present as tough, uncaring, and scornful, but this is usually just a front for an unhappy, lonely, rejected self-identity" (p. 150).

Thus, major DID researchers almost invariably recognized the presence of SP-like figures in their work, calling them "persecutor personalities." More recently, in their theory of the "structural dissociation of personality" (hereafter abbreviated as TSDP), Van der Hart et al. (2006) succinctly discuss this type of personality in their description of the "persecutory EP (emotional part of the personality)" among other parts of personality.

"... [persecutory EPs] claim they are abuser, and not the abused, and have the affects and behaviors of a perpetrator to varying degrees. In this sense, these Eps often cannot distinguish internal reality from external reality" (p. 82). They say that "... those [persecutory] Eps... are almost invariably present in chronically traumatized individuals." They also depicted the abovementioned mastermind nature, stating that "EPs are often unwilling to participate in therapy directly, and work 'behind the scenes' to sabotage progress..." (p. 312).

Some features of SPs: I would like to define SPs as having the following four major components.

2.1. Anger/aggressiveness

Anger and aggression are the primary components of SPs' emotional expression. However, it is often unclear to whom SPs are directing their anger. Indeed, they appear to direct their anger in a rather indiscriminate fashion, such as yelling at or lunging toward whoever is around them. However, it might also hurt the body of the host personality, or even attempt to kill him/her, which ultimately means killing itself.

It is worth noting that SPs' aggressiveness is typically accompanied by a lack of the same in the host and other main part of personality. Many parts of personality seen among patients with DID often do not know how to express, or even feel, angry and frustrated (which naturally serves to protect attachment bonds with the caregiving aspect of the aggressor.) SPs might typically appear in situations where other people have initially demonstrated aggressive

behaviors or intrusiveness towards the host personality. The host personality does not, however, typically intentionally "summon" or "invite" the SP into the scene in response to aggression from others. Instead, the host personality may become at a loss and thereby cause the SP to manifest. The whole process occurs rather instantly and automatically.

It is worth noting that in the *Studies of Hysteria* (1895), Freud proposed an opposite view, that a person intentionally and defensively mobilizes different parts of personality in such critical situations, and disagreed with Breuer's non-dynamic view (a "hypnoid state.") that such a state occurs automatically.

2.2. Difficulty being approached and identified

Generally speaking, SPs do not seem to have a distinct contour; in other words, they are not altogether "crystallized" or "elaborated" (Van der Hart et al., 2006) in their character formation, compared with other parts of personality. When they are "out" and active, they appear to be in a trance-like or somnambulistic state, or in a clouded consciousness, and lack the capacity to respond to particular questions asked by clinicians (see my clinical case in A clinical example). One hypothesis is that the SP is formed in the midst of severe traumatic experiences with heightened autonomic arousal and suppressed of the hippocampus (van der Kolk, 2014), which might have somehow inhibited the process of elaboration. Another hypothesis is that in the original scene of aggression where the SP was formed, the perpetrator might have tried to belie or obscure his/her involvement ("I didn't do it") or obliterate the trauma as a fact ("Nothing really happened"). Sometimes it is the very victim who refuses to identify the perpetrator ("It was not my dad who did it. Someone else I don't know did it"). However, I need to stress that these two hypotheses remain highly speculative, with no research to back them up.

2.3. Temporary appearance in critical situations

When SPs appear, they typically remain for short periods, disappearing rather quickly. If their appearance takes the form of stormy or violent behaviors, it tends to last for an even shorter period. In these cases, SPs appear to consume a considerable amount of physical/mental energy and get quickly exhausted, literally unable to "stay up" any longer. These states are approximated to episodes of cultural-bound syndromes such as Latah and Amok characterized by sudden and incomprehensible violent attacks, which subside rather quickly, leaving the person amnesic of the episode (Kon, 1994). The triggering factors for the appearance of SPs vary, but they are often related to reminders of some critical or traumatic event. The way SPs appear is reminiscent of the mechanisms triggering flashbacks of past traumatic events occurring among patients with posttraumatic stress disorder.

2.4. An almost physical presence felt and experienced by the individual

Perhaps one of the unique characteristics of SPs is that they are felt by other parts on a high perceptual and physical level. They are often felt to be "shadowy" not only figuratively but visually. Quite often, SPs, with their persecutory and threatening nature, are thought of by non-SP parts as alienating and detestable. Sometimes SPs are considered very intrusive and forceful toward other parts. The host part of an individual with DID stated that when an SP is out and active, it feels like a violent outburst coming from within her body. If other parts are awake, they feel physically immobilized by a ghost, just like in sleep paralysis (Fig. 1).

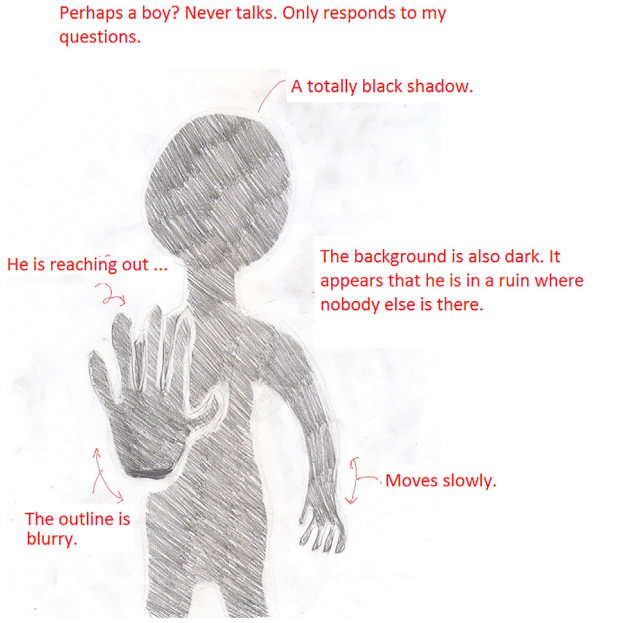

Fig. 1. Depicts a child's mind within his/her brain, facing an aggressor who has an internal object of a child.

3. Some prototypical SPs

In this section, I will demonstrate several types of SPs that I have observed in my clinical practice.

3.1. An SP with an aggressor's voice

Some SPs may represent themselves as someone that the host personality actually met and interacted with in the past, and who had some traumatic effect on the person.

Short clinical example: "A", a young female tutor, was teaching math for a teenage boy at his house. One day, A found herself increasingly irritated and frustrated because the boy would not focus on his task; although she nevertheless gently redirected and reprimanded him, he would not listen. Suddenly, her tone of voice switched and she took on a tone reminiscent of her mother, who had been very punitive and harsh in A's childhood. A was aware of what was happening to her and attempted to calm herself down and lower her tone. However, A realized that the change in her voice was beyond her control. The boy looked very scared and bewildered. Later, he reported to his parents that he had been verbally abused by A, so she was fired as his tutor.

3.2. A depressive and self-destructive SP

Some SPs are characterized by a depressive and pessimistic affect that is entirely inconsistent with the host personality's usual mood.

Short clinical example: "B", a teenage girl with DID, who is usually optimistic and cheerful, occasionally becomes very depressed and even suicidal. Her parents were oblivious of their daughter's dissociative disorder, and would often become bewildered by the sudden change in her mood. One day, when her pet hamster died, B's reaction was that of sadness and grief, but to a moderate and understandable degree. However, that night, a depressive SP appeared, lamenting the pet's death and crying profusely, accusing the host personality of not having taken better care of the hamster. The SP expressed a desire to follow the deceased pet to heaven. B's parents were reminded of this situation during B's last psychiatric hospitalization several years ago, which

occurred after B became seriously self-injurious and suicidal when her best friend became emotionally distant from her.

3.3. An SP that asserts itself on behalf of the host personality

Some SPs appear to manifest in order to express anger and aggression on behalf of the host personality, who seem unable to even feel or experience these affects during certain stressful or traumatic situations. As discussed later, this coincides with some author's description of the "protective functions of some parts" (Van der Hart et al., 2006).

Short clinical example: "C" is a young single woman who works for a local restaurant. Although C is generally satisfied with her working environment, she is unhappy with her male boss, who often asks her out for a drink after work, which tends to last many hours, sometimes until early the next morning. Despite knowing that she would end up exhausted by accepting his invitations, C feels that she cannot decline them because he is her boss and because of her own nature. Her therapist proposed to C to see if "someone else can say 'no' to the boss's invitation on C's behalf."

In the following session, C reported that one day, after their restaurant had sent off their last customers and the boss had again asked her if she wanted to join him for a drink, "someone" took her over and became suddenly aggressive. This "someone" began knocking off tables, throwing chairs, screaming at her boss and demanding that he not ask C out again, because C cannot say "no" or express her feelings to anyone, despite being completely fed up with her boss's invitations. The boss was quite taken aback—being completely unaware of C's dissociative disorder—but accepted her demands nonetheless. The whole process occurred without A's awareness. Immediately following this episode, C's child personality showed up, scared about what seems to have happened with all of the tables and chairs scattered around, and asked the boss to reassure and console her. The boss did so, still bewildered by the situation. C was later told about what had happened by her boss, who even apologized to her for not being aware that C did not like being invited out to drink.

3.4. A competitive SP

Some SPs can be very competitive with the host personality and may possess attributes that differ considerably from those of the host, such as age and gender, which makes the two personalities entirely incompatible.

Short clinical example: a young woman training to be a nurse, "D", had an SP who seemed to be a middle-aged male. He often appeared when she was changing into her nurse uniform in the women's locker room and became aroused by the view of other undressed women. Once he appeared, he felt very uncomfortable with D's "girlish body" and expressed his determination to "take a step towards a sex change operation" if the situation allowed. He demanded that D should step down because he is the real owner of the body and is therefore entitled to "run their life." Fortunately, this SP showed up very infrequently and was easily exhausted when outside, so he quickly returned to being dormant.

4. The way SPs are formed: a hypothesis

I will propose some ideas about the way SPs are formed in patients with DID. Perhaps what is most mysterious and enigmatic about DID is the process in which some parts of personality are formed and observed as having autonomy and their own sense of subjectivity. These parts are certainly somewhere in the individual's *psyche*, but it might be questionable if they are in the individual's *mind*, as some of them act as though they are strangers and appear antagonistic and competitive to the main part of his/her personality. Some might reasonably wonder if this process can really be described in terms of internalization, identification, incorporation, and so on, as these analytic concepts are primarily applied to internal objects for non-dissociating individuals. Nonetheless, attempts have been made to explain and understand the mechanism behind the presence of various parts of personality. TSDP (Van der Hart et al., 2006) is one of the major theoretical systems to delineate how dissociative parts are formed in the context of Janetian theory.

In this study, I will draw mainly on Sandor Ferenczi's theory in his attempt to describe the way some aspects of aggressors get internalized in children's minds (Ferenczi, 1932–1933, 1952). Contemporary authors such as Jay Frankel (2002), Elizabeth Howell (2014), and Adriano Schimmenti (2017) base their ideas on Ferenczi's concept of "identification with the aggressor" (hereafter abbreviated as IWA) and discuss their views on the way persecutory parts of the personality are formed in dissociative patients. It was Ferenczi who introduced the term "introjection" as "the opposite of projection" and stated that "the neurotic helps himself by taking into the ego as large as possible a part of the outside world, making it the object of unconscious phantasies" (Ferenczi, 1952, p. 40). In DID, this process of "taking in" occurs in a very distinct way, perhaps unlike what "introjection" generally means. What is introjected in the dissociative process is not simply in the form of some representational "internal object", but by far more "elaborated" and "emancipated", to the point of apparently having its own will and acting as an agent.

4.1. Ferenczi's and A. Freud's concept of IWA

The notion of IWA was proposed by Ferenczi (1932–1933) and Anna Freud (1936) in the same period of the history of psychoanalysis, but separately. These authors did not refer to each other's notions, which could be one of the reasons for the misunderstanding of the concept (Howell, 2014). Nevertheless, the notion of IWA is relevant in many ways to understanding the formation of SPs in psychodynamic terms. A. Freud included IWA as one of the defense mechanisms the ego possesses. The main feature of A. Freud's IWA is the reversal of the role (Laplanche & Pontalis, 1974); she believed the child goes through an initial stage of development in which the aggressive relationship is reversed. "[B]y impersonating the aggressor, assuming his attributes or imitating his aggression, the child transforms himself from the person threatened into the person who makes the threat" (p. 113). Thus children use it as a defense or "coping strategy" and become aggressors themselves. A similar perspective was proposed by René Spitz in his discussion of the notions "no and yes" (1957).

What is also characteristic of A. Freud's idea of IWA is that it lacks any dissociative nature and the whole process sounds like intentional and defensive maneuvers. The child "mimics" and "impersonates" the aggressor actively instead of becoming at a loss, helpless, and numb, as many children in a victimized position would become.

IWA in Ferenczi's sense has quite a different nuance. In his idea, what is assumed is pathological and traumatic situations where IWA occurs in defense. Ferenczi states that terrified children "subordinate themselves like automata to the will of the aggressor..." and "by anxiety-ridden identification and by introjection of the menacing person or aggressor" (pp. 162–163), the child becomes one with the attacker.

In Ferenczi's notion, there is some automata, like under hypnotic dissociation, the child identifies with the aggressor's mind. Apart from the difference of the implication of dissociative process, the key difference is that in A. Freud's IWA, the aggressed child becomes an aggressor, whereas in Ferenczi's IWA, the child becomes the aggressed child in the aggressor's mind. Jay Franke (2002) carefully guides us in exploring Ferenczi's original meaning

of IWA with its distinction from A. Freud's. In explaining these differences, Frankel draws on Heinrich Racker's (1968) notion of two types of countertransference identification, i.e., "concordant" and "complementary."

In concordant countertransference identification, the analyst identifies with the agency (id or superego) that the analys and is also identifying with. In contrast, in complementary countertransference, the analyst identifies with the agency with which the analysand is dis-identifying or objectifying. Thus, in an aggressor–victim situation, a child identifies with the aggressive side of the aggressor in concordant identification, whereas in complementary identification, the child would identify with the aggressor's internal object of the child, which is submissive and victimized. I propose that for the sake of clarity, we call A. Freud's type of IWA (Freud, 1962) "IWA-1", and Ferenczi's type "IWA-2", respectively.

Frankel argues that these two types of IWA were hinted at in Ferenczi's original paper. Ferenczi distinguished two mechanisms of identification and introjection, which are like two sides of the same coin. Frankel (2002) states that "Identification in Ferenczi's use means someone's trying to feel what another person feels, essentially by getting into that other person's head. In contrast, in introjection, one gets an image of someone into one's own head" (p. 106).

In reference to the types of SPs that I discussed earlier in this paper, IWA-1 is typically represented by (1), SP with aggressive voice, while IWA-2 is in a sense exemplified by (2), depressive and self-destructive SP.

4.2. The 3rd type of IWA

In this context, I would like to suggest that there could be the third type of IWA ("IWA-3"). In the aggressor/victim configuration, this type might not belong to either of them but is an observant bystander. Here is how I believe the formation process of IWA-3 would go. Although there might not be any room for the victimized child to "observe" the abusive scenes in reality in which she/he is directly involved, the child can have many occasions where he/she witnesses or observes similar abuse situations where someone else is implicated. These might be fictional scenes in the TV dramas or movies, or real-life situations in which the child is lucky enough to not be directly involved. In these scenes, he/she might observe people who would not remain in a victimized position, but rather fight back, flee, or somehow otherwise actively protect him/herself.

In other scenes, when a child is actually abused, there might be a bystander who would actively intervene and rescue the child or stop the abuser from further victimization. It is natural to hypothesize that a child would then identify and introject these protective figures who would fight back, flight from the abuser or who would rescue him/her, and this is how this third type of IWA would occur.

Historically, parts of personality with "protective" aspects have been described by many authors (Kluft, 1984; Putnam, 1989; Ross, 1997, etc.) TSDP (2006) mentions three EPs that are involved in protecting the host personality; fight, persecutory, and protector parts. The protector part certainly can be an aspect of SPs, which is represented by the SP that asserts itself on behalf of the host personality that I discussed earlier. It is my hypothesis that the SP with this aspect is formed through IWA-3, with the involvement of a bystander/rescuer in the abusive scene, either in reality or in the child's fantasy. In more recent work, Ellert Nijenhuis (2017) discussed two types of EPs: fragile and control EPs. From my point of view, the fragile EP might correspond to IWA-2 while the control EP is similar to IWA-1.

More recently, Schimmenti (2017) discussed three types of "traumatic identification." In his work, the first type is a dissociative part of the individual, which is identified with the victimized child. The second type involves identification with the perpetrator. The third type "concerns the internalization of a parental state of mind that has already been exposed to forclosure" (p. 164). Schimmenti's theory broadly corresponds with my idea of IWAs 1, 2, and 3. Certainly, his first type is close to IWA-2, and the second type to IWA-1. His third type could be very complex and multifaceted, which should imply any fantasy around trauma, independent of the direct abuse-victim configuration, and it could be akin to what I describe in the idea of IWA-3.

4.3. Communication among SPs and other parts, and internal enhancement of aggression

Parts of personalities are known to interact with each other without the knowledge of the host personality. This type of mutual influencing among parts of personalities is described as an indication of their "emancipation" (Van der Hart, 2006). For example, an aggressive SP (as a result of IWA-1) would continue to "abuse" the victimized SP (formed as a result of IWA-2) in its "inner relational configuration" (Howell, 2015) in the same way the aggressor torments or victimizes the child in real life.

As I described in Figs. 2–4, at least some loci are formed in the child's "brain" (i.e., the light moss green zone in the figures), if not in his mind (the blue zone) in its usual sense, thus allowing these SPs to function as agencies. While the host personality might be living a relatively uneventful life, this internal abuse and aggression can still be played out, which can keep the wound fresh and vivid. Although there is no way of knowing whether any interaction among the personality states occurs "automatically", there are several rationales to believe so. Specifically, the memory of trauma in the childhood usually remains vivid and painful, as though the victimization actually continues to occur.

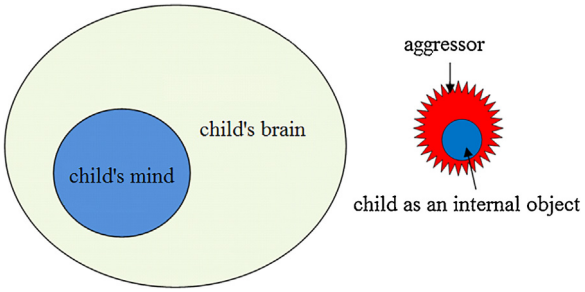

Fig. 2. Shows a state where two types of IWA (IWA-1 and IWA-2) occur and the aggressor part as well as the victimized child part are introjected to the child's "brain", if not his/her "mind".

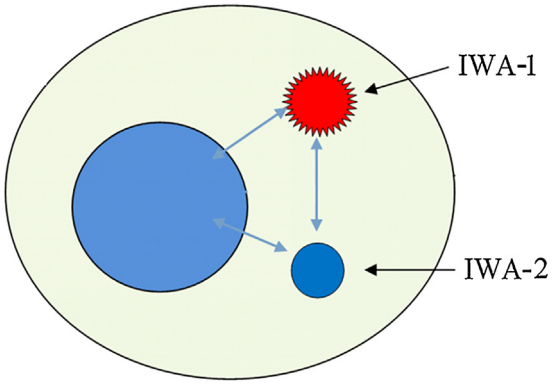

Fig. 3. Shows a state where the third, protective IWA is also hypothetically drawn into Fig. 2.

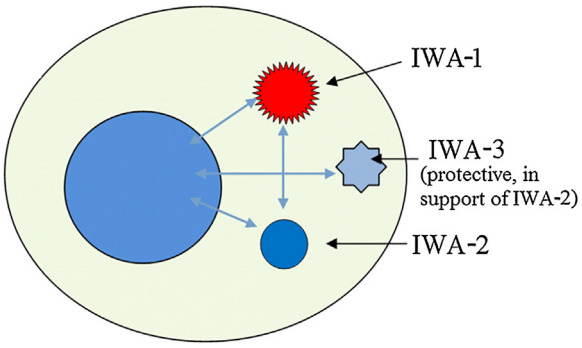

Fig. 4.

5. Implications for psychotherapeutic approach

5.1. General orientation

So far, I have described a hypothetical process wherein different types of SPs are formed, using some diagrams to make my points. I move on to discuss briefly how understanding this process could aid therapists in handling SPs in clinical settings. The International Society for the Study of Trauma and Dissociation (ISSTD) recommends a phase-oriented treatment for DID (International Society for the Study of Trauma and Dissociation, 2011). Generally, the approach to the SPs focused in this study would fall under phase 1, or "stabilization and symptom reduction." When an SP is attempting to express itself, allowing it to do so in a safe and supportive environment may reduce the patient's sense of urgency and stress, as well as their persistent hearing of voices. However, contact with an SP can also be considered a component of phase 2 ("confronting, working through, and integrating traumatic memories"; International Society for the Study of Trauma and Dissociation, 2011), as it has connotations of abreaction for both the SP and host personality and may allow for working through the trauma memory, given that the SP's verbal expressions might be a reprocessing of some traumatic memories.

The therapeutic approach to parts of personality close to SPs, such as persecutory EP (Van der Hart et al., 2006) and controlling EP (Nijenhuis, 2017), has been well discussed by these authors. Primarily, TSDP provides us with quite an informative and accurate guideline in its description of "working with persecutory parts of personality" (pp. 311–313) and a large part of my discussion goes along with it. Perhaps the most important initial part of treatment includes patient education. It is very useful to inform the main parts of personality of the nature of their SPs. According to TSDP (2006), "All parts of the patient should be educated early in therapy as to the function of persecutory parts within his or her personality system" (p. 312). TSDP also stresses the importance of letting the patients know the protective function of these parts of personality. Compared with other non-SP personality states, SPs are more difficult to access because they often resist being called into therapeutic situations. As per TSDP (2002), SPs are "often unwilling to participate in therapy directly", and "work behind the scenes to sabotage progress, which they regard as dangerous, as a threat to a precarious balance of the inner system" (p. 312). Partly in response to SPs' negativistic attitudes and penchant for being destructive, aggressive, and revengeful, therapists tend to be loath to handle them.

One of my patients (a teenage girl with DID) stated, "SPs are kind of like a group of those whose have been robbed of the chance to voice their feelings. They were stopped from voicing whatever they feel, especially anger. Other parts are not programmed to get angry, and that gets on their nerves. Oh, that's why they don't bother to attend the inner meeting. They know it's not worth it, as they are going to be voted down by others anyway..."

In his discussion of the therapeutic approach to the controlling EP, Nijenhuis stresses: "It would be important to fully include all dissociative parts in the treatment" (p. 530). He also underlines that it is therapeutic to emphasize to other parts "how important he [the controlling EP] and the other dissociative parts were" (p. 530). I fully agree with his even-handed and accepting approach to all parts of personalities, especially as whatever the therapist does or says can potentially be observed by SPs behind the scenes. In a sense, a therapist could *always* be facing SPs, at least indirectly, in any clinical setting. However, as to whether the therapist should directly address the SP is a difficult question with no single answer. According to TSDP (2006), "... [W]hether or not the therapist should attempt to work directly with these parts... depends upon the degree to which these EPs affect the personality system as a whole early in therapy." ensuring patient safety and maintaining the therapeutic relationship is essential to any therapeutic approach to dissociative patients. When SPs are expected to easily go out of control or become agitated to a degree that the therapist cannot subdue or control them, any attempt to directly contact them in therapeutic settings would be deemed inappropriate or untherapeutic. The therapist should not be to blame if he becomes rather protective of non-SP parts and tries to keep them away from SPs if they are very instigating and destructive. I consider it very important to listen to the voices of non-SP parts of personality regarding how they feel confused and threatened by the SPs. However, while stressing the SP's protective nature, it is also important to clarify that empathy should not deter them from venting their negative emotions toward SPs. Although I could not agree more with the TSDP stance that "the therapist must not avoid these parts, but rather be fully engaged with persecutor Eps in order for treatment to be successful" (Van der Hart et al., 2006, p. 313), it does not exclude the possibility that when SPs choose to stop being active and become dormant, they should sometimes be left untouched and be given space so the patient's functional level is secured. Again, whether to deal with SPs directly/indirectly depends largely on the therapeutic context and requires a high level of judgment on the part of the clinician.

5.2. Direct handling of SPs

With these caveats, therapists should still be prepared to handle SPs in a direct way, when clinically warranted. If some SPs continue to haunt a patient's life, refusing to "settle down" or "go back to sleep", they might need to be directly contacted and appropriately handled—both for the patient and therapist. Occasionally, there might be clinical situations on an outpatient basis where encounters with SPs occur spontaneously and inevitably, or even by necessity. Before I present case material in one of the last circumstances, I would like to state the conditions for handling SPs in a psychotherapeutic setting.

The therapist must have established a good therapeutic alliance with an identified SP that he/she intends to handle. That SP should also be cooperative enough to maintain the therapeutic structure. The host part of personality must be certain that the SP is not excessively disruptive or aggressive so that the therapist or patient is never in any physical danger.

The conditions in which the handling of an SP may be appropriate and therapeutic can be summarized as follows.

An SP has been appearing frequently enough in the patient's life for an extended period, and a continuation of that pattern in the near future is expected.

The SP is sufficiently cooperative with the therapist, and the host or SP itself can assure the therapist that any physically aggressive or disruptive behaviors can be avoided (or the therapeutic process should be suspended if any of such behaviors occur).

Access to the SP should be initiated tentatively, and the process should be postponed or given up if the patient's functional level, such as the level of agitation and frequency of the switching among parts of his personality, appears to be getting out of control.

The rationale for handling SPs that meet these conditions is as follows. If an SP establishes some communication with the therapist, the aggressive nature of the SP can be gradually modified and "detoxified", probably in a similar way that traumatic memories are abreacted and become less salient through exposure therapy or eye movement desensitization and reprocessing (EMDR). Although there are many ways of explaining neurologically how exposure techniques work (Myers & Davis, 2007), I would like to consider the curative process of dissociative cases from the standpoint of memory reconsolidation (Okano, 2015). The theory of memory reconsolidation posits that when past events are recalled, their contents can be modified in some ways and future recall will produce different contents. There are attempts to use this theory for therapeutic purposes (Ecker, Ticic, & Hulley, 2012).

SPs are parts of an individual's personality that have never had enough chance to express their feelings. Through experiences of expressing themselves, SPs' traumatic memories can be reorganized, hopefully in such a way that they would no longer be reminisced intrusively or automatically.

Clinicians should keep in mind that SPs should be treated in the most respectful manner possible. As the TSDP (2006) suggests, "the therapist should. . . [treat them]. . . by acknowledging and respectfully addressing them" (p. 312). If a clinician uses the term "SP" in their presence, they should be given an explanation for such a way of addressing them and try to get them to understand that there is no pejorative meaning and ask them if they prefer being addressed differently.

In this study, I would like to present case material in which such direct contact with an SP was required.

6. A clinical example

I would like to discuss a case, "Allen", that I treated long ago. He had DID and afforded me a good opportunity to reflect on the ways in which SPs can be handled in clinical settings. Allen was in his mid-twenties and was on extended sick leave after working as a dance instructor for around 5 months. After graduating from a local dance school, Allen had taken this job and had devoted a considerable amount of energy to it. In the first few months, Allen was welcomed by his fellow staff and was liked by his students, as he was eager to help them improve their dancing skills. However, his work-related stress mounted, as he was gradually given increasingly more classes to teach, and he began to appear rather inattentive during class and had trouble sleeping at night. He reported frequently getting forgetful and absent-minded for a while during his job.

Allen stated that he could identify several distinct personalities within himself, that he knew their names and ages as well as some of their profiles. However, he also said that there was "someone else" that he could not grasp. Allen then revealed that he had been suffering from voices that tormented him with negative phrases such as "you are useless", "you should never have been born", or "you are a total failure!" He thought that these voices derived from that "someone else", which he decided to call "unknown." Although he could "visualize" the other personalities, he could not picture unknown, except for a vague impression of its having a grayish and "shadowy" figure. Unknown was usually hidden and dormant, except for certain periods wherein it became more active and conspicuous.

As for his social history, Allen was the only son of two schoolteachers. He had a strict upbringing and always felt that he was never good enough or worthy of praise in their eyes. He believed himself unlovable. His school grades were usually good, except that whenever he earned high scores on quizzes, his parents made a point of saying that the quizzes were too easy for him, rather than that he did a really good job.

6.1. Sessions involving contact with his SP

Allen stated that he often felt "a pressure from within" for unknown to come out and express itself. Allen describes the pressure as a sort of constant swirling inside his chest, desiring to come out. He also mentions that while he is by himself in his bedroom, he sometimes finds himself muttering some negative phrases in unknown's voice.

After careful discussion with Allen, we agreed that it might be at least worthwhile to have some sessions wherein I attempt to contact unknown, provided that Allen feels comfortable and secure enough to do so. I also made sure that there has been no incident where unknown had become violent, and he had no history of being a danger to others or destructive to objects.

The actual process of contact with the SP comprised 10 consecutive bi-weekly sessions, each consisting of a 45-minute interview broken into three parts.

In the first part of each session (10 minutes), Allen and I discussed how things were going in his life in general, especially after the previous session. Frequently, I asked how the previous session had affected him, to what extent the SP had appeared in his life, and how willing or reluctant he was to come to the session.

In the second part (20 minutes), in which the actual contact with the unknown was attempted, the typical process was as follows. I dimmed the lights of the office and asked Allen to get into a slouched position in a comfortable chair. I invited him to breathe deeply along my counting up to ten. Then, I asked Allen to let unknown out and express whatever it had to say, so long as it stayed in the chair.

Quite typically, after 2–3 minutes' silence, Allen began to show spasm-like movement in his extremities, while his eyes rolled upward. Then, unknown began expressing itself in bouts of loud laughter and a hissing voice; it sounded triumphant and somewhat intimidating and threatening. Then, unknown began mumbling words. The contrast from Allen's usual gentle and docile vocal expressions was obvious. The content of the speech was not consistent or coherent; rather, it was typically monosyllabic and full of innuendo. These vocalizations included "I feel so good to be out here", "I will kill them", "I should be the one", "you should do it", etc. Unknown occasionally provided descriptions of what it (or Allen himself) might have gone through, but this was usually so fragmentary and unintelligible that I could not obtain any details. I sometimes uttered words, such as "I'm here to listen to you" or "you might have gone through a hard time." Unknown would either nod slightly in response to my utterances or not respond at all. After expressing itself for about 15 minutes, unknown would lose its momentum and its vocalizations would appear less frequently. I then would gently indicate that the time was almost up, and that Unknown should be ready to go inside and sleep. Unknown usually followed this cue and began relaxing Allen's extremities. I then slowly counted backwards from 5 and asked Allen to come back while I turned the light of the office back on.

In the third part of the sessions (15 minutes), I briefly discussed with Allen how he had experienced the past 20 minutes. He was usually oblivious of the entire scene, or sometimes vaguely remembered what unknown had said or how it had behaved.

6.2. Follow-up period

After these special sessions designed to contact the SP, we went back to our usual sessions. One of the major changes after these 10 sessions was that Allen began showing much less difficulty in suppressing Unknown, and found that it manifested itself less frequently. Allen stated that Unknown was still there, but he felt much less internal pressure. The auditory hallucinations, which mainly derived from the SP, reduced to more than 60%. After this series of sessions, Allen focused more on the real issue of hunting for jobs, which he carefully planned and ultimately achieved success in by getting a temporary job.

7. Discussion

In this clinical example, Allen demonstrated a rather prototypical picture of an SP that he calls "unknown." This name itself demonstrates the mysterious and inaccessible nature of his SP. Although direct contact with SPs on an outpatient basis can be risky and problematic, with Allen, I decided to try to reach unknown as he/she seemed to want to express him/herself in order to be better settled inside. Otherwise, Allen's physical sense of pressure and urgency was enormous and intolerable. We also agreed that if a couple of trial sessions did not work, we would stop the process. Unknown exemplified the four conditions mentioned earlier: aggressiveness, inaccessibility, temporary appearance, and the physical sensation that it elicits in the individual. As far as the types of IWA are concerned, unknown seemed to have gone through all of them, as evidenced by various fragments of his utterances. Some of his anger was directed toward Allen himself while the rest was obviously directed toward his parents. Still, some of them are trying to rescue Allen. This indicates that, possibly, all the IWAs (1–3) occurred to a different degree, allowing his SP (unknown) to possess all these features. At any rate, Allen and I could proceed with this process owing to our sense of security and a good therapeutic relationship.

8. Conclusion

In this study, I presented some ideas about what I call SPs and how they manifest themselves, as well as how they can be dealt with in clinical settings. Parts of personality similar or equivalent to SPs have been documented and discussed by various authors. While drawing on them I put together some of their specific features and characteristics: anger/aggressiveness, difficulty in identification, temporary appearance in critical situations, and a quasi-physical presence felt and experienced by the individual.

Based on Ferenczi's theory, three types of situations leading to the IWA are proposed:

- a child identifies with the aggressive aspect of the aggressor (i.e., "becoming" an aggressor);
- a child identifies with the internal image of oneself in the aggressor's mind and aggression is directed inward;
- a child identifies with a bystander (both in reality and fantasy) and aggression is used in support of the child.

I proposed that the delineation of the notion of SPs could be clinically beneficial, as the name reflects how (host parts of the) patients' personalities experience them. As many patients' lives center around fear and concern about how to avoid or deal with their own SPs, a psycho-educational approach to other parts of personality using this notion can be of help in focusing on the therapeutic orientation and goals. Although the clinical example demonstrates the way a patient's SP was directly contacted, I also underlined that whether to deal with SPs directly depends largely on the therapeutic context. There are many cases where SPs should be left dormant in order for the patient to stay functional.

Disclosure of interest

The author declares that he has no competing interest.

References

Ecker, B., Ticic, R., & Hulley, L. (2012). *Unlocking the emotional brain: Eliminating symptoms at their roots using memory reconsolidation*. London: Routledge.

Ferenczi, S. (1932–1933). 'Sprachverwirrung zwischen den Erwachsenen und dem Kind'. English trans.: 'Confusion of Tongues between Adults and the Child'. *Final Contributions, 162*, 256–265.

Ferenczi, S. (1952). *First contributions to psycho-analysis the international psycho-analytical library, 45:1–331*. London: The Hogarth Press and the Institute of Psycho-Analysis.

Frankel, J. (2002). Exploring Ferenczi's concept of identification with the aggressor: Its role in trauma, everyday life, and the therapeutic relationship. *Psychoanalytic Dialogues, 12*(1), 101–139.

Freud, A. (1936). *Das Ich und die Abwehrmechanismen English translation: The Ego and the Mechanisms of Defence (London: Hogarth, 1937; New York: International Universities Press, 1946.)*. CT, United States: International Universities Press's location is in Madison.

Freud, S. (1962). *Three Essays on the Theory of Sexuality, trans. James Strachey*. New York: Basic Books.

Howell, E. (2014). Ferenczi's concept of identification with the aggressor: Understanding dissociative structure with interacting victim and abuser self-states. *American Journal of Psychoanalysis, 74*(48–59), 48–59.

International Society for the Study of Trauma and Dissociation (2011). Guidelines for treating dissociative identity disorder in adults, third revision. *Journal of Trauma & Dissociation, 12*(2), 115–187.

Johnson, J. G., Cohen, P., Kasen, S., & Brook, J. S. (2006). Dissociative disorders among adults in the community, impaired functioning, and axis I and II comorbidity. *Journal of Psychiatry Research, 40*(2), 131–140.

Kluft, R. P. (1984). An introduction to multiple personality disorder. *Psychiatric Annals, 14*(1), 19–24.

Kon, Y. (1994). Amok. *The British Journal of Psychiatry, 165*(5), 685–689.

Laplanche, J., & Pontalis, J.-B. (1974). *The language of psycho-analysis*. New York: WW Norton & Company.

Murphy, P. E. (1994). Dissociative experiences and dissociative disorders in a nonclinical university student group. *Dissociation, 7*(1), 28–34.

Myers, K. M., & Davis, M. (2007). Mechanisms of fear extinction. *Molecular Psychiatry, 12*(2), 120–150.

Nijenhuis, E. (2017). *The trinity of trauma: Ignorance, fragility, and control. The evolving concept of trauma/the concept and facts of dissociation in trauma*. Göttingen, Germany: Vandenhoeck & Ruprecht Gmbh & Co.

Noll, R. (1989). Multiple personality, dissociation, and C.G. Jung's complex theory. *Journal of Analytic Psychology, 34*, 353–370.

Okano, K. (2015). *Kairi Shinjidai (new age of dissociation)*. Tokyo: Iwasaki Gakujutsu Publishing.

Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: The Guilford Press.

Ross, C. A. (1991). Epidemiology of multiple personality disorder and dissociation. *Psychiatric Clinics of North America, 14*(3), 503–517.

Ross, C. A. (1997). *Dissociative identity disorder. Diagnosis, clinical features, and treatment of multiple personality* (2nd ed.). New York: John Wiley and Sons.

Racker, H. (1968). *Transference and countertransference*. New York: International Universities Press.

Schimmenti, A. (2017). Traumatic identification. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis, 11*(2), 154–171.

Spitz, R. A. (1957). *No and yes: On the genesis of human communication*. New York: International Universities Press.

Van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. New York, NY: WW Norton.

van der Kolk, B. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma* (1st ed.). London: Penguin books.