CHAPTER SIX

Dissociation and dissociative disorders: Commentary and context

Elizabeth Howell, Ph.D.

In this chapter I discuss the personality organization of highly dissociative individuals as well as the dissociative organization of our culture. Not only does the first mirror the second, but there are also profound interactions, based largely on shame and shaming and victim/aggressor dynamics. These dynamics increase the dissociation between contradictory cultural beliefs, such as the enacted belief in the ownership of children and the right to abuse them (for example, manifested in the extremely high prevalence of child sexual abuse), existing side by side with the even greater rate of its denial. These dissociatively based contradictions in cultural knowledge also further isolate those people who are highly dissociative.

First, I am going to comment on Dr. Itzkowitz's case of Yolanda and introduce some generalities about Dissociative Identity Disorder (DID). Then, I will offer a response to Dr. Itzkowitz's observations regarding the spurned diagnosis.

Studies of 719 DID patients indicate that they spent 5.0 to 11.9 years in the mental health system before they were diagnosed as having DID (The International Society for the Study of Trauma and Dissociation's *Guidelines for Treating Dissociative Identity Disorders in Adults*, 2005). More generally, the average amount of time that a

patient with DID spends in the mental health system before being correctly diagnosed is about seven years. Of course many are never correctly diagnosed. It seems that Yolanda spent more than the average amount of time in the system before finding Dr. Itzkowitz, a therapist who was willing and able to listen to her alters' experiences, to understand them and their interrelationships, and in this way to help her to get better. Like so many of the patients in the mental health system who have DID but have been misdiagnosed, Yolanda previously bore diagnoses of schizophrenia, borderline personality disorder, and bipolar disorder. Many never recover from these diagnoses, never receiving any treatment that will enable them to get better.

DID generally starts at a young age, usually by the age of five, and rarely beyond the age of nine or ten (Loewenstein 1994). It is initially a useful coping response to an environment which is very difficult to endure. The problem is that dissociative responses—such as switching, blanking out, or going into a trance—become automatic, and, once the original abusive environment has been left behind, are of little use in life and may be detrimental.

A traumatically abused and terrified child may deal with overwhelming affect and pain by distancing herself from the experience to such a degree that she dis-identifies with the experience and becomes an observer (rather than an experiencer) of the event. In this depersonalized state, she then pseudodelusionally (Kluft 1984) views this as happening to another child. This "other child" then "holds" the affects and memories that would be unbearable to the host, thereby protecting the host from being continually overwhelmed and safeguarding the ability to function. Highly dissociative persons may also create internal protectors and guides, often modelled on a person with whom they had positive interpersonal experiences, as well as dissociated "identifications" (Howell 2002) with aggressors.

Like most severely dissociative people, Yolanda's system of alters mirrors the violent, dominant–subordinate, and neglectful family system in which she grew up. Understanding the relationship between and among the parts of the system is vital for understanding the dynamics of her system of alters, as it is in groups and families. Yolanda was severely neglected, abused, and unprotected. Several of her alters serve as protectors, but in different ways.

Mary is a part of Yolanda who does Yolanda a great service by "holding" the enormous anger resulting from so much abuse, unrequited longing, and chaos. This protects Yolanda from experiencing affect that would otherwise be overwhelming and that she does not know how to regulate. If Yolanda herself had expressed this anger as a child she might never have survived a drowning, or similar disaster of malevolence, like that from which her younger brother was luckily rescued.

Like many aggressive alters of persons with DID, Mary may well have started out as a protector. However, the function of protection merges into one of persecution. On the inside, Mary prevented Yolanda from being and feeling visible and angry when that could endanger her to violence from her mother or her mother's cohorts. One of her functions is that of a powerful personified internal model that pre-emptively keeps Yolanda in line to protect her from worse danger on the outside. Unfortunately, this involves inhibiting, restricting, cutting, and in other ways punishing Yolanda. One reason that protectors become abusing persecutors is that there has been more persecution than protection from the outside. An imitation cannot be better than the original, and it only has the original's methods at its disposal.

It is likely that Mary enacts and embodies a traumatic procedural identification with the aggressor (Ferenczi 1949; Frankel 2002; Howell 1999, 2002). To deal with the abuser, the child must get inside the head of that abuser. The result of dissociative identification, however, is that the abuser is now in the child's head (Frankel 2002). I have suggested that in this kind of traumatic identification, the abusive "part" of the self arises from the child's automatic mimicking of the abuser's omnipotent, devaluing behaviour. Terror often fosters a hypnoid narrowing of attention to only the most relevant stimulus; in this case, the abuser. The child who may need to calm or please the aggressor, focuses on the abuser's postures, facial expressions, and words, and automatically mimics them as enactive procedural dyadic learning.

If the abuser is a parent or close relative, the child is often much more intensely attached than if there has been no abuse. The abuse increases fear, and inasmuch as the attachment system reduces fear (Lyons-Ruth 2001), the need for the attachment object is greatly increased. With respect to dissociation, in order to preserve

attachment to the abuser and the part of the self who loves the abuser, the child must be unaware of the terrifying experiences at the abuser's hands. These self–other experiences are split off and often personified. In addition, we often find one particular internal dyad: One part of the self, usually the host, is unaware of the abuse, while another part mimics the abuser's behaviour as a form of enactive, procedural, dyadic learning (Howell 1999, 2002, 2005). Once the abuser is inside the child's head, in addition to punishing the host, she can also take executive control and lash out violently at others. As it was in her family, for Mary, violence is often an automatic procedural way of handling things.

While Mary holds rage from the perspective of a hostile self in a hostile world, Carlos holds terrifying and painful memories of physical abuse, even torture, such as being thrown into a closet. Carlos witnessed his mother attempting to drown their younger brother, a sight that must have been terrifying in and of itself as well as carrying the additional message of, "You misbehave, you may be next".

Alters are often quite concrete and highly stereotyped in their thinking. Carlos is six years old, an age at which gender stereotyping is high. Having one or more male alters is very common for females with DID. Because males are thought of as strong, and not weak and vulnerable like girls, the creation of male alters provides a sense of protection. Since there is generally no real protector on the outside, and because some sense of protection is necessary for sanity, as a bulwark against being overwhelmed by feeling helpless and knowing that one is alone in an incredibly dangerous and potentially annihilating world, protectors are created on the inside and pseudo-delusionally viewed as real persons. The existence of these protective male alters often does provide a sense of protection, such that fear is lessened. It is amazing how some male alters can have great strength—much, much more than the host could have in the same situation. In addition, a male alter is often a stereotyped response to having been anally raped. Persons intuit the learning theory model of gender identity: "If I was anally raped, I must be a boy".

Raymond, the nine-year-old is a superhero who has to hide and whisper. He is a protector to Rachel, and he also has to whisper. This is an appropriate response to an environment in which hard objects are flying, may even be hurled at you and may hit you; in which

you are always being told to shut up, or something similar; and are frequently reminded that Bad Mommy, like the Great Mother archetype, not only gives life, but can take it away (Neumann 1959).

Rachel feels helpless and wants to die. Raymond does not feel suicidal because his job is to protect Rachel, but this then leaves Rachel with the suicidality. It seems that something happened to Yolanda/Rachel in the Santeria sessions, but, if it did, so far these memories have been kept from the alters who have presented themselves.

Savana, the sexy one, is also quiet. Like Raymond, she probably had to be. One also has to wonder why she exists. Often the sexy ones have evolved as a response to sexual abuse, but neither she nor Yolanda has said anything about such experiences. In fact, none of the alters have reported sexual abuse, but that does not necessarily mean that it did not occur. Nor am I suggesting that it did. Like Carlos and Raymond, Savana does not appear at all angry. As far as we know, Mary is the only angry one.

The spurned diagnosis

Shame

By shame, I have in mind the terrible, at times unfathomable, feeling of being outcast from human society, of being shunned and spurned, of being wanted by no one, and having no one who empathizes with you (Lynd 1958). Part of this experience of shame is the focus on the inadequacies of oneself in the eyes of others and oneself, and of feeling mortified, wanting to disappear, to hide inside a crack in the wall (Lewis 1971). Shame focuses on the *overall badness* of the self, rather on the bad things one has done, as in guilt (Lewis 1971). Another aspect of shame that many abused people express is a deep feeling of worthlessness, resulting from being treated as expendable, degraded and often as not even human. It can be very difficult to shake off or escape from such feelings of shame.

Most likely, Yolanda has suffered the intense shame of being spurned in the family, of rarely having anyone to care about her, protect her, or listen to her. Any one of these latter would probably have been highly reparative and would have helped her to connect the traumatic moment with some comfort and to put it in the context of ongoing events.

In addition, having DID in itself creates intense shame. A person continually has to deal with not remembering what one has said or done. Thus, the person with DID must be quick with inferences and cover-ups. Unfortunately, this often convinces her, as well as others, that she is a liar. The person with DID is also beset with intrusions from other parts, such as flashbacks, thoughts being taken away and thoughts being inserted, as if from an outside source. She experiences "made" actions, such as an arm or a leg feeling as if it is being made to do something (as if from some external source) that she did not intend, and voices telling her that she is bad, worthless, and undeserving of life. Thus, it is a balancing act of trying to look normal but fearing one is crazy, and of trying to hide all of this for fear of being judged crazy or because one has been threatened with dire consequences. For instance, adults with DID often report that they were told as children that if they tell about the abuse, the abusers will come and kill them and/or their family. Or, they may be made to witness the death of a loved pet, inculcating in them the fear that this could happen to them as well. Or, in some ways more pernicious—they may have been told that knowledge of the abuse would be so unbearable as to kill a loved mother or other family member if they were to tell. Thus, the child is made to believe that she would be the agent causing a loved one's death. As she understands it, the price of love is the necessity to never tell about the abuse. All of these, which may be compounded by race, poverty, or disability, contribute to a sense of being alone and outcast.

In many ways, however, the most shaming aspect of DID may be that this extremely painful and disorganizing problem of living is so often viewed as not existing. There seems to be a public phobia of knowing about DID and child sexual abuse. Ironically, this phobia exists in a culture in which it is known that child abuse is frighteningly common.

Dissociatively based contradictions in public knowledge

Estimates of prevalence of contact sexual abuse of girls below the age of eighteen average about twenty-five per cent. One study of nine hundred women found a rate of thirty-eight per cent (Russell 1986); and Richard Gartner (1999) estimates a sexual abuse rate

of approximately seventeen per cent for boys. By far the majority of patients with DID have been severely abused, usually sexually abused. Current epidemiological research sets the prevalence of DID are 1.1% of the population, and of dissociative disorders at 17.3% for women (Sar, Akyuz and Dogan 2007, cited in Sar 2008).

Despite the fact that stories about the abduction and sadistic sexual torture of little children are often on the news, the denial of child abuse is rampant in our society. In my view, the spurning of DID is highly connected with knowing and not knowing about child sexual abuse. Side by side with the denial of childhood trauma and of severe dissociation, is an unmistakable cognizance of dissociative processes as they are embedded in our language. We regularly say things such as, "pull yourself together", "he is coming unglued", "she was beside herself", "don't fall apart", "he's not all there", "she was shattered", and so on.

The dissociative consequences of sexual and physical abuse are told in some well-known myths. For example, in the Greek and Roman myth, Persephone was abducted and implicitly raped by the god of the underworld, Hades. As a consequence of eating some pomegranate seeds while in the underworld, she would have to spend four or six months per year (depending on the version of the story) in Hades. Colin Ross (1989) has noted the correspondence between dissociative disorders and the myth of Osiris, the Egyptian god of the Nile who was dismembered by his brother Set, and then revived by his sister and wife, Isis, who put his dismembered parts back together and gave him new life.

Not only is dissociation implicit in our language and some of our myths, but the psychological problem that we now call DID has been with us for a long time, even if in current, educated, middle-class culture we are generally not so familiar with this. What we understand as DID has long been, and often still is, understood as demon possession (Ellenberger 1970)—as it was for Yolanda's family. When they are manifest, these "demons" speak in the first person, as they do in DID. It is quite common for people with DID to have parts named The Devil, Satan, Lucifer, or some other supernatural deity or entity of rage and destruction. In DID the demon part, when in executive control, refers in the third person to the "host"—and generally in contemptuous terms, for example, "She's a wimp", "She's an idiot", and "She deserves her punishment".

With the Enlightenment the dissociative symptoms of demon possession became medicalized (Ellenberger 1970). The dissociative symptoms were classified under the rubric of "hysteria", a term that was used to cover a range of problems (primarily in women) including what we would now call dissociative disorders, somatoform disorders, borderline personality disorders (BPD), post-traumatic stress disorders (PTSD) and reactive psychosis. Generally the central problem for people with hysteria was dissociation.

DID: Then and now

The current spurning of DID is in many ways repetitive of the way dissociation earlier lost favour in psychoanalysis. There are many similarities between the current situation for trauma and dissociation studies and Freud's situation in the late 1800s/early 1900s. As we know, psychoanalysis began with the study of hysteria and dissociation. *Studies on Hysteria* (Breuer and Freud 1893–95) and some of Freud's early writings focused on the traumatic etiology and dissociative features of hysteria. Breuer's patient, Anna O (Bertha Pappenheim) with her switching of languages and her amnesia for occurrences in other states, probably had DID (Ross 1989). As we know, in 1896 Freud presented his first theory of hysteria, the seduction theory that linked the symptoms of hysteria with child sexual abuse. He felt that his colleagues spurned him for this theory (Freud 1896; Ellenberger 1970). For a variety of reasons stated by him and hypothesized by others, he changed his mind. Brothers (1995), Kupersmid (1993), Masson (1984), and others have suggested that Freud's abandonment of his seduction theory was more the result of his own internal conflicts than of his officially stated reasons. Among these might well be fear of professional shame in his social circle, which was part of a patriarchal culture that implicitly permitted child sexual abuse.

Freud's theory of infantile sexuality replaced his seduction theory. Ironically, the Oedipus story that Freud presented left out much of its original context in child sexual abuse (Devereux 1953; Miller 1983; Ross 1982). King Laius, Oedipus's biological father, had abducted and raped the teenage son of a neighbouring king, thereby bringing on himself the curse that he would be murdered by his own son. In an attempt to avoid this curse, he arranged for his baby son to be left to die with a stake driven through his ankles (Oedipus in

fact means "swollen foot"). The little Oedipus was brought up by another neighbouring king, as his own son. And you know the rest of the story, in which he enacted the prophesied drama. How is it that Freud's "blind eye" to such an important part of this story has been so largely unnoticed?

Early work about dissociative disorders

Although Freud was for the most part contemptuous about the usefulness of theorizing about dissociation after *Studies on Hysteria* (Bromberg 1998) some of his contemporaries, such as Pierre Janet, Carl Jung, and Eugen Bleuler continued to write about dissociation. Janet was the first to explicitly link trauma and dissociation, starting in his 1889 doctoral thesis (van der Kolk and Van der Hart 1989). He noted that traumatic experiences and the "vehement" emotions they evoked could not be mentally and emotionally assimilated, and became split off from ordinary consciousness, operating "subconsciously" and autonomously (Janet 1907, 1925). These "fixed ideas" then intrude into consciousness as behaviour, emotions, and thoughts. Janet's word to describe the separation of aspects of experience such that some of it was rendered subconscious was *désagrégation*, "disaggregation", which meant dissociation.

Although Janet's work was largely eclipsed by Freudian theory, his influence has been considerable. Jung's concept of "complex" was highly influenced by Janet's concept of fixed ideas (Ellenberger 1970). And he also used Janet's term dissociation, in his descriptions of complexes. Bleuler (1911/50) who was influenced by Jung, used the term as well.

In his 1911 book, *Dementia Praecox*, Bleuler introduced the term "schizophrenia", drawn from the Greek, meaning "split mind". He chose this term to replace the earlier more inexact term, "dementia praecox". In this book, Bleuler stressed the importance of dissociation, even noting, "the patient appears to be split into as many different persons or personalities as they have complexes" (Bleuler 1911: 361). Thus, he is also writing about what today we call DID.

To a large degree then, dissociative disorders became subsumed under the category of schizophrenia. Writers such as Harold Searles and R.D. Laing who wrote on schizophrenia in the 1950s and 1960s describe many cases of "schizophrenia", as involving overt

switching of identity states, clearly cases of DID. Perhaps the literal translation of schizophrenia ("split mind") has remained lodged in the public subconscious such that the earlier assumptions of dissociativity continually re-emerge.

Meanwhile, across the Atlantic, William James and Morton Prince, among others, were highly interested in Janet's ideas and in multiple personality disorder (MPD). For the first few decades of the twentieth century MPD, now termed DID, was accepted and familiar. According to Hilgard (1977), three forces contributed to the waning of its familiarity. One was the rise of behaviourism, which eschewed anything unconscious or subconscious. Another was the rise of psychoanalysis with its focus on incestuous wishes. The last was the treatment of DID in academic studies in the United States that had the effect of significantly lessening interest in dissociation.

After around the 1920s and until recently, dissociation has been largely dissociated in psychoanalysis. Even theories that explained the dynamics of dissociation, such as those of Fairbairn and Ferenczi, generally used the word "splitting" rather than dissociation. In the 1950s Thigpen and Cleckley published *The Three Faces of Eve*; however, the description of this case was not linked to child abuse, and besides, by then this disorder was considered extremely rare.

Since the end of the Vietnam War and the advent of feminism, the idea of psychological trauma has become more acceptable. Yet, severe dissociation has not. To me this is somewhat illogical because, as I see it, the word "trauma" implies dissociation. I have proposed that trauma might be best defined as "the event(s) that cause dissociation", and that "thinking of trauma this way puts the focus on splits and fissures in the psyche rather than solely on the external event" (Howell 2005: ix). If an event cannot be assimilated, it cannot be linked with other experience, causing fissures in memory and experience, that is, dissociation. This conceptualization bypasses the confusing discussions about "objective" trauma (which does not result in post-traumatic stress to all of those exposed to it) versus "subjective" trauma (which can run the risk of categorizing anything that is distressing as traumatic).

Just as Freud's social environment was one in which child sexual abuse was common, so is ours. Just as Freud may have feared professional shame and becoming a social outcast, and just as academia played an important role in the diminution of interest in dissociation,

today it is not so different. Many of us learned in the education system, and/or subsequent training, that multiple personality disorder, now DID, is extremely rare. And many of us learned in our textbooks, as well as from Ernest Jones and Peter Gay that Ferenczi, who in his later work, wrote of profound dissociative states resulting from child abuse was crazy. And perhaps, most importantly, we know what happened to him!

Going against the tide, especially a strong ideological one, and one which is also academically supported, is never easy. Even without the issues of DID and child sexual abuse, it is understandable that clinicians might have a fear of professional shame. One issue that does not directly have to do with child sexual abuse is that some psychoanalysts, academics and senior mental health faculty have taught their students that DID does not exist. And this teaching has been passed on from teacher to student, and so on.

Another powerful viewpoint, often picked up by the media, is that symptoms of DID are the result, not of child abuse, but of misguided therapy. The suggestion made to the public is that the dissociated self states, the alters, are an iatrogenic result of psychotherapy, specifically, that therapists have suggested the alters into being. A related suggestion is that patients' memories of abuse are not real but have been "implanted" in their minds by their therapists. These stances have often been presented by the false memory syndrome foundation (FMSF), implying that such a diagnostic "syndrome" involving suggestion and implantation of false traumatic memories, is recognized and used by the mental health profession. There has been a small but powerful group of academics, some connected with this group, whose writings, supportive of these themes, have been published in major journals. Of course, bad therapy, in which the therapist's assumptions or beliefs may be stated as fact, do exist, for example, "You were abused by your father", or "You were not abused by your father, but have simply mistaken your desires for their enactment". It is also true that patients can be psychotic or vindictive toward their parents. However, I think that the people who have been abused and who have doubted their own experience as a result of the implantation of these ideas into the media far outnumber the victims of poor therapists who wrongly infer abuse. All of the foregoing contributes to shame that is experienced by both patients and their therapists.

Shame is multi-levelled

Shame becomes a multi-levelled issue, involving the patient, the therapist, and the larger society. As the DID patient is shamed, often by not being believed, the therapist may be professionally shamed for some of the same reasons: She or he may not be believed and may therefore be thought to be nuts, they may be accused of imagining a disorder (DID) where none exists, or be accused of implanting false memories. The repercussions of professional shame, as well as the effect on one's sense of safety and livelihood, can be very powerful and often contribute to burnout. In a larger society that is phobic of knowing about child abuse, therapists who treat DID have been disproportionately sued, reported to ethics boards on made-up charges, and worse.

Seeing is believing

Despite beliefs in iatrogenesis, seeing is believing. How can you deny it when a patient who is talking to you, suddenly glazes over, and asks, "Where am I? Who are you?" In one case the patient thought I was a school counsellor and that she was thirteen years of age. She used the name that she used then, not the one she does now. For me to have created this alter, whose memories (unavailable to the host) were not previously known by me and were corroborated by corresponding memories of other parts, would have been, at the very least, highly complex. How do you understand it when someone begins to speak like a child, asks to play on the floor, and as she is playing tells you of rapes and other horrors that she regularly suffers. Then she suddenly "comes to" as it were and says with great embarrassment, "What am I doing on the floor?" Or, as sometimes happens, a patient is sitting in front of you, frequently turning her head to the side and saying apparently to someone, "Shut up".

What do you make of it when someone screams in terror and pain on the phone and tells you that "she" is hitting her but no one else is actually there with them? In fact, the first time something like this happened to me, I didn't know what to make of it, and so I didn't make much of it—I didn't spell it out, it remained unformulated (Stern 1997). While in one sense I intuitively knew what was happening, I didn't try to pursue what to make of it for a while. This was knowing and not knowing. Probably it would have been different if I had seen it.

I am reminded of an almost identical series of events, told to me recently by two different colleagues about two DID patients who were hospitalized for suicidal behaviour. In both cases the patients told the hospital staff that they had DID. In both cases they were disbelieved: DID does not exist. In one case the therapist who called the hospital was told by the attending that DID did not exist because he had never seen it. In both cases the patients soon began to floridly switch. In one case the patient was quite educated about her condition, and had attempted to explain to the staff what DID is and what the symptoms are. As a consequence, the staff members were able to recognize and understand her switches. After the visible switches of both patients the staff believed that DID existed and that these particular patients had DID. But the next response was rather chilling. Now it was requested of these vulnerable, suicidal patients that they consent to being filmed. Fortunately both patients refused.

Of course, not all switching is obvious. However, there are some things to be alert to. If a patient markedly changes expression, posture, or tone of voice, or sometimes speaks in a child-like voice, one might inquire about these occurrences and subsequently ask something such as, "Do you remember when we were talking about such and such?" The result might be the discovery that the patient does not remember, or that there are large chunks of the sessions and of her daily life that she does not remember. Without inquiry into such memories or into such experiences as pleasure and joy, one may never discover that the patient lives life for the most part in a depersonalized state. It is important to be alert to changes in affect, posture, facial expression, voice tone, body language, glazed over eyes, and so on, and to ask your patient if she is aware of them.

In sum, while DID may be spurned, close investigation renders it undeniable.

References

Bleuler, E. (1911/1950). *Dementia Praecox or the group of schizophrenias* (Trans. J. Zinkin). New York: International Universities Press.

Breger, L. (2000). *Freud: Darkness in the Midst of Vision*. New York: Wiley.

Breuer and Freud (1893). On the psychical mechanism of hysterical phenomena: preliminary communication. *Standard Edition*. 2. London: Hogarth Press.

Breuer and Freud (1893–95). Studies on Hysteria. *Standard Edition*. 2. London: Hogarth Press, 1955.

Bromberg, P. (1998). *Standing in the Spaces: Essays on Clinical Process, Trauma, and Dissociation*. Hillsdale, NJ: The Analytic Press.

Brothers, D. (1995). *Falling backward: An exploration of trust and self-experience*. New York: Norton.

Chu, J.A., Loewenstein, R., Dell, P.F., Barach, P.M., Somer, E., Kluft, R.P., Gelinas, D.J., Van der Hart, O., Dalenberg, C.J., Nijenhuis, E.R.S., Bowman, E.S., Boon, S., Goodwin, J., Jacobson, M., Ross, C.A., Sar, V., Fine, C.G., Frankel, A.S., Coons, P.M., Courtois, C.A., Gold, S.N. and Howell, E. Guidelines for Treating Dissociative Identity Disorder in adults. *Journal of Trauma & Dissociation*. 6(4): 69–149.

Courtois, C. (1999). *Recollections of sexual abuse: Treatment principles and guidelines*. New York: Norton.

Devereux, G. (1953). Why Oedipus killed Laius—A note on the complementary Oedipus complex in Greek drama. *Internat. J. Psycho-Anal*. 32: 132.

Ellenberger, H. (1970). *The Discovery of the Unconscious*. New York: Basic Books.

Ferenczi, S. (1949). "Confusion of tongues between the adult and the child". *International Journal of Psycho-Analysis*. 30: 225–231.

Frankel, J. (2002). "Exploring Ferenczi's concept of identification with the aggressor: Its role in everyday life and the therapeutic relationship". *Psychoanal. Dial*. 12: 101–140.

Freud, S. (1896). The aetiology of hysteria. *Standard Edition*. 3. London: Hogarth Press, 1962.

Gartner, R. (1999). *Betrayed as Boys: Psychodynamic Treatment of Sexually Abused Men*. New York: Guilford.

Hilgard, E.R. (1977). *Divided Consciousness: Multiple Controls In Human Thought And Action*. New York: Wylie.

Howell, E.F. (1999) "Back to the States: Victim Identity and Abuser Identification in Borderline Personality Disorder," presented at the Sixteenth Annual Conference of the International Society for the Study of Dissociation, 12 November, 1999, Miami.

Howell, E.F. (2002). "Back to the 'states': Victim and abuser states in borderline personality disorder". *Psychoanalytic Dialogues*. 12(6): 921–957.

Howell, E.F. (2005). *The Dissociative Mind*. Hillsdale, NJ: The Analytic Press.

Janet, P. (1907). *The major symptoms of hysteria*. New York: Macmillan.

Janet, P. (1925). *Psychological Healing*, Vol. I. New York: Macmillan.

Kluft, R. (1984). "Treatment of multiple personality disorder". *Psychiatric Clinics of North America*. 7: 9–29.

Kupersmid, J. (1993). Freud's rationale for abandoning the seduction theory. *Psychoanalytic Psychology*. 10(2): 275–290.

Lewis, H. (1971). *Shame and Guilt in Neurosis*. New York, NY: International Universities Press.

Loewenstein, R. (1994). "Diagnosis, epidemiology, clinical course, and cost effectiveness of treatment for dissociative disorders and MPD". *Dissociation*. 7(1): 3–11.

Lynd, H.M. (1958). *On shame and the search for identity*. New York: Harcourt, Brace & World, Inc.

Masson, J. (1984). *The assault on truth*. New York: Signet.

Miller, A. (1983). *For Your Own Good*. New York: Farrar, Straus, Giroux.

Neumann, E. (1959). *The Great Mother*. Princeton, NJ: Princeton University Press.

Ross, C. (1989), *Multiple Personality Disorder*. New York, NY: John Wiley and Sons.

Ross, J. (1982). "Oedipus Revisited-Laius and the 'Laius Complex'". *The Psychoanalytic Study of the Child*. 37: 169–174. New Haven, CT: Yale University Press.

Russell, D. (1986). *The Secret Trauma: Incest in the Lives of Girls and Women*. New York: Basic Books.

Sar, V. (V2008). "Trauma and personal life in context: Personal life, social process, and public health". *Journal of Trauma and Dissociation*. 9(1): 1–8.

Sar, V., Ayyuz, J. and Dogan, O. (2007). "Prevalence of dissociative disorders in the general population". *Psychiatry Research*. 149(1–3): 169–176.

Thigpen, C. and Cleckley, H. (1957). *The Three Faces of Eve*. New York: McGraw-Hill.

van der Kolk, B. and van der Hart, O. (1989). "Pierre Janet and the breakdown of adaptation in psychological trauma". *Amer. J. Psychiatry*. 146: 1,530–1,540.