blue knot foundation

National Centre of Excellence for Complex Trauma

Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation*

*See in conjunction with *Practice Guidelines for Clinical Treatment of Complex Trauma* (updated; 2019).

BLUE KNOT FOUNDATION

Dr Cathy Kezelman AM
Pam Stavropoulos PhD

Empowering recovery from complex trauma

Practice Guidelines for Identifying and Treating
Complex Trauma-Related Dissociation

Authors: Kezelman C.A., Stavropoulos P.

Dr Cathy Kezelman AM
President – Blue Knot Foundation

Pam Stavropoulos PhD
Head of Research – Blue Knot Foundation

Blue Knot Foundation 2020 *Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation* Kezelman C.A & Stavropoulos P.A.
www.blueknot.org.au
Blue Knot Helpline 1300 657 380

© 2020 Blue Knot Foundation

Contents

`*When the clinician has a comprehensive understanding of trauma-based disorders and dissociative defences, the potential outcome of therapy improves, and clients get better'.*

Danylchuk & Connors, 2017: 7.

`*Dissociation is mostly not about dissociative disorders. It is about how a mind struggles to cope with the intolerable and unbearable'.*

Chefetz, 2015: 23.

Audience and Aims

Complex trauma-related dissociation underlies diverse presentations to health professionals and is often not detected. This means that many people do not receive appropriate responses and care. These *Practice Guidelines for Identifying and Treating Complex Trauma-related Dissociation* are for clinicians who work in a range of roles, come from different disciplines and have received diverse training but who want to enhance their ability to recognise and work with people experiencing complex trauma-related dissociation.

The following recommendations are designed to be read in conjunction with our updated 2019 *Practice Guidelines for Clinical Treatment of Complex Trauma* https://www.blueknot.org.au/Resources/Publications/Practice-Guidelines/Practice-Guidelines-2019. The updated 2019 guidelines explain why all clinicians need to attune to dissociation. Dissociation is common and its presentation and severity varies widely. Yet the challenges of complex trauma-related dissociation are more extensive and also extend beyond the new diagnosis of Complex PTSD. [1]

For example, `structural' dissociation describes divisions of the personality which are generated by early life trauma.[2] It requires clinical skills beyond identifying the presence of dissociation. The following guidelines address the complexity of trauma-related dissociation in more detail than is presented in the 2019 *Practice Guidelines for Clinical Treatment of Complex Trauma*. They can also be read in conjunction with the *Complementary Guidelines to Practice Guidelines for Clinical Treatment of Complex Trauma* https://www.blueknot.org.au/Resources/Publications/Practice-Guidelines/Complementary-Guidelines. The *Complementary Guidelines* address the distinctive features of therapy for complex trauma and the corresponding therapist competencies respectively (i.e. two additional short sets of guidelines). All Blue Knot guidelines are available for free download and purchase at www.blueknot.org.au

1 `Whereas continuous consciousness across states might be typical of complex PTSD, development of increasingly severe trauma-related disorders…increasingly becomes a risk the more prolonged and severe the traumatic events' (Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors,* Routledge, New York, 2017, p.67).

2 `Severe disruptions in the early development of attachment patterns between children and their caretakers seem to be precursors of dissociative pathology, including more complex structural dissociation of the personality' (Onno van der Hart, Ellert Nijenhuis & Kathy Steele, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization*, Norton, New York, 2006, p.85). The ensuing divisions `can range from very simple to extremely complex divisions of the personality' (van der Hart et al, ibid: 5).

Blue Knot Foundation

Blue Knot Foundation is the Australian National Centre of Excellence for Complex Trauma, empowering recovery, and building resilience for the more than five million adult Australians (1 in 4) with a lived experience of complex trauma (including abuse), their families and communities.

Formed in 1995, Blue Knot Foundation provides a range of services. These include:

- specialist trauma counselling, information, support and referrals
- educational workshops for survivors and their family members, partners and loved ones
- professional development training for workers, professionals and organisations from diverse sectors
- group supervision
- consultancy
- resources including fact sheets, videos and website information at www.blueknot.org.au
- advocacy
- research

At the forefront of pioneering trauma-informed policy, practice, training and research, Blue Knot Foundation actively supported the work of the Royal Commission into Institutional Responses to Child Sexual Abuse and the people engaging with it.

In 2012, Blue Knot Foundation released *Practice Guidelines for Treatment of Complex Trauma and Trauma-Informed Care and Service Delivery* www.blueknot.org.au/guidelines. These nationally and internationally acclaimed guidelines were a global first in setting the standards for clinical and organisational practice. In 2015, Blue Knot Foundation released an Economic Report, *The Cost of Unresolved Childhood Trauma and Abuse in Adults in Australia* to present the economic case for providing appropriate trauma-informed services for adult survivors. This publication was followed in 2016 by *Trauma and the Law – Applying Trauma-informed Practice to Legal and Judicial Contexts,* and in 2018 the paper *The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance of Trauma* was launched and released.

In 2018-19 Blue Knot Foundation released its *Talking about Trauma* series. In 2019 it released its updated *Practice Guidelines for Clinical Treatment of Complex* Trauma and accompanying *Complementary Guidelines to Practice Guidelines for Clinical Treatment of Complex Trauma.*

For more information, visit www.blueknot.org.au. If you need help, information, support or referral, call Blue Knot Helpline on 1300 657 380 or email helpline@blueknot.org.au between 9am-5pm Monday to Sunday AEST/AEDT.

Introduction

Research upholds that dissociation is transdiagnostic and correlated with a range of adverse and often severe health impacts.[3] As Spiegel notes in the *American Journal of Psychiatry*, the integration of dissociation into the field of mental health is long overdue.[4]

> `*Dissociative disorders are so common that it is essential for therapists to have undergone the trainings required for treating them; their prevalence is such that they cannot be left to a few specialists'*
> Schwarz, Corrigan et al, 2017: 227.

It might be thought that the prevalence of dissociation, a key feature of complex trauma, would assist its detection and treatment. However the variety and `paradoxical quality' of its symptoms `is rarely captured by traditional diagnostic models'.[5]

The phenomenon of dissociation – in simple terms `the deficiency of internal and external awareness'[6] – means not paying attention and `not being present'. It is the correlate of `a brain function that is designed to not know'.[7] As Forner highlights, dissociation is the `opposite' of mindfulness, where mindfulness is `internal and external awareness in abundance'. [8]

Expressed in this way, the challenges posed by dissociation are enormous. This is because mindful noticing and awareness are important to healthy functioning. Dissociation cuts across this capacity; `paying attention' *(mindsight)*[9] and `not paying attention' *(mindflight)*[10] are different and seemingly incompatible processes.

Mindfulness based approaches are now a shared feature of diverse varieties of psychotherapy. Mindfulness is also widely valued outside the therapy context. Because dissociation `interrupts' mindfulness and `being present in the moment', clinicians might be expected to be very aware of it as it poses challenges to client engagement in the `here and now' of therapy. In fact, the opposite is the case:

> `*One characteristic of dissociative phenomena is how frequently they are misdiagnosed or not accounted for at all. Many people in the mental health profession do not know what dissociation looks like or how to assess for it'.*
> (Danylchuk & Connors, 2017: 39)

3 `DDs are common in general and clinical populations and represent a major underserved population with a substantial risk for suicidal and self-destructive behavior' (Richard J. Loewenstein, `Dissociation Debates: everything you know is wrong', *Dialogues in Clinical Neuroscience*, 20, 3, 2018, p.229).
4 David Spiegel, `Integrating Dissociation', *American Journal of Psychiatry* (175:1, 2018). pp. 4-5.
5 Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors* (Routledge, New York, 2017), p.68.
6 Christine A. Forner, *Dissociation, Mindfulness and Creative Meditations* (Routledge, New York, 2017), p.xii.
7 Forner, *Dissociation, Mindfulness and Creative Meditations,* ibid.
8 Forner, *Dissociation, Mindfulness and Creative Meditations:* ibid.
9 Daniel J. Siegel, *Mindsight* (New York: Random House, New York, 2009).
10 As per the seminar description of complex trauma clinician and researcher Kathy Steele, MN, CS, `From MindFlight to MindSight: Overcoming the Phobia of Inner Experience', April 14 - 15, 2011, Trauma Center, http://www.traumacenter.org/training/Workshops.2010-11/Workshop_From_MindFlight_to_MindSight.php

This serious situation needs to be urgently redressed. Dissociative disorders have adverse impacts including `substantial risk for suicidal and self-destructive behavior'.[11] Additionally dissociative symptoms which do not meet diagnostic criteria can also significantly impact health and well-being.

Therapists' lack of knowledge of the process and impacts of dissociation is enormously costly in many ways. For this reason, the updated *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019) includes a dedicated discussion of the phenomenon of dissociation. The following guidelines supplement and extend that discussion.

Part 1 presents the guidelines in two sections. Part A (`Foundational Knowledge') provides the knowledge base needed for effective therapy for trauma-related dissociation. Awareness of key themes, principles, and concepts on the subject of dissociation assists responsible clinical practice. Yet health professional training does not usually feature information on the nature, process, and symptoms of dissociation. For this reason, this information is included here. It is a necessary prelude to the recommendations for practice which follow. Part B (`Clinical Application') presents the `translation to practice' of the material which precedes it.

Part 2 presents the research base which informs the guidelines. Chapter 1 *(`What is Dissociation and Why do We Need to Know about It?'*) considers different readings of dissociation, and its different expressions. It introduces the topic of dissociation (and is reproduced from the updated *Practice Guidelines for Clinical Treatment of Complex Trauma* for this reason). While often associated with disorder, dissociation takes many forms - `healthy and adaptive, pathological and self-protective'[12] - and *`it makes a vast difference how and in what context dissociation is used'*.[13]

Many clinicians and researchers contend, as is presented in the following pages, that dissociation can serve both defensive and benign `everyday' purposes. It is also argued that integration, coherence, and self-continuity are not innate, but rather result from *developmental and subsequent relational experience*. If states are the building blocks of consciousness and behaviour, self, identity, and well-being depend on *linkage between* self-states[14] which occurs with 'good enough' early caregiving relationships. The greater the need to protect from overwhelming experience, the greater the need to use dissociation for defensive purposes (and the increased potential for compromised psychological functioning).

This sheds light on the transdiagnostic role of dissociation in many disorders, including personality disorders, and why dissociation may operate `as a confounding factor in general psychiatry'[15] *(`Our mental life is full of discontinuities…For some, the cracks in identity are marked).*[16] The advantages of a `continuum' model of dissociation are also discussed in the first chapter.

Chapter 2 *(`Dissociation as default: Childhood legacies, structural dissociation, and unintegrated parts')* addresses the pathways to more severe forms of dissociation generated by adverse overwhelming childhood experience. Notable in this context are a lack of validation and/or inconsistent caregiving: i.e. in addition to trauma and abuse with which they may or may not co-occur. Disconnection pertains to self, different components of self-states, behaviour, and sense of reality:[17] *`Regardless of its extent, pathological dissociation always implies processes of multiple disconnection in self-experience'*[18]

11 Loewenstein, `Dissociation Debates: everything you know Is wrong', ibid, p.229.
12 Philip Bromberg, *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation* (Psychology Press, New York, 2001), p.310.
13 Dodi Goldman, `A queer kind of truth': Winnicott and the uses of dissociation' in Elizabeth Howell, & Sheldon Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis (*Routledge, New York, 2016), p.98; original emphasis.
14 Elizabeth Howell, ref. Putnam, 1992, 1997, *The Dissociative Mind* (Routledge, New York, 2005).
15 Vedat Sar, `The Many Faces of Dissociation: Opportunities for Innovative Research in Psychiatry', *Clinical Psychopharmacology and Neuroscience* (12, 3, 2014), p.171.
16 Spiegel, `Integrating Dissociation', ibid, p.4.
17 Adriano Schimmenti & V. Caretti, `Linking the Overwhelming with the Unbearable: Developmental Trauma, Dissociation, and the Disconnected Self', *Psychoanalytic Psychology* (33, 1, 2016), p. 120.
18 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable…', ibid.

Also discussed in chapter 2 is *structural* dissociation, which applies to divisions of the personality which are unintegrated due to early and severe developmental trauma (of which Dissociative Identity Disorder, DID, is the most severe form). The theory of structural dissociation elaborated by Van der Hart, Nijenhuis and Steele[19] is now corroborated by neuropsychological studies which reveal different patterns of brain activity for the contrasting states.[20] These findings are `inconsistent with the idea that DID is caused by suggestion, fantasy proneness, and role playing'.[21]

Chapter 2 concludes with discussion of the `Trauma Model' vis-a-vis the sociocognitive or `Fantasy Model'. It notes that the available evidence supports the Trauma Model, as well as research findings on the non-unitary nature of memory. In both contexts the differences between *explicit* (i.e. conscious, verbal) and *implicit* (largely non-conscious and non-verbal) memory need to be clearly understood.[22]

Chapter 3 *(`A Healthy Defence Gone Wrong':[23] Unintegrated self-states (`parts') and DID')* presents the `state' theory of personality proposed by Frank Putnam.[24] It defines personality as `the collective dynamics of a person's set of identity, emotional, and behavioral states'.[25] This is in contrast to theories which see personality as `a set of fixed, persistent, and globally defining traits that pervade all of the person's interactions with the world'.[26]

The state theory of personality speaks to the different ways we act according to the *context* in which we find ourselves. It also helps us understand both normal and disrupted developmental trajectories. Research establishes a relationship between the age of onset of traumatic experience, its duration, intensity, `and the severity of trauma-related psychopathology'.[27] In Dissociative Identity Disorder (DID), the most severe outcome of childhood trauma, separate and distinct identity states `may have little or no awareness of each other and thus often behave in conflicting, contradictory, and self-defeating ways'.[28]

Chapter 3 presents the evidence which supports the effectiveness and benefits of treating dissociative disorders, including DID. It also presents principles to assist clinical work when developmental pathways have been disrupted, `normal multiplicity' has been derailed, and diverse, rigid, and dissociated self-states have been generated. *Treatment of DID should not be undertaken in the absence of knowledge and expertise in this area*.[29] Yet this document presents helpful material for clinicians who also want to build their skills in these regards .

This publication includes appendices which summarise key features of complex trauma and dissociation and basic principles of self-care, together with a Reference list and Glossary.

19 Onno Van der Hart, Ellert Nijenhuis & Kathy Steele, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* (Norton, New York, 2006).
20 Yolanda Schlumpf, Antje Reinders, et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study' PLoS One, 9(6) 2014 10.1371/journal.pone.0098795
21 Schlumpf, Reinders, et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study', ibid.
22 See *The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance for Trauma* (Blue Knot Foundation, Sydney, 2018) https://www.blueknot.org.au/resources/publications/trauma-and-memory
23 Marlene Steinberg & Maxine Schnall, *The Stranger in the Mirror* (HarperCollins, New York, 2003), p.8.
24 Frank W. Putnam, *The Way We Are: How States of Mind Influence Our Identities, Personality and Potential for Change* (International Psychoanalytic Books [IPBooks], New York, 2016
25 Putnam, *The Way We Are,* ibid. p.159.
26 Putnam, *The Way We Are,* ibid.
27 Jenny Ann Rydberg, `Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, Myths, Misreports, and Misrepresentations', *European Journal of Trauma and Dissociation* (1, 2017), p.95.
28 Putnam, *The Way We Are,* ibid, p 159.
29 Also note that dedicated treatment guidelines for DID differ from the clinical guidelines for treatment of complex trauma. See *Guidelines for Treating Dissociative Identity Disorder in Adults*, 3rd Revision, International Society for the Study of Trauma and Dissociation, *Journal of Trauma & Dissociation*, 12:2, 2011, 115-187 https://www.isst-d.org/wp-content/uploads/2019/02/GUIDELINES_REVISED2011.pdf

Part 1
Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation

Practice Guidelines For Identifying And Treating Complex Trauma-Related Dissociation

The following guidelines are provided to support health professionals in their treatment of complex trauma-related dissociation. Complex trauma-related dissociation underlies diverse presentations but is often undetected which impedes appropriate responses and care. Dissociation is a multifaceted capacity, process, and response; note that `[t]he most important distinction for you to make is between mild dissociative experiences that are normal and experiences that range from moderate to severe' (Steinberg & Schnall, 2003: 33).

The most severe form of dissociation is `structural' dissociation which describes divisions of the personality generated by early life trauma (Van der Hart, Nijenhuis & Steele, 2006). In structural dissociation self-states may be rigid, discrete, and consciously inaccessible. This is in contrast to non-structurally dissociated clients whose early childhood did not require such severe dissociation of relational experience.

For clients who are structurally dissociated, the assumption of a coherent, integrated self is especially problematic and clinicians need to adjust their ways of working accordingly. Note, however, that less severe forms of dissociation can also be debilitating. Clients who do not meet the criteria for a dissociative disorder may still experience reduced quality of life. For this reason, all clinicians need to attune to, and be able to identify, dissociation in its varied forms.

Because most health professional training programs do not address dissociation, the following guidelines are in two parts. Part A (`Foundational Knowledge') presents key information and principles from the field of dissociation. Awareness of these principles provides the basis for responsible clinical work with dissociative clients. It will also help clinical work to occur more smoothly. Part B (`Clinical Application') presents recommendations for applying these principles; note that there is some necessary overlap between the two sections.

These guidelines complement and are designed to be read in conjunction with the updated Practice Guidelines for Clinical Treatment of Complex Trauma (2019). Also see the separate Blue Knot publication Complementary Guidelines to Practice Guidelines for Clinical Treatment of Complex Trauma (2019) which comprise two short sets of additional guidelines (i.e. Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches [complementary guidelines 1] and Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation [complementary guidelines 2]). All guidelines are available for free download and/or purchase at www.blueknot.org.au

Part A: Foundational Knowledge

(1) Regard dissociation – i.e. `partial or complete disruption of the normal integration of a person's psychological functioning'[30] - as `a basic aspect of human functioning rather than a rare, exotic phenomenon'[31] and attune to the context in which it occurs

Regarding dissociation *`as assuming a range of manifestations that can be adaptive as well as pathological'*[32] is a helpful conceptual approach for clinicians. This is because it `*makes a vast difference how and in what context dissociation is used'*.[33] Attuning to the `many faces of dissociation'[34] and the context in which it occurs helps orient clinicians to the challenging state/s, process, and symptoms of dissociation.[35]

A contextual approach to dissociation (and the concept of a continuum; see Guideline 2) conveys the difference between a normal mental process and *persistent activation of this process for defensive purposes* (i.e. to protect against overwhelm). When protecting against overwhelm, dissociation becomes the `default' position as experience is unconsciously organised in advance.[36] Dissociative *response* becomes a dissociative *structure* of mind,[37] which erodes vitality and quality of life and can severely impact health.

30 Paul F. Dell & John A. O'Neil, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond* (Routledge, New York, 2014), p. xxi.

31 Steven N. Gold & Stacey L. Seibel, `Treating Dissociation: A Contextual Approach', in Dell & O'Neil, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond*, ibid, p. 625.

32 Gold & Seibel, `Treating Dissociation: A Contextual Approach', ibid.

33 Dodi Goldman, `A queer kind of truth': Winnicott and the uses of dissociation' in Elizabeth Howell, & Sheldon Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis (*Routledge, New York, 2016), p.98; original emphasis.

34 Vedat Sar, `The Many Faces of Dissociation: Opportunities for Innovative Research in Psychiatry', Clinical Psychopharmacology and Neuroscience (12, 3, 2014), pp.171-179. Also note the view that `[a]ssociative process alerts our awareness that something is worth noticing. Dissociation tells us we need not pay any attention. The healthy result of this sorting is a coherent mind' (Richard Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* Norton, New York, 2015, p.1).

35 Dissociation can be understood in contrasting ways: e.g. as both process and state. It can be regarded as a lack of integration of the mind and mental systems, as an altered state of consciousness, as a defence mechanism and structure, and as a normative psychological process (also see Footnote 41). As with all challenging phenomena the topic of dissociation has stimulated debate; note that all readings expressed in this document are referenced in research.

36 Philip M. Bromberg, *Awakening the Dreamer: Clinical Journeys* (Routledge, New York, 2011), p.49. For further on this point see Guidelines 5 and 15.

37 That is, dissociation is `no longer a function of the mind; the mind becomes a function of dissociation'; *`thus turning the mind into a smoke detector and life into an unlived waiting period'* (Bromberg, *Awakening the Dreamer,* ibid).

(2) Recognise the benefits of a continuum model of dissociation in which `[t]he most important distinction…to make is between mild dissociative experiences that are normal and experiences that range from moderate to severe' [38] (also see Guideline 3)

A continuum model of dissociation[39] has a number of benefits. Conceptualising dissociation on a continuum – i.e. as a normal psychological capacity and process which can *become* problematic – draws attention to the contexts which contribute to ways of coping and managing stress which while effective in the short-term can become dysfunctional over time. Many prevalent psychological problems `seem to be about keeping dissociated experience out of awareness',[40] and `[t]he rising tide of trauma and dissociation studies has created a sea change in the way we think about psychopathology'.[41]

Describing 'problematic' dissociation – e.g. its progression to disorder - as `a healthy defense gone wrong'[42] is helpful. A continuum of trauma-related symptom severity has also been found across groups, `supporting the hypothesis that there is an association between the severity, intensity, as well as age at the onset of traumatisation, and the severity of trauma-related psychopathology' in which dissociation is involved.[43]

(3) Attune to the core dissociative symptoms of *depersonalisation* (estrangement from self), *derealisation* (estrangement from environment), *amnesia*, *identity confusion,* and i*dentity alteration* which occur in different combinations

Dissociative symptoms can be mild, moderate or severe (see Guideline 2) and *`[d]ifferent constellations of [the five core symptoms] define[] the particular dissociative disorder a person ha[s]'.*[44] When all five symptoms are present, the diagnosis is Dissociative Identity Disorder

38 Marlene Steinberg & Maxine Schnall, *The Stranger in the Mirror*: *Dissociation, The Hidden Epidemic* (HarperCollins, New York, 2003), p.33.

39 I.e. in contrast to the initial and circumscribed understanding of `divisions or dissociations in the personality or consciousness… that [have] resulted from a dissociative personality structure' (Martin Dorahy & Onno van der Hart, `Relationship between Trauma and Dissociation: An Historical Analysis', ch.1 in Eric Vermetten, Martin Dorahy & David Spiegel, ed. *Traumatic Dissociation: Neurobiology and Treatment* (American Psychiatric Publishing, Washington DC, 2007, p.6). Describing the latter as `the narrow conceptualization of dissociation' (which dates to the late nineteenth century and which `has been reintroduced in modern times') Dorahy and van der Hart note that the concept has now widened to a `diffuse' understanding `which presumes multiple origins for dissociative experiences [and] can account for many and various clinical and nonclinical psychological phenomena' (Dorahy & Van der Hart, ibid, pp.6-7). This more recent `broad' understanding of dissociation (which is not shared by all in the field) encompasses normative expressions as well. For consideration of definition and contrasting conceptions of dissociation, see Stephen Braude, `The Conceptual Unity of Dissociation: A Philosophical Argument', ch.2 in Dell & O'Neil, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond*, ibid, pp.27-36.

40 Elizabeth Howell, *The Dissociative Mind* (Routledge, New York, 2005), p.ix.

41 Howell, *The Dissociative Mind,* ibid.

42 Steinberg & Schnall*, The Stranger in the Mirror,* ibid, p.8.

43 Jenny Ann Rydberg, `Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, Myths, Misreports, and Misrepresentations', *European Journal of Trauma and Dissociation* (1, 2017), p.95.

44 Steinberg & Schnall, *The Stranger in the Mirror*, ibid, p.32.

(DID; see Guideline 10). But there are various dissociative disorders,[45] and dissociation can also be disabling in the absence of a dissociative disorder:

`*Most mental health practitioners are not trained to identify complex trauma and dissociation in their clients. If they do know about dissociation, they may only think of the most extreme form of that, Dissociative Identity Disorder, perceive that to be rare, and miss any signs of…milder forms of dissociation in the clients they see*'.[46]

(4) Acknowledge the prevalence of complex trauma-related dissociation and the many treatment implications

`*Multiple lines of evidence support a powerful relationship between dissociation/DD [i.e. dissociative disorders] and psychological trauma, especially cumulative and/or early life trauma.…DD are common in general and clinical populations and represent a major underserved population with a substantial risk for suicidal and self-destructive behavior*'.[47]

It is `*not uncommon for people with multiple traumas to have dissociative issues of varying kinds*'[48] *(`[m]ost people with complex PTSD have experienced chronic interpersonal traumatization as children'* and `*have severe dissociative symptoms')*.[49] Also note that the chronicity, severity, and age of onset of adverse childhood experiences are `highly correlated with level of dissociation'[50] and with `the prevalence of extensive comorbidity in dissociative clients'.[51]

(5) Understand that activation of dissociation for defensive purposes in childhood, while initially protective, is the forerunner of dissociative pathology in adulthood

When faced with threat (which can occur outside of abuse scenarios, e.g. via a caregiver with their own unresolved trauma history)[52] children are caught in a `biological paradox' between the `survival reflex' and the `attachment circuit'.[53]

45 Dissociative disorders include Depersonalization disorder (DPD) (which often also involves derealisation), Dissociative amnesia (DA) (for which Dissociative fugue is a specifier), and Other Specified Dissociated Disorder (OSDD). OSDD is the diagnostic category which in DSM-5 replaces the previous classification of Dissociative Disorders Not Otherwise Specified (DDNOS). It `applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class'

46 Lynette Danylchuk & Kevin Connors, *Treating Complex Trauma and Dissociation* (Routledge, New York, 2017), p 7.

47 Richard J. Loewenstein, `Dissociation Debates: everything you know is wrong', *Dialogues in Clinical Neuroscience* (20, 3, 2018), p.229.

48 Danylchuck & Connors, *Treating Complex Trauma and Dissociation,* ibid, p.7.

49 Onno Van der Hart, Ellert Nijenhuis & Kathy Steele, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* (Norton, New York, 2006), p.112.

50 Gold & Seibel, `Treating Dissociation: A Contextual Approach', ibid, p. 626.

51 Gold & Seibel, `Treating Dissociation: A Contextual Approach', ibid, p.634.

52 Erik Hesse, Mary Main et al, `Unresolved States Regarding Loss or Abuse Can Have `Second Generation Effects: Disorganisation, Role Inversion, and Frightening Ideation in the Offspring of Traumatized Non-Maltreating Parents', ch.2 in Marion Solomon, & Daniel J. Siegel, ed. *Healing Trauma* Norton, New York, 2003 pp.57-106.

53 Daniel J. Siegel, *Pocket Guide to Interpersonal Neurobiology* (Norton, New York, 2012), 21-10): `One message- a feeling of terror induced from the parent's behavior – activates two circuits that create opposite actions to go away from and go toward the same person' (Siegel, ibid, 21-4); `Inside the child is an *unresolvable war between two impulses, and the internal world of the child collapses' (*Siegel, ibid). Also see van der Hart et al, *The Haunted Self*, ibid, with respect to the `divisions of the personality', i.e. from relatively simple to `extremely complex' which can ensue (van der Hart et al, ibid).

`*An environment of trauma and impaired caregiving elicits overwhelming negative affect; consequently, the brain selects and reinforces pathways that encourage avoidance of affect and associated traumatic content'*[54]. Thus `*[t]he mind becomes organized around the principle of dissociation from affect'*.[55]

Adult dissociation and potential disorder will vary according to severity and duration of early overwhelm, the predominant dissociative symptoms and the form in which they occur: `*What makes a difference in kinds and severity of problems in living is not only the severity of the dissociative fissures but also the way the dissociative parts are structured in internal relationships'*.[56] Also see Guideline 3).

(6) Know that the new diagnosis of Complex PTSD (ICD-11, 2018) does not capture the severity of impacts of complex trauma-related dissociation

The *International Classification of Diseases* in its eleventh iteration (ICD-11) includes a diagnosis of Complex PTSD (note that the current version of the *Diagnostic and Statistical Manual of Mental Disorders*, DSM-5, does not include this diagnosis but includes a dissociative subtype of PTSD). Yet while formal diagnosis of Complex PTSD is welcome and long overdue, it is not sufficient. For example, it necessitates meeting the criteria for `standard' PTSD. This is problematic as `*many individuals having suffered the most severe complex trauma do not describe core PTSD symptoms'*.[57] Diagnosis is also not the only lens through which complex trauma should be regarded and addressed.

Neither the diagnosis of Complex PTSD in the new ICD-11, nor the dissociative subtype of PTSD in DSM-5, encompass the breadth of complex trauma and dissociation. Just as `there is more to trauma than PTSD',[58] so there is more to complex trauma than Complex PTSD: `*Whereas continuous consciousness across states might be typical of complex PTSD, development of increasingly severe trauma-related disorders…increasingly becomes a risk the more prolonged and severe the traumatic events'*.[59]

(7) Understand that chronic dissociation is not solely a phenomenon of the `mind' but somatic as well

Neuroimaging studies show that dissociation `is accompanied by altered activation of brain structures…involved in regulating awareness of bodily states, arousal, and emotions' (thus providing `concrete, theoretically consistent evidence that dissociation exists').[60] When activated, unintegrated mental states lead to a `flood of dysregulation',[61] which means that dissociation also operates `at a somatic level'.[62] This can entail `discontinuities and

54 Joyanna Silberg, *The Child Survivor* (Routledge, New York, 2013), p.22.
55 Silberg, *The Child Survivor,* ibid, p.21.
56 Elizabeth Howell & Sheldon Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis* (Routledge, New York, 2016), p. 37.
57 Lisa Schwarz, Frank Corrigan, et al, *The Comprehensive Resource Model* (Routledge, New York, 2017), p.21.
58 Robin Shapiro, *The Trauma Treatment Handbook* (Norton, New York, 2010), p.11.
59 Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors* (Routledge, New York, 2017), p.67.
60 Bethany Brand, `What We Know and What We Need to Learn About the Treatment of Dissociative Disorders', *Journal of Trauma & Dissociation* (13:4, 2012), p.395.
61 Adriano Schimmenti & Vincent Caretti, `Linking the Overwhelming with the Unbearable: Developmental Trauma, Dissociation, and the Disconnected Self', *Psychoanalytic Psychology* (33, 1, 2016), p.116.
62 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable…', ibid, p. 117.

possible distortions in the perception of one's own body', which may be experienced `as a conglomerate of unintelligible, disconnected sensations rather than as a unitary whole'.[63]

Reduced capacity to integrate and cognitively represent bodily states can lead to `distressing somatic complaints, concerns and symptoms, together with abnormal thoughts, feelings, and behaviours in response to them';[64] *`Somatization is a dissociative process…and we pay a steep price when this possibility is overlooked in the medical investigation of chronic pain'.*[65]

(8) Understand that chronic dissociation is not always trauma-related

The inability, for any reason, of caregivers to attune psychologically to their children can foster severe and `default' dissociation in adulthood (whereby dissociation becomes the primary, automatic, and `go to' response around which the mind organises).[66] Notwithstanding the prevalence of trauma-related dissociation, `problematic dissociation does not proceed from trauma alone'.[67]

`[N]ormative developmental pathways gone awry'[68] – for whatever reason – do not enable self-states to link. Research shows that `[t]he best predictor of dissociation in adulthood is emotionally unresponsive care-giving',[69] and this can occur in the absence of trauma. Isolated self-states can be generated by care-giving which is not necessarily traumatic or abusive, but which `is somehow unresponsive to the particular needs of a child'.[70]

(9) `Structural' dissociation describes division of the personality in which discrete self-states that have never been associated stay unlinked and stems from severe early life trauma

A persistent need to activate a dissociative response for defensive purposes in early childhood can lead to `divisions or dissociations in the personality or consciousness'; i.e. a `structural dissociative organization' of personality.[71] The 2006 text *The Haunted Self* [72] describes the origin, characteristics and functions of structurally dissociated parts of the personality, in which dissociation between an `Apparently Normal Part' of the personality (ANP) attempts to cope with daily life tasks and an `Emotional Part' (EP) holds and re-experiences the trauma.[73] Depending on the age of the child and the duration and severity of the trauma, the dissociative splits can be more complicated and `can range from very simple to extremely

63 Schimmenti & Caretti, ibid, p.119.
64 Schimmenti & Caretti, ibid.
65 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid, p.27, ref Nijenhuis, 2000.
66 Silberg, *The Child Survivor,* ibid.
67 Howell, *The Dissociative Mind*, ibid, p. 17; ref. Steven N. Gold, *Not Trauma Alone: Therapy for Child Abuse Survivors in Family and Social Context* (Routledge, New York, 2000).
68 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid, p. 90.
69 Lyons-Ruth et al, 2006, cited in Chefetz, *Intensive Psychotherapy for Persistent Dissociative Disorders,* ibid, p.89.
70 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid.
71 Dorahy & Van der Hart, `Relationship between Trauma and Dissociation: An Historical Analysis', ibid, p.6; `Severe disruptions in the early development of attachment patterns between children and their caretakers seem to be precursors of dissociative pathology, including more complex structural dissociation of the personality' (van der Hart Nijenhuis & Steele, *The Haunted Self,* ibid,p.85).
72 Van der Hart, Nijenhuis & Steele, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization,* ibid.
73 Van der Hart, Nijenhuis & Steele, *The Haunted Self,* ibid, p.304.

complex divisions of the personality'.[74] The most complex structurally dissociated divisions of the personality are those of Dissociative Identity Disorder (DID; see next Guideline).

(10) Dissociative Identity Disorder (DID) is the most `extreme' of the dissociative disorders and is distinguished by the most complex structural divisions of the personality in which multiple self-states coexist with limited or no co-consciousness of one another due to severe childhood trauma

Because DID arises in severe early life trauma, the `extreme' nature of this disorder – which is protective in the first instance– is consistent with extreme trauma experienced at an early age. Partly for this reason the DID diagnosis is often described as `controversial' despite its large evidence base *(`Scepticism about numbers of self-states is a potential intellectualization and deflection of the sad reality…an intolerance of the reality of severe abuse')*.[75]

In DID, all five symptoms of dissociation are present (i.e. *depersonalisation*, *derealisation, amnesia, identity confusion*, and *identity alteration*; see Guideline 3). The official prevalence rate of DID is 1.5% of the population;[76] `switches' between diverse self-states can be subtle (see Guideline 31) and can be `under the radar' even for clinicians.[77] A patient not responding to medication prescribed to treat the designated condition or diagnosis `is one of the classic suggestive diagnostic cues to DID'.[78]

An open access paper: https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction___An_Empirical.2.aspx in the *Harvard Review of Psychiatry* identifies and refutes common recurrent myths about DID.

(11) Know that neuroscientific findings with respect to DID now uphold the theory of structural dissociation of the personality

`[I]n accordance with the Theory of Structural Dissociation of the Personality (TSDP), studies of dissociative identity disorder (DID) have documented that two prototypical dissociative subsystems of the personality, the `Emotional Part' (EP) and the `Apparently Normal Part' (ANP), have different biopsychosocial reactions to supraliminal and subliminal trauma-related cues and that these

74 Van der Hart, Nijenhuis & Steele, ibid, p 5.

75 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid, p. 116; `the controversies surrounding [DID] have the same source as the disorder itself: the very human wish to avoid acknowledging overwhelming helpless and pain' (Jeffrey Smith, MD, in Robert Oxnam, *A Fractured Mind,* Hachette, New York, 2005, p.264).

76 *iagnostic and Statistical Manual of Mental Disorders*, fifth edit; DSM 5 (American Psychological Association Washington DC, 2013).

77 Noting Putnam's (1986) prior research that clients with DID `average 6.8 years in the mental health care delivery system before receiving an accurate diagnosis', Richard Kluft references his own studies as well in stating that `*94% of DID patients show only mild or suggestive evidence of their conditions most of the time. Yet DID patients often will acknowledge that their personality systems are actively switching and/or far more active than it would appear on the surface* (Loewenstein et al, 1987)' Richard Kluft, `A Clinician's Understanding of Dissociation: Fragments of an Acquaintance', in Dell & O'Neil, ed. Dissociation and the *Dissociative Disorders: DSM-V and Beyond*, ibid, p.600.

78 Kluft, ref Kluft, 1987, 1991, 2005, `A Clinician's Understanding of Dissociation', ibid, p.601.Also see Andreas Laddis, `A Simple Algorithm for Medication of Patients with Complex Trauma-Related Disorder', *Frontiers in the Psychotherapy of Trauma and Dissociation*, (1, 2, 2018), pp.244-266.

reactions cannot be mimicked by fantasy prone healthy controls nor by actors.'[79]

Current neuropsychological research lends additional support to the claim of Van der Hart, Nijenhuis & Steele that `*the mental and behavioural actions of survivors shift with the type of dissociative part that exerts executive control.'*[80] Research consistently supports the `Trauma', rather than `Fantasy' model of DID.[81] Neuropsychological studies confirm the differences between genuine DID and simulation of it: `*Results of the new post hoc t tests on the psychophysiological measures confirm the trauma model of DID. Results obtained from the brain data do not support the fantasy model of DID.'*[82]

(12) Understand the differences between *explicit* (conscious, verbal) and *implicit* (largely non-conscious, non-verbal) memory, the nature of traumatic memory as a potent implicit form,* and research findings that recovered (delayed onset recall) memory is no more likely to be reliable or unreliable than continuous memory

`*Contrary to the widespread myth that traumatic memories are seldom if ever forgotten, much trauma is not remembered until something happens to bring it to mind';*[83] `*Research…has firmly established the reliability of the phenomenon of recovered memory.'*[84]

*See Guidelines 30-32 of *Practice Guidelines for Clinical Treatment of Complex Trauma* (updated, 2019*)* and *The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance for Trauma* (Blue Knot Foundation, 2018) https://www.blueknot.org.au/resources/publications/trauma-and-memory

79 Yolanda Schlumpf, Antje Reinders et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study' PLOS One (9, 6, 2014) https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0098795

80 Van der Hart et al, *The Haunted Self*, ibid, p. ix.

81 Rydberg, `Research and Clinical Issues in Trauma and Dissociation', ibid, Bethany Brand, E.H. Vissia, et al, `DID is Trauma-Based: Further Evidence Supporting the Trauma Model of DID', *Acta Psychiatrica Scandinavica* (134, 6, 2016), pp.560-563; Antje Reinders, T.M. Willemsen et al, `The Psychobiology of Authentic and Simulated Dissociative Personality States', *The Journal of Nervous and Mental Disease* (204, 6, 2016), pp.445-459; Reinders, Marquand et al, `Aiding the diagnosis of dissociative identity disorder: pattern recognition study of brain biomarkers', *The British Journal of Psychiatry,* 1-9, 2018, p.455; Constance Dalenberg, Bethany Brand et al, `Evaluation of the Evidence for the Trauma and Fantasy Models of Dissociation', *Psychological Bulletin* (138, 2012), pp.550-588.

82 Reinders, Willemsen et al. `The Psychobiology of Authentic and Simulated Dissociative Personality States', ibid, p. 455.

83 C.R. Brewin, `A Theoretical Framework for Understanding Recovered Memory Experiences' Nebraska Symposium on Motivation, in R.F Belli, ed. *True and False Recovered Memories, Toward a Reconciliation of the Debate* (Springer, New York, 2012), p.165.

84 Constance Dalenberg, `Recovered memory and the Daubert criteria: recovered memory as professionally tested, peer reviewed, and accepted in the relevant scientific community', *Trauma, Violence & Abuse* (7, 4, 2006), p.274; `*Substantial research examining both naturalistic and laboratory situations has demonstrated that recovered memories are equally likely to be accurate as are continuous, never-forgotten memories'* (M.R. Barlow, K. Pezdek et al, citing multiple sources, `Trauma and Memory', ch.16 in S.N. Gold, ed. *APA Handbook of Trauma Psychology* (American Psychological Association, 2017, pp.307-331).

(13) Understand that dissociation can be viewed as inherent to `the normal multiplicity of states of consciousness'[85] which is consistent with revised conceptions of `self' as non-unitary

`Though [the self] is a unit, it is not unitary' (Le Doux, 2002*)*
`The mind is a mosaic; we all have parts' (van der Kolk, 2015).

Diverse research is converging regarding the various `states' of what we call `self'.[86] This also means that *`the experience of being a unitary self…is an acquired, developmentally adaptive illusion'*.[87] This is not necessarily a problem for a sense of coherent identity, because *`[w]hen all goes well, a person is only dimly or momentarily aware of the individual self-states and their respective realities because each functions as part of a healthy illusion of cohesive personal identity – an overarching cognitive and experiential state that is felt as `me'*[88] *(`…the important issue is not how many parts there are, but how they hang together')*.[89]

While dissociation and discontinuity are a feature of all subjectivity,[90] severe dissociation disrupts the fluidity and flexibility of self-states in disabling ways.[91] This also means that the greater the dissociation, the greater the likelihood the client may not identify with `I' statements due to lack of a coherent sense of self (see Guidelines 23-25)

(14) Attune to a `state' theory of personality (according to which the self is not unitary; see previous guideline)

The state theory of personality - defined as `the collective dynamics of a person's set of identity, emotional and behavioural states'[92] - differs from standard conceptions of personality in alternatively proposing that *`[w]e are all multiple to some degree'*.[93] This contrasts with views of personality as `a set of fixed, persistent, and globally defining traits that pervade all of the person's interactions with the world'; the `state' model `allows a far wider range of disparate behaviors'.[94]

85 Philip M. Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation: A Psychoanalytic Perspective', in Dell & O'Neil, *Dissociation and the Dissociative Disorders*, ibid, p. 638.

86 *`The self is characterized by a complex multiplicity of subunits and subselves… and even the multiple parts themselves have parts' (*Elizabeth E. Howell, *The Dissociative Mind*, ibid, p. 48; ref Erdelyi, 1994). States are the building blocks of consciousness and behaviour (Putnam, 1992, 1997; in Howell, *The Dissociative Mind,* ibid, p.170); `Developmentally, lack of integration characterizes our beginnings (Siegel, 1999) and facilitative maturational environments enable disconnected sets of experiences to be linked (Putnam, 1997; in Howell, ibid, p.17). As LeDoux elaborated more recently, *`[t]he fact that all aspects of the self are not usually manifest simultaneously, and that their different aspects can even be contradictory, may seem to present a complex problem. However this simply means that different components of the self reflect the operation of different brain systems, which can be but are not always in sync'* (LeDoux, 2002: 31, cited in Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid, p.641).

87 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid, p.642. Indeed, Bromberg speaks of `the inherent dissociative structure of the mind' (Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid, p. 644.

88 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid

89 Howell, *The Dissociative Mind,* ibid*,* p.48.

90 `In the process of being brought up by humans, and as a result of experiencing anxiety and learning how to avoid it, dissociative gaps in consciousness inevitably form' (Howell, *The Dissociative Mind*, ibid, p.93, ref. Sullivan, 1953).

91 This is consistent with *`a conceptual shift toward `a view of the mind as a configuration of discontinuous, shifting states of consciousness [which] have varying degrees of access to perception and cognition because many domains of dissociated self-experience have only weak or non-existent links to the experience of `I' as a communicable entity'* (Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', p. 638).

92 Frank W. Putnam, *The Way We Are: How States of Mind Influence Our Identities, Personality and Potential for Change* (International Psychoanalytic Books, New York, 2016), p.159.

93 Putnam, *The Way We Are,* ibid, p.121.

94 Putnam, ibid, p.159.

It also helps us understand the *changes and fluctuations* of state we all experience, but which (in emphasising `fixed, persistent, and globally defining traits') traditional and still current theories of personality do not help us comprehend.[95] In the state theory of personality, the marker of health is not fixity but fluidity. It is `*how well we can keep it together, how harmoniously we can bridge, coordinate and even integrate the different parts of ourselves that determines how functional we are*.'[96]

(15) Understand how a state theory of personality assists understanding of both healthy development and compromised functioning `when things go wrong'

States are the building blocks of consciousness and behaviour,[97] and `lack of integration characterizes our beginnings.'[98] This means that `*[c]onstructing a mental self-continuity of consciousness, memory and identity is a task, not a given*'.[99] `Good enough' primary care-giving and interpersonal connections foster links *between* mental states *(intrapsychic)*: `*In the normal course of development…we are usually able to integrate our ongoing interaction…with our social surroundings into a coherent sense of self*.'[100]

Early life trauma and disrupted attachment impede linkage of mental states. Trauma impacts normal multiplicity, creating rigid self-states which negatively affect functioning, self-concept, and relationships:

`*The dissociative concept of multiple self-states is enormously helpful in understanding both normal experience and pathological conditions*.'[101]

95 `In a mental health world that rejects the notion that personality and identity can be fragmented and compartmentalised, therapists are rarely trained to see the splits, much less the life-or-death battle for control being waged by `selves' with opposite aims and instincts' (Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid, p. 1).

96 Putnam, *The Way We Are,* ibid, p.121. It also makes intuitive sense in according with lived experience: `[t]oday we easily grasp the notion that there is the work-self and the self that shows up at home, distinct from that which shows up at parties, sporting events, or with intimate friends' (May Benatar, Emma and Her Selves, IPBooks, New York, 2018, p.8); `[A]lthough most people still subscribe to the idea of a core sense of self, flexibility of self-concept…is a sign of our times' (Steinberg & Schnall, *The Stranger in the Mirror,* ibid, p. 83). Indeed, `[c]onscious role switching has become such a part of our lives…that not being able to switch when the situation demands is a problem for some people' (Steinberg & Schnall, ibid, p. 105).

97 Putnam, 1992, 1997; in Howell, *The Dissociative Mind,* ibid, p.170.

98 Howell, *The Dissociative Mind*, ibid, p.17, ref Siegel, 1999.

99 David Spiegel, `Integrating Dissociation', *American Journal of Psychiatry* (175:1, 2018), p.4.

100 Steinberg & Schnall, *The Stranger in the Mirror*, ibid, p.103.

101 James A. Chu, *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative Disorders,* 2nd edit. John Wiley and Sons, New Jersey, 2011), p.46. As Chefetz notes, `[t]he original, seminal contributions to understanding dissociative phenomena (Braun, 1984; Kluft 1985; Kluft & Fine 1993; R.J. Loewenstein 1991; Putnam 1989) and complex posttraumatic stress disorder ([Complex] PTSD) (Herman, 1992; Horowitz 1986; Terr 1991; van der Kolk, Hostetler, Herron & Fisler 1994) have evolved to a more nuanced literature over time. This has developed perspectives from developmental psychology and behavioral states (Putnam 1997 [2016]), attachment (IJzendoorn 1995; Lyons-Ruth 2003; Main & Hesse, 1990; Solomon & Siegel 2003) and the neurobiology of states of mind (Reinders et al 2003; 2006 [2016, 2018] Siegel 1999) have been adopted. There has also been an effort at a synthesizing model of `structural' dissociation (Van der Hart Nijenhuis & Steele, 2006) and a multiple self-state model in relational psychoanalysis (Bromberg 1998, 2006, 2011, Howell 2005, 2010 [Howell & Itzkowitz, 2016] D.B. Stern (1997 [2010])' (Chefetz, *Intensive Treatment for Persistent Dissociative Processes,* ibid, pp.58-59.

(16) Understand that trauma-generated dissociation has implications for understanding and treating personality disorders

Personality disorders (PD) have traditionally been regarded as untreatable. But the lens of dissociation provides a different perspective (`*[t]he rising tide of trauma and dissociation studies has created a sea change in the way we think about psychopathology')*.[102] This is because the need to keep traumatic experience out of awareness means that `the person surrenders self-state *coherence* to protect self-*continuity*'.[103] From this perspective, disruption to the developmental trajectory means that trauma-generated dissociation is `a healthy defence gone wrong',[104] and a PD can be regarded as an `emergent structure' that results from the *rigid* consolidation of certain character traits in the service of dissociative protection'.[105]

That is, `*[i]ndependent of type, a personality disorder (narcissistic, hysteric, schizoid, borderline, paranoid, etc) constitutes a* personality style *organised as a proactive dissociative solution to the potential repetition of childhood trauma'*.[106]

The clinical implications of this revised reading are major, in that `personality disorders' cease to exist when the underlying dissociation which gives rise to them is successfully treated.[107] Note that the trauma-generated need to dissociate what is overwhelming in childhood experience is consistent with John Bowlby's concept of `defensive exclusion'.[108] What threatens the attachment bond to the primary care-giver is dissociated and the greater the dissociation, the greater the risk of compromised mental functioning as an adult.

102 Howell, *The Dissociative Mind,* ibid, p. ix.

103 Bromberg, *Awakening the Dreamer* (Routledge, New York, 2011), p.68; emphasis added; and where `[t]he dissociation must be preserved, *sometimes at any cost,* to prevent the return of unbearably traumatic self-experience' (Bromberg, *Standing in the Spaces,* Psychology Press, New York, 2001, p.180; emphasis added).

104 Steinberg & Schnall, *The Stranger in the Mirror*, ibid.

105 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid, p.644; original emphasis.

106 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid.

107 For elaboration of this perspective in the context of Borderline Personality Disorder (BPD), see Russell Meares, *A Dissociation Model of Borderline Personality Disorder* (Norton, New York, 2012).

108 John Bowlby, `The Origins of Attachment Theory' [1981] in Bowlby, *A Secure Base: Clinical Applications of Attachment Theory* (New York: Routledge 2006), p.39. While the term dissociation was not widely referenced in Bowlby's time, commentators have compared his concept of `defensive exclusion' with the protective use of dissociation to defend against overwhelm. Gold and Seibel also cite Peter Barach's reading that `the detachment [Bowlby] describes is actually a type of dissociation', and reference Liotti's view that dissociation `was specifically linked to a disorganised/disoriented attachment style, resulting not from parental detachment, but from an ongoing pattern in early childhood of frightened and/or frightening parental behavior' (Gold & Seibel, `Treating Dissociation', ibid, ref Barach [1991] & Liotti [1992] respectively). The work of Winnicott is also regarded as consistent with current readings of dissociation; see Dodi Goldman, ` A queer kind of truth': Winnicott and the uses of dissociation', ch.8 in Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, pp.97-106.

(17) Note the commonality but also differences between dissociative disorders and what are traditionally regarded as personality disorders *(where attempt to protect from recurrence of trauma is the key feature in common)*

Contemporary pioneer in the study and treatment of dissociative disorders, Philip Bromberg, points out that when faced with reminders of past trauma and the associated hyperarousal, `the mental structure of a person with a *dissociative disorder* is usually not stable enough to successfully prevent *symptoms* from being triggered'.[109] This vulnerability to symptoms means that the person with a dissociative disorder can appear `sicker' than someone with a personality disorder,[110] the rigid mental structure of which precludes such `leakage':
`*But in* both *cases (dissociative disorders and personality disorders) mental functioning is mediated by the adaptive effort of a dissociative mental structure that is designed to prevent the intrusion of unbearable trauma*'.[111]

The *difference* between them can be described as that between the *ego-syntonic dissociation* of personality disorders (which is not perceived as inconsistent with overall functioning) and the *ego-dystonic dissociation* of dissociative disorders (which is disruptive to self-conception and which manifests in symptoms):

`*The symptoms of the dissociative disorders are direct manifestations of discontinuities between states of consciousness that the personality disorders are designed to mask*'.[112]

`*In the personality disorders, discontinuities between states of consciousness are expressed only indirectly and `characterologically' as a relationally impaired but relatively `enduring pattern of inner experience and behaviour that…is inflexible and pervasive across a broad range of social situations*'.[113]

109 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid, p.645; original emphasis.
110 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid, p.645.
111 Bromberg, ibid; italics added, note that the word `both' is emphasised in the original.
112 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid, p.645; original emphasis (i.e. the complete sentence).
113 Bromberg, ibid, ref DSM-IV (i.e. which was current at the time); American Psychiatric Association, Washington DC, 1994, p.275); emphasis added.

Part B: Clinical Application

(18) Attune to the possibility of dissociation from the first contact point

This requires attuning to the many different expressions and forms of dissociation and recognising that many diverse and otherwise competent health professionals need to upskill in this area. Even when dissociation is severe and trauma-related, clinicians often don't detect it: *`Many Complex PTSD presentations are so enmeshed in co-morbid factors that the traumatic antecedents can be readily neglected by clinicians'*.[114]

This underlines the need for training to identify dissociative symptoms, because even chronic forms may be undetected and clinicians routinely `miss any signs of…milder forms of dissociation in the clients they see':[115]
`The fact is that people with dissociative disorders present with subjective experiences that are normal, but which for a clinician can easily be discounted as a person being quirky, inattentive… or having a constitutionally bad memory'.[116]

(19) Ask appropriate questions

Even when conducting detailed assessments (which can be challenging with dissociative clients)[117] clinicians often fail to consider *experiential state changes, gaps in memory, and distortions in perceptions*.[118]

Yet `[t]he questions needed to elicit evidence of dissociative symptoms are simple'- *`at a minimum'* clients should be asked about experiences of amnesia, depersonalisation, and derealisation:[119] `People with dissociative experience come to us hoping clinicians can help them understand what subjectively plagues them';[120] `We must speak up because our [clients] are unlikely to do so'.[121]

114 Schwarz, Corrigan et al, *The Comprehensive Resource Model*, ibid, p.23.
115 Danylchuk & Connors, *Treating Complex Trauma and Dissociation,* ibid, p 7.
116 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, ibid.
117 The process has been described as `like herding cats' (van der Hart et al, *The Haunted Self,* ibid, p.223). Hence the importance of timing and pacing.
118 James A. Chu, *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative Disorders,* 2nd edit. (John Wiley and Sons, New Jersey, 2011), p.62.
119 Chu, *Rebuilding Shattered Lives,* ibid 62-63. For depersonalisation and derealisation, one might ask: `Do you ever have the experience of feeling as if your body or emotions are unreal? ...feeling detached from your body or that you are outside your body observing yourself? …feeling as though your surroundings are foggy or unreal?' (Chu, *Rebuilding Shattered Lives*, ibid, pp.62-63). If these are present, the clinician should proceed to `inquire about identity confusion and identity alteration' (Chu, ibid, p.210).
120 Richard A. Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes* (Norton, New York, 2015), p.59.
121 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid, p.94.

(20) Attune to signs of discontinuity

`*Listening for signs of the compartmentalization of experience is very important*' (Chefetz, 2015:235)

This helps identify `hidden' parts/self-states which emerge under stress and of which the client may be unaware. Additional `signposts' to detecting dissociative experience include *isolation, exclusion,* and *deflection.*[122] Note that dissociative experience `is mostly subtle to the outside observer', and that `[u]nless we are specifically curious about it', it is `simply overlooked'.[123]

Attuning to the body is central[124] as is noting micro fluctuations and shifts. Encouraging the client to report experiences of discontinuity is also recommended.[125] Note, however, that `in the initial period of their clinical presentation, the responsibility for increasing curiosity about things dissociative falls to the clinician'.[126]

(21) Attune to the relationship between dissociation and shame

`*Shame is a great instigator, maintenance, and enhancer of dissociation*'.[127]

Shame also `expands the clinician's focus from fear or anxiety to the sense of a damaged self'.[128] Also see Guideline 4 of *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019).

(22) Attune to the difference between a `cohesive' and a `coherent' narrative and to the way in which clients respond to initial contact and inquiry as much as to what they say

Unresolved trauma is not articulated coherently.[129] As the findings of the Adult Attachment Interview (AAI)[130] also confirm, *the way* early experience is conveyed is more significant than the content of the narrative (i.e. *whether* childhood trauma occurred). This relates to the distinction between a `cohesive' narrative (i.e. a verbal account which holds together

122 Chefetz, ibid, p.26.
123 Chefetz, ibid, p.18.
124 `*Psychological experience roosts on the body'* (Chefetz, ibid, p.21).See Guidelines 2 & 9 of *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019).
125 Chefetz, ibid, p.235.
126 Chefetz, ibid, p.94.
127 Richard P. Kluft, `A Clinician's Understanding of Dissociation: Fragments of an Acquaintance', in Dell & O'Neil, *Dissociation and the Dissociative Disorders: DSM-V and Beyond*, ibid, p.614.
128 Christine Courtois & Julian Ford, *Treating Complex Traumatic Stress Disorders* (The Guilford Press, New York, 2009), p.17.
129 `Groundbreaking studies by van der Kolk and Fisler (1995) and Foa and her colleagues (Foa, Molnar et al, 1995) established objectively that the retelling of traumatic memories by traumatised persons with PTSD often fails to exhibit a coherent narrative structure' (Paul Frewen & Ruth Lanius, *Healing the Traumatized Self* (Norton, New York, 2015), p.140.
130 See `The Adult Attachment Interview (AAI)' in Daniel J. Siegel & Mary Hartzell, *Parenting from the Inside Out* (Penguin, New York, 2004, pp.141-153; also Murphy, Steele, et al, 'Adverse Childhood Experiences (ACEs) Questionnaire and Adult Attachment Interview (AAI): Implications for parent child relationships', *Child Abuse and Neglect* (38, 2, 2014, pp.224-233), and Schickedanz, Halfon et al, 'Parents' Adverse Childhood Experiences and Their Children's Behavioral Health Problems', *Pediatrics* (142, 2, 2018).

logically but lacks affective expression and emotional tone) and a `coherent' narrative (which `involves a more holistic, visceral process of reflection').[131]

Listening for a coherent narrative necessitates being alert to *`lapses in reasoning or discourse when our [clients] touch on personal experiences of trauma and/or loss'.*[132] It also underlines the importance of paying close attention to non-verbal communication and the body: *`Traditional talking therapy approaches might work with individuals who are less fragmented or traumatised, but it does not work with clients whose habits of self-alienation and self-rejection recreate the rejections and humiliations of childhood'.*[133]

(23) Recognise the limits of a `whole person' approach when working with dissociative clients

Dissociative clients may have diverse, trauma-generated, and unintegrated internal states which have varying degrees of consciousness for one another. This challenges the extent to which these clients experience themselves as a `whole person' (see Guideline 13). It also challenges the extent to which therapists can experience them in this way as well:

`Attempts to process [client responses] as if they were those of a whole integrated individual are usually frustrating at best. Therapists often find themselves dismissing such clients as `resistant', `unmotivated', or `guarded', without realising that they have been stymied by a series of parts whose job it is to distance in relationships, avoid the trauma, and detach emotionally';[134]
`The challenges of utilizing any treatment approach effectively become greater when amnesic barriers and/or intense conflicts between parts create an inability for the whole person or system to work with the therapist, much less work with itself'.[135]

This means that a `states of consciousness' approach[136] - which is explicitly or implicitly used by a number of diverse therapy approaches including transactional analysis, ego state therapy, and hypnotherapy[137] - is more likely to be beneficial than a `whole person' orientation (see Guideline 27). Note, however, that multiple modes of consciousness approaches themselves need to be modified for working with dissociative clients; see Guidelines 26 & 28).

131 Siegel & Hartzell, *Parenting from the Inside Out,* ibid, p.128. In a coherent, as distinct from a cohesive narrative, affect can be incorporated without intrusions of unassimilated `right brain' traumatic experience.

132 David Wallin, *Attachment in Psychotherapy* (The Guilford Press, 2007), p.242.

133 Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation* (Routledge, New York, 2017), p. 63.

134 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid, p.111.

135 Fisher, ibid, p.156.

136 For an introductory discussion of this point (which is consistent with a state theory of personality, see Guidelines 14 and 15) see `A States of Consciousness Model of Trance and Trauma' in Robert Schwarz, *Tools for Transforming Trauma* (Routledge, New York, 2002), pp.31-33, and chapter 3 in Part 2 of this document.

137 See Guideline 27 and ch.3 of this document. For a helpful discussion of how diverse therapies which utilise a states of consciousness orientation can be related to the `state-dependent aspects of trauma' in a phase-based manner, see Schwarz, `A Neo-Ericksonian Framework for Treating Trauma', ch.2 in Schwarz, *Tools for Transforming Trauma,* ibid, pp.21-50. For a detailed account of the potential of hypnotherapy in treatment of trauma-related dissociation, see Maggie Phillips & Claire Frederick, *Healing the Divided Self* (Norton, New York, 1995).

(24) Defer use of `I' statements (because identifying with the personal pronoun `I' is often challenging for dissociative clients)

Diverse counselling approaches frequently assume a coherent identity and encourage the use of `I' statements. But this is usually premature and counterproductive for clients who are dissociative. Self-continuity and identity are *shaped by experience,* and in complex trauma - particularly childhood trauma - they are often disrupted:

`The usual motto of `united we stand, divided we fall' is rendered useless. So a new strategy comes into plan. `United we collapse, divided we survive'. The person automatically begins to dissociate aspects of the experience into separate compartments of the mind'.[138]

This means that *`many domains of dissociated self-experience have only weak or non-existent links to the experience of `I' as a communicable entity'*.[139]

Encouraging a client to use `I' statements is counterproductive and undermines the therapy when dissociated self-states impede a coherent sense of self.[140]

(25) Orient to `parts' language and work

Orienting to working with `parts' is helpful for working both with structurally dissociated clients (i.e. whose early life trauma generated divisions of the personality)[141] and clients for whom internal diversity is less severe and not chronic. This is because it represents a natural extension of client work more generally.

Utilising the language of parts (as in `a part of me' feels this way rather than `I' feel this way)[142] resonates with many non-traumatised clients due to the `normal multiplicity' of subjectivity (see Guideline 13). It also resonates with traumatised clients for whom referring to `parts of the personality' or `parts of yourself' is usually `an apt description of their subjective experience'.[143] This makes the intrinsically challenging therapeutic process less volatile.

Ego-state therapy, which has various expressions, can be similarly helpful in this regard. Internal Family Systems (IFS),[144] one of the most well-known and widely practised ego-state psychotherapies, can be an important conduit to learning the necessary skills. As Fisher notes, `IFS is a parts therapy' which `teaches therapists to become fluent in speaking the language of parts'.[145] It also helps therapists to attune to their own internal diversity, as *`[n]ot only are they asked to speak the language with their clients, but they are also expected to become mindful of their own parts'.*[146]

138 Robert Schwarz, *Tools for Transforming Trauma*, ibid, p.100.

139 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', p. 638.

140 Note, for example, the following not atypical comments: *`I don't know who I am and I never have known. Nearly all of my life I have not even seen myself as a person…I can track the activities of my living and know what I have done, but even though I know what I have done and my various roles in life, I don't know who I am*' (Debra Bruch, *Fractured Mind*, 2nd edit, Bruwicked Productions, Michigan, 2016, p.77).

141 See Guideline 5 and as is clearly apparent in the following comments of experience of DID: `Each part has its own role or experiences of life, and those experiences were dependent on whatever trauma was being inflicted on me… Each part developed his or her own identity…And so it seems as if each part of me… is his or her own person with a separate identity' (Bruch, *Fractured Mind*, ibid).

142 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid, p.119.

143 Van der Hart, Nijenhuis, & Steele, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization*, ibid, p.4.

144 Richard C. Schwartz, *Internal Family Systems Therapy* (The Guilford Press, New York, 1995).

145 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid, p.8.

146 Fisher, ibid.

NOTE THAT `STANDARD' EGO STATE THERAPIES ARE NOT NECESSARILY ATTUNED TO THE CHALLENGES OF WORKING WITH DISSOCIATIVE CLIENTS AND THAT THE EGO STATES OF STRUCTURAL DISSOCIATION AND DISSOCIATIVE IDENTITY DISORDER (DID) DIFFER FROM THOSE OF CLIENTS WHO ARE NOT STRUCTURALLY DISSOCIATED:

(*`[a]ll alters necessarily fall under the rubric of ego states, but most ego states are not alters';*[147] see Guidelines 26 & 28).

(26) Understand that parts/self-states can be very diverse in severely dissociated clients and the clinical implications

*`Therapists must anticipate that various dissociative parts of a traumatized individual may have quite different reactions… and that only a small portion of those reactions may be evident during the session'.*[148] In chronic and `structural' dissociation (see Guideline 9) some dissociative parts of the personality may not present in therapy at all:

`The part of the patient that functions in daily life[149]*…is the part of survivors that initially interacts directly with the therapist in most cases';*[150]

`A common error is to assume that the experience of [the presenting part] in therapy is the patient's entire experience. Thus the therapist should phrase words in such a way that all parts can be heard and understood'.[151]

`Taking the part/s for the whole' is a risky error. This is especially in relation to self-harming and suicidal[152] parts of the personality which should be directly engaged by the clinician where possible.[153]

(27) Recognise that a non-unitary conception of self informs a range of contrasting psychotherapeutic modalities which utilise the language of `ego states', `parts', `self-states' and `states of consciousness', which is valuable when working clinically with clients with complex trauma and dissociation as well as more generally

`The concept of discrete SOCs [states of consciousness] appears in a variety of therapy models, including transactional analysis…and ego state therapy';*[154] *`it is today a familiar idea

147 Richard P. Kluft, `Dealing with Alters: A Pragmatic Clinical Perspective', *Psychiatric Clinics of North America* (29, 2006), p.284 and Guideline 28.

148 Van der Hart, Nijenhuis & Steele, *The Haunted Self*, ibid, p.226.

149 Which is called the `Apparently Normal Part' (`ANP') of the personality in the account and nomenclature of Van der Hart, Nijenhuis & Steele, ibid; see Guideline 9).

150 Van der Hart, Nijenhuis & Steele, *The Haunted Self*, ibid, p. 269.

151 Van der Hart, Nijenhuis & Steele, ibid, p.270.

152 Also noting both the distinction and the potential overlap between the two; see Guidelines 35 and 36 in *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019).

153 E.g. *`I need to speak directly to the part that…'* Where this is not possible or otherwise desirable, alliance-building with parts which can assist to mitigate such risk is essential. Also see `The Management of Suicide Risk', in Chu, *Rebuilding Shattered Lives,* ibid, pp.136-141.

154 Schwarz, *Tools for Transforming Trauma*, ibid, p.31; ref Berne, 1977; Watkins & Watkins, 1997.

in interpersonal and relational psychoanalysis that the self is not simple and unitary but a more or less cohesive collection of self-states'.[155]

Problems arise when impaired state linkage precludes co-consciousness and access to and flexibility between self-states (see Guideline 15). This highlights the differences between healthy multiplicity and self-systems which are organised around the need to dissociate for defensive purposes due to trauma and disrupted attachment (of which the personality divisions of structural dissociation are the most severe).

(28) Understand that trauma-generated parts of the personality can take different forms, that the ego states of structural dissociation differ from the ego-states which characterise health, and that the personality parts of DID (`alters') are distinctive in particular ways

`[W]hat is known as borderline personality appears to have a particular kind of dissociative structure, in which two main parts oscillate, as opposed to DID, in which there are usually more parts that take over executive function at different times'.[156]

Clinician and trauma-related dissociation expert Richard Kluft has discussed the many paths and dynamics by which structurally dissociated parts and the multiple self-states of DID can incubate and proliferate (*`[a]ll alters necessarily fall under the rubric of ego states, but most ego states are not alters');*[157]

`Ego states that are also alters generally have four characteristics that are not intrinsic to the ego state phenomenon per se:

(i) they have their own identities, involving a sense of self (a centre of initiative and experience)

(ii) *they have a characteristic self-representation, which may be discordant with how the patient is generally seen or perceived*

(iii) they have their own sense of autobiographic memory, distinguishing what they understand to be their own actions and experiences from those done and experienced by other alters

(iv) *they have a sense of ownership of their own experiences, actions, and thoughts, and may lack a sense of ownership of and a sense of responsibility for the action, experiences, and thoughts of other alters'.*[158]

155 *`In each life, the multiple self arises in the first place because each of us is different in the presence of different others'; `[t]he multiple self as the expectable, everyday condition of identity is…a very helpful addition to our conceptualisation of the role of context in understanding'* (Donnel Stern, *Partners in Thought: Working with Unformulated Experience, Dissociation, and Enactment,* Routledge, New York, 2010, p. 48-9). Diverse states of consciousness relate to internal substructures which `can include feeling states, patterns of attention, degrees of sympathetic and parasympathetic arousal, quality of internal dialogue and mental images, memories and so on' (Schwarz, *Tools for Transforming Trauma,* ibid, p.31). Moreover, `different self-states may be simultaneously knowable; there is no implication that a person need be uncomfortable about knowing one self-state while he is `in' another' (Stern, *Partners in Thought,* ibid, p.48).

156 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p. 37; ref Howell, 2002, ibid.

157 Kluft, `Dealing with Alters: A Pragmatic Clinical Perspective', ibid, p.284.

158 Kluft, `Dealing with Alters', ibid, ref. Kluft, 1991; Kohut, 1977.

(29) Use a conversational style, seek to demystify, and attune to spoken language at all times

Spoken language should be as natural and conversational as possible.[159] It should also be used with care. It is important to address the client appropriately. While `parts' language resonates for many clients (see Guideline 25) reference to `self-states', `aspects' and `different ways of being you'[160] may also appeal and client preference should be respected.

(30) Ensure that all treatment modalities are `dissociation-informed' as well as trauma-informed

Attuning to the frequently subtle signs of dissociation is essential. This is because when clients `zone out' they are unable to pay attention. This limits the benefits of therapy (note that many clients seek therapy in the first place because they are unable to `stay present').

The specific need for all therapy to be dissociation – as well as more generally trauma – informed applies to all modalities. This includes otherwise well-evidenced therapeutic approaches.

For example, Eye Movement Desensitisation Reprocessing (EMDR) is a well evidenced trauma treatment which has also been adapted for dissociative clients.[161] Yet not all EMDR practitioners are `dissociation savvy'.[162] If using EMDR with clients with trauma histories, the modified protocol which prioritises resource installation prior to trauma processing[163] is strongly advised.

(31) Understand that dissociative shifts may be subtle and that even chronic dissociative disorders may not manifest as overt

This has led to the description *`psychopathologies of hiddenness',*[164] where *`[w]hat we usually see is the dissociative surface'.*[165] It also further supports the advice of Chefetz that `[w]e must speak up because our [clients] are unlikely to do so'.[166]

159 This helps to build rapport and also assists healing: `keeping the structure of therapy a mystery does the patient a disservice' (David Wallin, *Attachment in Psychotherapy,* The Guilford Press, New York, 2007, p.201).

160 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid.

161 Deborah L. Korn, `EMDR and the Treatment of Complex PTSD: A Review', *Journal of EMDR Practice and Research* (3, 4, 2009, pp.264-278); also see Anabel Gonzalez, `Eye Movement Desensitization and Reprocessing (EMDR) in Complex Trauma and Dissociation: Reflections on Safety, Efficacy and the Need for Adapting Procedures', *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 2, 2018, pp. 192-211).

162 *`No clinician should use EMDR therapy with a client suffering from a dissociative disorder unless he is educated and experienced in working with this population…The potential for harm with this type of client is great if EMDR reprocessing is used inappropriately or injudiciously'* (Francine Shapiro, *Eye Movement Desensitization and Reprocessing (EMDR) Therapy,* 3rd edition, The Guilford Press, Washington, DC, 2018, pp. 342-343).

163 See Korn, `EMDR and the Treatment of Complex PTSD: A Review', ibid; Gonzalez, `Eye Movement Desensitization and Reprocessing (EMDR) in Complex Trauma and Dissociation', ibid; Sandra Paulsen, *When There Are No Words: Repairing Early Trauma and Neglect From the Attachment Period With EMDR Therapy* (Bainbridge Island, WA: Bainbridge Institute for Integrative Psychology Publication**,** 2017); Carol Forgash & Margaret Copeley, ed. *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* (Springer, New York, 2007), and Laurel Parnell, *Attachment Focused EMDR: Healing Relational Trauma* (Norton, New York, 2013).

164 Gutheil in Kluft, 1985, Kluft, `A Clinician's Understanding of Dissociation', ibid, p.600.

165 Kluft (2005) in Kluft, `A Clinician's Understanding of Dissociation', ibid.

166 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid, p.94.

(32) Recognise that mindfulness and dissociation are rival brain activities (Forner, 2017) which challenges attempts to promote dual awareness

Dual awareness (i.e. the capacity to be aware of two experiences simultaneously and to observe internal sensations while retaining awareness of surroundings) is a skill to be promoted in therapy as early as possible (see *Practice Guidelines for Clinical Treatment of Complex Trauma*, 2019). But paying attention to sensations is initially profoundly unsettling for trauma survivors. Unless clinicians are dissociation-informed, the rival activities of mindfulness and dissociation can impede the therapy.

Dissociation is `the deficiency of internal and external awareness' while `mindfulness is internal and external awareness in abundance'*: `One is a basic function that is designed to know; the other is a brain function that is designed to not know*'.[167] Moving to mindful awareness (and `mindfulness is one of the interventions that helps put the human back on track')[168] is especially challenging when dissociation is the client's `default' coping response. Clients need to be adequately resourced because initial attempts to `notice' body responses and sensations can be distressing when dissociation is the `go to' response.

(33) Attune to the `emotional bypassing' of dissociation which limits the ability to recognise, experience, and regulate affect

Contextual trauma therapy holds that `*emotional arousal indirectly contributes to the occurrence of dissociative episodes*'.[169] Intense emotions `potentiate dissociative reactions when they override cognitive processing',[170] and `the ability to…sustain attention on the immediate present' is disrupted.[171] This means that dissociative clients may be `[b]affled by their own conduct',[172] and wrongly regarded as `treatment resistant' by therapists who are not attuned to and knowledgeable about dissociative processes.

(34) Recognise the treatment implications of the above regarding all interventions

As dissociation limits the recognition and regulation of emotion, interventions that `foster reduction in the frequency and intensity of dissociative episodes'[173] are needed. A range of strategies and techniques are also available: *`A constellation of strategies widely employed by therapists who are knowledgeable about dissociation to help clients counteract the propensity to dissociate are `grounding' or `anchoring' techniques':*[174] *`What this group of techniques has in*

167 Christine Forner, *Dissociation, Mindfulness and Creative Meditations* (Routledge, New York, 2017), p. xii.

168 Forner, *Dissociation, Mindfulness and Creative Meditations,* ibid, p xv.

169 Gold & Seibel, `Treating Dissociation: A Contextual Approach', ibid, p.633.

170 `Dissociative clients often have poor capacities to recognise that they are experiencing affect, let alone to monitor the fluctuating intensity of feelings. When they are aware that they are experiencing emotion, it is often only dimly, because they frequently have difficulty identifying and labelling what type of feeling it is. For all these reasons, they are vulnerable to experiencing rapid escalation in affective levels without adequate ability to keep either their emotions or the expression of their feelings in check' (Gold & Seibel, `Treating Dissociation', ibid, p.629).

171 And which `plays a more direct role in activating dissociative episodes by interrupting the experiential, connection to the here and now' (Gold & Seibel, ibid, p.633).

172 Gold & Seibel, `Treating Dissociation', ibid, p.629.

173 Gold, & Seibel, `Treating Dissociation', ibid**.**

174 Gold, & Seibel, `Treating Dissociation', ibid, p.630; ref. Dolan, 1991; Phillips & Frederick, 1995; Simonds, 1994.

common is that they all involve learning to direct one's attention to subjective experience and the surrounding environment in the immediate present'.[175]

Note, however, that because dissociation and mindfulness are opposite functions (see Guideline 32) standard grounding techniques may not be appropriate (see next guideline and Guidelines 16 and 34 of *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019).

(35) Standard grounding techniques and imagery may not be appropriate and/or may need to be modified for dissociative clients

Clinicians often try to `anchor patients in the present by focusing them on their sensory perceptions of their environment'[176] (where the goal, `*with practice',* is for clients to `*extend their awareness of tactile sensations to more subtle, proprioceptive sensations')*.[177] But in the case of chronic dissociation, such efforts can be problematic, appearances of stabilisation can be deceptive, and `grounding' can be a superficial concept[178] unless tailored specifically. For example, when multiple dissociative self-states exist (as in DID) grounding techniques which seem stabilising for the `presenting self' may be problematic for other self-states/parts.[179]

Similar caveats apply to `relaxation' techniques and imagery: `*The usefulness of relaxation and imagery methods …may be compromised by unfavourable risk/benefit ratios… Many traumatized individuals struggling to keep control, and who may be hypervigilant, feel threatened by relaxation approaches'.*[180] Also see Guidelines 16 & 29 in *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019) regarding the need to select all interventions with care and the benefits and risks of using imagery in the clinical context.

(36) Utilise dissociation as a resource for therapeutic benefit

While interventions that foster `reduction in the frequency and intensity of dissociative episodes'[181] are needed, clinicians should take care not to regard dissociation in an over-simplified way as `the problem to be solved.' In the context of trauma, `*[t]he same psychological mechanisms that make it easier to reassociate and reorganise* SoCs *[states of consciousness] toward flexibility and resourcefulness can also produce highly limiting and rigid SoCs that become dysfunctional'.*[182]

175 Gold, & Seibel, `Treating Dissociation', ibid, p.630; see `Learning to Directly Counteract Dissociative Reactions', ibid, pp.630-631 for discussion and illustration of this point; also see Guideline 35).

176 Richard P. Kluft, `Trying to Keep it Real: My Experience in Developing Clinical Approaches to the Treatment of DID', *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 1, 2017), p.31.

177 Gold & Seibel, `Treating Dissociation', ibid, p.631.

178 Kluft, `Trying to Keep it Real', ibid, p.31.

179 The risks are greatest in DID (which the clinician may not detect) because `not only may imagery techniques that are usually assumed to be benign trigger connections to traumatic scenarios…but due to amnesia, inquiry with accessible personalities may seem to indicate a particular scenario is safe, only to find that in practice, it proves upsetting to other groups of alters' (Richard P. Kluft, `Hypnosis in the Treatment of Dissociative Identity Disorder and Allied States: An Overview and Case Study', *South African Journal of Psychology* (42, 2, 2012), p.146.

180 Richard P. Kluft, ref Gruzelier, 2000, Kluft, 2012, Orne, 1967, `Hypnosis in the Treatment of Dissociative Identity Disorder and Allied States', ibid.

181 Gold, & Seibel, `Treating Dissociation', ibid, p.629**.**

182 Schwarz, *Tools for Transforming Trauma*, ibid, p.33.

Reconceptualising symptoms as the outgrowth of initially protective strategies to defend against being overwhelmed (see Guideline 12 of *Practice Guideline for Clinical Treatment of Complex Trauma,* 2019) not only enables a view of clients as resourceful. It also assists clinicians to utilise symptoms - *including dissociative symptoms* - therapeutically within the treatment:[183] *`the more germane questions are, from where is the person dissociating and to where is she associating?'*[184]

Clinically utilising dissociation to address the challenge of dissociation, while seeming paradoxical, is consistent with regarding symptoms as the outgrowth of coping strategies which have ceased to be protective due to unresolved underlying trauma.[185] The challenge is to recognise *`the dissociation/association mechanism as a dynamic process'* whereby *`[t]he therapist works to create and maintain resourceful [states]'*.[186] There are now a range of methods and techniques from diverse fields by which this might be done,[187] and which can potentially be implemented within the phased treatment approach to complex trauma.[188]

(37) Skill development is necessary over and above the client-therapist relationship

Learning skills - assisted by using the relevant tools, strategies and techniques- promotes `mastery, competence, and resourcefulness' in clients.[189] It is essential for effective therapy for complex trauma and dissociation for this reason (see Guideline 16 in *Practice Guidelines for Clinical Treatment of Complex Trauma,* 2019). Skills development is optimised within the therapeutic relationship, and the relational context is important to healing from complex trauma.[190] But the relational context is not sufficient without learning the necessary skills:

`[C]omplex trauma absolutely requires attachment resources other than the therapist-client attunement';*[191] *`While the therapist alliance is a key aspect of treatment, it is erroneous to believe that the relationship alone will lead to substantive change'.[192]

183 I.e. rather than attempting to eradicate them when symptoms also contain potent `emotional learnings' (Bruce Ecker, `Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *International Journal of Neuropsychotherapy* (6, 1, 2018), p.6.

184 Schwarz, *Tools for Transforming Trauma*, ibid, p.42; emphasis added.

185 And also that *`for many survivors, resilient strategies and maladaptive coping skills are interlaced and occur simultaneously'* (Sandra Bloom & Brian Farragher, *Destroying Sanctuary* (OUP, Oxford, 2011, p.16).

186 Schwarz, *Tools for Transforming Trauma,* ibid, p.43. Also note the contention of Kluft that *`[w]orking with dissociation to cure dissociation became a characteristic aspect of the therapeutic process'* (Kluft, `A Clinician's Understanding of Dissociation', ibid, p.622).

187 For example, the `Tearless Trauma' technique of Energy Psychology (Church, *Psychological Trauma*, Energy Psychology Press, CA, 2015, pp.42-44) and many techniques from hypnotherapy. For discussion of these and other potentially valuable interventions in this regard, see `New' and Emerging Treatments', ch.4 in Part 2 of *Practice Guidelines for Clinical Treatment of Complex Trauma,* 2019, pp.140-176. Also see ch 3 in Part 2 of this document.

188 For elaboration of the recommended phased treatment approach to complex trauma, see Guideline 21 and chapter 3 of *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019), and Guideline 19, ch 4 and the latter part of ch 5 for a discussion of the potential integration of diverse interventions within the phased treatment model.

189 Schwarz, *Tools for Transforming Trauma*, ibid, p.217.

190 `Recovery can take place only within the context of relationships; it cannot occur in isolation' (Judith Herman, *Trauma and Recovery* (Perseus, New York [1992] 1997), p.133.

191 Schwarz, Corrigan et al, *The Comprehensive Resource Model: Effective Therapeutic Techniques for the Healing of Complex Trauma,* ibid, p.130.

192 Gold & Seibel, `Treating Dissociation', ibid, p.632.

(38) Understand the difference between experience which is *unpleasant* (i.e. anxiety-inducing) and experience which is *unbearable* (i.e. overwhelming; traumatic) and the treatment implications

Experience which is unbearable is traumatic because it is overwhelming; it is threatening not only of itself but also to the identity and integrity of the psyche (and so needs to be dissociated). This is qualitatively different from experience which, while distressing, unpleasant and anxiety-inducing, does not need to be radically separated from the self. The distinction between `bad me' (experience which is `associated with the increasing gradient of anxiety') and `not me' (the product of severe anxiety, memory of which must be avoided at all costs and which is `out of consciousness and dissociated' for that reason) captures these differences.[193]

The difference between experience which is *unpleasant* (albeit distressing) and experience which is *unbearable* (i.e. `not me' and thus requires dissociation) is major. But the two are often conflated with problematic implications for treatment, as in the `evidence-based' treatment/s of exposure therapy.[194] Failure to address the risks of *precipitate* exposure to aversive stimuli for people whose anxiety is unbearable, and who lack sufficient self-regulatory capacity, increases the risk that dissociation, decompensation and retraumatisation will be triggered as a result of, and even during, the treatment itself.[195] In 2018, an editorial of the *American Journal of Psychiatry* noted that patients *`with significant dissociative symptoms respond less well to standard exposure-based psychotherapy and better to treatments that assist them with self-stabilization as well'.*[196]

(39) Note that boundaries are more challenging at all levels in relation to severe dissociation

Boundary violation is a key characteristic of most interpersonal trauma, especially when it occurs in childhood. The most basic boundary is between `that which is me and that which is not me';[197] in trauma and dissociation the situation is complex because `not me' is *`out of consciousness and dissociated'* due to severe anxiety[198] and self-states may be numerous and lack co-consciousness.[199] See `Revisiting Boundaries', Guideline 15 in *Guidelines to Differences between Therapy for Complex Trauma and Standard Counselling Approaches*, and `(Re)Consider Boundaries', Guideline 5 in *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation.*[200]

193 Sullivan, 1953; in Elizabeth Howell, *The Dissociative Mind*, ibid, p.95; `Dissociation is mostly not about dissociative disorders. It is about how a mind struggles to cope with the intolerable and unbearable' (Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid, p.23).

194 The foundational premise is that facing anxiety-inducing stimuli reduces presenting symptoms and distress. Exponents of exposure therapies generally contest the need for a prior `stabilisation' phase of treatment (i.e. in contrast to the phased approach to treatment of complex trauma; see Cloitre, Courtois et al. *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults*, 2012 https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf

195 These risks are compounded by use of exposure therapies by clinicians who are not knowledgeable about and able to identify and treat dissociation. See `Revisiting Phased Treatment for Complex Trauma', Ch.3 in *Practice Guidelines for Clinical Treatment of Complex Trauma*, 2019, pp.121- 139.

196 David Spiegel, `Integrating Dissociation', *American Journal of Psychiatry*, 175:1, 2018, p.4 (and recall that most people with complex trauma `have severe dissociative symptoms'; Van der Hart, Nijenhuis & Steele, *The Haunted Self,* ibid).

197 Schwarz, *Tools for Transforming Trauma*, ibid, p. 78.

198 Howell, *The Dissociative Mind,* ibid, p.96, ref Sullivan, 1953.

199 Bromberg, *Standing in the Spaces*, ibid; Stern, *Partners in Thought*, ibid, Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, ibid.

200 Both are contained in the publication *Complementary Guidelines for Clinical Treatment of* Complex *Trauma* (Blue Knot Foundation, 2019) https://www.blueknot.org.au/Resources/Publications/Practice-Guidelines/Complementary-Guidelines

(40) Understand that self-states which are inaccessible because they are dissociated reduce the capacity to experience internal conflict (`dissociation is *inherently* nonconflictual')[201]

This may seem counterintuitive, because conflict is a `given' in relationships. This means we assume that everyone has the capacity to experience conflict, and that reducing internal conflict is `a good thing'. But ambivalence and internal conflict are largely absent and alien for the person with dissociated self-states; because conflict could not be tolerated it was dissociated in the first place. Rather, `each state of consciousness holds its own experientially encapsulated `truth'.[202]

Communication *between* self-states, which needs to be fostered therapeutically, intensifies the awareness of intrapsychic conflict and needs to happen before a person can experience it. In fact, people need to be able to experience conflict for spontaneity and vitality. While it is possible to experience too *much* conflict it is also possible to experience too *little.*[203] This means that *`[i]n the case of dissociated self-states, conflict is not a given but a goal'*[204] (also see the following three guidelines).

(41) Recognise the limits of the concept of `resistance'

If a dissociative client lacks ` the experience of intrapsychic conflict'[205]- i.e. which relates to `not me'[206] - conventional notions of `resistance' are not appropriate:

`*[W]hat we have traditionally labelled `resistance'* is *`not…a patient's avoidance of unpleasant insight but….a protest against the analyst's non-negotiated disconfirmation of a dissociated part of the patient's self'*.[207]

Therapists who insist on the notion of `resistance' risk becoming intransigent. This can also lead to `treatment failure or treatment impasse in…a large number of patients'.[208]

(42) Understand that not experiencing internal conflict (i.e. due to isolated and dissociated self-states) means that conflict-theory approaches are inapplicable

`Conflict resolution' is a staple of standard clinical practice. Yet like the concept of `resistance', it is inappropriate for clients for whom dissociated self-states are inaccessible: `An analyst working from a conflict-theory perspective' will face many problems, to which *`[p]atients will*

201 Bromberg, *In the Shadow of the Tsunami and the Growth of the Relational Mind* (Routledge, New York, 2011), p.101; original emphasis.
202 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation: A Psychoanalytic Perspective', in Dell & O'Neil, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond*, ibid, p.638.
203 As Stern points out, without denying the prevalence of conflict, `we must accept that there are times when we do not experience *enough* internal conflict, that a significant part of the pain in human relatedness occurs because conflicts that might be actualised within us are not' (Donnel Stern, *Partners in Thought,* ibid, p.101).
204 Stern, *Partners in Thought,* ibid.
205 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid, p.638.
206 Sullivan, 1953 in Howell, *The Dissociative Mind,* ibid, p.96.
207 Bromberg, *In the Shadow of the Tsunami,* ibid, p.139.
208 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid, p.640.

respond in various ways, none of them therapeutically facilitating'.[209] The clinical implications of this are major:
`for any patient, in those areas where the natural dialectic between conflict and dissociation is either compromised or shut down, conflict interpretations are useless or even worse'.[210]

Rather, `(l)inking self-states together…is a central task of treatment and often begins through the relational link between individual self-states and the therapist'.[211]

(43) Understand that dissociated experience is *relationally enacted* including in the therapy relationship

The repetition (`re-enactment') of overwhelming unassimilated experience is a well-known feature of trauma.[212] Re-enactment relates to implicit, rather than explicit, memory,[213] and requires therapists to know about the nature of traumatic memory[214] and pay attention to non-verbal communication and the body.[215] The phenomenon of *enactment* – in which internal experience is the only realm action can be expressed when it can't be felt or thought about[216] - is relationally reproduced and has been described as `the interpersonalisation of dissociation'.[217] What cannot be tolerated by the person who is dissociating will be projected onto someone else.[218]

Enactments are also frequent *in the therapy room* as attachment dynamics are inevitably activated. Because what cannot be felt or thought about (because unbearable) is *enacted relationally*, enactments of dissociated experience form a bridge between the *intra*personal

209 Bromberg, *In the Shadow of the Tsunami,* ibid, p.78.
210 Bromberg, *In the Shadow of the Tsunami,* ibid, p.101.
211 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, ibid, p.346; ref. Putnam, 1989.
212 `Because…dissociated affective memories have not been symbolized, they can only be enacted' (Wallin, *Attachment in Psychotherapy,* ibid, p. 105). Described by Freud (1920) as the `repetition compulsion', the re-enactment of trauma has been widely discussed and linked to the impetus towards healing (`*This unconscious tendency to try and resolve the unfinished narrative lies at the heart of what Freud called the* repetition compulsion' (Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, ibid, p.41; ref Freud 1920, and Horowitz, 1986, who referred to the `*completion tendency*'). In the view of Levine, `[r]e-enactment represents the organism's attempt to complete the natural cycle of activation and deactivation' as `[t]he drive to complete and heal trauma is as powerful and tenacious as the symptoms it creates' (Peter Levine, *Waking the Tiger* (North Atlantic, Berkeley, CA, 1997), pp.197 & 173 respectively.
213 See Guidelines 30 and 31 in *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019). As Fisher points out, it is helpful for therapists to consider the question `*[i]s there a pattern in the client's life that might be telling a story of unresolved trauma being re-enacted at an implicit level?*' (Fisher, *Healing the Fragmented Selves of Trauma Survivors,* ibid, p.118.
214 See Guideline 12.
215 `By becoming aware of what the [client] enacts with us, evokes in us, or embodies, we have the opportunity to begin to know something about the [client's] `unthought unknown' (Wallin, *Attachment in Psychotherapy,* ibid, p.131; emphasis added. For recommendations for addressing implicit material, see Guidelines 2, 14 & 18 of *Practice Guidelines for Clinical Treatment of Complex Trauma*, 2019).
216 `We take action…because that's all that's left to us when emotion is isolated alongside thought, behaviour, and even bodily sensation (Braun 1988) as a result of dissociative processes' (Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, ibid, p.255); *`[E]xperience that is unformulated because it has never been attended to must, of necessity, be enacted'* (Howell, *The Dissociative Mind,* ibid, p.208; referencing Stern, 2004); *`Enactments.... translate internal experience into action*' (Wallin, *Attachment in Psychotherapy,* ibid, p.270).
217 *`Enactment is the last-ditch unconscious defensive effort to avoid being the person one must not be, accomplished by trying to force onto the other what defines the intolerable identity*'; *`The only course of action left to the dissociator who needs to protect himself from such imminent danger is the externalisation of the way of being that one must not take on oneself – the interpersonalization of the dissociation*' (Stern, *Partners in Thought*, ibid, p.14). Also see Philip Bromberg, *Standing in the Spaces,* ibid, *Awakening the Dreamer,* ibid, and *The Shadow of the Tsunami,* ibid.
218 `[T]he price for defensive control over consciousness is that the dissociated experience is enacted' (Stern, *Partners in Thought,* ibid, p.92); *`I will `play out' the state of self I cannot tolerate experiencing directly, and I will thereby unconsciously influence those with whom I relate to adopt a variation on the same dangerous response that led me to dissociate the self-state in the first place*' (Stern, ibid: 84). Also see the previous footnote.

and the *inter*personal.[219] The role of the therapist is to assist linkage of dissociated self-states of the client `in order for the experience of intrapsychic conflict to be possible'.[220] Experience of internal conflict (the absence of which means the problem is seen to lie solely with the other person) is a necessary condition for enactments to be negotiated.[221]

This is challenging because the therapist necessarily *participates in* these enactments, which can ignite their own unconscious processes. Hence clinicians *`need…to become attuned to and aware of their own dissociative experiences'*.[222] Therapists are responsible for identifying their unwitting co-contribution[223] to enactments and for addressing impasses in therapy. Issues of `the person of the therapist', identification of countertransference,[224] and the role of clinical supervision are critical in order to recognise and effectively address enactments see subsequent guidelines).

(44) `Person of the therapist' issues are critical in therapy for complex trauma[225]

`The first person to feel the effects of things not working well is the client'
(Danylchuk & Connors, 2017: 172).

The ability of the therapist (i.e. as well as the client) to `stay present' can be very demanding of the clinician. This is because the therapist witnesses the traumatic material at the same time as monitoring client safety: *`Being present and real is very powerful, and often very difficult'*.[226] The exacting nature of the work also highlights the need `to continue to tend to one's own psyche while working in this field'.[227]

Experienced complex trauma clinicians recommend prior personal therapy, ongoing reflective practice and trauma-informed clinical supervision: *`As therapists, our egos and performance anxiety can be as significant an obstacle to trauma work as that of the protective nature of the [client's internal] system itself…The therapist's attunement to themselves as well as their client will allow for the most appropriate choices in the course of treatment, and it is there that the therapist's willingness to engage in their own personal healing work is imperative'*.[228]

219 Howell, *The Dissociative Mind,* ibid, pp. 204 & 208.

220 Bromberg, `Multiple Self-States, the Relational Mind, and Dissociation', ibid, p.643. *`It is largely in enactments within the treatment that… unthought and uncommunicated islands of experience* [`not me'] become *thinkable, and therefore linkable...by virtue of having impacted the [therapist's] mind'* (Howell, *The Dissociative Mind*, ibid, p. 106); the therapist functions as *`a relational bridge';* whereby holding of different aspects of the client's self in mind `helps the [client] to do the same' (Howell, ibid: 105) and where `[w]ithout a safe enough other, the repetition cannot resolve' (Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid, p.44).

221 Note that as the enactment occurs within the therapy dyad and relationship, *the therapist*, who is a participant in the enactment may not initially be able to see their own contribution to it (see next paragraph within the text): `Enactments end as a result of a change in affect and relatedness [i.e. rather than via interpretation and verbal exchange], which provides a change in each participant's perceptions …of the other and himself' (Stern, *Partners in Thought*, ibid, p. 124).

222 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid, p.99.

223 `For in spite of what we may believe we're consciously *choosing* to do with the [client], it is often our *unconscious* needs, feelings, and interactions that are decisive [and] that come through to the [client] via the channels of nonverbal communication' (Wallin, *Attachment in Psychotherapy,* ibid, p.270).

224 `Awareness of countertransference has the potential to put the brakes on destructive enactments' (Wallin, *Attachment in Psychotherapy,* ibid, p.249). See Constance Dalenberg, `Maintaining the safe and effective therapeutic relationship in the context of distrust and anger: Countertransference and complex trauma', *Psychotherapy: Theory, Research, Practice, Training, (41*, 4, 2004), pp.438-447.

225 Reproduced from *Guidelines to Therapist Competencies for Working with Complex Trauma and Dissociation* (where it appears as Guideline 8), ibid.

226 Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, ibid, p. 171.

227 Danylchuk & Connors, ibid, p.167.

228 Schwarz, Corrigan et al, *The Comprehensive Resource Model,* ibid, pp.226-227.

(45) The nature of the work involves all aspects of self and requires ongoing self-care

`Knowing one's own history and emotional vulnerabilities is essential for staying in this field in a way that supports the health of both therapist and client'
(Danylchuk & Connors, 2017: 168).

Witnessing the impacts of complex trauma impacts the therapist. But the challenge of the work can also activate self-protective responses of which the therapist may be unaware. This speaks to the importance of ongoing self-work as well as all facets of self-care:

`It is not a problem for the therapy if the therapist's affect is aroused. Without affect, how can a therapist empathize? …. The issue becomes whether or not the feelings overwhelm the therapist or force the therapist to psychologically leave the room'.[229]

The greater our self-knowledge in relation to our own history and coping strategies around intense emotion, the more attuned and effective the therapy. Unconscious self-protective strategies utilised by therapists include covert distancing, and attempts to `contain' the client which may stem from our own difficulty in containing what they evoke in us. Projection and over-identification can also occur on the part of the therapist, regardless of whether or not they have their own trauma history.[230] Also see Appendix 2, `Self Care for Therapists who Work with Complex Trauma'.

(46) Know that dissociative disorders, including DID, and complex trauma-related dissociation are treatable as evidenced by neuroplasticity, the `earned security' of reworked attachment and the resolution of trauma

`If we have but one closing message…it would be that healing and recovery are possible'.[231]
Identifying dissociation early is important to the recovery process.

`[A] dissociative disorder is no different from any other physical or psychiatric illness',* and with the appropriate treatment, clients *`have a good prognosis for recovery'.[232]

`That even those whose sense of self has been most brutally shattered can learn to reunite the broken parts of themselves, and thereby heal, is a lesson that gives hope and wisdom to us all'.[233]

229 Schwarz, *Tools for Treating Trauma,* ibid, p.219.
230 For discussion of these issues in the context of complex trauma, see `The Trauma Therapist' (Part 4 in Danylchuk & Connors, *Treating Complex Trauma and Dissociation*, ibid, pp.163-177. For a helpful guide to self-care, see Coleman, Chouliara & Currie, `Working in the Field of Complex Psychological Trauma: A Framework for Personal and Professional Growth, Training, and Supervision' (*Journal of Interpersonal Violence,* 2018), pp. 1 –25.
231 Frewen & Lanius, *Healing the Traumatized Self,* ibid, p. 318.
232 Steinberg & Schnall, *The Stranger in the Mirror,* ibid, p.113.
233 Steinberg & Schnall, ibid, p. 128.

References

Barlow, M.R., Pezdek, K. & Blandon-Gitlin, K. (2017) `Trauma and Memory', ch.16 in Gold, S.N., ed. *APA Handbook of Trauma Psychology: Foundations in Knowledge* American Psychological Association, pp.307-331.

Benatar, M. (2018) *Emma and Her Selves: A Memoir of Treatment and a Therapist's Self-Discovery* New York: IPBooks.

Bloom, S. L. & Farragher, B. (2011) *Destroying Sanctuary: The Crisis in Human Service Delivery* Oxford, OUP.

Bowlby, J. [1988] (2006) *A Secure Base: Clinical Applications of Attachment Theory* New York, Routledge.

Brand, B.L. (2012) `What We Know and What We Need to Learn About the Treatment of Dissociative Disorders', *Journal of Trauma & Dissociation,* 13:4, 387-396.

Brand, B., Sar, S. et al (2016) `Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder' *Harvard Review of Psychiatry* (24, 4), pp. 257-270. https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction___An_Empirical.2.aspx

Brand, B.L, Vissia, E.M. et al (2016) `DID is Trauma-Based: Further Evidence Supporting the Trauma Model of DID', *Acta Psychiatrica Scandinavica* (134, 6), pp.560-563.

Braude, S.E. (2014) `The Conceptual Unity of Dissociation: A Philosophical Argument', in Dell, P.F. & O'Neil, J.A., ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond* New York, Routledge, pp.27-36.

Brewin, C.R. (2012) `A Theoretical Framework for Understanding Recovered Memory Experiences' Nebraska Symposium on Motivation, in Belli, R.F. ed. *True and False Recovered Memories, Toward a Reconciliation of the Debate* New York: Springer, pp.149-173.

Bromberg, P.M. (2011) *Awakening the Dreamer: Clinical Journeys* New York, Routledge.

Bromberg, P.M. (2014) `Multiple Self-States, the Relational Mind, and Dissociation: A Psychoanalytic Perspective', in Dell & O'Neil, *Dissociation and the Dissociative Disorders*, New York, Routledge, pp. 637-652.

Bromberg, P. M. [1998] (2001) *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation* New York, Psychology Press.

Bromberg, P.M. (2011) *The Shadow of the Tsunami and the Growth of the Relational Mind* New York, Routledge.

Bruch, D. (2016) *Fractured Mind*, 2nd edit, Michigan, Bruwicked Productions.

Chefetz, R.A. (2015) *Intensive Psychotherapy for Persistent Dissociative Processes: The Fear of Feeling Real* New York, Norton.

Chu, J.A. (2011) *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative* Disorders, 2nd edit. New Jersey, John Wiley and Sons.

Church, D. (2015) *Psychological Trauma*, CA, Energy Psychology Press.

Cloitre, Courtois et al. (2012) *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults* https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf

Courtois, C.A. & Ford, J.D. (2009) *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide* New York, The Guilford Press.

Dalenberg, C. J. (2004) `Maintaining the safe and effective therapeutic relationship in the context of distrust and anger: Countertransference and complex trauma' *Psychotherapy: Theory, Research, Practice, Training,* 41(4), pp.438-447. https://psycnet.apa.org/doiLanding?doi=10.1037%2F0033-3204.41.4.438

Dalenberg, C. J. (2006) `Recovered memory and the Daubert criteria: recovered memory as professionally tested, peer reviewed, and accepted in the relevant scientific community', *Trauma, Violence & Abuse* (7, 4), pp.274-310. https://www.ncbi.nlm.nih.gov/pubmed/17065548

Dalenberg, C., Brand, B. et al (2012) `Evaluation of the Evidence for the Trauma and Fantasy Models of Dissociation', *Psychological Bulletin* (138), pp.550-588. https://www.ncbi.nlm.nih.gov/pubmed/22409505

Danylchuk, L. & Connors, K. (2017) *Treating Complex Trauma and Dissociation* New York, Routledge.

Dell, P.F. & O'Neil, J.A., ed. (2014) *Dissociation and the Dissociative Disorders: DSM-V and Beyond* New York, Routledge.

Dorahy, M.J. & Van der Hart, O. (2007) `Relationship between Trauma and Dissociation: An Historical Analysis', ch.1 in Vermetten, E., Dorahy, M. & Spiegel, D. ed. *Traumatic Dissociation: Neurobiology and Treatment* Washington DC, American Psychiatric Publishing, pp. 3-36.

Ecker, B. (2018) `Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *International Journal of Neuropsychotherapy* (6, 1), pp. 1-92.

Fisher, J. (2017) *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation* New York, Routledge.

Forner, C. (2017) *Dissociation, Mindfulness and Creative Meditations* New York, Routledge.

Frewen, P. & Lanius, R. (2015) *Healing the Traumatized Self: Consciousness, Neuroscience, Treatment* New York, Norton.

Gold, S.N. (2000) *Not Trauma Alone: Therapy for Child Abuse Survivors in Family and Social Context* New York, Routledge.

Gold, S.N. & Seibel, S.L. (2014) `Treating Dissociation: A Contextual Approach', in Dell & O'Neil, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond,* New York, Routledge, pp.625-636.

Herman, J. [1992] 1997), *Trauma and Recovery* New York, Perseus.

Hesse, E., Main, M. et al (2003) `Unresolved States Regarding Loss or Abuse Can Have `Second Generation Effects: Disorganisation, Role Inversion, and Frightening Ideation in the Offspring of Traumatized Non-Maltreating Parents', ch.2 in Solomon, M.F. & Siegel, D.J., ed. *Healing Trauma* New York: Norton, pp.57-106.

Howell, E. (2005) *The Dissociative Mind* New York, Routledge.

Howell, E. & Itzkowitz, S. (2016) *The Dissociative Mind in Psychoanalysis: Understanding and Working with Trauma* New York: Routledge.

Kluft, R.P. (2014) `A Clinician's Understanding of Dissociation: Fragments of an Acquaintance', in Dell & O'Neil, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond*, New York, Routledge, pp.599-623.

Kluft, R.P. (2006) `Dealing with Alters: A Pragmatic Clinical Perspective', *Psychiatric Clinics of North America* (29), pp.281-304.

Kluft, R.P. (2012) `Hypnosis in the Treatment of Dissociative Identity Disorder and Allied States: An Overview and Case Study', *South African Journal of Psychology* (42, 2), pp. 146-155.

Kluft, R.P. (2017) `Trying to Keep it Real: My Experience in Developing Clinical Approaches to the Treatment of DID', *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 1), pp. 18-44.

Kumar, S.A., Brand, B.L. & Courtois, C.A. (2019) `The Need for Trauma Training: Clinicians' Reactions to Training on Complex Trauma', *Psychological Trauma: Theory, Research, Practice, and Policy,* Online First Publication, http://dx.doi.org/10.1037/tra0000515

Levine, P. A. (1997) *Waking the Tiger: Healing Trauma* Berkeley, CA, North Atlantic Books.

Loewenstein, R.J. (2018) `Dissociation Debates: everything you know is wrong', *Dialogues in Clinical Neuroscience* (20, 3), pp.229-242. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6296396/

Murphy, Steele, et al (2014) 'Adverse Childhood Experiences (ACEs) Questionnaire and Adult Attachment Interview (AAI): Implications for parent child relationships', *Child Abuse and Neglect* (38, 2, pp.224-233.
https://www.sciencedirect.com/science/article/abs/pii/S0145213413002561?via%3Dihub

Oxnam, R. B. (2005) A *Fractured Mind: My Life with Multiple Personality Disorder*, New York, hachett.

Phillips, M. & Frederick, C. (2010) *Empowering the Self through Ego-State Therapy* E-book,
http://reversingchronicpain.com/EmpoweringSelfEgoStateTherapy/EST_ebook.pdf

Phillips, M. & Frederick, C. (1995) *Healing the Divided Self: Clinical and Ericksonian Hypnotherapy for Post-Traumatic and Dissociative Conditions* New York, Norton.

Putnam, F.W. (2016) *The Way We Are: How States of Mind Influence Our Identities, Personality and Potential for Change* New York: International Psychoanalytic Books [IPBooks].

Reinders, A., Marquand, A.F. et al (2018) `Aiding the diagnosis of dissociative identity disorder: pattern recognition study of brain biomarkers', *The British Journal of Psychiatry,* 1-9
https://www.ncbi.nlm.nih.gov/pubmed/30523772

Reinders, A., Willemsen, A. T. et al (2016) `The Psychobiology of Authentic and Simulated Dissociative Personality States', *The Journal of Nervous and Mental Disease* (204, 6), pp.445-459. https://www.researchgate.net/publication/301685740_The_Psychobiology_of_Authentic_and_Simulated_Dissociative_Personality_States_The_Full_Monty

Rydberg, J. A. (2017) `Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, Myths, Misreports, and Misrepresentations', *European Journal of Trauma and Dissociation* (1), pp.89-99.

Sar, V. (2014) `The Many Faces of Dissociation: Opportunities for Innovative Research in Psychiatry', *Clinical Psychopharmacology and Neuroscience* (12, 3), pp.171-179.

Schickedanz, A., Halfon, N. et al (2018) 'Parents' Adverse Childhood Experiences and Their Children's Behavioral Health Problems', *Pediatrics* (142, 2) e20180023; DOI: https://doi.org/10.1542/peds.2018-0023

Schlumpf, Y. R., Reinders, A. A.T.S. et al. (2014) `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study' PLoS One, 9(6) https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0098795

Schwarz, R. (2002) *Tools for Transforming Trauma* New York, Routledge.

Schwarz, L., Corrigan, F. et al (2017) *The Comprehensive Resource Model: Effective Therapeutic Techniques for the Healing of Complex Trauma* New York, Routledge.

Schwartz, R.C. (1995) *Internal Family Systems Therapy*. New York: The Guilford Press.

Shapiro, R. (2010) *The Trauma Treatment Handbook*: Protocols Across the Spectrum (New York, Norton).

Schimmenti, A. & Caretti, V. (2016) `Linking the Overwhelming with the Unbearable: Developmental Trauma, Dissociation, and the Disconnected Self', *Psychoanalytic Psychology* (33, 1), pp.106-128.

Silberg, J. (2013) *The Child Survivor: Healing Developmental Trauma and Dissociation* New York, Routledge.

Stavropoulos, P. & Kezelman, C. (2018) *The Truth of Memory and the Memory of Truth: Different Types of Memory and the Significance for Trauma* Sydney, Blue Knot Foundation. https://www.blueknot.org.au/resources/publications/trauma-and-memory

Steinberg, M. & Schnall, M. (2003) *The Stranger in the Mirror Dissociation, The Hidden Epidemic* New York, HarperCollins.

Stern, D. (2010) *Partners in Thought: Working with Unformulated Experience, Dissociation, and Enactment,* New York, Routledge.

Siegel, D.J. & Hartzell, M. (2004) *Parenting from the Inside Out* New York, Penguin.

Spiegel, D. (2018) `Integrating Dissociation', *American Journal of Psychiatry*, 175:1, pp.4-5.

Van der Hart, O., Nijenhuis, E. & Steele, K. (2006) *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* New York, Norton.

Wallin, D. (2007) *Attachment in Psychotherapy* New York, The Guilford Press.

Part 2
Research Base

Contents
(Part 2, Research Base)

Chapter 1

What is Dissociation and Why do we Need to Know about It?

> `*The occurrence of compartmentalized function in human beings is normal. The central issue is not whether it occurs but the extent to which the compartments share information, emotion, worldview, and so on'.*
> (Chefetz, 2015: 129).

> `*Even though dissociation can arise from other sources as well, problematic or maladaptive dissociation is often a chronic, rigidified outcome of trauma'.*
> (Howell, 2005:23).

The topic of dissociation is conceptually challenging and until recently has largely been the domain of trauma specialists. In recent years, however, a wealth of information highlighting the prevalence and significance of dissociation has become available. The importance of this information cannot be overemphasised. All who work with and relate to people who experience the impacts of trauma need to familiarise themselves with the nature of dissociation.

Information about dissociation also needs to be integrated within and across the mental health sector as a whole. This is not only to enable better recognition and treatment of trauma (in that trauma-related dissociation continues to be the least recognised response to experience of overwhelm). It is also to highlight the relationship of dissociation to mental health per se. Indeed, a further challenge to addressing the importance of dissociation is the misconception that it relates only to trauma.

As the title of a recent article conveys, there are `many faces of dissociation'.[234] Acknowledging its normative as well as problematic `faces' is thus one of the first and key points that needs to be considered.

1.1 Association and dissociation: a constant interplay

> *'Associative process alerts our awareness that something is worth noticing. Dissociation tells us we need not pay any attention. The healthy result of this sorting is a coherent mind'*
> (Chefetz, 2015:1)

While insufficiently acknowledged and recognised, dissociation is often paired with the term `disorder' in the context of mental health. This implies that dissociation occurs when something `goes wrong'. But this is also *a particular reading* of dissociation. While it can certainly be(come) problematic, in the broader sense described in the above quotation dissociation is also part of normal and adaptive psychological processes.

234 Vedat Sar, `The Many Faces of Dissociation: Opportunities for Innovative Research in Psychiatry', *Clinical Psychopharmacology and Neuroscience* (12, 3, 2014), pp.171-179. On the normative expressions of dissociation, see Lisa Butler, `The Dissociations of Everyday Life', *Journal of Trauma and Dissociation* (Vol.5, No.2, 2004), pp.61-88. Note that conceptualisation of dissociation is also a topic on which contrasting perspectives can be held; see subsequent discussion.

Even in the context of trauma (i.e. trauma-related dissociation) the same point can be made. As subsequently addressed, dissociation - `not paying attention' - can be powerfully protective at the time of the initial trauma when other responses (e.g. `fight' or `flight') are ineffective or unavailable. The problem arises when the underlying trauma is not resolved, and trauma-related dissociation *remains* a coping mechanism.

> *Dissociation is a complex capacity which works in a number of ways. It relates to healthy `everyday' processes as well as to development of disorder/s (i.e. both when there is no cause for concern and when things `go wrong').*

1.2 What is dissociation?

Dissociation is commonly described as *`partial or complete disruption of the normal integration of a person's psychological functioning'.*[235] The terms `disruption', `normal' and `integration' can imply a reading of dissociation as problematic (i.e. where `integration' is the norm and the `disruption' of dissociation is an impediment to the smooth functioning of psychological processes). In fact, indicators of dissociation are highly prevalent and do not necessarily signify disorder.[236]

An ongoing challenge is lack of consensus regarding definition of dissociation. Most would agree, however, that dissociation *occurs beyond conscious awareness and control,* that it *varies in intensity*, and that it *impedes linkage between different registers of functioning*:

`In essence, aspects of psychobiological functioning that should be associated, coordinated, and/or linked are not'.[237]

Disconnection between domains which `should' be linked implies an unhealthy inability to access registers of functioning necessary for daily life (i.e. rather than the normative interplay between association and dissociation described by Chefetz above). Dissociation of itself is an inherent capacity of the mind and occurs in healthy and `normal' people.[238] It is the *persistent* inability to connect, access, and move between different registers of functioning which impedes health and well-being. If severe, unrecognised and untreated, this can erode quality of life and pose a serious health threat.[239]

The challenge of dissociation relates to its protean nature in that it encompasses distinct forms and mechanisms.[240] It is also conceptualised both as a *continuum* or dimensional model (from normative to pathological) and as a *taxon* or categorical model (which makes a qualitative distinction between what is normal and what is pathological and which emphasises symptoms):[241]

---

235 Paul Dell & John O'Neil, ed. *Dissociation and the Dissociative Disorders* (Routledge, New York, 2011), p. xxi; also James A. Chu, *Rebuilding Shattered Lives* (John Wiley & Sons, New Jersey). 2011, p.41.

236 J. Stone, `Dissociation: What is it and Why is it Important?' *Practical Neurology* (6, 2006), pp.308-313.

237 David Spiegel, Richard Loewenstein et al, `Dissociative Disorders in DSM-5', *Depression and Anxiety* (28, 2011), p.826). As Chefetz also describes `[w]hen there is active dissociative process, ordinarily expectable linkage may not occur' between *behaviour, affect, **s**ensation,* and *knowledge* as per the `BASK' model developed by Bennett Braun in 1988 (Richard Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, (Norton, New York, 2015), p.25.

238 Stone, `Dissociation: What is it and Why is it Important?', ibid, p.310; Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, ibid.

239 Note that the most severe of the dissociative disorders is Dissociative Identity Disorder (DID).

240 The differences between *compartmentalisation* and *detachment* are commonly accepted. See, for example, Richard Brown, `Different Types of `Dissociation' Have Different Psychological Mechanisms', *Journal of Trauma and Dissociation* (*7*:4, 2006), pp.7-28, E. Holmes, R. Brown, et al `Are there two qualitatively distinct forms of dissociation? A review and some clinical implications', *Clinical Psychology Review* (25: 1, 2005), pp.1-23, and Butler, Dorahy & Middleton, `The Detachment and Compartmentalization Inventory (DCI): An assessment tool for two qualitatively distinct forms of dissociation', *Journal of Trauma and Dissociation* (20.5, 2019), pp.:526-547.

241 Spiegel, Loewenstein et al, `Dissociative Disorders in DSM-5', ibid, p.827; Elizabeth Howell, *The Dissociative Mind* (Routledge, New York, 2005) pp.18-19.

`…dissociation has been used to describe a range of dimensional, adaptive processes not just categorical disorders. There is a tendency to conflate the [different conceptualizations]…leading to confusion about what is being described'.[242]

Dissociation can be understood in several ways – as a lack of integration of the mind and mental systems, as an altered state of consciousness, as a defence mechanism and structure, and as a normative psychological process.

These diverse definitions highlight the limits of a purely `symptom-based' perspective.

As two prominent contemporary researchers and clinicians of trauma-related dissociation point out, `[d]epending on how it is understood, the construct of dissociation describes many psychological phenomena or few'.[243] The initial understanding of dissociation (which `has been reintroduced in modern times') described `divisions or dissociations in the personality or consciousness… that resulted from a dissociative personality structure'.[244]

Terming this `the narrow conceptualization of dissociation', Dorahy and Van der Hart note that the concept has now widened to a `diffuse' understanding `which presumes multiple origins for dissociative experiences [and] can account for many and various clinical and nonclinical psychological phenomena'.[245] This more recent `broad' understanding is now more common in contemporary conceptualization of dissociation.[246]

Current research into the nature of unconscious processes is leading to increased attention to the phenomenon of dissociation *(`[t]oday the mental health field is paying more and more attention to dissociation and dissociative experiences').*[247] In the view of some, dissociation is not only undergoing reappraisal but is increasingly regarded as central to psychological functioning per se.[248]

Research in the neurobiology of dissociation is also assisting this reappraisal. It shows that dissociation `is accompanied by altered activation of brain structures…involved in regulating awareness of bodily states, arousal, and emotions'.[249]

`Exciting strides have begun to reveal the neurobiology of dissociation'
(Brand, 2012:394)

`[N]euroimaging studies provide concrete, theoretically consistent evidence that dissociation exists'
(Brand, ibid: 395).

242 Spiegel, Loewenstein et al, `Dissociative Disorders in DSM-5', ibid, p.826.
243 Martin Dorahy & Onno van der Hart, `Relationship between Trauma and Dissociation: An Historical Analysis', ch.1 in Eric Vermetten, Martin Dorahy & David Spiegel, ed. *Traumatic Dissociation: Neurobiology and Treatment* (American Psychiatric Publishing, Washington DC, 2007), p.6.
244 Dorahy & van der Hart, `Relationship between Trauma and Dissociation: An Historical Analysis', ibid, p.6.
245 Dorahy & van der Hart, ibid, pp.6-7.
246 Dorahy & van der Hart, ibid, p.7.
247 Elizabeth Howell, *The Dissociative Mind* (Routledge, New York, 2005), p. vii.
248 `Today, our concept of the unconscious is expanding, with dissociation taking at least an equal role to repression…. Many of these new theoretical perspectives rest on dissociation as central' (Howell, *The Dissociative Mind*, ibid, p.2).
249 Bethany Brand, `What We Know and What We Need to Learn About the Treatment of Dissociative Disorders', *Journal of Trauma & Dissociation* (13:4, 2012), p.395. Functional neuroimaging also shows `that trauma survivors with more dissociative symptoms had a pattern of hyperfrontality and limbic inhibition that was the opposite of that seen among those with the more common hyperarousal type of PTSD, who had limbic hyperactivation and hypofrontality' (David Spiegel, `Integrating Dissociation', *American Journal of Psychiatry* (175:1, 2018), p.4. Increased recognition of the role of dissociation also accounts for inclusion in DSM-5 of the dissociative subtype of PTSD.

It is important to note that while the phenomenon of dissociation is now attracting more sustained attention, insight into its nature and processes is not new. The pioneer of dissociation was French clinician and researcher Pierre Janet (see subsequent discussion) many of whose ideas and concepts `predate and anticipate current views of dissociative processes'.[250] Significantly, Janet's ideas have also been observed to correlate with current `bottom up' models of mental processing.[251]

1.3 An alternative model of mind: integration and coherence are developments not givens

> *`[Janet] believed that we begin life with the elements of consciousness relatively disconnected. Maturation is the process of integration'.*
> (Meares, 2012: 19).

> *`Constructing a mental self-continuity of consciousness, memory and identity is a task, not a given'.*
> (Spiegel, 2018:4).

Having `a mind of our own' is widely taken for granted.[252] But people for whom dissociative processes are persistent - i.e. frequent and ongoing rather than the daily `disconnects' of not paying attention to what occurs - *`don't and can't make that assumption'*.[253]

When dissociation is persistent it is often, although not always, trauma-related. But first it is helpful to consider how we envisage the human mind, which is commonly assumed to be naturally coherent and integrated (a reading which is challenged by the above quotes).

Inner life is subject to fluctuation, and a basic `division' between conscious and unconscious processes is widely accepted. But a foundational and innate coherence is also widely assumed. This is at the same time as early dependence on primary caregivers for psychological, as well as physical, development is also widely conceded.

The suggestion that the mind may be inherently dissociative (because inherently dependent and relational) and thus that integration, coherence, and self-continuity are products of *experience* rather than conferred at the outset, may be arresting to many.[254] Yet this is a reading that serious engagement with the topic of dissociation prompts us to consider. It also has many implications.

> *`[U]nlinked dissociated states are at the root of all self-experience'*
> (Goldman, 2016: 98).
>
> *`Self-states are what the mind comprises. Dissociation is what the mind does. The relationship between self-states is what the mind is'*
> (Bromberg, 2011, p.2).

250 Howell, *The Dissociative Mind,* ibid, p.51.
251 Spiegel, Loewenstein et al, `Dissociative Disorders in DSM-5', ibid, p.827.
252 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Disorders,* ibid, p.2.
253 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, ibid, p.2.
254 Not least because the privileging of consciousness and cognitive capacity, and the concepts of autonomy, choice, responsibility, and `authoring our own destiny' are intrinsic to the western political and philosophical tradition and mind more broadly (as the 17th century proclamation of Rene Descartes `I think therefore I am' underlines).

1.4 The emergent self: dissociation, relationality, and development of emotional coherence

> *`In the process of being brought up by humans, and as a result of experiencing anxiety and learning how to avoid it, dissociative gaps in consciousness inevitably form'*
> (Howell, 2005: 93, ref. Sullivan, 1953).

How do we become our `selves'? This is another way of asking how our minds cohere. With reference to the work of Daniel Siegel and Frank Putnam, Elizabeth Howell notes that *`[d]evelopmentally, lack of integration characterizes our beginnings…and facilitative maturational environments enable disconnected sets of experiences to be linked'*.[255]

Links between mental states (`intrapsychic') are fostered by *interpersonal* connections. States are the building blocks of consciousness and behaviour.[256] Hence development involves *linkage* of and between self-states (`parts') and different ways of being:

> *`The self is characterized by a complex multiplicity of subunits and subselves (Erdelyi, 1994), and even the multiple parts themselves have parts'*
>
> *`…the important issue is not how many parts there are, but how they hang together'*
> (Howell, 2005:48)

In the normal course of events and development, `we are usually able to integrate our ongoing interaction…with our social surroundings into a coherent sense of self'.[257] This occurs via `good enough' care-giving, which allows internalisation of positive relational interactions and healthy socialisation in which ruptures are repaired and the capacity to self-regulate is acquired.

But we also know that developmental trajectories can be disrupted. This is most obviously by deficient primary care-giving, although as the term `socialisation' implies, the process of child raising also needs to be seen within a wider socio-political context.[258]

> *`[T]he organization of the self [is] based on the interactive patterns of [early caregiving] relationships, on characteristic patterns of avoiding or diminishing anxiety that have developed in the course of these relationships, and on the degree to which severe anxiety has prevented experience from being remembered, codified, elaborated, and linked with other experience'*
> (Howell, 2005:93, ref Sullivan, 1953).

255 Howell, *The Dissociative Mind*, ibid, p. 17, ref Siegel (1999) and Putnam (1997).
256 Howell, *The Dissociative Mind,* ibid, p.170, ref. Putnam, 1992, 1997.
257 Marlene Steinberg & Maxine Schnall, *The Stranger in the Mirror* (HarperCollins, New York, 2001), p.103.
258 See Erdinck Ozturk & Vedat Sar, `The `Apparently Normal Family: A Contemporary Agent of Transgenerational Trauma and Dissociation', *Journal of Trauma Practice* (4, 3, 2006), pp.287-303.

In this reading, dissociation is central to development of the self (where *the extent of the need to dissociate* will differ rather than the need per se). `Self' is viewed as `an organization of evasions and detours, constituted to avoid anxiety and preserve a feeling of interpersonal security'.[259] Thus `[t]he internalization of the processes belonging to the human relationships of upbringing, as it is organized by anxiety, is the basis of what constitutes the psyche'.[260]

Clearly this conception of – and pathway to – development of the self is very different from traditional and more familiar notions of the assertive and self-actualising individual. It also presents a contrasting notion of what constitutes `I'. The `I', in this reading, is not about agency and/or a rational ego which seeks to tame instincts. Rather it is a view of self as fragile and avoidant of anxiety, *`protected only by dissociation and those security operations that undergird it. The self is organized around dissociative gaps'.*[261]

1.5 Impediments to linkage: `when things go wrong'

> *`People who have suffered more interruption of state linkage have more difficulty understanding their emotions and tend to feel buffeted by circumstances. As a result, they tend to rely on dissociation, and dissociation of self-states will be more frequent and severe'*
> (Howell, 2005: 170)

Dissociation, as discussed above, is the corollary of attempts to evade anxiety (stemming from `internalization of the processes belonging to the human relationships of upbringing').[262] As such, it is more than the accompaniment or even product of development. Rather it is constituent of the emergent self per se.

The process by which development and socialisation of self occurs via the mechanism of dissociation is akin to Bowlby's account of `defensive exclusion'[263] (which is reflexively deployed by all of us in the primary care-giving relationships on which we depend and thus need to maintain). Whatever threatens the care-giving relationship is `defensively excluded'- i.e. dissociated – in the interests of preserving the primary attachment.[264]

---

259 Howell, *The Dissociative Mind*, ibid, p. 95, ref. Sullivan, 1953.

260 Howell, *The Dissociative Mind*, ibid, p.93, ref. Sullivan, 1953 (`This self is often highly distorted, like the trees growing in the Grand Canyon; structured around the constraints, requirements, needs, anxieties, and forbidding gestures of significant others'). As Howell discusses `this psychic prohibition was not codified or symbolized anywhere in the mind. Rather, the personality was structured around it, the way a painting can be structured around unpainted spaces on the canvas' (ibid: 95)

261 Howell, *The Dissociative Mind*, [ref. Sullivan, 1953] ibid, p.95.

262 Howell, *The Dissociative Mind*, ibid, p.93, ref. Sullivan, 1953.

263 John Bowlby, `The Origins of Attachment Theory' [1981] in Bowlby, *A Secure Base* (New York: Routledge 2006, p.39). Despite the fact that the nature and significance of dissociation and trauma were long ignored by the traditional psychoanalytic community (which dates to Freud's `abandonment of the seduction theory'; see subsequent discussion) dissociation was infrequently referenced by earlier generations of psychotherapists. This does not mean, however, that its significance was not appreciated by pioneers (then regarded as dissidents) in the field. Note, for example, the following comments in relation to eminent psychoanalyst D.W. Winnicott - `At the very end of his life, Winnicott was poised once again to *destroy and thereby bring psychoanalysis to life* by placing his ideas about dissociation front and centre. The Notes for the Vienna Congress continue…One can hear Winnicott's plea as an attempt to more fully integrate into psychoanalytic theory a view of dissociation that had always been important to him. Despite operating within an *espoused* theory privileging repression as an explanatory construct, *in practice* Winnicott demonstrates a keen awareness of dissociation – both as a healthy natural capacity and as a defensive response to trauma. For Winnicott, *it makes a vast difference how and in what context dissociation is used'* (Dodi Goldman, `A queer kind of truth': Winnicott and the uses of dissociation' in Elizabeth Howell & Sheldon Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis, Routledge, New York, 2016*, pp.97-8).

264 Clearly this concept and the phenomenon of dissociation also shed valuable light on the phenomenon of `attachment to the perpetrator', whereby a child remains psychologically loyal even, and especially, to an abusive care-giver. See Joyanna Silberg, *The Child Survivor: Healing Developmental Trauma and Dissociation* (New York: Routledge, 2013).

For some people, however, the need to dissociative (`defensively exclude') is more extreme. In the `good enough' care-giving relationship, ruptures will be repaired and the experience of reliance on care-givers will not need to be so decisively compartmentalised as to be excised from consciousness completely. Sadly, and through no fault of their own, this is not the case for all children; for example, in abusive or otherwise traumatic care-giving relationships.[265]

Note that while childhood trauma is a pathway to generation of isolated self-states (see below) early relationships which do not foster linkage between self-states may not necessarily be traumatic. However, they will be `somehow unresponsive to the particular needs of the child'.[266] Research has also shown that `[t]he best predictor of adult dissociation is emotionally unresponsive parenting'.[267] The costs of the need to dissociate frequently and severely in childhood will be high. This is because what allows the attachment to the caregiver to be preserved will make it difficult for the child to subsequently attach to others:

> *`The drastic means an individual finds to protect his sense of stability, self-continuity, and psychological integrity, compromises his later ability to grow and to be fully related to others'.*[268]

Recognition of the pathways by which deficits in early childhood relationships can lead to problematic (as distinct from normative) dissociation in adulthood is not new. But as discussed below in relation to trauma, there are reasons why this understanding has not been widespread in the mental health sector.

In the current period the phenomenon of dissociation is beginning to receive increased attention, and the implications for understanding of well-being, as well as `disorder', are major.

Drawing on the prior concepts of American psychiatrist and psychoanalyst Harry Stack Sullivan (1892-1949), Elizabeth Howell presents a valuable summation of some of his key themes and their significance:

265 This includes the transmission of disrupted attachment to the offspring of parents whose own trauma is unresolved. See Erik Hesse, Mary Main et al. `Unresolved States Regarding Loss or Abuse Can Have `Second Generation Effects: Disorganization, Role Inversion, and Frightening Ideation in the Offspring of Traumatized Non-Maltreating Parents', ch.2 in Marion F. Solomon & Daniel J. Siegel, ed. *Healing Trauma* (Norton, New York, 2003), pp.57-106.

266 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Disorders,* ibid, p.90. Also see Steven Gold, *Not Trauma Alone* (Routledge: Philadelphia, 2000).

267 Lyons-Ruth et al, 2006, cited in Chefetz, *Intensive Psychotherapy for Persistent Dissociative Disorders,* ibid, p.89.

268 Philip Bromberg, *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation* (Psychology Press, New York, 2001), p.6.

`GOOD ME', `BAD ME' & `NOT ME'
(Sullivan, 1953 in Howell, 2005:95)

Self is organised around `the requirements of anxiety' (Howell, 2005:95) according to 3 conceptions:

- **`Good me'** *(ordinary conception of self; stems from affects and activities that have met with early approval)*
- **`Bad me'** *(stems from early behaviours which were not welcomed; `associated with the increasing gradient of anxiety')*

- **`Not me'** *(`out of conscious and dissociated'; the product of severe anxiety)*
  *`In Sullivan's terms, it is the partition between the `me' and the `not-me' that **is** the dissociative organization of the psyche'* (Howell, 2005: 96.).

Not to be seen, or to have an aspect of oneself not seen, by a significant other is shaming.[269] Shame is `a core affect' of complex trauma.[270] The childhood need to preserve attachment to care-givers via dissociation of what threatens the attachment bond can threaten *self*-connection, as well as the ability to attach to others in adulthood if the trauma is not resolved.

But the adverse impacts of frequent need to dissociate in childhood are not confined to trauma:
`Many of our [clients]...have suffered in childhood precisely the sorts of severe loss that research associates with an unresolved state of mind with respect to attachment. Yet loss of a different, less disorganizing kind is a feature of the history of most of our patients.'[271]

1.6 Both the norm and forerunner of disorder

`The dissociative concept of multiple self-states is enormously helpful in understanding both normal experience and pathological conditions'
(Chu, 2011:46).

The key role of normative dissociation in psychological well-being is ironically obscured by the very nature of its mode of operation. To the extent that a sense of continuity and integration is maintained `by systematically and routinely invoking processes that enable [us] to ignore the glaring gaps, inconsistencies, and lack of continuity in [our] experiences and behaviour'[272] we are unaware of being unaware. The `everyday' interplay of associative and dissociative processes in managing diverse psychological stimuli is so `second nature' that there may be few incentives to consider the phenomenon of dissociation at all.

269 Bromberg, *Standing in the Spaces*, ibid.
270 See Paul Frewen & Ruth Lanius, *Healing the Traumatized Self* (Norton, New York, 2015), p.206; ourtois & Ford, *Treating Complex Traumatic Stress Disorders* (New York, The Guilford Press, New York, 2009), p.17, and Guideline 4 of *Practice Guidelines for Clinical Treatment of Complex Trauma* (Blue Knot Foundation, 2019).
271 David Wallin, *Attachment in Psychotherapy* (The Guilford Press, New York, 2007), p.204.
272 Howell, ref Gold, 2004, *The Dissociative Mind*, ibid, p.36.

Yet as Bromberg elaborates, `even in the most well-functioning individual, normal personality structure is shaped by dissociation' as well as by other psychological processes.[273] In his numerous pioneering publications, Bromberg elaborates why the phenomenon of dissociation *(`in all its forms – healthy and adaptive, pathological and self-protective'*) is `[c]entral to any understanding of therapeutic growth'.[274]

If `unlinked dissociated states are at the root of all self-experience'[275] (i.e. notwithstanding our lack of awareness of this because the very nature of dissociation precludes it), and if self develops from childhood via the linking (or not) of self-states which were not continuous to start with, this is a model of the mind and psychological functioning which has non-clinical, as well as clinical, implications. As Howell suggests, `[a] model of the dissociative mind is potentially transformative of the way we conceptualize mental processes'.[276]

A continuum model of dissociation assists in understanding the diversity of expressions of dissociation (i.e. from normative and healthy to problematic and pathological). As with longstanding debates regarding continuum and dimensional vis a vis categorical and taxon models more broadly, it needs to be noted that some researchers and clinicians reject what are regarded as overly inclusive conceptualisations of dissociation in favour of more specific understanding/s.

A respected example of the latter is the theory of structural dissociation presented by Onno van der Hart, Ellert Nijenhuis, and Kathy Steele .[277] Yet the range and breadth of experiences arguably encompassed by dissociation is widely remarked (see previous comments) and is the subject of lively debate. As one writer and clinician contends, `it makes a vast difference how and in what context dissociation is used'.[278]

That dissociation `in all its forms' is, in Bromberg's reading, `[c]entral to any understanding of therapeutic growth'[279] clearly also has many implications for clinicians.

1.7 When experience is overwhelming: trauma-related dissociation

> *`the escape when there is no escape'*
> (Putnam, 1992:104)

If integration is not innate and the self is not `given', experience of coherence and self-continuity is relational and critically shaped by the developmental process. From this perspective, dissociative self-states - rather than coherence- is inherent. *Development is inexorably relational, and linkage between self-states is initially fostered (or not) by the experiences of our formative years*.[280] Individual well-being, itself inherently relational, is not static. Rather it derives from the ease with which diverse self-states can be accessed and moved between.[281]

273 Bromberg, *Standing in the Spaces*, ibid, p.270.
274 Bromberg, *Standing in the Spaces*, ibid, p.310.
275 Goldman, ` A queer kind of truth', ibid, p.98.
276 Howell, *The Dissociative Mind*, ibid, p.8. Hence, she says, `we need to reformulate our psychological theory accordingly' (Howell, ibid: xi).
277 Onno van der Hart, Ellert Nijenhuis, & Kathy Steele, *Structural Dissociation and the Treatment of Chronic Traumatization* (Norton: New York: 2006).
278 Goldman, `A queer kind of truth'; ibid, p.98 (original emphasis).
279 Bromberg, *Standing in the Spaces*, ibid: 310.
280 Note that this does not mean the impacts of overwhelming early life stress cannot be resolved (i.e. the established possibility of movement to the attachment status of `earned secure'; see Daniel J. Siegel, `An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma', in Solomon & Siegel, ed., *Healing Trauma,* Norton, New York, 2003, p.16).
281 Hence the title of Bromberg's celebrated text *Standing in the Spaces*, ibid.

Yet while dissociative gaps in consciousness are `part and parcel' of the developmental process and the need to avoid anxiety,[282] trauma-related dissociation – i.e. *dissociation* as *a defence against overwhelming experience* – is of a different order.

> *Mild and moderate experiences of stress are common. But when generated by stress that is overwhelming, the ability to segue between self-states is impeded substantially.*
> *This means that `associative capacity – access to thoughts, feelings, normal abilities, and judgement – is lost or becomes limited'.*
> (Chu, 2011: .41; original emphasis)

Disruption to the ability to move between self-states can occur for various reasons and is not always the product of trauma. But as Bromberg notes, *when utilised as a defence in the face of overwhelm*, dissociation `is a defence unlike any other…It functions because conflict is unbearable to the mind, not because it is unpleasant'. [283] Putnam's much quoted phrase of dissociation as `the escape when there is no escape' is emblematic.

> *`If the overwhelming traumatic event could not be taken in…it is dissociated. There is a split in experience. Experience that is too overwhelming to be assimilated will cause a division of experiencing and knowledge. Part of self-experience will be separated or split off from one another, and one part of ourselves will not know of other parts of ourselves….the result of trauma is dissociation'*
> (Howell & Itzowitz, 2016: 35).

In the case of trauma of any kind, the resulting `split in experience' is dissociative:[284] *`the person surrenders self-state coherence to protect self-continuity'.*[285]

Dissociative disorders are frequently correlated with a history of significant trauma.[286] Inclusion of the dissociative subtype of PTSD in DSM-5 reflects further evidence of the relationship between trauma and dissociation.[287] Significantly, functional neuroimaging reveals that trauma survivors with more dissociative symptoms (such as depersonalization and derealisation) show a pattern of brain activation that is `the opposite of that seen among those with the more common hyperarousal type of PTSD'.[288]

> *`[A] substantial subgroup of those with PTSD have significant dissociative symptoms, and indeed, they respond less well to standard exposure-based psychotherapy and better to treatments that assist them with self-stabilization as well… So identifying and understanding dissociative symptoms in PTSD beyond the standard flashbacks, numbing and amnesia improves treatment outcome as well as our understanding of the disorder'.*
> (Spiegel, 2018, p.4).

282 Howell, *The Dissociative Mind,* ibid, p.93, ref. Sullivan, 1953.
283 Philip Bromberg, *Awakening the Dreamer: Clinical Journeys* (Routledge, New York, 2011), p.7.
284 `[A]ll of these [different] kinds of trauma, seemingly massive, or ordinary, large, small, occurring in childhood or adulthood, while different and having different effects, cause some degree of dissociation' (Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p.35.
285 Bromberg, *Awakening the Dreamer,* ibid, *p.*68 (emphasis added)
286 David Spiegel, `Integrating Dissociation', *American Journal of Psychiatry* (175:1, 2018), p.4.
287 `The inclusion of the dissociative subtype in DSM-5 was based on evidence that a substantial minority (about 14%) of a large sample (25, 018) of individuals with PTSD also suffer significant depersonalization and/or derealization and are characterized by a history of more severe and earlier trauma, suicidal ideation, and more functional impairment' (`Spiegel, `Integrating Dissociation', ibid, p.4).
288 Other studies, too, have `employed latent class analysis and related techniques to look at the clustering of symptoms among trauma survivors and identified a distinct subgroup with dissociation' (Spiegel, `Integrating Dissociation', ibid, p.4).

1.8 Dissociation is not the same as repression and why the differences matter

In the context of a response to overwhelming stress, it is important to understand the differences between dissociation and repression. The two are often conflated,[289] and the differences are easily confused because both are unconscious processes.[290]

Repression occurs when `single or a few memories, perceptions, affects, thoughts, and/or images are thought to become relatively unavailable to full conscious awareness'.[291] It relates to instances of conflict which need not involve traumatic experience and do not manifest indirectly in nightmares, intrusive images, flashbacks, and somatoform symptoms *(`large blocks of ordinary experience do not become unavailable to consciousness along with the psychologically conflictual information'*).[292]

Dissociation, in contrast, relates not only to *content* but also to *state* of mind. In the context of trauma, it is generally correlated with *distinct gaps and deletions in continuous memory for life history and/or experience*.[293] This is much less common in repression, where `the material that is unavailable is so limited in scope'.[294]

As a response to trauma[295] (i.e. unlike its `benign' everyday expressions) dissociation is extensive in its impacts: *`Not only is their amnesia for the trauma, but the person frequently has dissociated that certain basic assumptions about the self, relationships, other people, and the nature of the world have been altered'*.[296]

How can these differences between repression and trauma-related dissociation be accounted for? It is suggested that the unconscious motivation for dissociation is different than that for repression.[297] While the motivation for repression is avoidance of *certain kinds of experience,* the motivation for dissociation is avoidance of *a certain kind of identity* and the state of being which accompanies it: *`One must not be the person to whom that thing happened, the person who has the feelings, memories and experiences that come with being that person'.*[298]

> *With trauma-related dissociation - in contrast to the less extensive and impactful experience of repression - we are in the realm of the `not me'; i.e. the state of being which is unbearable, not just unpleasant, which cannot be tolerated, and which must be defended against at all costs.*
> (Stern, 2010: 13, ref Sullivan, 1954; Bromberg, 1998, 2006).

289 See Richard J. Loewenstein, `Dissociative Amnesia and Dissociative Fugue', in Larry K. Michelson & William J. Ray, ed. *Handbook of Dissociation* (Plenum Press, New York, 1996). p.311.

290 For helpful discussion of these challenges of conceptualisation, see Elizabeth Howell, `Models of Dissociation in Freud's Work: outcomes of dissociation of trauma in theory and practice', ch.6 in Elizabeth Howell & Sheldon Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis* (Routledge, New York, 2016), pp.73-84.

291 Loewenstein, ibid, following Rapaport, 1942.

292 Loewenstein ibid, p.311.

293 Loewenstein ibid, ref. Steinberg, 1994.

294 Loewenstein ibid, p.311.

295 Dissociation is `a basic part of the psychobiology of the human trauma response: a protective activation of altered states of consciousness in reaction to overwhelming psychological trauma' (Loewenstein, ibid, p.312, citing Putnam, 1991).

296 Loewenstein, ibid, p. 312, citing multiple references.

297 Donnel B. Stern, *Partners in Thought: Working with Unformulated Experience, Dissociation, and Enactment* (Routledge, New York, 2010), p.13.

298 Stern, *Partners in Thought*, ibid, p.13.

A related difference which likewise has significant clinical implications is that the motive for repression is avoidance of conflict. In dissociation, however, internal conflict is not experienced because the experience which would give rise to it is not formulated: *`It is not that [conflict] is `moved' to a hidden location in the mind or changed in such a way that it is unrecognizable - it is simply not allowed to come into being'.*[299]

REPRESSION	**DISSOCIATION**
Assumes:	*Assumes:*
PRE-FORMULATED experience	*UN*-FORMULATED experience
Conflict *unpleasant*	Conflict *unbearable* (Bromberg, 2011:7)
`In repression, the contents were once known and then forgotten'	`[C]annot be disavowed because it was never known'
[because unpleasant]	*[because unbearable]* (Bromberg, 2001)
(Stern, 2004, in Howell, 2005:208)	(in Howell, 2005:208)

It is argued that `[r]epression is always something that one *does*, but dissociation can happen *to* one'.[300]

Both dissociation and repression `serve to divide conscious from unconscious'.[301] But the differences highlighted above are significant and are insufficiently recognised. Repression has traditionally been the centrepiece defence in the theory and practice of psychotherapy,[302] and privileged as the more important. Yet repression `is a subcategory of dissociation'[303] and refers to `a particular kind of dissociation'.[304]

Repression, like all unconscious processes, displaces reason. It was the form of defence about which Freud had most to say[305] after his changed thinking which defined the classical, as distinct from pre-analytic, period in psychoanalysis (see below). Repression is also more specific than trauma-related dissociation, and to the extent that what is repressed was once known, this `suggests that we mostly know the basic content of the unconscious mind.'[306] In this sense, `[r]epression is an active defence that connotes mastery'.[307]

299 Stern, *Partners in Thought*, ibid, p.92.
300 Howell, *The Dissociative Mind*, ibid, p.199; original emphasis.
301 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p.75.
302 `Freud's most relied-upon defence was repression' (Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p.38).
303 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p.75.
304 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p.75.
305 `Freud chose to build his edifice on the cornerstone of repression' (Howell & Itzkowitz, ibid), p. 81; see subsequent discussion.
306 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p. 38.
307 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p. 38.

By contrast, and as most apparent in the context of overwhelm, dissociation as *state of mind* (i.e. beyond specific content) attests `to our utter helplessness and lack of agency at times of trauma'.[308] Repression, as Freud came to elaborate, related to forbidden wishes, fantasies, and impulses, where `[m]uch of the unconscious content involves sexual and aggressive impulses…that connote agency and power'.[309] This is in contrast to dissociation in the sense of protective warding off of *overwhelming* experience. For Freud, defence in general and repression in particular were active, whereas for Janet dissociation `encompassed both the active and the passive'.[310]

The significance of Freud's own ambivalence on this topic – and his famous `turning away' from his initial thoughts on it; see below – had major implications for the place of trauma in the field of psychoanalysis and psychodynamic psychotherapy. This is in ways which have only recently begun to be redressed. In fact, it is ironic that psychoanalysis – and other areas of psychotherapy which followed it - had very little to say about trauma at all for a long period.[311]

It is well-known that Freud's initial 1896 conceptualisation of `the seduction theory' (which regarded premature sexual experience, i.e. incest, as the cause of adult psychopathology in the form of `hysteria')[312] was supplanted less than two years later. The theory of infantile sexuality and the Oedipus complex was introduced instead, `which primarily emphasized the child's sexual fantasies, rather than real events (seductions/child abuse) as the root cause of neurosis'.[313]

Perhaps less well known outside the field - but with fateful consequences for a range of psychological approaches and which it has taken years to redress - is that Freud's `abandonment of the seduction theory' signalled a shift of emphasis to internal, intrapsychic processes *at the expense of* real world occurrences:[314]

> *`The importance of reality as a determining factor in the patient's behaviour faded into the background… The focus of analytic interest turned to the mechanisms by which fantasies were created'.*[315]

> *The costs in so many ways have been enormous:*
> *`the result of Freud's disavowal was the subsequent denial of the reality of abuse by generations of psychiatrists, psychologists, and other mental health professionals'*
> (Chu, 2011:.4; also see Howell & Itzkowitz, 2016: 81).

308 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p. 38.
309 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p. 38.
310 Howell, *The Dissociative Mind,* ibid, p.64.
311 For recent, accessible, and valuable accounts of the reasons for this omission in the context of the history of psychoanalysis, see Elizabeth Howell & Sheldon Itzkowitz, `Is trauma-analysis psycho-analysis?' and `From trauma-analysis to psycho-analysis and back again', chapters 1 & 2 in Part 1 `History of complex trauma and dissociative problems in living', in Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, pp.7-19 & 20-32 respectively.
312 Freud, `The Aetiology of Hysteria', 1896; in Howell & Itzkowitz, p.26.
313 Howell & Itzkowitz, ibid: 26; as Howell & Itzkowitz note, notwithstanding this major shift `he did not deny that child sexual abuse did sometimes occur' (ibid).
314 This point is made strongly and starkly by James Chu, who cites Zetzel and Meissner (1973) that abandonment of the seduction theory and belief `that the patient's reports of infantile seduction were not based on real memories but fantasies *marked the beginning of psychoanalysis as such*' (James Chu, *Rebuilding Shattered Lives,* 2011, ibid, p.4; referencing Zetzel & Meissner, 1973:72-73; emphasis added).
315 Zetzel & Meissner, ibid, in Chu, ibid.

This is because *the emphasis on fantasy entailed a corresponding move away from the reality of trauma and the nature of the dissociative processes it generates.*[316] Replacement of the seduction theory with the theory of infantile sexuality and the Oedipus complex *`became the cornerstone of the psychoanalytic understanding of mind, and exogamous trauma took a back seat to fantasy'.*[317]

It needs to be emphasised that clinically, as well as conceptually, Freud's `U-turn' has had serious practical impacts up to the present period. Although the field of psychoanalysis has undergone major change, the legacy of its founder has cast a long shadow in this major respect. As Chu notes, the view that `fantasies derived from Oedipal wishes' implied `that adult women were often unable to distinguish between fantasy and reality, and essentially blamed the patient for her own victimisation'.[318] As adult women were disbelieved and inappropriately treated in this way, so, too, were children:[319] *`even when professionals believed that sexual abuse had occurred, the major emphasis was the resulting intrapsychic conflicts and not on the actual experience and aftereffects of the molestation'*.[320]

Thus trauma researchers and clinicians long found psychoanalytic approaches inhospitable (a situation which has now changed) - *`Freud chose to build his edifice on the cornerstone of repression… which is an agentic defense. Dissociation, which connotes greater helplessness, was largely left by the wayside'*.[321]

As Freud's views and influence grew, the ideas of Janet were eclipsed. But it was Janet, rather than Freud, who was `the first to explain the link between trauma and dissociation'.[322] It was also Janet's pioneering understanding of the complex ways in which dissociated memories *(`such as in sensory perceptions, affect states, intrusive thoughts, and behavioural reenactments')*[323] can become encoded in the body that anticipated current understanding of how this occurs.[324]

Reappraisal of trauma-related dissociation within the field of psychoanalysis (such that valuable contributions are now made at both conceptual and clinical levels) was assisted by what has come to be known as the post-Freudian `relational turn' (sometimes described as the movement from `one person psychology' to `two person psychology').[325] It is neither possible nor necessary to detail

316 `[T]he differentiation of what is real from what is fantasy becomes obscured by the inability to notice or know what has been dissociated' (Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p.81.

317 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p. 26; emphasis added. As these authors underline (and as the work of Chu ibid and many others attests), `the classical, Freudian model filters out, or minimizes, the contributory factor of reality in general' (Howell & Itzkowitz, ibid: 7); they further note `[t]he repudiation of real experience as relevant data in the classical model of psychoanalysis' (ibid, p.9).

318 James Chu, *Rebuilding Shattered Lives* (John Wiley & Sons, New Jersey, 2011), p.4.

319 As Chu elaborates, well into the late twentieth century, `psychodynamic psychiatry was still dominated by classic psychoanalytic thinking, where conflicts about sexual drives, instincts, and fantasies were considered more important than the possible reality of occurrence of sexual abuse' (Chu, *Rebuilding Shattered Lives,* p.4). Arguably it is only since the 2013-17 Australian Royal Commission into Institutional Responses to Child Sexual Abuse that the extent of the reality of child sexual abuse (ie across mainstream societal institutions and with the major omission of the institution of the family which was not part of the Royal Commission brief) has finally become widely and unarguably apparent.

320 Chu, *Rebuilding Shattered Lives*, ibid, p.4; emphasis added.

321 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p.81.

322 Howell, *The Dissociative Mind*, ibid, p.51.

323 Howell, *The Dissociative Mind*, ibid, p.51.

324 As van der Hart explains, `Janet observed that patients suffering from trauma-related dissociative disorders tend to initially be hindered in the integration of their traumatic memories by a host of other `unfinished business' (Ellenberger, 1970). Thus, his therapy, presaging most current approaches to complex trauma, was characterized by a phase-oriented approach, consisting of (1) stabilization, symptom reduction, and preparation for the resolution of traumatic memories; (2) treatment of traumatic memories; and (3) personality (re)integration, rehabilitation, and relapse prevention (Van der Hart, Brown, and Van der Kolk, 1989)' (Onno van der Hart, `Pierre Janet, Sigmund Freud, and Dissociation of the Personality', Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, pp.50-51).

325 Lewis Aron, `One-person and two-person psychologies and the method of psychoanalysis', *Psychoanalytic Psychology* 7(4), 1990, pp.475-485.

the nature of this shift here.[326] The key point is the way in which this conceptual and clinical shift expanded psychodynamic purview from emphasis on the *intrapsychic* (the inner world of the client at the expense of their actual relationships with others) to the *interpersonal* (which allows more scope for consideration of these relationships).

The former (`one-person psychology') is very different in ways which have major implications for the understanding and treatment of trauma:

> *`This one-person psychology involving erotogenic stages, in which the child is the sole guilty one with respect to unsocialized impulses, does not leave room for the existence of a perpetrator'.*
>
> *`In contrast, accepting relational trauma requires accepting the possibility of an aggressor, abuser, or perpetrator'*
> (Howell & Itzkowitz, ibid: 28)

Clearly this is a seismic shift in its clinical, as well as conceptual and philosophical, implications. *We are irrevocably relational beings.* Prioritising the intrapsychic over the interpersonal (as was the case in the field of psychoanalysis prior to `the relational turn') is not only problematic but untenable. In their account of the nature of this shift and its many repercussions[327] Howell and Itzkowitz underline that *`meaning emerges from interpersonal-relational experience and not from intrapsychic drives and fantasies'.*[328]

Appreciating the centrality of relationality correspondingly paves the way for acknowledging *relational and interpersonal trauma,* in which the role of dissociation (in its protective capacity as a defence against overwhelm; *`the escape when there is no escape')* can likewise be acknowledged and reinstated as central.[329]

1.9 Dissociation is transdiagnostic and implicated in diverse forms of disorder

Although less familiar than the diagnoses of PTSD, anxiety, and depression (which are more commonly diagnosed in part because dissociation remains insufficiently understood and frequently escapes detection)[330] a number of dissociative disorders feature in diagnostic manuals. The core symptoms of dissociation are *depersonalization, derealisation, amnesia, identity confusion,* and *identity alteration,*`[d]ifferent constellations' of which define `the particular dissociative disorder a person ha[s]':[331]

326 The shift within psychoanalysis towards emphasis on and exploration of the relational and interpersonal has been widely discussed. Among its many implications, as Howell and Itzkowitz also consider, was reappraisal of method and of what is appropriate data for the field; e.g. therapist as *participant* as well as observer, `the centrality of the analytic relationship', and of `what we listen for and what we validate' (Howell & Itzkowitz, ibid, p.14).

327 I.e. in contrast to `[t]he repudiation of real experience as relevant data in the classical model of psychoanalysis' (Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, p.9).

328 Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid: 13 (emphasis added).

329 I.e. both as a response to trauma vis a vis repression (*`dissociation is the primary unconscious defensive process, replacing repression'* (Stern, ibid, p.13) and conceptualization of the mind per se (i.e. that *`the unconscious structure of mind is fundamentally dissociative rather than repressive in nature'* (Davies, 1996:564 in Howell, *The Dissociative Mind*, ibid., p.2).

330 Hence the subtitle of the text by Marlene Steinberg and Maxine Schnall, *The Stranger in the Mirror: Dissociation, The Hidden Epidemic* (HarperCollins, New York [2001] 2003).

331 Steinberg, *The Stranger in the Mirror,* ibid, p.32.

`Dissociative amnesia, depersonalization, derealization, identity confusion, and identity alterations are core phenomena of dissociative psychopathology characterized by a spectrum of severity.'[332]

In this `spectrum' model, DID is placed at the extreme end of the continuum.

Yet a comprehensive meta-analysis of studies examining dissociative experiences[333] reveals that these feature in many disorders other than those designated as dissociative. As Spiegel has discussed, a meta-analysis using the Dissociative Experiences Scale (DES) found that dissociative experiences are present `among a wide variety of psychiatric populations'.[334]

The highest DES scores were found, unsurprisingly, among patients diagnosed with DID.[335] The next highest scores were found among those diagnosed with PTSD (which, as Spiegel notes, is also unsurprising both because of the frequent correlation of dissociative disorders with a history of trauma and inclusion of the dissociative subtype of PTSD in DSM-5).[336]

The group with the third highest DES scores was those with Borderline Personality Disorder (a disorder for which, significantly, there is `growing evidence of trauma history as an etiological factor').[337] Lower `but still substantial' DES scores were identified among patients with schizophrenia, eating disorders, somatic symptom disorders and anxiety disorders, followed by those with depression and bipolar disorder.[338]

Significantly, *`all of the clinical samples had higher dissociation scores than those found in healthy samples'.*[339] As Spiegel discusses, while in some cases this may be attributable to comorbidity with psychiatric disorders explicitly recognized as dissociative, in the context/s of disorder dissociation per se tends to be a marker of psychopathology.[340]

> *Dissociation is prevalent in a wide range of mental disorders and associated with significant morbidity and the detrimental effects of non-treatment.*

Similarly, psychiatrist Vedat Sar notes that as well as constituting disorders in their own right, `dissociation may accompany almost every psychiatric disorder and operate as a confounding factor in general psychiatry'.[341] This is consistent with the findings of neurobiological and psychopharmacological research.[342]

332 Vedat Sar, `The Many Faces of Dissociation: Opportunities for Innovative Research in Psychiatry', *Clinical Psychopharmacology and Neuroscience*, 2014, p. 171.
333 Lyssenko, Schmahl et al. `Dissociation in Psychiatric Disorders: A Meta-Analysis of Studies Using the Dissociative Experiences Scale, *American Journal of Psychiatry* (175, 2018), pp.37-46. As Spiegel discusses, the authors' `thorough search of electronic databases led them to 216 articles involving 15,219 people', and `employed sophisticated meta-analytic techniques to compare findings across these studies' (David Spiegel, `Integrating Dissociation', *American Journal of Psychiatry*, 175:1, 2018, p.4).
334 Spiegel, `Integrating Dissociation', ibid, p.4.
335 Spiegel, `Integrating Dissociation', ibid, p.4.
336 Spiegel, `Integrating Dissociation', ibid, p.4.
337 Ibid. Also see Russell Meares, *A Dissociation Model of Borderline Personality Disorder* (Norton, New York, 2012).
338 Spiegel, `Integrating Dissociation', ibid, p.4.
339 Spiegel, `Integrating Dissociation', ibid, p.4.
340 Spiegel, `Integrating Dissociation', ibid, p.4.
341 Sar, `The Many Faces of Dissociation', ibid, p.171; emphasis added.
342 Sar, `The Many Faces of Dissociation', ibid, p.171.

A similarly significant equation and co-existence is that between dissociative disorders, suicide attempts and non-suicidal self-injury. A recent meta-analysis has found that dissociative disorder (DD) patients `were more likely to report SA and NSSI in comparison to non DD psychiatric ones'.

(Calati, Bensassi & Courtet, `The Link between Dissociation and both Suicide Attempts and Non-Suicidal Self-Injury: Meta-analyses', Psychiatry Research (Vol 251, 2017), p.103.

Dissociation was found to be a predictor related to suicide attempt and self-harm independent of other concurrent diagnoses.[343]

The significance of dissociation as a transdiagnostic presence has implications not only for diagnosis, health risk and effective treatment/s. It also has implications for response to treatment/s per se. For example, a comparison of bipolar patients with and without comorbid dissociative disorder (where comorbidity of dissociative disorder with bipolar disorder is `especially common')[344] found that `[d]issociative psychopathology seems to be an important predictor for poor treatment response and high relapse rates, at least with panic and obsessive-compulsive disorders'.[345]

A subsequent study[346] extends this finding. Noting that recent data support use of an early exposure intervention to reduce acute stress and PTSD symptoms after trauma exposure, it explored `a comprehensive predictive model that included history of trauma exposure, dissociation at the time of the trauma and early intervention, physiological responses (cortisol and heart rate) to determine which variables were most indicative of reduced PTSD symptoms for an early intervention or treatment as usual'.[347] The findings suggested `that dissociation at the time of the 1st treatment session was associated with reduced response to the early intervention' (where *`[n]o other predictors were associated with treatment response')*.[348]

The above meta-analysis and studies provide a strong argument for screening for dissociation in relation to all psychological disorders and issues as a matter of course and not just in particular cases.

A further reason to screen for dissociation is provided by the findings of a number of studies that dissociative disorders are often misdiagnosed as psychotic disorders (`and such patients may suffer iatrogenic worsening of their disorders due to years of misdiagnosis and mistreatment').[349] This is

343 Raffaella Calati, Ismail Bensassi & Philippe Courtet, et al, `The Link between Dissociation and both Suicide Attempts and Non-Suicidal Self-Injury: Meta-analyses', *Psychiatry Research (*Vol 251, 2017), p.103. Also see Brad Foote, Yvette Smolin et al al, `Dissociative Disorders and Suicidality in Psychiatric Outpatients', *The Journal of Nervous Diseases* (Vol.196 Issue 1, pp.29-36) and J. Tanner, D. Wyss et al (2017) `Frequency and Characteristics of Suicide Attempts in Dissociative Identity Disorders: A 12-month follow-up study in psychiatric outpatients in Switzerland', *European Journal of Trauma and Dissociation* (1, 2017, pp.235-239).

344 Bahadir, Karamustafalioglu & Ozer, `Comparison of Bipolar patients with and Without Comorbid Dissociative Disorder', *European Neuropsychopharmacology* (Vol 22, Supplement 2, 2012), p.S299.

345 Bahadir et al, `Comparison of Bipolar patients with and Without Comorbid Dissociative Disorder', ibid.

346 M. Price, M. Kearns et al. `Emergency Department Predictors of Posttraumatic Stress Reduction for Trauma-Exposed Individuals With or Without an Early Intervention', *Journal of Clinical Psychology* (82, 2, 2014), pp.336-341.

347 Price, Kearns et al. `Emergency Department Predictors of Posttraumatic Stress Reduction for Trauma-Exposed Individuals With or Without an Early Intervention', ibid, p.336.

348 Price, Kearns et al, `Emergency Department Predictors of Posttraumatic Stress Reduction for Trauma-Exposed Individuals With or Without an Early Intervention', ibid; emphasis added.

349 David Spiegel, Richard Loewenstein et al (2011) `Dissociative Disorders in DSM-5', Depression and Anxiety 28, 2011, p.829. As Howell notes, `[t]he hallmark of psychosis is not only poor reality-testing, but also the inability to distinguish the internal from the external. It is exactly this distinction that trauma disrupts' (Howell, *The Dissociative Mind*, ibid, p.x). Also note that `[t]here is now a well-established link between childhood maltreatment and psychosis' (Barker, Gumley et al. `An Integrated Biopsychosocial Model of Childhood Maltreatment and Psychosis', *The British Journal of Psychiatry* (Vol 206, Issue 3, 2015, p.177).(a3) School of Clinical Sciences, University of Edinburgh, Royal Edinburgh Hospital, Edinburgh, UK

despite the fact that the appropriate screening tools `show that DDs [i.e. dissociative disorders] can be distinguished from psychotic disorders (and other disorders) with excellent discriminant validity'.[350]

The frequent coexistence of bipolar disorder with dissociative disorders has prompted the suggestion that for people with BPD, `DD comorbidity should be investigated'.[351] But the above meta-analysis and studies suggest that such an investigation should be wider ranging. Indeed, Philip Bromberg suggests that all of the personality disorders- often regarded as untreatable - are dissociation based:[352]

> *`[T]he concept of personality `disorder' might usefully be defined as the characterological outcome of the inordinate use of dissociation and that independent of type (narcissistic, schizoid, borderline, paranoid, etc.) it constitutes a personality structure organized as a proactive, defensive response to the potential repetition of childhood trauma'.*[353]

Bromberg's conceptualisation of the personality disorders as *dissociation based*[354] provides valuable insights into their potential aetiology (i.e. as defences against childhood trauma) and treatment. It also comprises an arresting reconceptualization of `disorder' per se. `Disorder', in this reading, is germinated when normal childhood development is thwarted.

A reading of `disorder' as stemming from the derailing of normal developmental processes takes us full circle. It is a view according to which the many faces of dissociation *`in all its forms – healthy and adaptive, pathological and self-protective'*[355] become comprehensible. Correspondingly, the implications of this revised understanding for reconceptualization of health care delivery and treatment are considerable.

350 Spiegel, Loewenstein et al, ibid. Also see Ellason & Ross, `Positive and negative symptoms in dissociative identity disorder and schizophrenia: a comparative analysis', *Journal of Nervous and Mental Disease* (183, 1995, pp. 236-247); Kluft, `First-rank symptoms as a diagnostic clue to multiple personality disorder', *American Journal of Psychiatry* (144:1997, pp.293-298); Boon and Draijer, *Multiple personality disorder in the Netherlands* (Swets and Zeitlinger, Lisse, 1993).

351 Bahadir Bakim, Elif Baran et al. `Comparison of the Patient Groups with and Without Dissociative Disorder Comorbidity among the Inpatients with Bipolar Disorder', Family Practice and Palliative Care (1, 2, 2016), p.35).

352 As Howell has discussed, `[o]ne of Bromberg's insights involves his view that dissociation is the underlying condition of all personality disorders. Personality disorders are based on characterological structures organized as proactive, defensive responses to the potential repetition of childhood trauma. Conceptualizing personality disorders in this way allows defences to be understood in terms of dissociative processes resulting from their traumatic etiology. Bromberg (1995) sees DID as providing a `touchstone' for understanding personality disorders' (Howell, *The Dissociative Mind,* ibid, p.104).

353 Philip Bromberg, `Psychoanalysis, Dissociation, and Personality Organization' in *Standing in the Spaces*, ibid, p.200. Bromberg continues: `If, early in life, the developmentally normal illusion of self-unity cannot safely be maintained when the psyche-soma is flooded by input that the child is unable to process symbolically, a configuration of "on-call" self-states is gradually constructed in which a 'personality disorder' represents ego-syntonic dissociation no matter what personality style it embodies. Each type of personality disorder is a dynamically `on-alert' configuration of dissociated states of consciousness that regulates psychological survival in terms of its own concretized blend of characteristics. In each type, certain self-states hold the traumatic experiences and the multiplicity of raw affective responses to them, and others hold whichever ego resources (pathological and nonpathological) have proven effective in dealing with the original trauma and making sure the pain would never again be repeated (e.g., vigilance, acquiescence, paranoid suspiciousness, manipulativeness, deceptiveness, seductiveness, psychopathy, intimidation, guilt-induction, self-sufficiency, insularity, withdrawal into fantasy, pseudomaturity, conformity, amnesia, depersonalization, out-of-body experiences, trance states, compulsivity, substance abuse). Bromberg, *Standing in the Spaces*, ibid, pp.200. Also Bromberg, `Personality Disorders and Dissociative Disorders', 42.4 in in Dell and O'Neill, ed. *Dissociation and the Dissociative Disorders*, ibid, pp.644-646.

354 Also see Meares, *A Dissociation Model of Borderline Personality Disorder*, ibid.

355 Bromberg, *Standing in the Spaces,* ibid, p.310.

1.10 Revisiting disorder: the role and challenge of dissociation

> *`The most important distinction…to make is between mild dissociative experiences that are normal and experiences that range from moderate to severe'* (Steinberg, 2003: 33)

> *`Dissociation is mostly not about dissociative disorders. It is about how a mind struggles to cope with the intolerable and unbearable'*
> (Chefetz, 2015: 23).

Given its many expressions, dissociation is a challenging phenomenon to consider. But the stakes of so doing are enormous. And while attempts to explain dissociation can be daunting, the continuum model is of great assistance because it applies a familiar approach to what may be an unfamiliar topic.

A continuum, spectrum, or dimensional model of dissociation, while not subscribed to by all, has a number of benefits. Not least is that it demystifies a phenomenon which, in light of its more severe and `extreme' expressions, remains widely misrepresented, misunderstood, and in the case of DID, controversial and stigmatised.[356]

When conceptualised as a continuum, and as a normal psychological capacity and process which can *become* problematic in particular circumstances (e.g. unresolved trauma, in which the dissociative response was *initially* protective) we can begin to understand the contexts which contribute to maladaptive coping and to a way of managing stress which can become dysfunctional.

This, in turn, can reduce stigma and self-blame for those who experience chronic forms of dissociation (as in dissociative disorders). It can also increase understanding and empathy on the part of health professionals who need to attune to the prevalence of dissociation, both of itself and in combination (`comorbid') with other presentations and conditions.

> *`As I kept hearing about these symptoms from patients, I realised what a hidden epidemic dissociation is. I saw that the psychiatric community and the public were labouring under the misperception that dissociation was an all-or-nothing matter - either you were a `Sybil' or you were free and clear.*
> *What was missing from the equation was the continuum of dissociation, the same mild to moderate to severe range that occurs in depression or anxiety'*
> (Steinberg, 2001: xiv).

Description of problematic dissociation - and its progression to disorder - as `a healthy defense gone wrong'[357] is valuable in the context of a continuum as well.

> *Put simply, dissociation can be regarded as an inherent capacity of the mind, where `mind' is comprised of various self-states which are linked and moved between flexibly or inflexibly depending on the nature of the relationships we have. While primary care-giving relationships in childhood are initially and powerfully formative, their impacts are amenable to reworking later in life*
> (Siegel, 2003).

356 See Bethany Brand, Vedat Sar et al, `Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder' *Harvard Review of Psychiatry,* Vol.24, Issue 4, July-August 2016, pp. 257-270.https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction___An_Empirical.2.aspx

357 Steinberg & Schnall, *The Stranger in the Mirror,* ibid, p.8.

Well-being derives from the interplay of associative and dissociative processes; we cannot notice and pay attention to everything and dissociation is in this and other ways normal and healthy.[358] But dissociation can also serve defensive, as well as `everyday', purposes. The greater the need to defend against overwhelming experience, the increased need for dissociation and increased potential for compromised psychological functioning.

Psychotherapist Elizabeth Howell contends that `[t]he rising tide of trauma and dissociation studies has created a sea change in the way we think about psychopathology'.[359] This is because many prevalent psychological problems `seem to be about keeping dissociated experience out of awareness'.[360] The lens of dissociation sheds light on`[m]uch of what used to be seen as neurosis', and `[m]ore and more problems in living are being understood as being trauma-generated'.[361]

The fact that dissociation and disruption to developmental pathways can also be generated outside of trauma (and that *`[t]he best predictor of adult dissociation is emotionally unresponsive parenting')*[362] further underlines the prevalence of problematic, as well as normative, dissociation in the general population as well as in clinical contexts. Thus the need to bring dissociation out from 'under the radar' - and for health professionals, in particular, to learn about its nature, functions, and prevalence - is urgent.

Dissociation, by its nature, can be hard to detect. The risk of lack of detection is also high in the absence of information about what to look for.[363] Hence it has been easy for dissociation to itself become dissociated from understanding of mental health (a risk which the many challenges it poses, particularly in relation to the prevalence of childhood trauma, has increased).[364] This is also consistent with Spiegel's contention that dissociation needs to be better integrated within the field of psychiatry: *`Just as we identify and treat uncontrolled extremes of mood and defects in cognition, we can help many of our patients more if we identify problems with integration of identity, memory, perception, and consciousness'.* [365]

Identification and appropriate treatment of such problems – which are a common feature of diverse psychological disorders as noted[366] - is critical. A dissociative disorder `is no different from any other physical or psychiatric illness' in that it is treatable and has `a good prognosis for recovery'.[367] But in the absence of screening for dissociation, i.e. for *`the same mild to moderate to severe range that occurs in depression or anxiety',*[368] problematic dissociation is likely to remain undetected at enormous cost in all regards.

In short, `even in the most well-functioning individual, normal personality structure is shaped by dissociation'.[369] This means that dissociation is not only pathological. As discussed, disorder is often a result of disruption to normal development. Indeed it is time to integrate dissociation into mainstream understanding and treatment, both clinical and non-clinical. Conceptualising dissociation according to a continuum model is arguably the best way to achieve this.

358 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, ibid, p.1.
359 Howell, *The Dissociative Mind*, ibid, p.ix.
360 Howell, *The Dissociative Mind*, ibid, p.ix.
361 Howell, *The Dissociative Mind*, ibid.
362 Lyons-Ruth et al, 2006 in Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, ibid, p.89 (emphasis added).
363 It is also a complex set of responses about which there are misconceptions; for e.g. while equated with passivity and `shut down', it is possible to be behaviourally active while in a dissociated state.
364 The aetiology of the severe dissociation of DID in childhood trauma remains confronting and thus difficult to accept for many. Also note Spiegel's contention that `dissociative disorders have themselves been dissociated from psychiatric nosology' (Spiegel, `Integrating Dissociation', ibid, p.4) and Margaret Hainer, `The Ferenczi Paradox: His importance in understanding dissociation and the dissociation of his importance in psychoanalysis', ch.5 in Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis,* ibid, pp.57-69..
365 Spiegel, `Integrating Dissociation', ibid, p.5.
366 Spiegel, `Integrating Dissociation', ibid.
367 Steinberg & Schnall, *The Stranger in the Mirror*, ibid, p.113.
368 Steinberg & Schnall, *The Stranger in the Mirror*, ibid, p.xiv.
369 Bromberg, *Standing in the Spaces*, ibid, p. 270 *(`[c]entral to any understanding of therapeutic growth is the phenomenon of dissociation in all its forms – healthy and adaptive, pathological and self-protective...'* (ibid, p. 310).

Chapter 1
Summary of key points and themes

1. The importance of the phenomenon of dissociation is increasingly but insufficiently recognised within and outside the field of mental health.

2. While often associated with disorder, dissociation can be expressed in many forms (`*healthy and adaptive, pathological and self-protective*...' Bromberg, 2001: 310); `*it makes a vast difference how and in what context dissociation is used'* (Goldman, 2016:98).

3. Neuroimaging reveals that dissociation `is accompanied by altered activation of brain structures…involved in regulating awareness of bodily states, arousal and emotions' (Brand, 2012).

4. Dissociation can be understood in several ways – as a lack of integration of the mind and mental states, as an altered state of consciousness, as a defence mechanism and structure, and as a normative process *(`even in the most well-functioning individual, normal personality structure is shaped by dissociation';* Bromberg, 2001).

5. When dissociation is persistent it is often, although not always, trauma-related. Persistent inability to connect, access, and move between different registers of functioning impedes health and well-being. If severe, unrecognised and untreated, it can erode quality of life and pose serious health risks.

6. Repression occurs when `single or a few memories, perceptions, affects, thoughts, and/or images are thought to become relatively unavailable to full conscious awareness' (Loewenstein, 1996). Dissociation, in contrast, relates not only to *content* but also to *state* of mind. In trauma it is generally associated with distinct gaps and deletions in continuous memory for life history and/or experience. This is much less common in repression, where `the material that is unavailable is so limited in scope' (Loewenstein, ibid: 311).

7. The motive for repression is avoidance of conflict. In dissociation, however, internal conflict is not experienced because the experience which would give rise to it is not formulated: `*It is not that [conflict] is `moved' to a hidden location in the mind…it is simply not allowed to come into being'* (Stern, 2010: 92).

8. Repression relates to experience which was pre-formulated and unpleasant while dissociation relates to experience which was unformulated because it was unbearable (`not me'; Sullivan, 1953 in Howell, 2005; `[r]epression is always something that one *does,* but dissociation can happen *to* one'; Howell, ibid: 199).

9. The pioneer of understanding of trauma-related dissociation was Pierre Janet (1859-1947) whose ideas prefigure contemporary views of it.

10. Integration, coherence, and self-continuity are not innate but rather result from developmental and relational experience (`*Constructing a mental self-continuity of consciousness, memory and identity is a task, not a given';* Spiegel, 2018:4).

11. Links between mental states are fostered by *interpersonal connections*. States are the building blocks of consciousness and behaviour, and self, identity and well-being depend on *linkage between* self-states (Howell, 2005, ref. Putnam, 1992, 1997).

12. In the normal course of events and development, `we are usually able to integrate our ongoing interaction…with our social surroundings into a coherent sense of self' (Steinberg & Schnall, 2001, 2003:103). `Good enough' care-giving allows internalisation of positive relational interactions and healthy socialisation in which ruptures are repaired and the capacity to self-regulate is acquired. But developmental trajectories can be disrupted, in the first instance by deficient primary caregiving.

13. Impediments to linkage of self-states can occur in various ways. Research shows that `[t]he best predictor of adult dissociation is emotionally unresponsive parenting' (Lyons-Ruth et al, 2006, in Chefetz, 2015: 89).

14. The process by which development and socialisation of self occurs via the mechanism of dissociation is akin to Bowlby's account of `defensive exclusion' (Bowlby, 1981; 2006). What threatens the care-giving relationship is `defensively excluded'- i.e. dissociated – in the interests of preserving the primary attachment. For some people, most obviously in contexts of trauma, the need to dissociate (`defensively exclude') is extreme.

15. Chronic dissociation in childhood comes at great cost. This is because the coping strategy that permits continued attachment to care-givers impedes the ability to attach securely later on: *`The drastic means an individual finds to protect his sense of stability, self-continuity, and psychological integrity, compromises his later ability to grow and to be fully related to others'* (Bromberg, 2001:6).

16. It is possible for childhood trauma and other developmental deficits to be resolved and for secure attachment to be achieved (Siegel, 2003).

17. When generated by stress that is overwhelming (i.e. trauma) the ability to move flexibly between self-states is impeded substantially *(`the person surrenders self-state coherence to protect self-continuity';* Bromberg, 2011:68). The capacity to access thoughts, feelings, and important registers of functioning is limited or lost (Chu, 2011:41).

18. Dissociative disorders are frequently correlated with a history of trauma (Spiegel, 2018:4) and inclusion of the dissociative subtype of PTSD in DSM-5 is significant.

19. Studies show that dissociation features in many disorders: *`dissociation may accompany almost every psychiatric disorder and operate as a confounding factor in general psychiatry'* (Sar, 2014:171).

20. The significance of dissociation as a transdiagnostic presence and its correlation with suicide attempts and non-suicidal self-injury (Calati, Bensassi et al, 2017) has implications for diagnosis, health risk, and effective treatment/s. It also has implications for treatment/s response per se (Price, Kearns et al. 2014).

21. A continuum model of dissociation, while not subscribed to by all, has a number of benefits. When conceptualised as a continuum, and as a normal psychological capacity and process which can *become* problematic in particular circumstances (e.g. unresolved trauma, in which the dissociative response was *initially* protective) we can begin to understand the contexts which contribute to maladaptive coping and to ways of managing stress which can become dysfunctional.

22. The description of problematic dissociation - and its progression to disorder - as `a healthy defense gone wrong' (Steinberg & Schnall*,* ibid: 8) is helpful.

23. Dissociation can be regarded as an inherent capacity of the mind, whereby `mind' comprises self-states which are variously linked. Primary care-giving relationships in childhood are initially and powerfully formative in shaping the degree to which the interplay between self-states is flexible and adaptive but maladaptive impacts are potentially amenable to being resolved.

24. Well-being derives from the interplay of associative and dissociative processes; we cannot notice and pay attention to everything and dissociation can be normal and healthy (Chefetz, 2015). But dissociation can also serve defensive as well as benign and `everyday' purposes.

25. The greater the need to defend against overwhelming experience, the greater the need for dissociation and increased potential for compromised psychological functioning.

26. An understanding of dissociation in its various forms, both clinical and non-clinical, needs to be integrated into the public domain in general and within and across health sectors and services in particular.

Chapter 2

Dissociation as Default: Childhood legacies, structural dissociation, and unintegrated parts

> *`Research has shown that increased dissociation scores are more related to the quality of child-caregiver interactions than to child abuse… the psychological unavailability of the caregiver was the single strongest predictor of dissociation'*
> Schimmenti, 2017: 97.

> *`[C]urrent advances in affective neuroscience, developmental research, and psychoanalysis can constitute a fruitful theoretical framework through which many clinical issues related to dissociation might be better identified, understood, and addressed'*
> Schimmenti & Caretti, 2016:107.

While the capacity to dissociate is inherent and normal,[370] as a response to trauma it protects a person from being overwhelmed.[371] If dissociation is primarily utilised for defensive purposes, especially in childhood, it can have severe impacts on development and so adult health.

Research shows that `experiences of abuse and neglect in the context of attachment relationships may force a child to an excessive and pervasive activation of dissociative defense'.[372] This can mean that `*one's entire psychic functioning might become organized around dissociation*'.[373] If this happens it has profound impacts on health and development.

There is a well-established link between child abuse and neglect and dissociative symptoms *(`Decades of clinical and empirical research have shown that child abuse and neglect are strongly related to dissociative symptoms')*.[374] Yet the diverse pathways by which childhood experience can generate problematic dissociation in adulthood are less well known.

370 For detailed discussion of this understanding, noting that there are diverse views on how to conceptualise dissociation, see the previous chapter (`What is Dissociation and Why Do We Need to Know About it?')

371 See the previous chapter.

372 Adriano Schimmenti, ref Bromberg, 1998, Chefetz, 2015, `The Developmental Roots of Dissociation: A Multiple Mediation Analysis', *Psychoanalytic Psychology* (34, 1, 2017), p.96.

373 Schimmenti (ref Bromberg, 1998, Chefetz, 2015), `The Developmental Roots of Dissociation', ibid; emphasis added. As Silberg also explains, `[t]he mind becomes organized around the principle of dissociation from affect, which generalizes to not remembering experiences related to the affect or to not feeling pain related to the affect' (Joyanna Silberg, *The Child Survivor: Healing Developmental Trauma and Dissociation,* New Routledge. New York, 2013, p.21). When this occurs, `[t]he act of dissociation creates a paradoxical mental structure that becomes a regularly avoided thorn in an otherwise healthy mind' (Richard Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes*, New York: Norton. 2015, p. 24).

374 Schimmenti, ref. Dalenberg et al, 2012; Kluft, 1985, 1990, 2013), `The Developmental Roots of Dissociation', ibid, p.96.

In the 1980s the origins of `excessively activated dissociative processes' were largely identified to be associated with child *sexual* abuse[375] (which often co-occurs with other forms of adverse childhood experience). While this was an important recognition, it may, as Schimmenti points out, have delayed understanding of `the complex relationships between *the entire spectrum of negative attachment experiences in childhood and the presence of overly activated dissociative processes*'.[376]

2.1 Psychological unavailability of caregivers as `the single strongest predictor of dissociation'[377] in children

The finding that the psychological unavailability of caregivers - i.e. `*their difficulty or unwillingness to attune with the child's needs*' [378]- is `the single strongest predictor of dissociation'[379] highlights that adult dissociative pathology may result from childhood experiences other than abuse and indeed outside of child abuse per se.[380]

*Caregivers' inability (for any reason) to psychologically attune to their children can foster severe and `default' dissociation in adulthood* (whereby dissociation becomes the primary, automatic, and `go to' response around which the mind organises).[381]

> *`Research shows that hostile or intrusive parental behaviour is only partially related to later dissociation, whereas the caregiver's disrupted communication, flatness of affect and lack of positive affective involvement are strong predictors of dissociation'.*
> (Schimmenti & Caretti, 2016: 114, citing many sources)

These research findings highlight not only the need to be attentive to the wide range of variables and risk factors which impede parental non-attunement, but also to the still under recognised prevalence of dissociative disorders within the general population. They also convey the myriad clinical challenges for practitioners who are insufficiently attuned to - and thus unable to detect - dissociative pathology which may underlie and coexist with `comorbid' symptoms (and which if clinicians are unaware of underlying dissociation become the sole treatment focus).

---

375 Schimmenti, `The Developmental Roots of Dissociation', ibid, p.96.

376 Schimmenti, The Developmental Roots of Dissociation', ibid, p.97, citing Chefetz, 2015 and Liotti, 1999) emphasis added (`although physical and sexual abuse in childhood may be episodic, emotional neglect and lack of parental responsiveness may characterize the entire developmental environment', ibid, ref Schimmenti & Bifulco, 2015; Infurna et al, 2016).

377 Schimmenti, `The Developmental Roots of Dissociation', ibid, p.97.

378 Schimmenti, `The Developmental Roots of Dissociation', ibid, p.97; emphasis added.

379 Schimmenti cites Ogawa, Sroufe, Weinfield, Carlson & Egeland (1997) – a study of a sample of 168 young adults aged 18-19 years which found `that the *psychological unavailability* of the caregiver during the adolescents' first two years of life, lack of caregiver attention, and disorganized attachment at 12-18 months predicted the adolescents' dissociation scores' (Schimmenti, `The Developmental Roots of Dissociation', ibid, p.97. A subsequent study by Dutra, Bureau et al (2009) reached similar conclusions. Schimmenti points out that these findings do not suggest that emotional neglect is the only factor leading to high levels of dissociation, but rather `that among the many types of child maltreatment, those related with psychological unavailability of the caregivers and their difficulty or unwillingness to attune with the child's needs are the most critical variables to take into account for predicting increased levels of dissociation' (Schimmenti, `The Developmental Roots of Dissociation', ibid, p.97.

380 As previously noted, this includes by non-maltreating caregivers with unresolved trauma histories (Hesse, Main et al, `Unresolved States Regarding Loss or Abuse Can Have `Second Generation' Effects: Disorganization, Role Inversion, and Frightening Ideation in the Offspring of Traumatized, Non-Maltreating Parents', ibid). Also see Erdinc Ozturk & Vedat Sar, `The `Apparently Normal Family: A Contemporary Agent of Transgenerational Trauma and Dissociation', *Journal of Trauma Practice* (4, 3, 2006), pp.287-303.

381 Silberg, *The Child Survivor,* ibid; Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid
.

2.2 A(nother) pathway to dissociation: inconsistent caregiving

Psychological unavailability of caregivers, which is a strong predictor of childhood dissociation, comes in many guises. Liotti has highlighted the role of *inconsistent* and *contradictory* interactions between parents and children.[11]

Inconsistent interactions without relational repair activate the need to dissociate whatever threatens the attachment bond, undermine movement towards cohesion and meaning, and militate against the possibility of integration of experience.[382]

Inconsistent interactions between child and caregiver may seem less problematic than abuse, neglect, or the many other adverse experiences. Liotti's research, however, contributes further findings to the already recognised developmental pathways that link disorganized attachment and pathological dissociation.[383]

Continuity of caregiver attunement is important in a range of ways. It not only fosters the child's expectation that their needs will be met. Contingent communication, in which the caregiver's response `matches' or `fits' the child's emotional experience,[384] promotes the growth, coherence and continuity of identity, as well as the capacity to relate to others. It is a vital pre-requisite to the ability to self-regulate and manage internal states.[385]

> *'When post-traumatic stress disorder (PTSD) first made it into the diagnostic manuals, we only focused on dramatic incidents like rapes, assaults, or accidents to explain the origins of the emotional breakdowns in our patients. Gradually, we came to understand that the most severe dysregulation occurred in people who, as children, lacked a consistent caregiver'.*
> (van der Kolk, in Porges, 2011: xi-xii)

Schimmenti cites Leonard Shengold, author of the pioneering text on the impacts of childhood deprivation and abuse,[386] that `our identity depends initially on good parental care and good parental caring – on *the transmitted feeling that it is good to be here', while the intimate affective climate of developmental trauma may represent the exact opposite condition, such as `it is no good that you are here; you are only a problem'.'*[387]

Episodic, inconsistent care does not communicate to the child that s/he is valued and important. Rather it impedes formation of consistent self-representations,[388] and fosters estrangement from self as well as dissociation of affect. This means that it has deleterious effects on physiological regulation and functioning, as well as on self-esteem and identity formation.

382 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable: Developmental Trauma, Dissociation, and the Disconnected Self', *Psychoanalytic Psychology* (33, 1, 2016), p.113.
383 Schimmenti & Caretti, ref Liotti, `Linking the Overwhelming with the Unbearable', ibid, p. 114.
384 David Wallin, *Attachment in Psychotherapy* (The Guilford Press, New York, 2007), p.106.
385 I.e. the `right brain to right brain' attunement and communication elaborated by Allan Schore and others (see Schore, *Affect Regulation and the Origin of the Self* (Lawrence Erlbaum, New Jersey, 1994). Citing diverse research, van der Kolk notes that `[e]motional abuse, loss of caregivers, inconsistency, and chronic misattunement' have appeared as `the principal contributors to a large variety of psychiatric problems' (van der Kolk, ref Dozier, Stovall, & Albus, 1999; Pianta, Egeland, & Adam, 1996, `Foreword' to Stephen W. Porges, *The Polyvagal Theory*, Norton, New York, 2011, p. xii).
386 Leonard Shengold, MD *Soul Murder: The Effects of Childhood Abuse and Deprivation* (New Haven: Yale University Press, 1989); Shengold, *Soul Murder Revisited* (New Haven: Yale University Press, 1999; 2000).
387 Schimmenti & Caretti, ref Shengold, 1989: 24, `Linking the Overwhelming with the Unbearable', ibid, p. 109.
388 And fosters `competitive internal working models' (Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p. 119, in the discourse of attachment theory).

2.3 The need for validation and the failure to receive it

The extensive and devastating impact of overwhelming experience in childhood - when the self is `under construction' - renders a child very vulnerable to disruption of the whole developmental trajectory. It is telling to compare the effects of adverse childhood experience with the impacts of trauma in adulthood. Even 'single incident' trauma in adults can disrupt 'at multiple levels of functioning and in conscious and unconscious modalities of awareness and behavior'.[389] *Therefore it is not surprising that a child who is overwhelmed in a dependent caregiving relationship is especially vulnerable to disruption of developmental trajectories across all domains.*

The `Still Face' experiment and research,[390] as Schimmenti and Caretti also underline, helps us understand how developmental trauma `can lead to affect dysregulation *and* dissociation'.[391] Infants are exquisitely attuned to the facial responses of their caregiver, rapidly discern any withdrawal of interest and focus, and also rapidly regress to dorsal vagal `shut down' when their attempts to elicit a response are not met with a reaction.[392]

Little wonder that if inconsistent and contradictory care promotes dissociative responses, the absence (psychological unavailability) and withdrawal of engagement is experienced as catastrophic. This both elicits *and requires* dissociation. As with Bowlby's `defensive exclusion',[393] this both protects the child from pain and maintains the attachment on which the child's survival depends.

Neurobiology of childhood trauma

`When a child is threatened, there are two circuits in the brain that are activated simultaneously, and that are incompatible'
(Siegel, 2012:21-12)

`One message – a feeling of terror induced from the parent's behavior – activates two circuits that create opposite actions to go away from and go toward the same person'
(Siegel, 2012:21-4)

The child is caught in a `biological paradox' between the `survival reflex' and the `attachment circuit'
(Siegel, 2012:21-10)

`*Inside the child is an unresolvable war between two impulses, and the internal world of the child collapses*'
(Siegel, ibid)

389 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.108.

390 The `Still Face' experiment, established and first conducted in the 1970s by American developmental psychologist Edward Tronick, observes the fluctuating distress responses of an infant when a previously attuned and engaged caregiver suddenly withdraws from emotional engagement and presents the child with a blank expression (i.e. `still face'). At first startled, the infant attempts to re-engage the caregiver before rapidly moving to agitation and then withdrawal and `collapse'.

391 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.112

392 As Lane, Ryan et al point out, `[i]n the case of emotion as a subjective experience, there is no information in the external environment that corresponds to the child's internal experience except that which is provided by an attuned other' (Richard Lane, Lee Ryan et al, `Memory reconsolidation, emotional arousal, and the process of change in psychotherapy', *Behavioral and Brain Sciences*, 2015, p.5.

393 John Bowlby, `The Origins of Attachment Theory', in *A Secure Base* (Routledge, New York, 2006); see discussion in the previous chapter.

As Silberg explains in her aptly named text *The Child Survivor*,[394] children `often rely on dissociative strategies to cope with the dilemmas in their world'.[395] When seriously impaired caregiving environments elicit overwhelming negative affect, `the brain selects and reinforces pathways that encourage avoidance of affect and associated traumatic content'.[396] While obviously protective, this also disadvantages the child in terms of the ability to be psychologically and emotionally present so s/he can learn, grow, and develop optimally.

2.4 Unintegrated states and `parts'

As discussed in the previous chapter, `self' does not precede relational experience. Primary caregiving relationships are powerfully formative -although their legacy is not impervious to subsequent reworking -,[397] of the `self' we become. The quality of our primary caregiving relationships assists and/or impedes our movement towards selfhood, and our ability to flexibly and appropriately access self-states. `Good enough' caregiving helps this process, and deficient caregiving - unrepaired relational ruptures - will impede it.

Reference to `states' and `parts' of the self are helpful ways to conceptualise both healthy and unhealthy developmental trajectories. Such descriptors are also valuable clinically. As van der Kolk notes, `[t]he mind is a mosaic' and `[w]e all have parts'.[398] Reference to `parts' and/or `self-states' is a common feature of many varieties of psychotherapy, with different terms used to describe the widely acknowledged phenomenon of diverse states of consciousness.[399] The key point in terms of adverse childhood experience is the disruption entailed by defensively invoked dissociation, which arises `from a traumatic disruption in the early developmental acquisition of control and integration of basic behavioral states'.[400] Thus Frank Putnam has elaborated a powerful account of trauma-related dissociation `as non-integration of discrete behavioral states'.[401]

The impacts of overwhelming stress on the brain and body are well known and those of trauma-related dissociation are increasingly substantiated. Neuroimaging studies `provide concrete, theoretically consistent evidence that dissociation exists',[402] and `is accompanied by altered activation of brain structures…involved in regulating awareness of bodily states, arousal, and emotions'.[403] Thus it becomes easier to consider that overwhelming stress in early life may generate

394 Silberg, *The Child Survivor,* ibid.

395 Whereby automatic responses `such as rage, retreat, or regression' assist avoidance of emotional engagement' (Silberg, *The Child Survivor,* ibid, pp. xiii-xiv).

396 Silberg, *The Child Survivor*, ibid, p.22 (`*We wonder why our chronically traumatized clients don't respond to our reassurances, their new caregiver's affection, or to our standard interventions. Dissociative processes in children and adolescents organize the brain in such a way as to inhibit the healing effects of corrective experiences, as even attempts to soothe can trigger avoidance programs',* Silberg, ibid, p.21).

397 As per the reworked attachment status of `earned security' or `secure attachment' (Siegel, `An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma', ibid.

398 Bessel van der Kolk, *The Body Keeps the Score* (Penguin, New York, 2015), p.282.

399 The diverse nomenclature used to describe internal states is discussed in the following chapter. For a powerful contemporary account of what is proposed as `the state nature of personality' which `incorporates most of the phenomena covered by the current developmental and dimensional approaches' to personality and which alternatively proposes that `we are all multiple to some degree', see Frank Putnam, *The Way We Are: How States of Mind Influence Our Identities, Personality and Potential for Change* (International Psychoanalytic Books, 2016). The quotes cited in this footnote are from pp.159 and 121 respectively.

400 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ref Putnam, 1997:152, ibid, p.111.

401 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ref Putnam, 1997:152, ibid, p.111.

402 Brand, `What We Know and What We Need to Learn about the Treatment of Dissociative Disorders', ibid, p.395.

403 Bethany Brand, `What We Know and What We Need to Learn About the Treatment of Dissociative Disorders', *Journal of Trauma & Dissociation* (13:4, 2012), p.395.

particular parts or self-states to which conscious access is impeded.[404] It also becomes easier to appreciate that the depth and duration of the stress, and the age at which it is experienced, might generate dissociative divisions of the personality in various combinations and forms.[405]

The core dissociative symptoms are *depersonalisation*, *derealisation, amnesia, identity confusion* and *identity alteration,* and their particular combination will determine the type of dissociative disorder.[406] While `excessive activation' of defensive dissociation in childhood (notwithstanding its initially protective function) is the forerunner of dissociative pathology in adulthood, problematic adult dissociation and potential disorder varies according to the severity and duration of early overwhelm and the configuration of the dissociative symptoms.[407]

While the presence of unintegrated states `impairs the functioning of many people who suffer from clinical disorders and maladaptive behaviors',[408] Schimmenti and Caretti contend that `*even patients who show only specific and limited unintegrated mental and/or bodily states may suffer from multiple dissociative connections in the self'.*[409] These are `often linked to implicit memories of relational failures in attachment bonds' which cause problems engaging with self-experience as well as in relationships with others.[410]

> *`We suggest that these unintegrated mental states are generated from recurrent episodes of disruption and irreparable relational breakdowns in the child-caregiver interactions. The presence of these states in a patient does not necessarily imply exposure to severe abuse or neglect but they always emerged from significant failures in the caregiver's abilities of mirroring, elaborating and/or sharing emotions and cognitions according to the patient's emotional needs during childhood'*
>
> Schimmenti & Caretti, ref. Schimmenti & Bifulco, 2013; Schimmenti, Guglielmucci, Barbasio & Granieri, 2012, 2016, p.115.

Regardless of the prevalence of trauma-related dissociation*, `problematic dissociation does not proceed from trauma alone'.*[411] It includes `not only the `shattered self' of posttraumatic severed connection, but also more general failures of integration'.[412] As Chefetz notes, `normative developmental pathways gone awry'[413] – for whatever reason - do not foster linkage between self-states. Thus, generation of isolated self-states can stem from care-giving which is not necessarily traumatic or abusive but which `is somehow unresponsive to the particular needs of a child'.[414]

The effects are manifold:

404 I.e. in contrast to the normative self-states of the `good enough' early experience of primary care-giving relationships.

405 See discussion in next subsection (2.5).

406 Marlene Steinberg & Maxine Schnall, *The Stranger in the Mirror* (HarperCollins, New York, 2001), p.32 and as noted in the previous chapter.

407 `What makes a difference in kinds and severity of problems in living is not only the severity of the dissociative fissures but also the way the dissociative parts are structured in internal relationships' (Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p.37) and see subsequent discussion.

408 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.120.

409 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.121.

410 Where the latter are described as `phobia of mental contents and phobia of attachment' Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.121. For detailed explication of the many phobias which characterise structural dissociation, see van der Hart et al, *The Haunted Self,* ibid.

411 Howell (ref. Gold, 2000), *The Dissociative Mind,* ibid, p.17; emphasis added.

412 Howell (ref Putnam, 1992, 1997), *The Dissociative Mind,* ibid, p.17.

413 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid, p.90.

414 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid.

`Regardless of its extent, pathological dissociation always implies processes of multiple disconnection in self-experience':

a. `a disconnection with reality'
(disrupted sense of continuity and spontaneity)

b. `a disconnection in interpersonal relationships'

c. `a disconnection in behaviors'
(`because they are procedurally tied to the detection and avoidance of potential threats, rather than being naturally and freely directed at the exploration of environments and relationships')

d. `a disconnection in the self'

e. `a disconnection or a reduced connection between the different components of the individual states'
(`with little or no integration between emotional activation and its representation, and the alternation of competing responses to the same stimulus testifying to the early disorganization')

Schimmenti & Caretti, 2016: 120

These disruptions of self disturb the person who `appears unable to integrate them into the consciousness – either because of the inadequate development of neural circuits related to the functional integration, or because of the necessity to defensively exclude from awareness these experiences.'[415]

In depicting the resultant `Catch 22', Schimmenti and Caretti invoke Schopenhauer's `porcupine dilemma',[416] in which the person is trapped between the desire for relational connection and the fear of retraumatisation as a result of it.

`Excessive activation' of dissociation is linked to affect dysregulation and to a range of problematic impacts.[417] Critically, these include impairment of the ability to reflect coherently on experience - `mentalise'[418] - predicated on what is referred to as `theory of mind'; i.e. `the capacity to think in terms of internal states' and to `organize the understanding of one's own and others' experience in terms of mental state constructs (beliefs, feelings, desires, intentions, and their expectable transactional relationships in a given situation').[419]

415 As per Bowlby (1980) `to maintain a minimum sense of integrity and continuity of the self' (Schimmenti & Caretti, ibid, p.120).

416 Schimmenti & Caretti, ref Arthur Schopenhauer 1788-1860, `Linking the Overwhelming with the Unbearable', ibid, p.121.

417 Affect metabolism may `generate significant alterations in the network of cortical and subcortical interactions that foster the development of self-awareness and the ability to organize mental and affective states' (Schimmenti, `The Developmental Roots of Dissociation', ibid, p.96. For the impacts of developmental trauma on the brain, see Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, pp.110-111, and De Bellis, `The Psychobiology of Neglect', *Child Maltreatment* (10, 2005), pp.150-172.

418 Referencing the work of Mary Main (1995, 1999), Peter Fonagy (1996, 2006) and others, Wallin notes that this ability – rather than being `embedded' in experience or `defensively dissociated' from it - is `a marker of both our own attachment security and our ability to raise children…who will also be secure' (see `The Stance of the Self toward Experience: Embeddedness, Mentalizing, and Mindfulness', ch.9 in Wallin, *Attachment in Psychotherapy*, ibid, pp.133-166).

419 Schimmenti, `The Developmental Roots of Dissociation', ibid, p.97.

A functioning `theory of mind' is crucial for mentalisation `because it constitutes the basic capacity allowing one to interpret reality at both cognitive and affective levels'.[420] This is also a prerequisite to the capacity to experience and show empathy. Deficient mentalisation impairs the ability to relate to others and hence to oneself and the absence of good relating is debilitating and incompatible with health and well-being.[421] Chronic dissociation is not solely a `mind' phenomenon. Persistent activation of unintegrated mental states leads to a `flood of dysregulation'[422] that results in dissociation `at a somatic level'.[423] For example, `discontinuities and possible distortions in the perception of one's own body' may be experienced `as a conglomerate of unintelligible, disconnected sensations rather than as a unitary whole'.[424] A reduced capacity to integrate and cognitively represent bodily states (severe dissociation is often accompanied by alexisomia as well as alexythimia)[425] can lead to `distressing somatic complaints, concerns and symptoms, together with abnormal thoughts, feelings, and behaviours in response to them'.[426]

2.5 Towards *structural* dissociation of the personality

Structural dissociation describes a severe type of dissociation whereby, in the context of early overwhelming experience, discrete self-states that have never been associated remain unlinked. Initially conceptualised in the late nineteenth century (and `reintroduced in modern times'),[427] structural dissociation refers to `divisions or dissociations in the personality or consciousness'; i.e. a `structural dissociative organization' of personality.[428]

The 2006 text *The Haunted Self* by Onno Van der Hart, Ellert Nijenhuis and Kathy Steele[429] is a detailed account of the origin, characteristics and functions of structurally dissociated parts of the personality. Drawing on the work of WWI doctor Charles Myers, Van der Hart, Nijenhuis and Steele describe dissociation between an `Apparently Normal Part' of the personality (ANP) which avoids all things traumatic and attempts to *cope with daily life tasks*, and an `Emotional Part' (EP) which *holds and reexperiences the trauma:*

> *`A number of survivors of chronic child abuse and neglect present with a type of primary structural dissociation in the form of one ANP that is the adult ....and one ...`child' EP that holds all the traumatic memories'.*[430]

420 Schimmenti, `The Developmental Roots of Dissociation', ibid, p. 97.

421 Schimmenti (ibid: 97) notes `research has shown that the overall accuracy in identifying complex internal states is reduced in people who have been neglected or abused in childhood (Nazarov et al, 2014; Pears & Fisher, 2005) even though they could be even more accurate than other people in the process of identifying negative feelings (Wagner & Linehan, 1999) and that this `likely happens because their interpersonal functioning has been sensitized early to threats and dangers, thus their mind has been forced to operate as a `smoke detector' (van der Kolk, McFarlane & Weinstein 1996)'.

422 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.116.

423 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.117.

424 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid 119.

425 While the more familiar term alexithymia describes the inability to describe emotions which are often expressed somatically, *alexisomia* relates to the inability to describe somatic sensations (Ogden et al, *Trauma and the Body,* ref Bakal, 1999; Ikemi & Ikemi, 1986, ibid, p.16).

426 Attesting, as Schimmenti and Caretti discuss, to a dysregulated and reduced window of tolerance for both psychic and somatic pain, as expressed in the diagnosis of somatic symptoms and related disorders' (ibid, p.119).

427 Martin Dorahy & Onno van der Hart, `Relationship between Trauma and Dissociation: An Historical Analysis', ch.1 in Vermetten, Dorahy, & Spiegel, ed. *Traumatic Dissociation* (American Psychiatric Publishing, Washington DC, 2007, p.6); the work of Nijenhuis et al. (2002, 2004) is cited as significant in this regard.

428 Dorahy & van der Hart, `Relationship between Trauma and Dissociation', ibid, p.6.

429 Onno Van der Hart, Ellert Nijenhuis, & Kathy Steele, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* (Norton, New York, 2006).

430 Van der Hart et al, *The Haunted Self,* ibid, p.304; emphasis added.

Depending on the age of the child and the duration and severity of the trauma, the dissociative splits can be considerably more complicated and `*can range from very simple to extremely complex divisions of the personality.*'[431]

> `*Severe disruptions in the early development of attachment patterns between children and their caretakers seem to be precursors of dissociative pathology, including more complex structural dissociation of the personality*'
> (van der Hart et al, 2006:85)

A MODEL FOR UNDERSTANDING DISSOCIATIVE PARTS

(Van der Hart, Steele & Nijenhuis, *The Haunted Self 2006)*

- *Primary structural dissociation* = a single ANP & a single EP
- *Secondary structural dissociation* = a single ANP, 2+ EP
- *Tertiary structural dissociation* = 1+ ANP; 2+ EP

The most complex divisions occur in Dissociative Identity Disorder (DID):
`*These children must alternate so quickly and frequently among emerging defensive and daily life action systems that these systems, hence their EPs and ANPs, can become mixed in quite chaotic manifestations'* (van der Hart, 2006:78)

`*The older the child is prior to abuse and neglect, the more likely action systems of daily life have become more cohesive, and thus it is less likely that more than a single ANP would develop*' (ibid:84)

The theory of structural dissociation has a prominent place within the trauma field. Its status is such that it has been combined with other approaches,[432] and it is also referenced by clinicians and researchers whose depiction departs somewhat from its original formulation and whose conceptualisation may be contested for this reason.[433] Not all researchers and clinicians of dissociation subscribe to the `continuum' model, and Van der Hart, Nijenhuis and Steele question readings which generalise beyond the specific conceptualisation in their 2006 text.

431 Van der Hart et al, *The Haunted Self,* ibid, p. 5; emphasis added.

432 For example Janina Fisher extols the theory of structural dissociation while also drawing on Sensorimotor psychotherapy (SP) and Internal Family Systems therapy (IFS) (Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid). Note that Fisher's conceptualisation of the `Going on with Normal Life' part of the personality is not identical to the `Apparently Normal Part' as elaborated by van der Hart, Nijenhuis & Steele, in *The Haunted Self,* ibid.

433 In this category is the work of Schimmenti & Caretti, itself respected, which cites Steele, Van der Hart & Nijenhuis when contending that `[s]everal authors have speculated that patients who suffer from developmental trauma (not necessarily from developmental trauma *disorder*)* often present unintegrated mental states that may qualify them as structurally dissociated, regardless of the disorders they suffer and even in the absence of a dissociative disorder diagnosis…they show a part of their psychic functioning which seems to operate independently from the other parts….This part does not occur at random; it appears at specific moments and/or with specific interactions, and it likely involves a system of traumatic memories with their related emotional, behavioral and psychological states' (Schimmenti & Caretti, 2016: 115; ref Meares, 2000; Schimmenti & Caretti, 2010, van der Kolk, 1995). **I.e. a particular diagnostic category proposed by Bessel van der Kolk which has yet to be included in diagnostic manuals.*

The disabling impacts of dissociation which stems from early relational trauma are complex and can take many forms. While the theory of structural dissociation describes a number of these in a cogent and comprehensive way, other conceptualisations are also valuable.

A range of researchers and clinicians present `variations on the theme' of chronic dissociation and the early life trauma which characteristically underpins it.

For example, Howell and Itzkowitz remark on how different kinds and severity of problem impact *`not only the severity of the dissociative fissures but also the way the dissociative parts are structured in internal relationships'* (2016: 37; emphasis added)

`…what is known as borderline personality appears to have a particular kind of dissociative structure, in which two main parts oscillate, as opposed to DID, in which there are usually more parts that take over executive function at different times'.
Howell & Itzkowitz, ref Howell, 2002, ibid.

Severe dissociative divisions and internal parts - including the possibility of multiple parts - become comprehensible, although no less challenging, in the context of overwhelming childhood experiences.

The number and nature of dissociative parts of the personality has, unsurprisingly, attracted both interest and scepticism. This is especially in relation to the complex and challenging phenomenon of DID. This means it is important to highlight that *the theory of structural dissociation of the personality is now explicitly supported by neuroscientific findings:*

`In accordance with the Theory of Structural Dissociation of the Personality (TSDP), studies of dissociative identity disorder (DID) have documented that two prototypical dissociative subsystems of the personality, the `Emotional Part' (EP) and the `Apparently Normal Part' (ANP), have different biopsychosocial reactions to supraliminal and subliminal trauma-related cues and that these reactions cannot be mimicked by fantasy prone healthy controls nor by actors'.
Schlumpf, Reinders et al, 2014
10.1371/journal.pone.0098795

The possibility that the severe dissociative divisions of the personality associated with DID can be `mimicked' or simulated is *not consistent with neuroscientific findings.* Yet it has generated an ongoing debate between proponents of different paradigms and is discussed in section 2.6 below.

Clinician and expert in trauma-related dissociation Richard Kluft has discussed the many paths to DID, and the dynamics that characterise its multiple self-states including the impetus to proliferate.
(Kluft, 2006: 284-286).

`Scepticism about numbers of self-states is a potential intellectualization and deflection of the sad reality…an intolerance of the reality of severe abuse'
(Chefetz, 2015:116).

2.6 The `Trauma' vs `Fantasy' Model

The evidence base for the relationship between structural dissociation and childhood trauma (note that DID represents the most complex and intricate of dissociative divisions) is both large and nuanced.[434] But the `Trauma Model' has been contested by an alternative paradigm.

The `Fantasy Model'[435] (also described as the sociocognitive, iatrogenic or non trauma-related model) disputes the Trauma Model understanding of DID (it should be recalled that there are various forms of psychological impairment involving dissociation which do not combine all the dissociative symptoms, which are less severe, and which do not necessarily feature extreme differentiation of multiple self-states) .[436] The debate between the `Trauma' and `Fantasy' models is ongoing[437] and has many implications.

The Trauma Model[438] regards DID as `at the far end of the spectrum of trauma-related psychiatric disorders and related to a combination of factors such as chronic emotional and physical abuse and neglect and/or sexual abuse from early childhood, insufficient integrative capacity, and lack of affect regulation by caretakers'.[439] Proponents of the `Fantasy Model' contest this.

> *`Supporters of the opposed trauma and fantasy models…of DID are engaged in a debate regarding the validity of DID as a mental disorder and its causes (i.e. traumatization or fantasy proneness, suggestibility, suggestion, and simulation'.*
> Reinders, Willemsen et al, 2016: 446; citing multiple references

There is a stark contrast between the reading of DID as a serious trauma-related disorder or as the product of fantasy, simulation and/or suggestibility. These divergent views have serious implications for treatment. Clearly a trauma-related disorder requires different treatment than an ailment which derives from fantasy proneness, suggestibility or simulation. This `paradigm clash' also has implications for whether DID will be treated at all.

This dispute also extends to attitudes to the phenomenon of recovered memory. Proponents of the Fantasy Model who dispute the aetiology of DID in childhood trauma also contest the legitimacy of the phenomenon of recovered memory of childhood sexual abuse. This has major implications for responses to, and appropriate treatment of, the many child sexual abuse survivors whose memories of abuse are recovered in adulthood but who do not necessarily have DID.

434 `Consistent clinical observations and retrospective findings indicate that dissociative identity disorder (DID)… is intimately related to severe traumatization, including emotional neglect …This conclusion is supported by the results of prospective longitudinal research of dissociation' (Schlumpf, Reinders et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study', ibid, citing multiple sources).

435 Exponents of which include Scott O. Lilienfeld, Steven Jay Lynn, Jeffrey M. Lohr and Nicholas Spanos (see Spanos, `Multiple Identity Enactments and Multiple Personality Disorder: A Sociocognitive Perspective', *Psychological Bulletin* (116, 1, 1994, pp.143-165).

436 And note, again, the `normal multiplicity' of self-states as discussed in the previous chapter and see Putnam, *The Way We Are*, ibid. and the following chapter.

437 As Reinders and Willemson note, *The Journal of Nervous and Mental Disease* has served as `a platform of debate between proponents of the fantasy and trauma model regarding 2 original publications (Boysen and VanBergen, 2013, Paris 2012) which were extensively commented on (Brand et al, 2013, Boysen and VanBergen, 2013; Dell, 2013; Martinez-Taboas et al, 2013; McHugh, 2013; Paris, 2013; Ross, 2013, and Sar et al, 2013)'. Antje Reinders, Antoon Willemsen et al, `The Psychobiology of Authentic and Simulated Dissociative Personality States', *The Journal of Nervous and Mental Disease* (Vol.204, No.6, 2016), p.445.

438 Prominent proponents of the Trauma Model include American trauma specialists Constance Dalenberg, David Spiegel, Bethany Brand, Paul Dell, Colin Ross and Richard Kluft, Dutch experts Onno van der Hart and Ellert Nijenhuis, and Turkish psychiatrist Vedat Sar. See Dalenberg, Brand et al, `Evaluation of the Evidence for the Trauma and Fantasy Models of Dissociation', *Psychological Bulletin* (138, 2012), pp.550-588.

439 J.A. Rydberg, `Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, `Myths, Misreports, and Misrepresentations' (*European Journal of Trauma and Dissociation*, 1, 2017), p.95, citing multiple references.

In this way the `Trauma' vs `Fantasy' debate echoes the so-called `Memory Wars' of the 1990s in which claims of recovered memories of child sexual abuse provoked a backlash which contested their legitimacy. This backlash also gave rise to The False Memory Syndrome Foundation which was established to support those accused of child sexual abuse and defend against what were regarded as bogus accusations.[440] While different in significant ways,[441] the current `Trauma' vs `Fantasy' debate can be regarded as a contemporary incarnation of these earlier debates.[442]

As questions about the nature of memory indicate,[443] the contrasting perspectives of the `Trauma' vs `Fantasy' debate raise complex and challenging issues for diverse stakeholders. The dispute also has political implications which should not be ignored, even as the focus should lie on the empirical evidence for the opposing perspectives. But in a world which is only belatedly recognising the extent and impacts of childhood trauma, appeals to evidence are not always sufficient to dispel misconceptions.[444]

Although evidence to date does not support the Fantasy Model (recall previous reference to MRI study findings that distinguish `ANP' from `EP' states and genuine from simulating participants[445]) its claims and support for them are still being circulated.[446]

There is also continued `controversy' regarding the legitimacy of the DID diagnosis. This is despite the solid evidence base which attests to its validity.[447]

440 The False Memory Syndrome Foundation was founded in 1992 by Peter and Pamela Freyd in response to the claim of their daughter Jennifer (now a prominent psychologist and pioneer of the concept of betrayal trauma) of sexual abuse by her father.

441 Prominent proponents of the current `Fantasy Model' are university-based academics who engage in research in contrast to the majority of previous FMSF members and sympathisers. Also note that due to the influence of the latter (who were also active in generating lawsuits), the term `false memory' has attached to and shaped a particular conception and context (i.e. the recovered memories of survivors of child sexual abuse) rather than necessarily relating to the broader questions of the veracity of memory and the nature of traumatic memory (even with obvious areas of overlap).

442 This reading should not be overplayed. Aside from the contrasting nature of FMSF members and exponents of the current `Fantasy Model', current neuroscientific and other research in the area of memory has evolved considerably since the 1990s and refined understanding has changed the landscape of current debates. For detailed discussion of these points and associated issues, see *The Truth of Memory and the Memory of Truth, Different Types of Memory and the Significance for Trauma* (Blue Knot Foundation, Sydney, 2018). https://www.blueknot.org.au/resources/publications/trauma-and-memory

443 For current pertinent research in relation to memory, see *The Truth of Memory and the Memory of Truth,* ibid.

444 Investments in maintaining existing beliefs can vary from reluctance to financially compensate survivors to genuine individual and societal overwhelm which can foster denial of a reality that is extremely painful to contemplate (i.e. the social defence mechanism of post-traumatic avoidance; see Herman, *Trauma and Recovery,* ibid).

445 Schlumpf, Reinders et al., `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder', ibid.

446 This includes clinicians who may not necessarily work or be up to date with more recent research around complex trauma-related conditions and the non-unitary nature of memory (`Although the sociocognitive model of dissociation has little empirical support (Dalenberg et al, 2014), it has many endorsers among clinicians' (Schimmenti, `The Developmental Roots of Dissociation', ibid, p.99.

447 See Martin Dorahy, Bethany Brand et al, `Dissociative Identity Disorder: An empirical overview', *Australian and New Zealand Journal of Psychiatry* (48, 5, 2014), pp. 402 - 417. https://www.researchgate.net/publication/262025048_Dissociative_identity_disorder_An_empirical_overview and Bethany Brand, Vedat Sar et al, `Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder', *Harvard Review of Psychiatry* (24, 4, 2016), pp. 257-270.https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction___An_Empirical.2.aspx

It is also despite systematic addressing of the several myths surrounding DID which likewise continue to proliferate [448] (and which again indicate political factors and interests which appear to negate appeals to evidence).[449]

The claim of Fantasy Model proponents that recovered memory in general and DID in particular are the product of `suggestion' is reminiscent of an earlier period in which women were largely dismissed as inherently `suggestible' and unreliable narrators of their own lived experience. It should be obvious, even without the current sophisticated research on memory which highlights its complexity,[450] that not all recovered memory is necessarily reliable. But current research findings show that *no* variety of memory is infallible:

> *`Substantial research examining both naturalistic and laboratory situations has demonstrated that recovered memories are as equally likely to be accurate as are continuous, never-forgotten memories'*
> (Barlow et al, 2017, citing multiple references)

Current research into memory - which yields new insights that the public as well as professional groups need to know[451] - confirms that `[i]f recovered memory experiences appear counter-intuitive, this is in part due to misconceptions about trauma and memory'.[452]

The phenomenon of `forgetting'[453] traumatic experience is a feature of *all* types of trauma,[454] i.e. not of child sexual abuse alone. Yet the term `recovered' memory is almost exclusively applied to this cohort. This, again, underlines both the urgent need for current research insights into the nature of memory to be widely accessible, and the often covert interests and politics which can feed ignorance about the workings of memory.[455]

---

448 Brand, Sar, et al `Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder' ibid.

449 Lest it be doubted that confusion is intentionally orchestrated by individuals and groups which stand to benefit from so doing, and that concerted attempts to discredit scientific evidence occur on a large scale, the field of agnotology tells us otherwise. A neologism for `study of the cultural production of ignorance', it reveals that `whole industries devote themselves to sowing public misinformation and doubt about their products and activities' (Michael Hiltzik, `Cultural production of ignorance provides rich field for study', *Los Angeles Times,* 9 March 2014). The obvious case is the tobacco industry, which long attempted to undermine public acceptance of the scientifically established links between smoking and lung disease. Revealingly, a 1969 internal memo recorded the comment `[d]oubt is our product', with the recommendation that the strategy `should not be to debunk the evidence....but to establish a `controversy' (Hiltzik, `Cultural production of ignorance provides rich field for study', ibid). Viewed in this light, reference to a `controversy' about DID – i.e. as an alternative to contesting of the scientific evidence which supports it – could be read as an(other) instance of the phenomenon described by the field of agnotology. The effect is that `both sides' of the `controversy' are encouraged to receive equal time in the interests of an apparent neutrality that belies calculated construction and manipulation. Significant in this context is the contention of some that child maltreatment constitutes `the tobacco industry of mental health' (Maia Szalavitz, cited in Rachel Boehm, `The Lingering Effects of Child Abuse', Network, 2 October 2012).

450 For an accessible account of key and current research findings on memory, the nature of traumatic memory and implications for its resolution, see Peter Levine, *Trauma and Memory: Brain and Body in a Search for the Living Past* (North Atlantic Books, Berkeley, 2015).

451 See *The Truth of Memory and the Memory of Truth,* ibid.

452 C.R. Brewin, `A Theoretical Framework for Understanding Recovered Memory Experiences', in R.F. Belli, *True and False Recovered Memories: Toward a Reconciliation of the Debate* (Springer, New York, 2012), p.149.

453 With conscious recall; remembering `in the form of physical sensations, automatic responses and involuntary movements' (Ogden et al, *Trauma and the Body*, ibid: 165) is characteristic of trauma. As Levine notes, `[t]raumatic memories may also take the form of unconscious `acting out' behaviors' (Levine, *Trauma and Memory*, ibid, p.8).

454 `Post-traumatic amnesia extends beyond the experience of sexual and combat trauma and is a protean symptom which reflects responses to the gamut of traumatic events' (van der Hart et al, `Trauma-Induced Dissociative Amnesia in World War 1 Combat Soldiers', *ANZJP*, 33, 1, 1999, pp.37-46). As Brewin confirms, `[c]ontrary to the widespread myth that traumatic events are seldom if ever forgotten, much trauma is not remembered until something happens to bring it to mind' (Brewin, `A Theoretical Framework for Understanding Recovered Memory Experiences', ibid, p.165).

455 See previous discussion and *The Truth of Memory and the Memory of Truth,* ibid.

Proponents of the Trauma Model acknowledge that dissociative personality states are not immune from - but present evidence that they are not *attributable to* - cultural influence.[456] They also agree that `false-positive' cases can occur in a treatment setting and that some psychiatric patients can simulate DID.[457] But they `also note that there are differences between authentic and imitated DID… and that there is no evidence that DID can be (sub)consciously created by sociocultural factors'.[458]

There are studies that are consistent with the Trauma Model. The previously cited 2014 study by Schlumpf, Reinders et al was the first to show `that two different prototypes of dissociative parts (i.e. ANP and EP subtype active defence) are associated with different patterns of brain identity following rest instructions in a challenging environment'.[459] Actors were shown to have `different perfusion patterns compared to genuine ANP and EP'; *`[c]omparisons of neural activity for individuals with DID and non-DID simulating controls suggest that the resting-state features of ANP and EP in DID are not due to imagination'*.[460]

These results were found to be consistent with the theory of structural dissociation of the personality *`and inconsistent with the idea that DID is caused by suggestion, fantasy-proneness and role-playing'.*[461] Correspondingly, they are *`inconsistent with the sociocognitive model of DID'.*[462]

Subsequent studies have confirmed these findings. In 2016, Reinders, Willemsen et al presented `new and extended data analysis' which replicated support for the `Trauma' over the `Fantasy' model.[463] In the same year, Brand et al found similarly.[464] In 2017, describing his study `to test a developmental model of dissociation', [465] Schimmenti noted the emphasis on suggestibility by proponents of the Fantasy Model and included checks `to partially rule out the possibility of a reverse causation'.[466] He predicted and found `that reduced levels of theory of mind and higher levels of alexithymia resulting from childhood emotional neglect may foster an overactivation of the dissociative processes that serve to protect the self from psychically painful experiences'[467] (*`[t]he alternative sociocognitive model… did not find empirical support')*.[468]

In the often fine-grained exchanges around the various points of contention,[469] adherents of the Fantasy Model have conceded some points to proponents of the Trauma Model.[470]

456 Brand, Sar, et al `Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder', ibid; Reinders, Willemsen et al, `The Psychobiology of Authentic and Simulated Dissociative Personality States', ibid.

457 Reinders, Willemsen et al, ref. Draijer & Boon, 1999, `The Psychobiology of Authentic and Simulated Dissociative Personality States', ibid, p.447.

458 Reinders, Willemsen et al, ref Gleaves 1996, `The Psychobiology of Authentic and Simulated Dissociative Personality States', ibid, p.447. Evidence in support of the Trauma Model over the Fantasy Model was also presented in the recent PhD thesis of Australian researcher Mary-Anne Kate for which she received a university medal.

459 Schlumpf, Reinders et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study', ibid.

460 Schlumpf, Reinders et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study', ibid.

461 Schlumpf, Reinders et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study', ibid.

462 Schlumpf, Reinders et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study', ibid.

463 Reinders, Willemsen et al `The Psychobiology of Authentic and Simulated Dissociative Personality States', ibid.

464 Bethany Brand, E.M. Vissia et al, `DID is Trauma-Based: Further Evidence Supporting the Trauma Model of DID', *Acta Psychiatrica Scandinavica* (134, 6, 2016), pp.560-563.

465 Schimmenti, `The Developmental Roots of Dissociation: A Multiple Mediation Analysis', ibid, p. 96.

466 Schimmenti, `The Developmental Roots of Dissociation', ibid, p. 99.

467 Schimmenti, `The Developmental Roots of Dissociation', ibid, p.101.

468 Schimmenti, `The Developmental Roots of Dissociation', ibid, p.102.

469 See Constance Dalenberg, Bethany Brand et al. `Reality Versus Fantasy: Reply to Lyn et al (2014)', *Psychological Bulletin,* 140 (3): 2014; pp.911-920 doi: 10.1037/a003668

470 E.g. that the meta analysis results of the authors' work `support the TM hypothesis that trauma exposure is a causal risk factor for the development of dissociation' (Dalenberg, Brand et al. `Reality Versus Fantasy: Reply to Lyn et al', ibid, p.911).

These have been welcomed by the latter and include the complex role of trauma in the phenomenon of dissociation and the involvement of both direct and indirect paths.[471]

While empirical research into DID is still at an early stage,[472] evidence to date clearly upholds that:

(1) The concept and theory of *structural dissociation of the personality* is `supported by clinical and empirical evidence'.[473]

(2) DID is empirically and clinically validated and is a well-established diagnosis.[474]

(3) Memory is not unitary and involves different subsystems and types. The major distinction is between *explicit*, conscious memory and *implicit* unconscious memory.[475] Traumatic memory is a form of implicit memory which differs from conscious recollection[476]and stems from dissociation of experience too overwhelming to process.

(4) `Recovered' memory (i.e. delayed onset recall) of trauma is common among various cohorts (i.e. not only survivors of child sexual abuse) and is no more likely to be reliable or unreliable than continuous memory.[477]

(5) Research studies confirm the differences between genuine DID and simulation of it: *`Results of the new post hoc t tests on the psychophysiological measures confirm the trauma model of DID. Results obtained from the brain data do not support the fantasy model of DID'.*[478]

Empirical and clinical support for the existence of dissociative divisions of the personality and the theory of structural dissociation – where the most severe dissociative divisions occur in DID which is consistently linked to severe childhood trauma[479] - is ground-breaking. It also provides a strong foundation and legitimacy for the `parts' work that is essential for the effective treatment of structural dissociation (see next chapter).

471 Dalenberg, Brand et al. `Reality Versus Fantasy: Reply to Lyn et al', ibid, p.911.

472 Reinders, Willemsen et al `The Psychobiology of Authentic and Simulated Dissociative Personality States', ibid, p. 455. Note the recent contention that while recalling the limitations of a single case, `personality switch can affect executive functions, and this can be measured with available scales' (Teresa Costabile, Leonilda Bilo et al, "Dissociative identity disorder: Restoration of executive functions after switch from alter to host personality", *Psychiatry and Clinical Neuroscience,* 72, 2018, pp. 189). As Costabile, Bilo et al relate, `[a] few cases of linking executive function to dissociative disorders have been previously reported, but they did not explore the effect of personality switch on neuropsychological performance. Awareness of this may be helpful for clinicians, who should not consider these symptoms as secondary to organic diseases'.

473 Schlumpf, Reinders et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study', ibid.

474 Dorahy, Brand et al, `Dissociative Identity Disorder: An empirical overview', ibid; Brand, Sar, et al `Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder' ibid.

475 For detailed explication of these different varieties of memory (which themselves comprise subtypes), see Levine, *Trauma and Memory,* ibid.

476 E.g. is remembered `in the form of physical sensations, automatic responses and involuntary movements' (Ogden et al, ibid: 165) rather than in conscious and verbalisable form. Research shows that trauma `can disrupt memory in many ways' and that severe trauma `can interact with memory at any one or more of its various stages' (Barlow et al, ibid: 315).

477 See Barlow, Pezdek, & Blandon-Gitlin, `Trauma and Memory', ch.16 in Gold, S.N., ed. *APA Handbook of Trauma Psychology: Foundations in Knowledge* (American Psychological Association, 2017), pp.307-331; Chu, *Rebuilding the Shattered Self*, ibid, p.80; both sources cite multiple references. The impacts of stress on the brain, the different neural networks in which memory is stored, and the differences between conscious, explicit, and nonconscious implicit memory shed light on the phenomenon of delayed conscious recall (i.e. `recovered memory'; see discussion in *The Truth of Memory and the Memory of Truth, Different Types of Memory and the Significance for Trauma*, ibid.)

478 Reinders, Willemsen et al `The Psychobiology of Authentic and Simulated Dissociative Personality States', ibid, p. 455.

479 As the first sentence of the study by Schlumpf, Reinders et al underlines, `[c]onsistent clinical observations and retrospective findings indicate that dissociative identity disorder (DID)… is intimately related to severe traumatization, including emotional neglect …This conclusion is supported by the results of prospective longitudinal research of dissociation' (Schlumpf, Reinders et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study', ibid, citing multiple sources.

Chapter 2
Summary of key points and themes

1. Dissociation, especially in childhood, and if primarily used for defensive purposes, can severely impact development and so adult health

2. While child abuse and neglect have long been strongly correlated with dissociative symptoms, research now shows `complex relationships between the entire spectrum of negative attachment experiences in childhood and the presence of overly activated dissociative processes' (Schimmenti, 2017: 97).

3. Psychological unavailability of caregivers *(`their difficulty or unwillingness to attune with the child's needs')* has been found to be `the single strongest predictor of dissociation' (Schimmenti, 2017: 97).

4. Caregiving which is *inconsistent* is another pathway to dissociation (Liotti, 1992, 2006).

5. *Structural* dissociation relates to divisions of the personality which are unintegrated due to early overwhelming experience (van der Hart et al, 2006). While DID is its most severe form, developmental trauma may lead to unintegrated mental states where `a part of…psychological functioning seems to operate independently of other parts' (Schimmenti & Caretti, 2016: 115).

6. The model of structural dissociation presented by van der Hart, Nijenhuis & Steele in *The Haunted Self* (2006) describes the presence of an `Apparently Normal Part' of the personality (`ANP') which attends to everyday life and an `Emotional Part' (`EP') which holds the trauma. Depending on the age of the child and the duration and severity of the trauma, the dissociative divisions can be more complicated and *`can range from very simple to extremely complex divisions of the* personality' (van der Hart et al*,* ibid: 5; emphasis added).

7. The theory of structural dissociation is now corroborated by studies of neuropsychologists which reveal different patterns of brain activity for `ANP' and `EP' states and which are `inconsistent with the idea that DID is caused by suggestion, fantasy proneness, and role playing' (Schlumpf, Reinders et al, 2014).

8. Despite solid evidence which attests to its legitimacy (Brand et al, 2016; Dorahy et al, 2014) and for reasons which do not relate to the evidence base alone, the diagnosis of DID and its aetiology in childhood trauma is often described as controversial. The `Fantasy' (also known as sociocognitive) Model repudiates the `Trauma' Model. Although there is little empirical support for it (Dalenberg et al, 2014), the claims made by the Fantasy Model, like the many myths about DID, continue to circulate.

9. Evolving psychobiological, psychophysiological, and other data support the Trauma Model and not the Fantasy Model: *`New results of the brain imaging data did not support the fantasy model. [The] study extends previously published results by offering important new supporting data for the trauma model of DID'* (Reinders, Willemsen et al, 2016); *`The alternative sociocognitive model… did not find empirical support'* (Schimmenti, 2017).

10. Current research findings necessitate better education about the nature of memory for both professionals and the general public. Memory is not unitary. Conscious (`explicit) memory differs from unconscious (`implicit') memory, and traumatic memory – resulting from an inability to process overwhelming experience - is expressed in `physical sensations, automatic responses and involuntary movements' (Ogden et al, 2006: 165) rather than spoken language.

11. `Contrary to the widespread myth that traumatic events are seldom if ever forgotten, much trauma is not remembered until something happens to bring it to mind' (Brewin, 2012:165).

12. Memory which is `recovered' after being forgotten at a conscious level occurs in many types of trauma and studies show that recovered memories *`can often be corroborated and are no more likely to be confabulated than are continuous memories'* (Chu, 2011: 80; Barlow et al, 2017; emphasis added).

Chapter 3

`A Healthy Defence Gone Wrong':[480] Unintegrated self-states (`parts') and DID

> *`Most of us…typically experience minor discontinuities in memory and identity and manage to `keep it together' for the most part. However, when a person's different identities destructively compete with each other, generate continuing conflict with significant others, or are grossly inappropriate for the situation, it may be time for outside help'.*
>
> *Frank Putnam, The Way We Are: How States of Mind Influence Our Identities, Personality and Potential for Change*
> (IPBooks, New York, 2016), p.16.

Recognising dissociation, multiplicity, and diverse self-states or `parts'[481] as inherent features and processes of the mind challenges psychological models which regard personality as `a set of fixed, persistent, and globally defining traits that pervade all of the person's interactions with the world'.[482] While theories of personality differ, the majority share this premise.[483]

This is despite the `considerable body of evidence' which attests to `*state dependence* in learning, memory, and recall', whereby `when a person is in one emotional and physiologic state, it is more difficult to access memories and experiences of a different state'.[484] That is - we feel and behave differently according to the context/s in which we find ourselves.

How personality is conceptualised has major implications for understanding and appropriate treatment of structural dissociation, DID, and complex trauma related conditions more broadly:

> *`In a mental health world that rejects the notion that personality and identity can be fragmented and compartmentalised, therapists are rarely trained to see the splits, much less the life-or-death battle for control being waged by `selves' with opposite aims and instincts'.*
> (Fisher 2017: 1).

480 Marlene Steinberg & Maxine Schnall, *The Stranger in the Mirror* (HarperCollins, New York, 2003), p.8.

481 Note that nomenclature is discussed in a subsequent section of this chapter.

482 Frank W. Putnam, *The Way We Are: How States of Mind Influence Our Identities, Personality and Potential for Change* (IPBooks, New York, 2016), p.159.

483 Indeed, in the reading of Frank Putnam they `require' it (*The Way We Are,* ibid). Notwithstanding their internal diversity, Putnam summarises current theoretical approaches as *developmental* and *dimensional* respectively, where the former is predicated upon attachment dynamics with early caregivers (`how we come to be who we are', p.151) and the latter `view people along continuums…how you are now without regard to your history' (p.155). In both cases, `[a]ll of the current ways of thinking' about personality `require' it to be conceptualised as fixed and continuous according to `globally defining traits that pervade all of the person's interactions with the world' (Putnam, *The Way We Are,* ibid, p.159).

484 James Chu, ref Eich & Metcalfe, 1989; Tobias et al, 1992; van der Kolk, 1994, *Rebuilding Shattered Lives* (John Wiley, New Jersey, 2011), p.101; emphasis added.

3.1 Towards a state model of personality

In contrast to an understanding of personality in terms of `fixed, persistent, and globally defining traits', Putnam's description of a `state' model of personality `allows a far wider range of disparate behaviors'.[485] It also helps us understand the *state change/s and fluctuations* to which we are all subject, but which traditional and still current theories of personality do not help us to comprehend.[486]

Regarding multiplicity as the norm rather than the exception (in that *`[w]e are all multiple to some degree'*[487]) helps us to consider what might be happening when things `go wrong'.

This means that fixity is not the marker of health either. Rather, it is *`how well we can keep it together, how harmoniously we can bridge, coordinate and even integrate the different parts of ourselves that determines how functional we are'*.[488]

Trauma and dissociation impede the flow and access between psychological states. As discussed in previous chapters, severe dissociation is consistently associated with childhood trauma which generates dissociative self-states which are more marked, frequent, and severe than in the absence of trauma.[489]

Recent publications contend that the `time has come for a comprehensive appreciation of the role played by dissociative mechanisms derived from such developmentally traumatic experiences in exacerbating or even inducing psychopathology'.[490] This is not a new recommendation.[491] As Schimmenti and Caretti assert, there is now `a wealth of theoretical and empirical findings illustrating how these experiences might dramatically damage the possibility of organising mental states into a cohesive higher-order structure, what clinicians usually call the *self*'.[492]

> *The `state model' defines personality as `the collective dynamics of a person's set of identity, emotional and behavioural states'*
> (Putnam, 2016: 159).
>
> *It draws evidence from diverse fields including neuroscience and attachment theory. Significantly, it helps us to understand how normal multiplicity and self-states rigidify when a person is traumatised, in ways which impact functioning, self-concept, and relationships.*

In the absence of trauma-related dissociation, we are more likely to consciously recall and have relatively smooth unimpeded access to the self-state appropriate to the particular context (*`[t]oday we easily grasp the notion that there is the work-self and the self that shows up at home, distinct from that which shows up at parties, sporting events, or with intimate friends'*).[493]

485 Putnam, *The Way We Are,* ibid, p.159.
486 Additional to its specific advantages, Putnam contends that the state model of personality `incorporates most of the phenomena covered by the current developmental and dimensional approaches' (Putnam, ibid).
487 Putnam, *The Way We Are,* ibid, p.121 (emphasis added).
488 Putnam, *The Way We Are,* ibid, p.121.
489 `Research suggests a strong connection exists between developmentally adverse experiences within the attachment relationship, such as parental abuse, neglect, and failures of care, and the presence and severity of dissociative symptoms in adulthood' (Adriano Schimmenti & Vincenzo Caretti (ref Chu, Prey, Ganzel, & Matthews, 1999; Dalenberg et al, 2012; Egeland & Susman-Stillman, 1996), `Linking the Overwhelming with the Unbearable: Developmental Trauma, Dissociation, and the Disconnected Self', *Psychoanalytic Psychology* (Vol.33, No.1, 2016), p.107.
490 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.107.
491 As Schimmenti & Caretti (ibid) point out, `[m]any researchers who work in the field have shared this idea for a long time now (e.g. Herman, 1992; Ross, 2000; van der Kolk et al, 1996)'.
492 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.107 (original emphasis).
493 May Benatar, *Emma and Her Selves: A Memoir of Treatment and a Therapist's Self-Discovery* (IPBooks, New York, 2018), p.8.

The social requirement to shift roles and states has become normalised. In fact `*not* being able to switch when the situation demands'[494] can itself be a problem: `*although most people still subscribe to the idea of a core sense of self, flexibility of self-concept…is a sign of our times*'.[495]

But ease of access to self- states is less likely with unresolved trauma (which impedes flexibility).). The severe dissociation generated by unresolved childhood trauma produces correspondingly severe rigid self-states which the person may not be able to access or recall. Childhood trauma is associated with a range of dissociative psychopathology, the most severe of which is Dissociative Identity Disorder (DID); `*a collection of separate and distinct identity states that may have little or no awareness of each other and thus often behave in conflicting, contradictory, and self-defeating ways.*' [496]

Yet the extreme nature of DID (i.e. commensurate with the extreme developmental trauma sustained)[497] speaks to psychic processes which are misrepresented if viewed only through the lens of the exceptional..[498] The `extreme' phenomenon of DID is both more subtle and more common than many working in the mental health sector realise

We are `[a]ll of us…always – in one or another state of being'.[499] This also means that `[i]t is the rare person who can achieve the psychological distance from which to carefully examine the contradictions in his or her behaviour'.[500] DID is a form of structural dissociation which corresponds to the severity of trauma which generated it, in which *simultaneous ways of being rigidly keep contradiction at bay*. It also represents a particular trajectory (i.e. one of many) of major disruption to the developmental process.

> *DID serves as a window to what `goes wrong' - in this case radically - in the normal developmental process when adaptive state-change is derailed. In the absence of severe developmental disruption, state-change is less extreme but remains an ongoing feature of psychological functioning.*
>
> *Problematically unintegrated self-states in which `a part of… psychic functioning… seems to operate independently from the other parts'* (Schimmenti & Caretti, 2016: 115; ref Steele, Van der Hart & Nijenhuis, 2006) *may also be more common than is recognised.*

494 Steinberg & Schnall, *The Stranger in the Mirror*, ibid, p.105 (original emphasis).
495 Steinberg & Schnall, *The Stranger in the Mirror*, ibid, p.83.
496 Putnam, *The Way We Are,* ibid, p.159; emphasis added.
497 As Benatar describes, DID is understood by those who treat it to be `an acute variant' of chronic post-traumatic stress; `the consequence of severe childhood abuse' (Benatar, *Emma and Her Selves*, ibid, p.16). To this extent, and in light of the multiple compartmentalised self-states it generates, it might also be regarded as the most complex form of complex trauma.
498 As a 1990 paper published in the *Journal of Humanistic Psychology* noted, humanistic psychology extols `the healthiest, most fully developed individuals as models for human potential', where dissociation of consciousness has tended to be regarded as pathological (Douglas Richards. `Dissociation as Transformation', *Journal of Humanistic Psychology*, 1990). Yet the paper also noted `increasing evidence… that dissociated states of consciousness can also be components of a healthy developmental path. The phenomenon of dissociation into more than one personality, each with a separate sense of self-identity, allows for complex transformative processes to occur within the `community of selves'. Evidence for these processes comes from clinical studies of multiple personality, experimental studies of hypnosis, and introspective accounts by dissociators' (Richards, `Dissociation as Transformation', ibid).
499 Putnam, *The Way We Are,* ibid, p.160.
500 Putnam, *The Way We Are,* ibid, p.139.

3.2 Normal multiplicity and multiplicity gone awry

Attention to `*the collective dynamics*'[501] of identity and emotional and behavioural states illuminates both normative states and disorders. The *interaction* of these collective dynamics distinguishes the `state' model of personality.[502] Traditional and otherwise contrasting and limiting theories of personality- which insist on unity, stability, and continuity – do not account for the nature of this interaction.

> *`It is the nature of the human mind to be subdivided… Parts exist from birth… multiplicity is inherent in the nature of the mind'.*
> (Schwartz, 1995: 57)

Neuropsychological studies are increasingly refining our understanding of the plurality of subjectivity. With specific reference to the activity of `parts' in relation to DID, they are also extending understanding of both normal and `non-norm' states.[503]

> Multiplicity of mental states in the context of the neurological functioning of `parts' in DID is now empirically validated, with identification of distinct patterns of brain activity.
> (Schlumpf, Reinders et al., 2014; Reinders, Willemsen et al, 2016).

> Personality state-dependent measures for diagnosed DID and DID-simulating controls have been obtained and neutral personality states vis-a-vis trauma-related personality states have been tested.
> (Vissia, Giesen et al, 2016; Reinders, Willemsen et al, 2016; Schlumpf, Reinders et al, 2014).
>
> *`A continuum of trauma-related symptom severity was found across groups, supporting the hypothesis that there is an association between the severity, intensity, as well as age at the onset of traumatisation, and the severity of trauma-related psychopathology'*
> (Rydberg, 2017: 95).

501 Putnam, *The Way We Are,* ibid, p.159.

502 I.e. `the integration of a person's identity, 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, *The Way We Are,* ibid, p.160).

503 As per the confirmed neurological differences between DID and simulation of it. See Schlumpf, Reinders et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study' (PLoS One, 9, 6, 2014); Reinders, Willemsen et al, `The Psychobiology of Authentic and Simulated Dissociative Personality States', *The Journal of Nervous and Mental Disease* Vol.204, No.6, 2016, pp.445-459; Vissia, Giesen et al, `Is it Trauma or Fantasy-based? Comparing Dissociative Identity Disorder, Simulators, and Controls', *Acta Scandinavica* (134, 2, 2016), pp.1-18; Brand, Vissia et al, `DID is Trauma-Based: Further Evidence Supporting the Trauma Model of DID', *Acta Scandinavica* (134, 6, 2016, pp.560-563). For a prior study in this area, see Reinders, Nijenhuis et al `Psychobiological Characteristics of Dissociative Identity Disorder: A Symptom Provocation Study' *Biological Psychiatry* (60, 7, 2006), pp.730-740 and discussion in the previous chapter. The question of `norm' vis-a-vis `non norm' relates to Putnam's contention that `[w]e are all multiple to some degree or another' (*The Way We Are,* ibid, p.121). As discussed previously, during a typical day we change our state of being many times as we change contexts and roles. For the most part this natural process occurs in the background as we traverse our daily routines *(`Indeed, `normality' and `abnormality' can be defined in terms of how well someone instinctively matches his state of being to the daily flow of changing social situations'* (Putnam, *The Way We Are,* ibid, emphasis added, p.121).

Robert Oxnam's comments on lived experience of DID are edifying:

`I have come to think that a lot of people, possibly all people, have multiple personae. Everyone I know reports feeling differently in different places and with different people. Many describe various `roles' or `masks'.…Probably the biggest difference between `normal multiplicity' and [DID] is that most people recall what happens when they move through their array of personae. By contrast, [DID] is characterised by rigid memory walls that prevent such recall'.[504]

As noted previously, severe dissociative divisions between internal states - including multiple disconnected parts – become comprehensible in the aetiological context of overwhelming childhood experiences.

3.3 Internal diversity: ego-states, normal multiplicity and the movement to disruption

> *`It is well appreciated that the minds of normal subjects and of psychiatric patients have a certain degree of differentiated modularity. Concepts such as ego states, representations of interactions that have become generalised, affect scripts, and core conflictual relationship themes address, from different perspectives, the phenomenon of persistent patterns of structure and behaviour that can be found to underlie aspects of human psychology'.*
> (Kluft, 2006: 283, ref Watkins & Watkins 1997)

The term `ego states' is helpful in considering the internal `parts' of personality.[505] This is also because it is common within the field of psychology and widely referenced by diverse psychotherapeutic modalities. As Kluft describes, the pioneering work of John and Helen Watkins[506] is `[o]ne of the most widely accepted approaches to describing such phenomena'.[507]

In this approach an ego state is described as an *`organized system of behaviour and experience whose elements are bound together by some common principle but that is separated from other such states by boundaries that are more or less permeable'.*[508] It is widely believed that ego states characterise the internal world of all individuals.[509]

504 Robert Oxnam, *A Fractured Mind: My Life with Multiple Personality Disorder* (Hachette, New York, 2005), p.5.
505 Note that ego states of health also differ from those of structural dissociation as subsequently discussed.
506 John G. Watkins & Helen H. Watkins, *Ego States: Theory and Therapy* (Norton, New York), 1997.
507 Richard P. Kluft, MD, `Dealing with Alters: A Pragmatic Clinical Perspective', *Psychiatric Clinics of North America* (29, 2006), p.283. For a recent authoritative account informed by the work of the Watsons, see Maggie Phillips & Claire Frederick, *Empowering the Self through Ego-State Therapy* E-book, 2010 http://reversingchronicpain.com/EmpoweringSelfEgoStateTherapy/EST_ebook.pdf
508 Watkins & Watkins, `Ego-state therapy in the treatment of dissociative disorders', in Kluft & Fine, ed. *Clinical Perspectives on Multiple Personality Disorder* (American Psychiatric Press, Washington DC, 1993, pp.277-99.
509 As is apparent in the following description: *`Ego states exist as a normal aspect of personality development. Every individual has a number of different ego states, each of which is designed to assist the personality in important ways. Ego states evolve as creative ways of coping with the demands of external environments, allowing us to master developmental challenges such as distinguishing between acceptable responses in social, home, and school situations'* (Phillips & Frederick, *Empowering the Self through Ego-State Therapy,* ibid, p. 2). These writers note that *`[a]n "ego state" is one of a group of personality states that is relatively stable across time'* and *`is distinguished by a specific role, emotion, behavioral, memory, and/or cognitive function'* (ibid)

The work of Watkins and Watkins is especially salient in the present discussion. This is because these psychologists upheld the normality of internal diversity of each individual by invoking various `ego states',[510] while focusing specifically on the more discrete mental states associated with structural dissociation and what was then called Multiple Personality Disorder (MPD; i.e. now Dissociative Identity Disorder, DID).[511]

In considering `the theoretical concepts of ego-state therapy', (Helen) Watkins emphasised `two processes that are cogent in the development of the human personality: *integration* and *differentiation*'.[512]

Via *integration,* `a child learns to put concepts together, such as dog and cat, and thus to build more complex units called animals'.[513]

Via *differentiation,* `the child separates general concepts into specific meaning, such as discriminating between `good doggies' and `bad doggies'.[514]

> Both processes `are normal and adaptive' in facilitating the ability to differentiate between behaviours appropriate in a particular context. But *`[w]hen this separating process becomes excessive and maladaptive, it is usually called `dissociation'.*
> (Watkins, 1993: 233; emphasis added)

> *`Psychological processes do not exist on a rigid either/or basis. Anxiety, depression, and other affects lie on a continuum with lesser or greater degrees of intensity.*
>
> *So it is with differentiation-dissociation.*
>
> *Multiple personality disorder (MPD) [now called DID] represents that extreme and maladaptive end of the continuum that begins with normal differentiation. It is a matter of degree or intensity.*
>
> *We are therefore concerned with a general principle of personality formation in which the process of separation has resulted in discrete segments, called ego states, with boundaries that are more or less permeable'.*
> (Watkins, 1993: 233; emphasis added).

510 As Cardena notes in his review of Watkins & Watkins (ibid), the theory of ego states developed and applied by the Watkins for clinical practice has its historical roots in Freud's psychodynamic model of personality (Etzel Cardena, review of Watkins & Watkins, ibid, *American Journal of Clinical Hypnosis,* 43, 2, 2000, p.159).

511 Watkins & Watkins, `Ego-state therapy in the treatment of dissociative disorders', in Kluft & Fine, ed. *Clinical Perspectives on Multiple Personality Disorder,* ibid; Watkins & Watkins, `Hazards to the Therapist in the Treatment of Multiple Personalities', in B. Braun, ed. Symposium on Multiple Personality*, Psychiatric Clinics of North America*, 7, 1984, pp.111-119. As Helen Watkins described, `[e]go-state therapy is a psychodynamic approach in which techniques of group and family therapy are employed to resolve conflicts between various "ego states" that constitute a "family of self" within a single individual. Although covert ego states do not normally become overt except in true multiple personality, they are hypnotically activated and made accessible for contact and communication with the therapist. Any of the behavioral, cognitive, analytic, or humanistic techniques may then be employed in a kind of internal diplomacy' (Helen H. Watkins, `Ego State Therapy; An Overview', *American Journal of Clinical Hypnosis,* Vol 35, No 4, 1993), p.232.

512 Helen H. Watkins, `Ego State Therapy; An Overview', *American Journal of Clinical Hypnosis*, Vol 35, No 4, 1993), p.232; emphasis added.

513 Watkins, `Ego State Therapy; An Overview', ibid.

514 Watkins, `Ego State Therapy; An Overview', ibid.

It is valuable to understand g ego states as normal parts of the internal diversity of personality[515] (i.e. where it is also possible for `extreme' and `maladaptive' configurations to exist at the *`end of the continuum that begins with normal differentiation'* and where *`[i]t is a matter of degree or intensity')*. It is also a non-stigmatising way to address what `goes wrong' to compromise the ability to access and move flexibly between ego states (`parts').

> Reference to `ego states' is a helpful entry point to consideration of the more problematic divisions of personality generated by disrupted development and experiences of overwhelm.
>
> But the ego states of *structural* dissociation also differ from the ego-states which characterise health and well-being in ways which need to be understood.

Understanding the differences between ego states in the context of well-being and those of compromised mental health is important. It also requires consideration of the diverse terminology used to describe the more discrete – and thus much *less* permeable - ego states which characterise structural divisions of the personality.

3.4 `*What's in a name?'* Diverse language describes the inner world of structural dissociation

The following remarks of American trauma and dissociation expert Richard Kluft convey the diverse language used to describe the internal world of people with structural dissociation. Note that `the nomenclature of parts' has continued to evolve since the time at which these comments were made:

> *`Alternate identities or personality states are core phenomena of dissociative identity disorder (DID) and found in several forms of dissociative disorder not otherwise specified (DDNOS)' [since amended in DSM-5 to `Other Specified Dissociative Disorders; i.e. OSDD] Whether they are called identities, personalities, personality states, ego states, subpersonalities, parts, disaggregate self-states, alters, or any number of other descriptive terms…they form a central and often colourful and controversial feature of these disorders'.*
> (Kluft, 2006: 281).

The term `alter' (i.e. `other' and used by Kluft throughout the 2006 article from which the above comment is drawn) is not favoured by many. To the extent that it has `twilight zone' connotations, it is arguably problematic for this and other reasons.[516] Additional terms to those listed above have emerged in the intervening period. They are often used interchangeably although they are not invariably equivalent.

Reference to `dissociative parts of the personality' (rather than `alters') is favoured by Van der Hart, Nijenhuis, and Steele .[517] These clinicians and researchers describe the main presenting part of a structurally dissociated person as the `Apparently Normal Part' (ANP); others have used the term `host'. Yet `host' is also problematic, and not all clinicians in the trauma and dissociation field favour reference to `ANP' to describe the part of the structurally dissociated personality which copes with tasks of daily life.

515 Also Phillips & Frederick, *Empowering the Self through Ego-State Therapy*, ibid, p.2.

516 For example for survivors of cult and ritual abuse the term `alter' may have quite literal connotations of trauma.

517 Onno Van der Hart, Ellert Nijenhuis & Kathy Steele, *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* (Norton, New York, 2006).

An alternative to the terms `ANP' and/or `host' is `front' person;[518] i.e. the part of the structurally dissociated personality which attends to requirements of everyday life. Likewise, this part of the person is most frequently visible to other people (where less visible dissociative parts have been described as `insiders').[519] Another alternative term is Janina Fisher's reference to the `Going on with Normal Life' part of the personality.[520]

In his work with structurally dissociative clients, Richard Chefetz uses the language `different ways of being you'.[521] To the extent that, as Putnam points out, *`[w]e are all multiple to some degree or another',*[522] this conceptualisation can apply to *all* clients.

Simple reference to `parts' is also universally as well as more specifically applicable. As Van der Hart, Nijenhuis and Steele point out, clients who have experienced trauma widely welcome the language of parts, and `generally find `parts of the personality' or `parts of yourself' an apt description of their subjective experience'.[523]

Clinically, reference to `parts' has great potential utility. Yet *the `parts' of a structurally dissociated person differ from those of a person who is not structurally dissociated* (see box below) in particular ways.

As Van der Hart et al elaborate, `dissociative parts' of complex trauma survivors commonly include *persecutory* parts, *protector* [fight] parts, *child* parts, and *observer* parts, where `the mental and behavioural actions of survivors shift with the type of dissociative part that exerts executive control'.[524]

Reference to `parts' and/or `self-states' by clinicians and in the literature is now common. More particularised terminology may or may not be used as well (and different descriptors can be applied to the more particular `parts', `self-states', or `ego states' associated with structural dissociation).[525] While `self-states' and `ego states' have had different historical usage,[526] these terms are often conflated and used interchangeably.

---

518 See Alison Miller, *Becoming Yourself* (Karnac, 2014). Note that while this particular text focuses on the context/s of ritual abuse and mind control, the term `front person' is regarded as applicable to structurally dissociative people more broadly. As Miller describes, she *`use[s] the term "front person" to describe the primary identity who lives everyday life….. Front people are created to be unaware of the abuse and also of the multiplicity, and to "pass for normal" in the real world…Most people assume that the adult who functions in the world is the "real" person, and the other personalities or ego states, whether or not they come out and take over conscious awareness, are less real. But this assumption is a misunderstanding. All the parts reside in the same brain and the same body, whether or not they believe they do, and all are real and important'* (Miller, *Becoming Yourself*, ibid, pp. 29-31).

519 Miller, *Becoming Yourself*, ibid. Miller uses the word `insiders' to describe self-states who hold different aspects of traumatic memories: `Sometimes I will call the insiders (as well as the front person) "parts", "states" or "identity states" as they are parts of a single brain. But I do respect their sense of being themselves, in their own experience separate people, as they have lived separately from the rest of that brain and often they do not know what happened to the others or that the body has grown up, and other parts don't know about them' (Miller, *Becoming Yourself,* ibid, pp. 29-31).

520 Janina Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid, p.25; for diagrammatic representation of the nomenclature favoured by Fisher see *Healing the Fragmented Selves of Trauma Survivors* ibid p.68.

521 Richard Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes* (Norton, New York, 2015), p.66.

522 Putnam, *The Way We Are*, ibid, p.121.

523 Van der Hart, Nijenhuis & Steele, *The Haunted Self*, ibid, p. 4.

524 Van der Hart et al, *The Haunted Self,* ibid, p. ix.. As Schimmenti and Caretti note, `[t]his does not occur at random; it appears at specific moments and/or with specific interactions, and it likely involves a system of traumatic memories with their related emotional, behavioral and psychological states' (Schimmenti & Caretti, ref. Meares, 2000; Schimmenti & Caretti, 2010, van der Kolk, 1995, `Linking the Overwhelming with the Unbearable', ibid, p. 115.

525 As per Van der Hart et al's reference to protector parts, fight parts and observer parts (Van der Hart et al, *The Haunted Self,* ibid, and as per previous footnote.

526 As Dell relates, `[e]arlier clinical theorists tended to speak of ego-states and splits in the ego (e.g., Fairbairn, 1981; Federn, 1952; Freud, 1940a, 1940b; Guntrip, 1969; Watkins & Watkins, 1997), whereas modern trauma theorists increasingly speak of self-states (Beere, 2009; Blizard, 1997; Bromberg, 1998, 2001; Dell, 2001a, 2003; Davies & Frawley, 1994; Howell, 1997a, 1997b; Kluft, 1988; Peterson, 1996a, 1996b; Siegel, 1999) and a self that is split into different parts (Kalsched, 1996; Putnam, 1997; Spiegel,1986)' Paul Dell & John O'Neill, *Dissociation and the Dissociative Disorders: DSM-V and Beyond* (Taylor & Francis, New York, 2009).

Notably, all three terms – i.e. `parts', `self-states', and `ego-states' - are applicable to all clients (and us all!)[527] This has the advantage of demystifying and destigmatising unintegrated states, which may also enhance understanding, empathy and support for people who are structurally dissociative. The key point is that the less permeable the boundaries between parts, self-states or ego-states (i.e. Watkins' `*boundaries that are more or less permeable')*[528] the greater the dissociation (and the most severe dissociation occurs in the context/s of *structural* dissociation).

When a term is used broadly specificity is sacrificed. This can mean distinctive features of *dissociative* parts of the personality are unclear, and conceptualisation may become too inclusive to be meaningful. This point is important, because as Kluft underlines (using the language of `alters' to describe dissociative parts of the personality and in a point which applies to all its synonyms and alternatives) `*[a]ll alters necessarily fall under the rubric of ego states, but most ego states are not alters'*.[529]

> *`Ego states that are also alters generally have four characteristics that are not intrinsic to the ego state phenomenon per se.*
>
> 1. *they have their own identities, involving a sense of self (a centre of initiative and experience)*
>
> 2. *they have a characteristic self-representation, which may be discordant with how the patient is generally seen or perceived*
>
> 3. *they have their own sense of autobiographic memory, distinguishing what they understand to be their own actions and experiences from those done and experienced by other alters*
>
> 4. *they have a sense of ownership of their own experiences, actions, and thoughts, and may lack a sense of ownership of and a sense of responsibility for the action, experiences, and thoughts of other alters'.*
>
> Kluft, 2006: 284; ref. Kluft, 1991; Kohut, 1977

As Kluft also notes, clinicians tend to find point 4 `unsettling'.[530]

When utilised protectively, dissociation has been likened to `a circuit breaker for the nervous system', whereby a person can `pull the plug' and go `offline' by separating various domains of functioning from consciousness.[531] The most striking illustration of this is observed in DID.

527 As per the title of Putnam's 2016 text *The Way We Are*, ibid.
528 Watkins, `Ego State Therapy: An Overview', ibid, p. 233.
529 Kluft, `Dealing with Alters', ibid, p.284; emphasis added. Note that while endorsing wide and non-stigmatising reference to `parts', specific reference by van der Hart et al to `dissociative parts of the personality' means that they do not conflate the parts of structurally dissociated clients with those of clients who are not structurally dissociated.
530 Kluft, `Dealing with Alters', ibid, p.284.
531 Benatar, *Emma and Her Selves: A Memoir of Treatment and a Therapist's Self-Discovery* (IPBooks, New York, 2018), p.13.

3.5 Becoming unstuck: the `off-line' self-states of DID

> *`Dealing with the scepticism of lay and professional people is part of the experience of every therapist treating DID. This is true of allegations of sexual abuse in general.'*
> Benatar, Emma and Her Selves (IPBooks, New York, 2018), p.16.

> *`Even in extreme cases, DID is highly amenable to treatment. The remarkable success that many patients have had in overcoming DID is an inspiration to everyone struggling to heal childhood wounds.'*
> Steinberg & Schnall, The Stranger in the Mirror (Harper, New York, 2003), p.114.

To reiterate, the disabling impacts of structural dissociation manifest in diverse ways and may elude diagnosis. The presence of unintegrated states more broadly `impairs the functioning of many people who suffer from clinical disorders and maladaptive behaviors',[532] and `even patients who show only specific and limited unintegrated mental and/or bodily states may suffer from multiple dissociative connections in the self'.[533]

The most severe disconnections, however, are found in DID, which is consistently linked to severe childhood trauma[534] and which is more common than is recognised. Frank Putnam states that he wrote his pioneering 1989 text *The Diagnosis and Treatment of Multiple Personality Disorder* following `daily phone calls' from therapists seeking assistance for the myriad challenges of treating this disorder, and from `repeating the same information over and over again, typically three to four times a week and often three to four times a day'.[535] The likelihood that clinicians, albeit unknowingly, will see clients with DID is greater than is commonly realised.[536]

Combinations of the core dissociative symptoms (i.e. *depersonalisation, derealisation, amnesia, identity confusion* and *identity alteration)* can lead to various dissociative disorders which may likewise escape detection when underlying dissociation is unrecognised.[537] All five symptoms are present in DID. Self-states in DID are extremely and thoroughly compartmentalised, and *`parts of experience… are sequestered in the overall personality so that literally the left hand doesn't know what the right hand knows'*.[538]

532 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.120.

533 Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.121; emphasis added. These are `often linked to implicit memories of relational failures in attachment bonds' which lead to problems in engaging with self-experience as well as relationships with others and are described as `phobia of mental contents and phobia of attachment' (Schimmenti & Caretti, `Linking the Overwhelming with the Unbearable', ibid, p.121). For detailed explication of the many phobias which characterise structural dissociation, see van der Hart et al, *The Haunted Self,* ibid. As noted in the previous chapter, `[r]egardless of its extent, pathological dissociation always implies processes of multiple disconnection in self-experience', which `continue to disturb the individual, who appears unable to integrate them into the consciousness – either because of the inadequate development of neural circuits related to the functional integration, or because of the necessity to defensively exclude from awareness these experiences, as Bowlby (1980) argued, to maintain a minimum sense of integrity and continuity of the self' (Schimmenti & Caretti, ibid, p.120).

534 As noted previously and as research consistently upholds, DID is consistently correlated with `severe childhood abuse' (Benatar, *Emma and Her Selves*, ibid, p.16) and the multiple compartmentalised self-states it generates suggests it can legitimately be regarded as the most complex form of complex trauma.

535 Frank Putnam, *The Diagnosis and Treatment of Multiple Personality* (Guildford Press, New York, 1989), p. vii.

536 `More than likely, DID is under-diagnosed as it is by nature a hidden condition and not readily disclosed by those afflicted. Additionally, many clinicians are not adequately trained to identify DID and will only discern it in the most florid of presentations' (Benatar, *Emma and Her Selves*, ibid, pp.15-16).

537 Also note the diagnostic category `Other Specified Dissociative Disorder' (i.e. OSDD) which has replaced the previous diagnostic category of Dissociative Disorders Not Otherwise Specified; DDNOS in DSM-5 and `applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class' (`Other Specified Dissociative Disorder', http://traumadissociation.com/osdd

538 Benatar, *Emma and Her Selves*, ibid, p.7.

> *In DID - the extreme end of the dissociative continuum commensurate with the severity of the trauma experienced - parts of the overwhelming experience/s are unconsciously consigned to states generated to protect the person from unbearable overload.*
>
> *Yet this comes at the cost of disabling disconnection (`the person surrenders self-state coherence to protect self-continuity').*
> (Bromberg, 2011:68; emphasis added)

John Bowlby's evocatively titled paper `On Knowing What You are Not Supposed to Know and Feeling What You are Not Supposed to Feel'[539] is significant here. While not specifically describing DID or referencing the phenomenon of dissociation (which was not commonly discussed in the period in which he practised and wrote) Bowlby's pioneering work in attachment and his concept of `defensive exclusion'[540] has much to contribute to current understanding of the aetiology of both childhood trauma in general and DID in particular. The cited paper discusses instances of childhood emotional invalidation and a range of parent-child configurations which, Bowlby believed, were `seriously neglected as causes of information and feeling becoming excluded from consciousness'.[541]

A striking contemporary illustration of circumstances that may generate DID is May Benatar's reference to the plot and song lyrics of the rock opera *Tommy (*`the story of a traumatised little boy who becomes deaf, mute, blind *and* a wizard at pinball, a game where participants generally have keen sight').[542] As a young child, Tommy's senses were intact prior to witnessing the murder of his father by his mother's lover. The song sung by his mother starkly conveys the impossible dilemma to which he was subject:

> *You didn't hear it*
> *You didn't see it*
> *You won't say nothing to no one*
> *ever in your life.*
> *You never heard it*
> *Oh how absurd it*
> *All seems without any proof.*
> *You didn't hear it*
> *You didn't see it*
> *You never heard it not a word of it.*
> *You won't say nothing to no one*
> *Never tell a soul*
> *What you know is the Truth.*[543]

In order to comply with his mother's demands, little Tommy dissociates what he knows and saw. He becomes blind, deaf, and mute.[544] John Bowlby may well have said that Tommy `knew what he was not supposed to know'. Bowlby's accompanying question *`[i]s there any wonder that in such circumstances feeling should become shut away?'*[545] is likewise apposite.

539 John Bowlby, `On Knowing What You are Not Supposed to Know and Feeling What You are Not Supposed to Feel', *A Secure Base* (Routledge, New York, [1988] 2006), pp.111-133.

540 John Bowlby, `The Origins of Attachment Theory', in Bowlby, *A Secure Base* (Routledge, New York, 2006), and see discussion in ch.1.

541 Bowlby, `On Knowing What You are Not Supposed to Know and Feeling What You are Not Supposed to Feel', ibid, p.,120. These include `inversion' of `the normal parent-child relationship' whereby the child is required to act as parent and bear the heavy but often `subtle and hidden' emotional cost (Bowlby, ibid, pp.120-121).

542 Benatar, *Emma and Her Selves*, ibid, p.7.

543 Cited in Benatar *Emma and Her Selves*, ibid.

544 Benatar, ibid, p.8.

545 Bowlby, `On Knowing What You are Not Supposed to Know and Feeling What You are Not Supposed to Feel', ibid, p.120.

The trauma-informed question `what *happened to* a person?' (i. e. rather than the more common question of what is `wrong' with a person) is helpful here. This is because it helps us understand the roots of adult dissociative pathology in severe childhood trauma. A primary attachment figure on whom the child depends for survival can subject the child to unbearable pressure.

> *The generation of multiple compartmentalised self-states can be a powerfully protective `solution' to an otherwise impossible dilemma. Thus it `makes sense' in the developmental context which gives rise to this response.*

The ACE study phrase `the problem is the solution' to describe the coping strategies generated by the need to protect from overwhelming childhood experiences (which in turn become adult health problems if the trauma is not resolved)[546] is also clearly applicable here. So, too, is Ecker's reference to `adaptive yet symptom-generating emotional learnings'.[547]

> *`Outside-Me was a competent grown-up in my 50s, involved with family and friends and holding two jobs, one during the week, the other on weekends…*
>
> *Inside-Me was a conglomerate of 10 or so people-parts whom I referred to variously as I, we, she, they or even ourself. I'd been that way ever since I could remember, but never thought to mention it to any of the five therapists I'd seen since I was 16'.*
> (`Me, Me, Me and My Therapist').
>
> `Me, Me, Me and My Therapist' Opinionator, The New York Times January 3, 2015 https://opinionator.blogs.nytimes.com/2015/01/03/me-me-me-and-my-therapist/?_r=0

The ingenuity - and simultaneous extremely high cost - of the myriad dissociative divisions of DID (i.e. *`an adaptation that allows a child to survive betrayal, cruelty, suffering, torture and neglect'* by dividing *`unimaginable suffering into manageable pieces')*[548] remains largely unrecognised. This is not only within popular culture (which persists in purveying stereotypical and distorted depictions of this complex disorder).[549] It is also by a significant proportion of professional culture and the `psy' professions. As noted previously, DID is routinely described as a `controversial' diagnosis[550] and myths about it continue to circulate despite the now large evidence base which refutes them.[551]

546 Vincent J. Felitti, Robert F. Anda et. al. `Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine,* 14, 4, 1998 pp.245-258).

547 Bruce Ecker, `Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *International Journal of Neuropsychotherapy* (6, 1, 2018), p.6.

548 Benatar *Emma and Her Selves*, ibid, p.13.

549 For example the 2016 Hollywood movie `Split' which depicts a violent psychiatric patient (played by James McAvoy) with 23 `personalities' who abducts and incarcerates young women.

550 This is notwithstanding its status *as* a diagnosis (which notably has also preceded a formal diagnosis of Complex PTSD by many years) and the solid evidence which substantiates it. See Dorahy et al, `Dissociative Identity Disorder: An empirical overview', ibid.

551 For a recent paper in the *Harvard* Review *of Psychiatry* which explicitly addresses and dispels the most common and recurrent of these myths one by one, see Brand et al `Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder', ibid.

DIAGNOSTIC CRITERIA
DISSOCIATIVE IDENTITY DISORDER D (DSM-5)

A. Disruption of identity characterized by two or more distinct personality states, which may be described in some cultures as an experience of possession. The disruption of marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning. These signs and symptoms may be observed by others or reported by the individual.

B. Recurrent gaps in the recall of everyday events, important personal information, and/or traumatic events that are inconsistent with ordinary forgetting.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The disturbance is not a normal part of a broadly accepted cultural or religious practice. Note: In children, the symptoms are not better explained by imaginary playmates or other fantasy play.

E. The symptoms are not attributable to the physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures)." [3]:292

Read more: http://traumadissociation.com/dissociativeidentitydisorder#dsm5

"Dissociative identity disorder is characterized by the presence of two or more distinct, nonintegrated or incompletely integrated subsystems of the personality (dissociative identities), each of which exhibits a distinct pattern of experiencing, interpreting, and relating to itself, others, and the world. At least two dissociative identities are capable of functioning in daily life, recurrently take executive control of the individual's consciousness and functioning and include a substantial set of sensations, affects, thoughts, memories, and behaviours. The symptoms are not consistent with a recognized neurological disorder or other health condition. The disturbance is sufficiently severe to cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning." Read more: http://traumadissociation.com/dissociativeidentitydisorder#icd

Hollywood misrepresentations[552] account in part for the ambivalence with which many still regard DID. Yet professional recognition of the prevalence of child sexual abuse has been hard won. This is attested to by a continuing lack of acknowledgement of DID within the field of psychiatry and the belatedly redressed omissions and distortions of psychoanalytic theory.[553]

As Benatar relates, like most therapists she didn't recognise the existence of multiple self-states `until it screamed in [her] face'.[554] Clinicians have been slow to recognise the reality of DID (previously known as multiple personality disorder and as hysteria in earlier periods). This is despite the contributions

552 Movie portrayals of DID (from the time in which it was known as Multiple Personality Disorder) have intrigued the public since Joanne Woodward's portrayal of real life patient Christine Sizemore in the 1957 movie `The Three Faces of Eve'. The subsequent depiction in the 1976 film `Sybil' starring Sally Field likewise attracted wide audiences. More recently the 36 episode television series `The United States of Tara', 2009-2011 starring Toni Collette, has similarly been widely viewed. Note that Hollywood representations of DID are not `all of a piece' and are of varying quality. For example the sensationalist and problematic portrayal by James McAvoy in the 2016 M. Night Shyamalan directed movie `Split' is very different from the more accurate representation in `The United States of Tara' for which DID expert Richard Kluft served as a consultant.

553 See Elizabeth Howell & Sheldon Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis (*Routledge, New York, 2016) and discussion in ch.1.

554 Benatar, *Emma and her Selves*, ibid, p.6.

on dissociation by Pierre Janet since the late nineteenth century,[555] renewal of interest in his work with publication of *The Discovery of the Unconscious* by Henri Ellenberger in 1970[556] and elucidatory papers since 1989[557] as well as the work of others.

It is also ironic that the myth of DID as a factitious, simulated, culturally induced or therapist implanted disorder still circulates notwithstanding evidence which refutes this misconception. The `Fantasy',[558] as distinct from the `Trauma', Model of DID retains adherents as discussed in the previous chapter. This is despite the lack of evidence to support the `Fantasy' model and the current neuropsychological studies which substantiate that DID is genuine and distinguishable from simulation of it (as also previously noted).[559]

> *`This [DID] is something that happens to hundreds of thousands, probably millions of people around the world. But abuse is probably the most hidden horror of what we face in our society so people don't talk about it'.*
>
> *`It's not like it's out of the human experience, it's just how bad the experience was early on, and what it did to the identity process'*
>
> Robert Oxnam https://www.youtube.com/watch?v=C12QD4A5bDE
> *Author of A Fractured Mind (2005)*

> The challenge of acknowledging the prevalence and severity of the childhood experiences which engender DID, the long omission of trauma as an area of focus within the `psy' professions, and Hollywood (mis)representations combine to perpetuate myths about DID which continue to circulate (see Brand et al, 2016 for refutation of these) and which impede the informed awareness that is urgently needed for appropriate treatment of this debilitating disorder.

555 See `Janet Redivivus: The Centenary of *L'automatisme psychologique, The American Journal of Psychiatry* (146:12, 1989), 1527-1529.

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

557 Onno Van der Hart & Rutger Horst, `The Dissociation Theory of Pierre Janet', *Journal of Traumatic Stress* (Vol 2, No, 4, 1989); Onno Van Der Hart, Paul Brown & Bessel van der Kolk, `Pierre Janet's Treatment of Post-traumatic Stress', ibid.

558 The `Fantasy' (also known as the sociocognitive) model is `associated with the notions that DID is iatrogenic and that recovered memories may be `implanted' by suggestive therapists' (Brand & Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID', ch.21 in Howell & Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis*, ibid, p.241). As Brand and Brown further elaborate, exponents of the `Fantasy' model `argue that the relationship between trauma and dissociation is weak and inconsistent, and if it exists, it may be limited to severe dissociative disorders' (Brand & Brown, ibid, ref Giesbrecht et al, 2008, 2010; ibid).

559 See Schlumpf, Reinders et al. `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study', ibid; Reinders, Willemsen et al, `The Psychobiology of Authentic and Simulated Dissociative Personality States', ibid, Vissia, Giesen et al, `Is it Trauma or Fantasy-based? Comparing Dissociative Identity Disorder, Simulators, and Controls', ibid.

3.6 Towards clinical treatment: ego state therapy, its potential and limits in contexts of chronic dissociation[560]

The existence of internal `parts' of the personality in the absence of disorder has been clinically, as well as experientially, attested to over a long period. Realisation of this has also been painstaking:

> *`…I learned of others that respected the multiplicity of the mind….Here were various therapists or theorists who, independently of one another, had made remarkably similar observations…Like me, none of these explorers had preconceptions about multiplicity or set out to create such models. Rather, each was led to this conclusion by listening carefully and openly to clients describing their inner lives'.*[561]

Based on the understanding that clients (like all of us) function better when there is less conflict between internal parts of the personality, and when wounded parts are acknowledged and soothed, Ego State Therapy has spawned a number of specific modalities which include Transactional Analysis (TA)[562] and Internal Family Systems therapy (IFS).[563] IFS directly influences the work of Janina Fisher with structurally dissociated clients.[564] The Developmental Needs Meeting Strategy (DNMS) developed by Shirley Jean Schmidt is also a recent ego-state influenced therapy approach which is specifically attuned to repair of early disrupted attachment.[565]

As well as being foundational to specific psychotherapeutic approaches, many key principles of ego state therapy have also been incorporated and subsumed more broadly within a range of psychotherapeutic modalities.

But the now wide receptivity to the concept of ego states (of which those of DID and forms of structural dissociation, as discussed above, are a distinct and insufficiently recognised variety)[566] *is not matched by widespread awareness of what happens when `normal multiplicity' goes awry.* Unless appropriately supplemented or specifically adapted, ego state therapy is not a `stand alone' treatment for clients who are chronically dissociated.

Everyday language attests to experience of `parts' of oneself which, particularly during periods of stress, may become discernible. As Chu notes, `[t]he feeling of internal fragmentation under stress has become a part of our common lexicon: *`I felt as though I was falling apart'; `I was shattered', `I was beside myself'.*[567]

560 See in conjunction with 3.3 (`Internal diversity: ego-states, normal multiplicity and the movement to disruption' & 3.17 (`Towards effective psychotherapy for clients with DID').

561 Richard C. Schwartz, *Internal Family Systems Therapy* (The Guilford Press, New York, 1995), p.2. Note that Schwartz, who founded IFS (a respected variety of Ego State therapy) is speaking here of multiple self-states more broadly (`the existence of subpersonalities in all of us') than in the specific context of DID (in which self-states have features which differentiate them from those of ego states per se; see Kluft, ibid and previous and upcoming discussion).

562 See the classic text by Eric Berne, *Transactional analysis in psychotherapy* (Grove Press, New York, 1961).

563 Schwartz, *Internal Family Systems Therapy*, ibid.

564 Fisher, *Healing the Fragmented Selves of Trauma Survivors,* ibid.

565 Shirley Jean Schmidt, *The Developmental Needs Meeting Strategy (DNMS): An Ego State Therapy for Healing Adults with Childhood Trauma and Attachment Wounds* (DNMS Institute, Texas, 2009. The differences between DNMS and IFS are summarised by Schmidt on the chart `IFS vs DNMS: Similarities and Differences' which is available at the following link www.dnmsinstitute.com

566 Viz Kluft's contention that `[a]ll alters necessarily fall under the broad rubric of ego states, but most ego states are not alters' (Kluft, `Dealing with Alters', ibid, p.284.

567 James Chu, *Rebuilding Shattered Lives,* ibid, p.41.

If experienced in early childhood - a context of high vulnerability - it becomes easier to apprehend how overwhelming stress may generate mental states which remain isolated, unintegrated and consciously inaccessible.

It also becomes easier to understand how trauma-generated states `hold' various aspects of the trauma which - commensurate with the extreme stress which precipitated them - manifest as contrasting and compartmentalised in adult life if the trauma is not resolved.

Recognition that *`[w]e all have parts'*[568] helps us understand that overwhelming experiences may generate parts which `hold' aspects of the trauma.

But trauma-related parts are different from the ego-states of non trauma-related parts.

This means that while standard forms of ego-state therapy may be helpful in `orienting to parts work', they cannot simply be extrapolated to the treatment of clients who are traumatised. Nor is ego-state therapy of itself appropriate to and sufficient for the treatment of clients who are structurally dissociated (recall Kluft's statement that `[a]ll alters necessarily fall under the broad rubric of ego states, but most ego states are not alters').[569]

The presence of multiple, discrete self-states in structurally dissociated adult clients (which in DID may be as many as they are varied)[570] *and the ways in which the ego-states of DID differ from those of non-structurally dissociated clients and the general population*[571] *renders `parts' work significantly different and considerably more challenging for therapists who work with structural dissociation.*

This is an important point of which all clinicians need to be aware. For example, as the multiple self-states of DID are generated by trauma in early childhood (i.e. prior to formation of `self' which is the product of relational experience rather than a `given')[572] the assumption of a `core' self common to many varieties of psychotherapy is arguably misconceived. To the extent that various self-states in DID are isolated, compartmentalised, and `have their own identities'[573] and characteristics, they are also discrete and `self-contained' – mini selves of a composite personality – which is challenging to most psychotherapeutic modalities.

DID and other structurally dissociated clients may experience no `core' or `overall' sense of self to `reclaim'.

568 van der Kolk, *The Body Keeps the Score*, ibid, p.282.

569 Kluft, `Dealing with Alters', ibid, p.284.

570 Kluft contends that `[i]t stands to reason that more abuse may generate more alters to cope with and sequester the additional overwhelming experiences' (Kluft, `Dealing with Alters', ibid, p.286) and has published a paper which `listed 20 pathways into extreme complexity' (ibid; Kluft, `The Phenomenology and Treatment of Extremely Complex Multiple Personality Disorder', *Dissociation*, 1, 4, 1988, pp.47-58). See `The development and nature of alter systems' and `The issue of complexity', in Kluft, `Dealing with Alters', ibid.

571 See Kluft, `Dealing with Alters', ibid, p.284; the points of difference are listed in the box under subheading 3.4 *(`What's in a name?' Diverse language describes the inner world of structural dissociation')* earlier in this chapter.

572 `Constructing a mental self-continuity of consciousness, memory and identity is a task, not a given. Our mental life is full of discontinuities….For some, the cracks in identity are marked…' (David Spiegel, `Integrating Dissociation', *American Journal of Psychiatry*, 175:1, 2018, p.4). Also see discussion in the previous chapter.

573 Kluft, `Dealing with Alters', ibid, p.284.

This has considerable clinical implications. The nature of `parts' work in this context is more complicated than that of standard ego state therapy,[574] in which an overarching albeit potentially struggling and besieged `self' is assumed.[575] Furthermore, parts in DID have a distinct sense of self (`their own identities')[576] each of which needs to be engaged and engaged *with* for effective therapy.

3.7 Probing the process: genesis and challenges of structural divisions of the personality

> `*It wasn't me*'
> (Kim Noble, 2011: 20)

What Van der Hart et al define as primary structural dissociation (i.e. a single dissociative part of the personality described as the `Apparently Normal Part' [ANP] which avoids trauma and attends to life tasks) and a single `Emotional Part' (which holds the trauma) is the prototype of the trauma survivor.[577] As others have also elaborated with respect to the survivor of childhood trauma, the external persona represents the `business as usual...daytime self', while `[i]In contrast, the child, internal persona, experiences shame, rage, terror, experiences that have been cordoned off and made unavailable to the adult self'.[578]

This means that the client's internal world `is organized around at least two different loci of experience' which are very different and mutually exclusive.[579] But depending on the age of the child and the severity and duration of the trauma, things can become considerably more complicated. As foreshadowed in the previous chapter, `[t]he older the child is prior to abuse and neglect, the more likely action systems of daily life have become more cohesive, and thus it is less likely that more than a single ANP would develop'.[580] Correspondingly, the younger the child and the more severe the trauma, the greater the likelihood of multiple dissociative splits which `can range from very simple to extremely complex divisions of the personality'.[581]

> `If, early in life, the developmentally normal illusion of self-unity cannot safely be maintained when the psyche-soma is flooded by input that the child is unable to process symbolically, *a configuration of `on-call' self-states is gradually constructed'*
> (Bromberg [1998] 2001: 200; emphasis added).

574 Note, however, that varieties of ego state therapy have emerged (such as the previously noted Developmental Needs Meeting Strategy [DNMS] developed by Shirley Jean Schmidt, ibid) which are more amenable to treating complex trauma presentations. Also see forthcoming discussion at 3.17.

575 Note, for example, the contention of Richard Schwartz that `[i]n addition to [the] collection of parts, at the core of everyone is a Self [capital `S'], which is the seat of consciousness. From birth this Self has all the necessary qualities of good leadership, such as compassion, perspective, curiosity, acceptance, and confidence. As a result, the Self [sic] makes the best internal leader, and will engender inner balance and harmony if it is allowed by the parts to lead' (Schwartz, *Internal Family Systems Therapy,* ibid, p.57). While sensitive to the internal disruption precipitated by trauma (in the face of which `[a] person's parts are organized to protect the Self at all costs and will remove it from danger and from leadership' ibid) and while Schwartz is co-author of a text which specifically addresses the impacts of child abuse (*The Mosaic Mind,* Norton, New York, 1995) the assumption of a prior coherent self which has been `fragmented' by life stress is problematic in diverse psychotherapeutic modalities.

576 Kluft, `Dealing with Alters'. Ibid, p.284.

577 `A number of survivors of chronic child abuse and neglect present with a type of primary structural dissociation in the form of one ANP that is the adult....and one ...`child' EP that holds all the traumatic memories' (van der Hart et al, *The Haunted Self*, ibid, p.304).

578 Howell, *The Dissociative Mind,* ibid, p.109, ref Davies & Frawley, 1994.

579 Davies & Frawley, 1992:55, cited in Howell, *The Dissociative Mind,* ibid, p.109.

580 Van der Hart et al, *The Haunted Self*, ibid, p.84.

581 Van der Hart et al, *The Haunted Self*, ibid, p.5. See the box `A model for understanding dissociative parts' at 2.5 (`Towards structural dissociation of the personality') in the previous chapter.

We know that experience with early caregivers gives rise to *implicit memories* (`schemas') within networks of the brain.[582] Research also suggests that `all aspects of the self are forms of implicit memory stored in neural networks that organize emotion, sensation, and behaviour'.[583] But the *disruption precipitated by early childhood trauma and `[t]he patterns and structures that are formed through dissociative processes'[584] are far more complex than many models of psychotherapy and child development can accommodate.[585]*

> `Margaret experienced a documented and brutal group rape at age 5 by two of her adolescent brothers and their friends. She developed several EPs [i.e. `Emotional Parts' which hold the trauma] that experienced the entire rape (i.e. parallel dissociation). One was angry *(fight),* one was terrified and crying for her mother *(attachment cry),* one watched from the doorway, and stated she couldn't tolerate being in the body *(flight),* one EP experienced unbearable physical pain, one squeezed her eyes shut and pretended to be somewhere else, and one EP was completely still and silent, though terrified, reenacting one of the boys holding his hand over her mouth to keep her quiet *(freeze)'*
> (van der Hart et al, 2006:70)

The differences between self-states/ego states/parts of the internal world of a person who is structurally dissociated and a person who is not structurally dissociated reveal the limits of models which are not based on this understanding (and which may be problematic without it).

> *Attempting to work therapeutically with chronically dissociated clients as if their `parts' are similar to those of non-traumatised clients is ill-advised and inappropriate.[586]*

The `trinity of trauma' elaborated by Ellert Nijenhuis[587] can shed light on this. The `trinity of trauma' comprises `ignorance, fragility and control', in relation to which Nijenhuis delineates `three prototypical conscious and self-conscious dissociative subsystems or `parts' which strive `to persevere in their existence in their own way'.[588] These correspond to `Apparently normal parts' (ANPs), `Fragile emotional parts' (fragile EPs) and `Controlling emotional parts' (controlling EPs). Nijenhuis states that `[w]hen dissociative parts know each other and agree on a division of tasks, they operate like two divisions in a company, each with their own assignments'.[589]

582 Louis Cozolino, *The Neuroscience of Psychotherapy* (Norton, New York, 2002); Norman Doidge, *The Brain that Changes Itself* (Penguin, New York, 2007); Siegel, `An Interpersonal Neurobiology of Psychotherapy, ibid.

583 Cozolino, *The Neuroscience of Psychotherapy,* ibid, p.233.

584 Wilma S. Bucci, `Divide and Multiply: A multi-dimensional view of dissociative processes', in Howell & Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis*, ibid, p.197.

585 This includes, as Bucci elaborates, psychological models `based on unconscious conflict, repression and defence'; i.e. the traditional classical model of psychoanalysis prior to `the relational turn'; see chs 1-2 in Howell & Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis*, ibid.

586 At the same time, variants of ego state therapy can assist and be adapted for complex trauma clients including those with structural dissociation; see 3.17 `Towards effective psychotherapy for clients with DID'.

587 Recall that Nijenhuis is a co-author, with Van der Hart and Steele, of the `classic' contemporary 2006 account of structural dissociation *The Haunted Self,* ibid. He has since gone on to publish three volumes in his `Trinity of Trauma' series which elaborate these concepts with somewhat different inflections (Ellert Nijenhuis, *The Trinity of Trauma,* Volumes 1-3, Vandenhoeck & Ruprecht GmbH & Co KG, Goettingen, 2015-2017). Nijenhuis advises that his more recent work does not replace but rather augments and complements the preceding text (`*both present action psychotherapies that are related and largely compatible, and both comprise a phase-oriented approach to trauma treatment'*; Vol.3, p.9). But there are also differences in the theoretical influences which animate them. For example, while *The Haunted Self* draws directly on the concepts of Janet, the *Trinity of Trauma* is inspired, along with other influences, `by contemporary enactivism and by Spinoza's work, which constitutes an early and powerful form of enactivism' (Nijenhuis, *Trinity of Trauma*, Vol 3, ibid, p.9).

588 Nijenhuis, *The Trinity of Trauma: Ignorance, Fragility, and Control – Enactive Trauma Therapy,* Vol. 3, ibid, p.17.

589 Nijenhuis, *The Trinity of Trauma, Vol.3,* ibid, p.33.

In this context he draws on the three prototypical forms of co-operation elaborated by Jarvilehto (2000) – i.e. *totalitarian, corporative*, and *communicative*.[590] For Nijenhuis, this apt conceptual delineation assists understanding `of interpersonal (and other) traumatisation, and thereby of traumatised individuals and their dissociative parts'.[591] It is pertinent to note that in his account of his long therapy for DID, Robert Oxnam references the concept of a `merger' (rather than `alliance') when describing the view of his therapist,[592] as a necessary step towards the `collaborative multiplicity'[593] (*`the new composite me'*)[594] towards which they were working.

3.8 Engaging multiple self-states: psychotherapy for DID

> *`Clinicians confronted with DID and related forms of [OSDD]…must determine how they will approach and address the alters'.*
> (Kluft, 2006:281).

Clinicians experienced in treating DID note that the internal world of the client `frequently replicates… experience of the relationships and circumstances that prevailed in his or her family of origin'.[595] It also involves interaction between various self-states which `may understand themselves to have all manner of relationships with one another'.[596] Co-consciousness may not exist between self-states and is a therapeutic task.

> *`[I]t helps to bear in mind that alters regularly cannot or will not own the experiences of other alters of whom they may not be aware and for whose experiences they may have amnesia'*
> Kluft, 2006: 293.

Thus the question of how the therapist should engage with the alters[597] of the DID client (i.e. the internal parts which differ from the ego-states of non-DID clients in particular ways) is critical.

Clearly responses to this question are shaped by understanding of and attitude towards structural dissociation in general and DID in particular. As Kluft notes, some clinicians regard `alter' states `as obstacles, distractions, or artifacts to be bypassed or suppressed'.[598] However, he also notes that `[t]hose experienced in the treatment of DID do not regard the alters as mere curious phenomena'.[599] Rather they are seen to express `the structure, conflicts, deficits, and coping strategies of the DID patient's mind'.[600]

590 Nijenhuis, *The Trinity of Trauma, Vol.3*, ibid, p.29.
591 Nijenhuis, ibid.
592 Oxnam, *A Fractured Mind,* ibid, p.103.
593 Oxnam, *A Fractured Mind,* ibid, p.230.
594 Oxnam, *A Fractured Mind,* ibid, p.111; emphasis added.
595 Kluft, `Dealing with Alters: A Pragmatic Clinical Perspective', ibid, p.286.
596 Kluft, `Dealing with Alters', ibid, p.286. (`Alters are complex phenomena not easily encompassed by simple descriptions or definitions that may acknowledge some of their features but that fail to address the full range of their characteristics ' (ibid, p.284).
597 As per Kluft's utilisation of this term (see previous discussion). Note that due to extensive referencing of Kluft's paper `Dealing with Alters: A Pragmatic Clinical Perspective', ibid, this term will be adhered to in the following comments.
598 Kluft, `Dealing with Alters', ibid. As Kluft also notes, `[a]ccessing alters is a venerable topic, discussed in depth in classic texts on the treatment of DID' (ibid, ref Putnam, *Diagnosis and Treatment of Multiple Personality Disorder*, ibid).
599 Kluft, `Dealing with Alters', ibid, p.282; emphasis added.
600 Kluft ibid, and where `the personality of a patient with DID is to have multiple personalities' (Kluft, `Dealing with Alters', ibid, citing Coons, 1984 & Kluft, 1987).

These contrasting perspectives again evoke the respective readings of the `Trauma' vis a vis `Fantasy' models (for which, as already discussed, evidence favours the former but where continuing myths surrounding DID perpetuate the misconception that it is `controversial').

Clinicians who subscribe to the `Fantasy' (or `sociocognitive') reading (according to which DID is regarded as the product of sociocultural influence, iatrogenesis and/or therapist suggestion) do not directly engage diverse dissociative self-states. This is on the ground that it `encourages' dubious phenomena and risks strengthening problematic beliefs, feelings and behaviours. In stark contrast, clinicians who work in accordance with the Trauma Model (for which there exists compelling neuropsychological as well as clinical evidence) [601] directly engage the alters of DID clients on the ground that this is required for treatment to be effective.

Note that there are also senses in which it is problematic to phrase the question in terms of *whether* to address DID alters, or even to imply that this is a conscious decision. This is because whether the therapist elects to engage them or not, various aspects of the self-system will be activated (directly or indirectly, and even if unwittingly) by the therapy context itself.[602]

Kluft describes how he initially followed the advice of `an eminent authority' that `nonreinforcement of the alters would lead to their disappearance'.[603] He tried to adhere to this advice. But it resulted in `[o]ne of two things' happening - either clients ceased talking about their experiences but remained `miserable' or there was an escalation of attempts to convey their concerns and overall deterioration.[604]

> *`Confronted with uniformly negative responses to my use of this strategy, I rethought the issue….*
> *I began to communicate with the alters and to make deliberate efforts to establish and maintain dialogue with them. With this approach, my patients uniformly stabilised and began to improve'.*
> Kluft, 2006: 288

> *`My experience has taught me again and again that approaching DID as if the alters were completely separate persons or as if the patient were a person whose subjective experience of having separate selves can be discounted is counterproductive.*
>
> *These approaches deny, dismiss, and disavow the nature of DID phenomenology and the subjective world of the DID patient. Such stances lead to failures of empathy and profound difficulties if not overt disruptions of the therapeutic alliance'.*
> Kluft, 2006: 289

601 `Results obtained from the brain data do not support the fantasy model of DID' (Reinders, Willemsen et al, `The Psychobiology of Authentic and Simulated Dissociative Personality States', ibid, p.455).

602 This is because the very presence of the therapist is `triggering' in eliciting attachment dynamics (`Contact itself is the feared element because it brings a promise of love, safety and comfort that cannot be fulfilled and that reminds [the client] of the abrupt breaches of infancy' [Hedges, 1997:114] in van der Hart et al *The Haunted Self,* ibid, p.264). It is also because non-verbal and unconscious communication is necessarily operative (Wallin, *Attachment in Psychotherapy*, ibid). As van der Hart et al go on to elaborate, `[a]ttachment phobias are manifested intensely in the therapeutic relationship...and their resolution is essential for successful treatment outcomes….Every interaction, every intervention will be influenced directly or indirectly by the manifestations of and the solutions to those phobias of attachment' (van der Hart et al, *The Haunted Self,* ibid, p.264).

603 Kluft, `Dealing with Alters', ibid, p.288.

604 Kluft, `Dealing with Alters', ibid, p.288.

It is not enough for therapists to simply wait for the alters of DID clients to emerge. This is because some who are active in the internal world `may never assume executive control' when the client is in the presence of external others; correspondingly they `may never manifest themselves in therapy unless they are sought out'.[605]

The concept of `the dissociative surface'[606] described by Kluft addresses the claim that attempts to engage non-presenting alters is illegitimate `trawling'. Unlike many clinicians who `assume that the host constitutes the patient's true identity and should be regarded as the core of who the patient really is', Kluft contends that there is `no scientific or clinical reason to proceed on this basis.'[607]

Even with non-dissociative clients `what you see' is not necessarily `what you get'. In DID, the presenting self `is often the manifestation of the `dissociative surface' of a far more complex phenomenon than is generally appreciated and represents an aggregate rather than a single entity'[608] *(`The patient is a single individual whose personality is to have multiple personalities').*[609]

> `[I]t is rarely sufficient simply to address the alters as they emerge. The alters are aspects of a process of defense and coping. It would be naïve in the extreme to imagine that the patient will predictably present in those alters most relevant to the conduct of the therapy…Therapists who await the emergence of alters to work with them may prolong the treatment considerably'.
> Kluft, 2006: 282

Failure to engage alters increases the risk that therapists will minimise the complexity of the client's internal world. A clinical focus on the `presenting self' also increases the risk of misreading what may appear to be progress when the client `seems to be well'.

> `The natural history of DID is that its manifestations wax and wane. It is common for therapists who are unaware of this phenomenon and who do not make efforts to access alters to mistake fluctuations and reconfigurations of the DID process for improvements and cures'.
> Kluft, 2006:295

605 Kluft, `Dealing with Alters', p.286.
606 Kluft, `Dealing with Alters', p.290. Kluft further speaks of events in the inner world of the DID client `[which] constitute a `third reality' to the patient and may be experienced as just as real as events that take place in external reality' (ibid, p.286).
607 Kluft, `Dealing with Alters', p.289. This is also an assumption which amplifies the risk that `major areas of the patient's mental life and autobiographic memory will be denied an empathic hearing (Kluft, ibid, p.282).
608 Kluft, `Dealing with Alters', ibid, p.290.
609 Kluft, `Dealing with Alters', ibid, p.289, citing Coons, 1984 & Kluft, 1991.

3.9 Many alters do not mean a worse treatment outcome

DID clients who are particularly obsessive, avoidant, `or without strong nondissociative defences'[610] are `prone to develop larger numbers of alters'.[611] As Kluft conveys, claims of `a large number of alters' should `be heard empathically and explored thoughtfully'.[612] He also advises that `[o]vert switches constitute a small minority of the alters' actual behaviour',[613] and that while a large number of alters is `potentially unsettling', `it need not be disquieting.'[614]

> `With some unique exceptions, large systems based on considerations other than the characteristics of the abuse that had been experienced generally collapse uneventfully as the treatment moves forward. A large number of alters derived from the extensiveness of the abuse suffered generally indicates a prolonged and difficult course of treatment because it may prove necessary to process all or most of that abuse, but it does not necessarily indicate a worse long-term outcome. Some complex DID patients demonstrate astonishing resilience'. Kluft, 2006: 287-288.

Regarding the diversity of the DID client's inner world with respect, empathy, and well-paced curiosity is an extension of how skilled therapists should relate to all their clients.

When a therapist is open to working and engaging with alters, `a whole new avenue of interaction'[615] with the client becomes possible. And as with all clients - albeit with extra layers of complexity in the context of DID - opportunities for soothing, validation and stabilisation likewise become available.[616]

610 In the latter case dissociation is the first rather than `last-ditch' response (Kluft, `Dealing with Alters', ibid, p.287).

611 Kluft, `Dealing with Alters', ibid, p.287.

612 Kluft, `Dealing with Alters', ibid, p.286. Note Kluft's listing of `20 pathways into extreme complexity' (`The Phenomenology and Treatment of Extremely Complex Multiple Personality Disorder', *Dissociation*, 1, 4, 1988, pp.47-58; referenced in `Dealing with Alters', ibid). To assist the challenging task of addressing of DID alters, also see his summary `Twenty Reasons for Working with and Accessing the Alters' (Kluft, ibid, pp.290-295) .These include `Acknowledging the dissociative surface', `Making alters stakeholders in the treatment', `Approach[ing] reluctance respectfully' *(in relation to which `An ego state therapy `family of self' model is very effective*', p. 291), `Using alters/alters' behaviour as communications', `Eroding amnesia by engaging alters'. `Enlisting more mature alters to care for child alters', and `Negotiating with alters as an aspect of treatment' (Kluft, `Twenty Reasons for Working with and Accessing the Alters', Box 1 in `Dealing with Alters'. ibid, pp.290-295).

613 Kluft, `Dealing with Alters', ibid, p.297; ref. Kluft, `The Inevitability of Ego State Therapy in the Treatment of Dissociative Identity Disorder and Allied States', in Bongartz, Revenstorf et al, ed. Munich 2000: the 15th *International Congress of Hypnosis* (MEG-Stiftung; Munich, 2000). pp. 69–77. Also see Kluft, `A Clinician's Understanding of Dissociation: Fragments of an Acquaintance', ch.40 in Paul F. Dell & John A. O'Neil, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond* (Routledge, New York, 2014), pp.599-623.

614 Kluft, `Dealing with Alters', ibid, p.287.

615 Kluft, `Dealing with Alters', ibid, p.288.

616 `Exploring the alters and their meanings, like exploring a patient's other productions such as fantasies and dreams, may be stabilising and encouraging for a patient who otherwise has never before felt heard or understood so completely' (Kluft, `Dealing with Alters', ibid, p.288).

Evidence which supports direct clinical engagement with alters in treatment of DID,[617] and the effectiveness of appropriate treatment for DID, continues to accumulate (see 3.16 `Evidence supports the effectiveness and benefits of treating DID' below). Jeffery Smith describes `the cardinal rule of DID treatment' as avoidance of what he calls `alterocentrism'; i.e. `forming an alliance with one alter against others'.[618] While there are many components of effective DID treatment, it is important to note at the outset that:

> `The treatment of DID is facilitated by therapists being prepared to work directly with alters. Interventions that access and involve the alters in the treatment are vital components of the successful treatment of DID and should be a part of the armamentarium of those who treat this patient population'
> Kluft, 2006:302

The comments of Robert Oxnam in relation to his own therapy for DID are also instructive: `*Aren't the required skills of [DID] therapy – learning to listen to voices in your own head and to shape more healthy behaviours based on these conversations – really at the heart of any psychological therapy?*'[619]

3.10 Care, caution, and orienting to the work

Directly addressing alters does not comprise the sole focus of DID treatment. It is important to proceed with caution at all times; the relational context of the therapy remains pivotal.[620]

There are also times and grounds to be reticent to directly engage alters. For example, `[t]he patient's circumstances may necessitate that therapy should address issues in external reality and defer any exploration of the DID itself'.[621]

> `Many therapists begin work with DID patients without having become conversant with the dissociative disorders field, its literature, and its opportunities for training. *Therapists should not proceed with exploratory work of any sort, access alters, or press for historical material until they have the expertise to undertake these endeavours in a manner that is safe for the patient'.*
> (Kluft, 2006: 296; emphasis added)

617 In his 2006 article (`Dealing with Alters', ibid) Kluft noted that `no substantial scientific literature or major series of successfully treated cases ha[d] been published that describes the definitive psycholytic treatment of DID (i.e. a treatment to the point of eliminating the condition) without addressing the alters' (ibid, p.281). By contrast, `available reports of successful treatment (eg Coons [1986], Kluft, [1984, 1993]) have involved therapies in which the alters are addressed' (Kluft, `Dealing with Alters', ibid, pp.281-282). Kluft cites his 1985 longitudinal study which found that 97% of patients who had DID (termed Multiple Personality at the time) and who received treatments which did not directly engage with alters `still satisfied diagnostic criteria for DID on follow-up' (Kluft, `Dealing with Alters', ibid, p.281). Thus `despite the support voiced for treatments that avoid working with the alters in DID, those who follow such plans of action are implicitly following an experimental path that is likely to prove therapeutically futile and may expose the patient to danger and excess morbidity' (Kluft, `Dealing with Alters', ibid, p.282. ref. Kluft, 1999, Coons, 1984). Also see Bethany Brand & Daniel Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID', ch.21 in Howell, & Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis* (Routledge, New York, 2016, pp.241-252) and upcoming discussion.

618 Jeffery Smith, `Understanding DID Therapy: The Case of Robert B. Oxnam', in Robert Oxnam, *A Fractured Mind*: *My Life with Multiple Personality Disorder* (Hachette, New York, 2005), p.270.

619 Oxnam, *A Fractured Mind*, ibid, p.97.

620 Elizabeth Howell, *Understanding and Treating Dissociative Identity Disorder: A Relational Approach* (Routledge, New York, 2011).

621 Kluft, `Dealing with Alters', ibid, p.296. Note that Kluft's prior paper `An Overview of the Psychotherapy of Dissociative Identity Disorder', *American Journal of Psychotherapy* (53, 1999 pp.289-319) remains valuable.

At a broad level this is also consistent with the *phased* treatment model for complex trauma.[622] Note, however, that the specificities of DID mean that this particular disorder *should not be conflated with complex trauma per se*, and that treatment recommendations for the latter cannot simply be transposed to treatment of DID.[623]

The overall functioning of the client is of primary importance, and safety and stabilisation are the highest priority.

While resourcing and the ability to tolerate and manage emotion are especially challenging for the DID client, the scope of the challenge only underlines its importance.

> *`Indeed, there are many times in the treatment of DID when concerns other than the phenomena of DID per se must be the center of clinical attention. The treatment of the DID is only one aspect of an overall therapeutic strategy and may be a minor or incidental concern for long periods in some therapies'*
> (Kluft, 2006: 283).

While honouring the centrality of stabilisation, *it is also important that treatment of the DID itself remains an ongoing goal.* Thus the complexity of the disorder and the corresponding complexity of `Phase 1' tasks of stabilisation in the context of DID (i.e. where `different states will be in different states' and where the treatment guidelines for DID[624] rather than for complex trauma in general apply) should not distract clinicians from the ongoing need to treat the DID. Nor should it absolve the therapist of responsibility to ensure such treatment (e.g. via appropriate referral) if therapists are not able to provide it themselves.[625]

3.11 Immediate caveats: stabilisation and safety

> *`Despite the diversity and strength of available methods, the urgency and immediacy of the pain of these patients may constrict the therapist's options dramatically. Every choice and consideration must respect the realities of the therapeutic encounter'.*
> Kluft, 2012: 146.

The centrality of safety and stabilisation requires immediate attentiveness to ways in which it can be assisted and maximised. Dissociation poses a challenge to therapeutic approaches not attuned to it. This is because the dissociated client is impeded from engaging and `being present', *including in session.* Unless clinicians are aware of, attuned to, and able to address this, the therapy will be impeded as well.

For example, the benefits of mindfulness have now been introduced into diverse psychotherapies. But dissociation can render standard application of mindfulness-based practices problematic if the presence of dissociation is not detected and addressed.[626]

622 Cloitre, Courtois et al, *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults* 2012 https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf
For detailed discussion of the phased treatment approach to complex trauma, see `Revisiting Phased Treatment', Ch.3 in Part 2 of *Practice Guidelines for Clinical Treatment of Complex Trauma* (Blue Knot Foundation, 2019).

623 Recommended guidelines for treatment of DID remain those of the ISSTD (2011) https://www.isst-d.org/wp-content/uploads/2019/02/GUIDELINES_REVISED2011.pdf

624 https://www.isst-d.org/wp-content/uploads/2019/02/GUIDELINES_REVISED2011.pdf

625 This is because failure to attend to DID results in partial treatment and a situation in which `a complete cure is deliberately withheld' (`To initiate a course of treatment that from the first denies a patient a definitive resolution of his or her difficulties remains a questionable course of action' (Kluft, `Dealing with Alters', ibid, p.283).

626 For a helpful text on this topic see Christine Forner, *Dissociation, Mindfulness and Creative Meditations: Trauma Informed Practice to Facilitate Growth* (Routledge, New York, 2017).

Safety and stabilisation are especially challenging in the context of DID.
The goal of `grounding' is a case in point.

> While the concept and methods of `grounding' have a preeminent place in `Phase 1' therapy for complex trauma,* the variegated alter systems of DID clients mean that different self-states may have contrasting responses to grounding techniques.
>
> **Recall that DID should not be conflated with complex trauma per se and that DID-specific guidelines, rather than those for `complex trauma' more broadly, should be adhered to:*
> https://www.isst-d.org/wp-content/uploads/2019/02/GUIDELINES_REVISED2011.pdf

In fact, grounding can be `a very superficial concept'.[627] While ostensibly bringing the client into `the here and now', it may elicit an *appearance* of restabilisation which is deceptive.[628]

Commonly, `efforts are made to anchor patients in the present by focusing them on their sensory perceptions of their environment'.[629] Kluft reports that he has found this `inadequate'.[630] Likewise, a safe ending to a session cannot be assumed: `*Bringing more restabilizing closure to a session for any trauma patient, but especially for a DID patient, can be more complex than such `grounding'.*[631]

Similar caveats apply to `relaxation' techniques and imagery. While potentially stabilising for many clients, they are again more complex in the context of DID.

> `*The usefulness of relaxation and imagery methods …may be compromised by unfavourable risk/benefit ratios…*
>
> *Many traumatized individuals struggling to keep control, and who may be hypervigilant, feel threatened by relaxation approaches. Many have been told to relax by abusers trying to calm or quiet them, and experience relaxation as the prelude to violation.*
>
> *Further, not only may imagery techniques that are usually assumed to be benign trigger connections to traumatic scenarios…but due to amnesia, inquiry with accessible personalities may seem to indicate a particular scenario is safe, only to find that in practice, it proves upsetting to other groups of alters'*
> Kluft, 2012: 146 (ref Gruzelier, 2000, Kluft, 2012,Orne, 1967)

For these and other reasons, clinicians need to take special care both in selecting the strategy, technique, or exercise to potentially assist DID clients to soothe and stabilise, and in implementing it (because different parts of the client may respond to it differently). The comprehensive workbooks by Steele, Boon and Van der Hart *Treating Trauma-Related Dissociation: A Practical Integrated Approach*[632] and Boon, Steele, and van der Hart *Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists*[633] are likely to be helpful.

627 Richard P. Kluft, `Trying to Keep it Real: My Experience in Developing Clinical Approaches to the Treatment of DID', *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 1, 2017), p.31.
628 Kluft, `Trying to Keep it Real: My Experience in Developing Clinical Approaches to the Treatment of DID', ibid.
629 Kluft, `Trying to Keep it Real', ibid, p.31
630 Kluft, `Trying to Keep it Real', ibid, p.31
631 Kluft, `Trying to Keep it Real', ibid, p.31; emphasis added.
632 Kathy Steele, Suzette Boon, & Onno Van der Hart, *Treating Trauma-Related Dissociation: A Practical Integrated Approach* (Norton: New York, 2017).
633 Suzette Boon, Kathy Steele, & Onno Van der Hart, *Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists* (New York: Norton, 2011).

The challenge of stabilisation in the context of dissociation and treatment of complex trauma-related disorders more broadly is an area to which clinicians practicing diverse psychotherapeutic modalities need to attune. Diverse, innovative, and safe approaches are needed, *because therapy will not be therapeutic if the client is persistently dissociated.* This is also an area to which diverse clinical orientations are making important contributions.[634]

Reference also needs to be made to the limits and risks of exposure-based therapies for dissociative clients, both with respect to complex trauma in general and DID in particular. This topic is addressed in detail in ch.3 of the updated *Practice Guidelines for Clinical Treatment of* Complex Trauma[635]. Clinician, researcher, and trauma expert Ellert Nijenhuis makes the important point that `[e]xposure is exposure inasmuch as individuals *or dissociative parts of individuals* engage in particular actions'.[636] To the extent that a client's dissociative parts (i.e. as distinct from the presenting self) may not engage in the therapy, this is clearly problematic not only in terms of its potential benefits but its several risks.

Nijenhuis cites comments of a former structurally dissociated client which provide strong grounds for criticism of exposure therapies in this regard *(`[h]er objections are also my objections'*).[637] The great importance of prior stabilisation and affect regulation skills (which are more complicated to acquire with chronic dissociation as discussed) are not prioritised by advocates of exposure therapies who contest phase-based approaches, which if not followed heightens the risk of retraumatisation.[638]

3.12 Helpful concepts, principles, and techniques

In charting the complex terrain of work with DID clients, trauma and dissociation expert Richard Kluft has developed a number of concepts, methods, and techniques to assist. In a recent paper which details his extensive experience over a long period,[639] he discusses how he modified methods learned in workshops and introduced his own approaches `to begin, control, direct and curtail the flow of material'[640] which can emerge in session.

It is not possible nor appropriate to discuss in detail each of `the three very important' clinical innovations described in Kluft's 2017 paper.[641] But their importance merits brief consideration. Kluft draws on hypnotic techniques (which along with psychodynamic concepts, informed his initial investigations).[642] Significantly, many of these can be applied outside of hetero-hypnotic induction `by making use of the patient's auto-hypnotic or spontaneous trance phenomena'.[643]

634 See, for example, Van der Hart, Groenendjik et al, `Dissociation of the Personality and EMDR Therapy in Complex Trauma-Related Disorders: Applications in the Stabilisation Phase', *Journal of EMDR Practice and Research* (7, 2) pp.81-94. Also see Jim Knipe, `Loving Eyes: Procedures to therapeutically reverse dissociative processes while preserving emotional safety', in Forgash & Copeley, ed. *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* (Springer, New York, 2007), pp.181-225.

635 `Exposure therapy/ies and questions which arise', 3.2 in `Revisiting Phased Treatment for Complex Trauma', ch.3 in *Practice Guidelines for Clinical Treatment of Complex Trauma* (Blue Knot Foundation, 2019), pp.124-128.

636 Ellert Nijenhuis, *The Trinity of Trauma,* Vol. 3, ibid, p.402; emphasis added.

637 Nijenhuis, *The Trinity of Trauma,* Vol.3, ibid, p.403.

638 See `Revisiting Phased Treatment for Complex Trauma', ibid, for full discussion of these points.

639 Richard P. Kluft, `Trying to Keep it Real: My Experience in Developing Clinical Approaches to the Treatment of DID', *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 1, 2017), pp.18-44.

640 Kluft, `Trying to Keep it Real', ibid. p.29.

641 Kluft, `Trying to Keep it Real', ibid, p.29.

642 Kluft, `Trying to Keep it Real', p.28.

643 Kluft, `Trying to Keep it Real', p.29. Similarly, Schwarz notes that while some hypnotic techniques require specialised training and practice, others can be utilised in trauma therapy – including for complex presentations – without training. See Robert Schwarz, *Tools for Transforming Trauma* (Routledge, New York, 2002).

3.13 Point to note: the role of clinical hypnosis[644]

> `*The study of dissociation begins in hypnosis*'
> (Howell & Itzkowitz, 2016: 21).

Although the topic of hypnosis is outside the scope of this discussion, its application to clinical practice in general and to dissociative disorders' treatment in particular should be noted. As hypnosis involves `dissociation, absorption, and suggestion',[645] it is obviously relevant to the treatment of problematic dissociation.

Hypnosis, as Kluft explains in his 2017 paper and elsewhere, is `a facilitator of treatment interventions, not a therapy or treatment in itself'.[646] Describing it in basic terms as `the redistribution of attention',[647] he advises that most dissociative disorders `involve the redistribution of attention toward certain things and away from others'[648] and `have many hypnotic elements'.[649] Thus it `is only natural to enlist the redistribution of attention that we call hypnosis in the service of treating dissociative disorders'.[650]

Indeed, Kluft argues that `*given the nature of hypnosis and that hypnotisability, a genetically mediated capacity, is high in dissociative disorder populations, it is inevitable that hypnosis will play a role in the treatment of DID patients, whether this is acknowledged or not*'.[651]

Hypnosis `played a prominent role in the first successful treatment of the condition now known as… DID', and `continues to be employed in its treatment in the twenty-first century'.[652] Unfortunately, `stage' performances and its purported role in memory retrieval[653] have led to unfounded criticism.[654] This means that the beneficial aspects of hypnotherapy (i.e. hypnosis in its clinical application) are often overlooked, to the great detriment of treatment of dissociative disorders.

---

644 Also see `Clinical Hypnosis: Hypnotherapy' in ch 4 (`New and Emerging Treatments) in *Practice Guidelines for Clinical Treatment of Complex Trauma* (Blue Knot Foundation, 2019).

645 Richard Kluft, *Shelter from the Storm: Processing the Traumatic Memories of DID/DDNOS Patients with the Fractionated Abreaction Technique* (CreateSpace South Carolina, 2013), p. 275.

646 Kluft, `Trying to Keep it Real', p.27.

647 Kluft, *Shelter from the Storm*, ibid, p.276.

648 Kluft, *Shelter from the Storm*, ibid, p.276; the exception is Depersonalization Disorder, to which this applies only in some forms (ibid)

649 Kluft, *Shelter from the Storm*, ibid, ref Bliss, 1986, Braun, 1983.

650 Kluft, *Shelter from the Storm*, ibid, p.276.

651 Richard P. Kluft, `Hypnosis in the Treatment of Dissociative Identity Disorder and Allied States: An Overview and Case Study', *South African Journal of Psychology* (42, 2, 2012), p.146; emphasis added.

652 Kluft, `Hypnosis in the Treatment of Dissociative Identity Disorder and Allied States', ibid, p.146. The first effective treatment of what we now call DID was by Antoine Despine in the 1830s (ibid)

653 The oversimplifications of the so-called `Memory Wars' of the 1990s (discussed elsewhere in this document) are significant in this context, and continue to influence current attitudes. Hence an understanding of the complexity of memory in light of current neuroscientific research needs to be urgently updated. https://www.blueknot.org.au/resources/publications/trauma-and-memory Kluft notes that in his own clinical practice, `most memory retrieval occurs without the use of major hypnotic techniques, and most of the therapeutic interventions [he] facilitate[s]with hypnosis are in the service of facilitating communication, containment, and integration' (Kluft, `Trying to Keep it Real', ibid, pp.27-28).

654 `To the extent that all hypnosis depends on the capacities of the subject or patient, and the response of low or non-hypnotisable subjects or patients to hypnotic suggestions either is minimal or due to other influences, it is fair to say that the capacity for hypnosis resides in the subject or patient, not in some special prowess of the hypnotist' (Kluft, *Shelter from the Storm*, ibid, p.274). For this reason, `almost all of the caricatured and stereotypic misrepresentations of hypnosis as a powerful and dominating exercise in authoritarian suggestion are misleading and false' (ibid). Kluft also notes, however, that `because under some circumstances such influence can be exerted upon some individuals, it is understandable that these concerns, however overstated, continue to flourish. When such influences are exerted, they usually rely on misleading the subject so that what the subject is being coerced to do is understood by the subject as consistent with the subject's values' (`Hypnosis, because it involves a redistribution of attention, has no essential connection with much that has been attributed to it'; (Kluft, *Shelter from the Storm*, ibid, pp.274-275).

> *`In Freud's era, hypnosis was used primarily to catalyse the efficacy of authoritarian suggestions. To this very day, many tend to connect hypnosis with an archaic authoritarian approach to the treatment of mental and physical problems that in no way resembles the methods and interventions that hypnosis has been used to facilitate in the last half-century or so'.*
> (Kluft, 2013: 275)

Given what he describes as `the inevitability of encountering autohypnosis and spontaneous trance phenomena' in clinical work with people with dissociative disorders, Kluft advises that therapists who treat DID and OSDD `will benefit from acquiring both a general knowledge of hypnosis and more specific expertise in the use of hypnosis'[655] when treating these clients.[656]

Many concepts and techniques Kluft describes - including hypnotic techniques - can be applied without the need for hetero-hypnotic induction (i.e. `by making use of the patient's auto-hypnotic or spontaneous trance phenomena'). [657] This means that his sophisticated yet accessible publications informed by his clinical hypnosis expertise will benefit all therapists who work both with trauma-related dissociation in general and DID in particular.[658]

3.14 Three clinical innovations: Kluft's *rule of thirds, the fractionated abreaction,* and *`bringing sessions to more safe and collected closures'.*[659]

*`The rule of thirds'* is that if direct trauma work is anticipated, `it should be begun in the first third of the session, continued through the second third, and brought to closure, reserving the final third for restabilization and processing'.[660]

*`The fractionated abreaction'* is the process by which `a traumatic scenario is broken down to a fraction of its original power along several dimensions'.[661] Only after processing `an initial small portion of the narrative and a diluted +/- partial intensity of the discomfort' is the client potentially ready `for exposure to more of the narrative and more of the dysphoria'.[662]

`Terminating Sessions Safely'* refers to `the three truncations' of `trauma, turmoil, and trance'[663] which, if ignored, will impede restabilisation: *`When the patient's mind is cleared of trauma and dysphoria, and returned to baseline alertness, the patient is far more prepared to leave the therapist's office in a stable, contained, and safe state'.[664]

655 Kluft, `Hypnosis in the Treatment of Dissociative Identity Disorder and Allied States', ibid, p.154. For a valuable text in this area, see Herbert Spiegel & David Spiegel, *Trance and Treatment: Clinical Uses of Hypnosis* 2nd Edit (American Psychiatric Publishing, Inc, Washington DC, 2004) and further references listed under `Clinical Hypnosis: Hypnotherapy' in ch 4 of *Practice Guidelines for Clinical Treatment of Complex Trauma* (Blue Knot Foundation, 2019).

656 A specific and helpful text in this regard is Maggie Phillips & Claire Frederick, *Healing the Divided Self: Clinical and Ericksonian Hypnoptherapy for Post-Traumatic and Dissociative Conditions* (Norton, New York, 1995). Also see Schwarz, *Tools for Transforming Trauma,* ibid.

657 Kluft, `Trying to Keep it Real', p.29.

658 See previous citations of Kluft's work in this chapter. Also see the publications of van der Hart et al, ibid, Chefetz, ibid, Howell & Itzkowitz ibid, Fisher, ibid, Howell & Itzkowitz, ibid, and others included in the reference list of this document.

659 Kluft, `Trying to Keep it Real', ibid.

660 Kluft, `Trying to Keep it Real', ibid, p.30; `Hypnosis in the Treatment of Dissociative Identity Disorder and Allied States', ibid, p.154.

661 Kluft, `Trying to Keep it Real', ibid, p.30.

662 Kluft, `Trying to Keep it Real', ibid, p.30.

663 Kluft, `Trying to Keep it Real', ibid, p.31; ref. Kluft, 2013).

664 Kluft, `Trying to Keep it Real', ibid, p.32.

> `They *[i.e. the three clinical innovations of `the rule of thirds', `the fractionated abreaction' and bringing sessions to safe closure]* are all designed to achieve maximal safety and stability at the end of the session. Because they are geared to make things go more slowly to prevent crises, they paradoxically speed up the treatment by working to minimise the disequilibrium, apprehensiveness, and chaos that must be contended with when the therapy moves into trauma work at too rapid a pace. They speak to [one of] my clinical axioms: `The slower you go, the faster you get there'.
> Kluft, 2017: 29.

The mere listing of each of these principles is insufficient for therapeutic work.[665] They are included here to introduce some valuable concepts and recommendations for effective therapy for DID, each of which requires reflection, training and practice.[666]

Additional guiding concepts are Kluft's notions of `*invitational inclusionism*'[667] – active welcoming of all alters of the client – and `*the slower you go, the faster you get there*'[668] (as briefly noted above).

The importance of `going slowly' in therapy - which enhances client safety and paradoxically increases time effectiveness - is underlined by the distinction Kluft also draws between `*getting better and feeling better*' (which he describes as `two different processes').[669] This distinction is extremely important,[670] because failure to appreciate it by the clinician can potentially derail the therapeutic process.

The increased capacity to experience emotion - i.e. as dissociation diminishes - includes painful feelings which may be highly distressing to the client who was previously insulated from them.

This can potentially precipitate a crisis within the therapy - not, paradoxically, because the therapy `isn't working' but precisely because it *is*.

> A client who is `getting better' and is not feeling better may not *feel* it as progress because less dissociation means a greater capacity to feel pain
> (Kluft, 2013: 79).

Clients may regret engaging in therapy and express a desire to terminate it when they experience painful feeling/s which accompany an increased *ability* to feel as dissociative barriers begin to decrease .[671] An appropriate level of clinical skill, as well as conceptual understanding, is mandatory for all clinicians who work with DID clients.

665 In its reduction of trauma exposure to tolerable limits, and gradual processing, the `fractionated abreaction' technique was initially informed by the cognitive therapy of Aaron Beck and the systematic desensitisation of Wolpe as well as `the dissociative talents of the patient' and the principles of hypnosis (Kluft, `Trying to Keep it Real', ibid, p.30). Also see the short appendix `What You Need to Know about Hypnosis to Understand the Fractionated Abreaction Technique' (Kluft, *Shelter from the Storm*, ibid: 273-276).

666 See subsequent comments and summary for information which can assist in this regard.

667 Kluft, `Trying to Keep it Real', ibid, p.27.

668 Kluft, `Trying to Keep it Real', ibid, p.29 and as previously noted.

669 Kluft, *Shelter from the Storm*, ibid, pp. 79-80.

670 Hence its inclusion (as Guideline 37) in the updated *Practice Guidelines for Clinical Treatment of Complex Trauma* (Blue Knot Foundation, 2019).

671 In this context Kluft's accompanying comments are also salutary: `However, the sense of pressure, which seems to correlate more with the load of work remaining to be done, may have diminished regardless. The sense of reduced pressure contributes to a sense of stability and accomplishment amidst the distress' (Kluft, *Shelter from the Storm*, ibid, p.79.

An increasing number of helpful papers is available for clinicians seeking to develop their knowledge in this area. See, for example, Warwick Middleton, "The First Individual with Dissociative Identity Disorder (DID) That One Knowingly Diagnoses and Treats",[672] and Kate McMaugh `My First Case of DID: Learnings from Treatment Failure'.[673] Middleton's paper orients clinicians to the necessary principles and McMaugh's describes `just one example of what may go wrong when DID is denied at a broad training level, in supervision and in clinical practice".[674]

3.15 `Is DBT enough?' Dialectical behaviour therapy and DID

The critical importance of stabilisation, safety, and coping skills to manage everyday life evokes the orientation and approach of Dialectical Behaviour Therapy (DBT).[675] Originally designed specifically for clients with Borderline Personality Disorder (BPD),[676] DBT is both popular and widely available. This raises the question of whether it is beneficial for clients with DID. In fact, DID is highly comorbid with BPD and clinical features between them can overlap[677].

> Developed in the 1980s by psychologist Marsha Linehan, DBT is a variant of Cognitive Behaviour Therapy. It is widely endorsed as evidence-based for BPD and now used to treat many people with psychological and emotional challenges other than BPD. Can it be similarly endorsed as an appropriate treatment modality for DID?

DBT has much to recommend it with respect to basic affect management, acquisition of self-soothing strategies, and functional coping mechanisms. People with DID also experience major challenges in these areas. Both DID and BPD are also associated with a high prevalence of suicidality which presents in diverse ways. At this level, and paralleling the `Phase 1' tasks of the recommended treatment for complex trauma,[678] participation of DID clients in DBT therapy groups may be beneficial.

672 Warwick Middleton, `The First Individual with Dissociative Identity Disorder (DID) That One Knowingly Diagnoses and Treats', *Frontiers in the Psychotherapy of Trauma and Dissociation* (3, 1, 2019, pp.60-75).

673 Kate McMaugh, `My First Case of DID: Learnings from Treatment Failure', *Frontiers in the Psychotherapy of Trauma and Dissociation* (3, 2, 2019, pp. 123–135).

674 McMaugh, `My First Case of DID: Learnings from Treatment Failure', ibid, p.123.

675 Dialectical Behavior Therapy has generated and continues to yield many publications since its development in the 1980s. For authoritative account of its principles and practice by its founder, see Marsha M. Linehan, *DBT Skills Training Manual,* 2nd edition (The Guilford Press, New York, 2015).

676 Borderline Personality Disorder (BPD) is routinely described as characterised by `a pervasive pattern of instability in affect regulation, impulse control, interpersonal relationships, and self-image', the clinical indicators of which include emotional dysregulation, suicidal tendencies and repeated self-injury (Lieb, Zanarini et al, `Borderline Personality Disorder', *The Lancet,* 364, 9432, 2004, p.453). Note that BPD is associated with consistent problems in interpersonal relating and is regarded as a stigmatising diagnosis by many. Its aetiology in trauma has long been contended by complex trauma clinicians and researchers (see Herman & van der Kolk, `Trauma Antecedents of Borderline Personality Disorder', ch.5 in van der Kolk, *Psychological Trauma*, American Psychiatric Publishing, VA, 1987, pp.111-126). Yet as Fisher points out, `[d]espite decades of research attesting to the relationship between early abuse and a later diagnosis of borderline personality disorder, it is rare for clients with borderline diagnoses to be treated as trauma patients or to be recognized as individuals whose `borderline' symptoms stem logically and tragically from the unsafe environments of their early lives' (Fisher, *Healing the Fragmented Selves of Trauma Survivors,* ibid, p.3). Also see Dolores Mosquera, *Rough Diamonds: A Glimpse into Borderline Personality Disorder* (CreateSpace, 2015) and Meares, *A Dissociation Model of Borderline Personality Disorder*, ibid.

677 For consideration of the similarities and differences between BPD and DID, see Brand, Sar et al `Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder' *Harvard Review of Psychiatry,* ibid, pp.264-265. As Brand, Sar et al note, research confirms BPD and DID to be discrete disorders notwithstanding some common features between them. Also see Dorahy, Brand, et al, `Dissociative Identity Disorder: An empirical overview' ibid.

678 And to which more general guidelines for treatment of complex trauma cannot simply be transposed; see the ISSTD 2011 Guidelines for Treatment of DID at https://www.isst-d.org/wp-content/uploads/2019/02/GUIDELINES_REVISED2011.pdf

Given the need for extensive `parts' work, however - and for clinical attunement to and direct engagement with the alter systems of DID clients as previously discussed – there are limits and potential risks of DBT for people with DID.

That people with DID face complex challenges cannot be overstated. Kluft's advice that while all alters are ego states most ego-states are not alters[679] must also be clearly understood. And once again, the contrasting orientations of the `Trauma' Model and the `Fantasy' Model shape attitudes and treatment recommendations.

As a cognitive behavioural therapy with a strong behavioural focus, DBT is not oriented to systematic `parts' work. It is certainly not oriented to the complex parts (`alters') of DID which DBT regards, if they are considered at all, as obstructions to treatment not to be engaged with lest they be reinforced. *This is very different from the approach of adherents of the Trauma Model.* It is also inconsistent with the recommendations of experienced DID clinicians (as discussed above).

Psychophysiological studies (i.e. that extend and are consistent with neuroimaging data obtained by Reinders et al over the past 15 years) have found that DID can be distinguished from simulation of it.[680] As Kluft and others note, `[t]he key issue in understanding the nature and function of an alter system and/or the phenomena within it in cases of clinical DID is coming to understand its internal rules, the alternate realities those rules support, and the objectives pursued in consequence':[681]

> *`Reinforcing, reifying, and creating alters, the usual meditations of sceptical scientistic critics and serious sociocognitive scholars alike, might be of theoretical interest, but in the clinical encounter entities with a firm sense of themselves react poorly both to neglect and to being treated dismissively'.*[682]

Hence the risk for DID clients who attend DBT groups is that therapist non-engagement with – and potential active discouragement of – the contrasting experience/s of alters may not only invalidate but may actually increase client distress.

Of course there are potential benefits of acquiring skills that improve coping and functioning in everyday life. But for the DID client, potential benefits may also be neutralised and undercut by contrasting responses of alters within the self-system overall.[683]

Strategies specifically attuned to the challenges of structural dissociation are more likely to assist.[684] The protection afforded by structural dissociation during a traumatic childhood is not easily relinquished. Resilient strategies and maladaptive coping skills may be *`interlaced and occur simultaneously'*[685] in DID.

679 Kluft, `Dealing with Alters', ibid, p.284.

680 As registered in contrasting brain activity for the two participant groupings (Reinders, Willemsen et al `The Psychobiology of Authentic and Simulated Dissociative Personality States', ibid). Also see Schlumpf , Nijenhuis, et al, `Functional reorganization of neural networks involved in emotion regulation following trauma therapy for complex trauma disorders', *Neuroimage: Clinical* (23, 2019), 101807.

681 Kluft, `Trying to Keep it Real', ibid, p.21.

682 Kluft, `Trying to Keep it Real', ibid, p.23. As Benatar notes in relating her own trajectory in understanding and treatment of DID, not only does neurological evidence now validate state switches (Benatar, *Emma and Her Selves,* ibid, p.18 and see previous references). The current state of the field now supports `that the individual identities must be dealt with directly for any progress to be made' (Benatar, ibid, p.12).

683 See previous discussion in relation to `grounding'.

684 Steele, Boon, & Van der Hart, *Treating Trauma-Related Dissociation: A Practical Integrated Approach*, ibid; Boon, Steele, & Van der Hart, *Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists,* ibid.

685 Bloom & Farragher, *Destroying Sanctuary* (OUP: Oxford, 2011), p.16; emphasis added.

`Parts' work, as noted previously, is common in diverse psychotherapeutic modalities. A degree of engagement of parts may likewise occur naturalistically within DBT groups, and to this extent be compatible with a basic (if undifferentiated and non-nuanced) orientation to DID. However, the configurations of structural dissociation within the internal world of DID are of a different order to that of people with BPD.[686]

A specific concern about the need to address `the parts part' in stabilisation of high-risk behaviour of structurally dissociated clients has been raised by Janina Fisher.[687] Her concern is that while DBT `addresses the skills required by the normal life part to tolerate the dysregulated emotions of the traumatised part', it `does not address fragmentation or how to differentiate the normal life self from the parts'.[688]

The combination of clinician disinterest in and/or aversion to engagement with DID alters, and the particular focus of DBT groups, highlights that DBT is not the `treatment of choice' for DID clients whose experience of DID remains unrecognised and also untreated.[689] While advocates of DBT do not define their approach as a full `treatment' even for the original target audience of BPD clients (in that this therapy is specifically addressed to the acquisition of coping skills) it can negatively impact on clients with DID.

The high comorbidity of DID means that DID clients will frequently be referred to DBT groups (i.e. the DID may not be apparent or diagnosed). The paucity of available treatment options for people with DID, and the prevalence and popularity of DBT groups, raises the possibility of adapting this therapy to better suit the needs of DID clients. In fact, this possibility is addressed in a recent paper by two American psychiatrists.[690] Its recommendations are thoughtful, and provide a pathway to better assist large numbers of DID sufferers who are unable to access appropriate services.

686 Viz Howell and Itzkowitz's contention that it is `not only the severity of dissociative fissures' (dependent on the kinds and severity of the problems which give rise to them) which makes a difference `but also the way the dissociative parts are structured in internal relationships…*what is known as borderline personality disorder appears to have a particular kind of dissociative structure, in which two main parts oscillate, as opposed to DID, in which there are usually more parts that take over executive function at different times'* (Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid, p.37, ref Howell, 2002; emphasis added). Also see Howell, *Understanding and Treating Dissociative Identity Disorder,* ibid. Note that in the theory of structural dissociation elaborated by van der Hart, Nijenhuis & Steele (*The Haunted Self*, ibid) BPD is *secondary* structural dissociation of the personality in contrast to the *tertiary* structural dissociation of DID.

687 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid, p.136.

688 Fisher, *Healing the Fragmented Selves of Trauma Survivors*, ibid, p.136. This, she says, is a shortcoming of otherwise valuable treatment approaches such as IFS and Sensorimotor Psychotherapy which nevertheless encourage ` a mindful interest and curiosity in the habitual patterns rather than a solution-oriented approach to safety issues' (see Fisher, ibid, pp.136-7).

689 Recall Kluft's contention that failure to attend to the DID per se (i.e. as distinct from the degree of stabilisation which is required to treat it) results in partial treatment and a situation in which `a complete cure is deliberately withheld' (`To initiate a course of treatment that from the first denies a patient a definitive resolution of his or her difficulties remains a questionable course of action' (Kluft, `Dealing with Alters', ibid, p.283).

690 Bradley Foote & Kimberly Van Orden, `Adapting Dialectical Behavior Therapy for the Treatment of Dissociative Identity Disorder', *American Journal of Psychotherapy* (70, 4, 2016), pp.343-364. Significantly, Foote & Van Orden note that a `staged' approach, in which stabilisation precedes any addressing of traumatic material, is a feature of both approaches (ibid, p.343).

3.16 Evidence supports the effectiveness and benefits of treating dissociative disorders including DID

> `*[R]ecent research continues to confirm earlier research: when treatment is provided that is consistent with expert guidelines for DID treatment (International Society for the Study of Trauma and Dissociation, 2011) DID patients show improvements in symptoms and functioning'.*
> (Brand & Brown, 2016: 246).

The Treatment of Patients with Dissociative Disorders (TOP DD) Study supports prior findings regarding the efficacy of appropriate treatment of DID and other dissociative disorders. These research findings are of critical importance for all workers in the field. As lead TOP DD convenor Bethany Brand notes, proponents of the `Fantasy' model not only contest the aetiology of DID but claim that DID treatment may be harmful.[691] Hence the findings that `DID improves with treatment consistent with expert guidelines' need to be widely disseminated.[692]

Referencing the prior case series of Kluft and others,[693] Brand et al conducted a meta-analysis of eight dissociative disorder treatment studies (2009). The moderate to strong effect sizes across the studies showed that DD treatment `was associated with decreased dissociation, depression, PTSD, suicidality and general distress'.[694] More recently,

> `Brand et al (2013) conducted a longitudinal, naturalistic study of 280 DID or DDNOS [now classified as OSDD] patients and 292 community clinicians treating these patients over a period of 30 months. It is the largest and most geographically diverse sample of DD patients ever studied, and the results were clear: over 30 months of treatment, DD patients showed significant decreases in dissociation, PTSD, overall distress, drug use, physical pain, and depression, and showed significant increases in adaptive behaviors such as socialising or attending school. The participants' Global Assessment of Functioning (GAF) scores, as rated by their therapists, increased over 30 months'.
> Brand & Brown, 2016: 246-247.

Another study which followed forty-eight inpatient survivors of child sexual abuse from pre-admission to one-year follow up post discharge found that dissociative disorder patients `require therapy which specifically addresses DID symptoms in order for amnesia and identity alteration to improve'.[695]

691 Bethany L. Brand & Daniel J. Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID', ch.21 in Howell & Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis: Understanding and Working with Trauma* (New York: Routledge, 2016), pp.241-252.

692 Brand & Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID', ibid, p.247. Also see Brand, Loewenstein, & Spiegel, `Dispelling myths about DID treatment: an empirically based approach' (*Psychiatry,* 77, 2, 2014), pp.169-189. The latter concluded that `evidence demonstrates that carefully staged trauma-focused psychotherapy for DID results in improvement, whereas dissociative symptoms persist when not specifically targeted in treatment' (Brand, Loewenstein, & Spiegel, ibid).

693 Notably Ellason & Ross (1997, 2004), Ellason, Ross & Fuchs (1996); Coons & Bowman (2001) as well as Kluft (1994); Brand & Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID', ibid, p.246. For details of the research findings of Kluft see discussion earlier in this chapter.

694 Brand & Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID', ibid, p.246.

695 Jepsen et al (2013) cited in Brand & Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID' ibid, p.247.

It is notable that critics who contest such findings do not cite credible grounds for so doing.[696] In fact critics have made significant concessions in the face of the growing evidence base which supports the effectiveness of appropriate treatment for DID.[697]

`The research on DID shows that long-term therapy that focuses on dissociation is associated with significant improvements in nearly every type of symptom and functioning that is assessed, while therapy that does not specifically address dissociation is significantly less effective in reducing dissociation'.[698]

3.17 Towards effective psychotherapy for clients with DID

As with all clients and all therapies, it is rare for `one size to fit all'. But at this point in the twenty first century - building on the foundations established in the late nineteenth - a number of principles and recommendations exist for the effective treatment of DID. As discussed above, these are substantiated both clinically and in terms of research.

The challenge is for therapists to operationalise these principles within an empathic, relational, and pragmatic approach based on understanding of the content, criterion, and construct validity of the DID diagnosis.[699] This includes a commitment to treating clients who are living with the drastic adaptations needed to withstand their severe adverse life experience.

It is important to reiterate that while complex and challenging, DID is a treatable disorder. The precondition for effective treatment of DID is its *clinical recognition,* without which it will continue to be overlooked, inappropriately responded to, and rationalised away.

Therapists need to become aware of the prevalence of DID (official estimate is 1.5%) and the protective functions it served in childhood. They also need to be aware of its extensive adverse consequences and diverse clinical presentations.

Clinicians also need to be aware of the evidence base which substantiates the legitimacy of DID, the principles for its effective treatment, and the reasons why myths and misconceptions about DID continue to circulate (Brand, Sar et al, 2016). https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction___An_Empirical.2.aspx

696 Brand & Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID' ibid, p.247. citing Brand, Loewenstein & Spiegel, `Dispelling Myths about DID Treatment', *Psychiatry*, 77(2):169-89. They further found that `iatrogenic harm is far more likely to come from depriving DID patients of treatment that is consistent with expert consensus, treatment guidelines, and current research' (Brand, Loewenstein, & Spiegel, `Dispelling Myths about DID Treatment', ibid, p.169).

697 Brand & Brown note that the evidence in favour of the Trauma Model (TM) rather than Fantasy Model (FM) has been `so consistently in support of the TM that FM theorists have recently conceded that some recovered memories are likely accurate and that trauma treatment does not generally worsen dissociation…This represents notable changes in the arguments put forward by the FM, and speaks to the compelling research that has amassed in support of the TM' (Brand & Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID' ibid, p 243).

698 Brand & Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID' ibid, p.247. BB, p.247 (`Claims that DID therapy actually worsens dissociation are not supported by any data'; ibid).

699 See Brand & Brown, `An Update on Research about the Validity, Assessment, and Treatment of DID' ibid, pp.243-246 and for summary of the evidence base which attests to the legitimacy of the DID diagnosis.

As with other complex trauma presentations,, and notwithstanding its often challenging expressions, medication is not the `treatment of choice'[700] for DID and is not necessarily indicated: *`Many of the symptoms suffered by patients who have DID appear to be reasonable targets for psychopharmacology, but…it is useful to try to learn what is behind the target symptom'.*[701]

An important first step is recognising the initially protective function of DID (i.e. an extreme case of `the problem is the solution'[702] in light of the extreme coping strategies required).

Where medication is necessary it is not a substitute for psychotherapy. Rather it should be integrated within the overall treatment, with awareness that different self-states of the DID client may respond differently to both the idea and experience/s of medication.[703]

> Orienting to working with `parts' remains a sound initial and foundational recommendation for working with DID clients. This is because this approach represents a natural (albeit more challenging) extension of client work more generally.

Ego-state therapy, which has various expressions, can be correspondingly helpful.[704] This is due to the `inevitability' of at least tacit utilisation of principles of this orientation in DID treatment.[705]

Among ego-state psychotherapies, Internal Family Systems (IFS) remains one of the most well-known and widely practised and can serve as an important conduit to the learning of necessary skills. As Fisher notes, `IFS is a parts therapy' which `teaches therapists to become fluent in speaking the language of parts'.[706] In addition, it has the advantage of helping therapists attune to their own internal diversity *(`[n]ot only are they asked to speak the language with their clients, but they are also expected to become mindful of their own parts').*[707] A recent text by Robin Shapiro, who is also a respected trauma therapist, is valuable in `orienting to parts'.[708]

700 See, for example, James Chu, `Psychopharmacology for Trauma-Related Disorders', ch.14 in Chu, *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative Disorders* (John Wiley & Sons, NJ, pp.246-254. For a recent paper on this topic which likewise references DID, BPD, and CPTSD (`all variants of complex trauma-related disorder') see Andreas Laddis, `A Simple Algorithm for Medication of Patients with Complex Trauma-Related Disorder', ibid

701 Kluft, `Dealing with Alters', ibid, p.300, ref. Richard Loewenstein, `Rational Psychopharmacology in the treatment of multiple personality disorder', *Psychiatric Clinics of North America* (14, 1991), pp.721-740. Also see Laddis, `A Simple Algorithm for Medication of Patients with Complex Trauma-Related Disorder', *Frontiers in the Psychotherapy of Trauma and Dissociation*, (1, 2, 2018), pp.244-266.

702 Felitti, Anda et al, `The Adverse Childhood Experiences (ACE) Study', ibid, and see previous discussion.

703 As per Kluft's underlining of `The importance of working with alters to optimise pharmacotherapy for dissociative identity disorder', in `Dealing with Alters', ibid, pp.300--301. Likewise Chu's contention that `[v]arious personalities [of the DID client] may report different responses to the same medications or may even claim to be able to block medication effects' (Chu, `Psychopharmacology for Trauma-Related Disorders', ibid, p.253.

704 A helpful introductory text (written by a clinician skilled in working with trauma as well as ego-state therapy approaches) is Robin Shapiro, *Easy Ego State Interventions: Strategies for Working with Parts* (Norton, New York, 2016).

705 Richard P. Kluft, `The Inevitability of Ego State Therapy in the Treatment of Dissociative Identity Disorder and Allied States', in Bongartz, Revenstorf et al, ed. *The 15th International Congress of Hypnosis* (MEG-Stiftung, Munich, 2000), pp. 69–77.

706 Fisher, *Healing the Fragmented Selves of Trauma Survivors,* ibid, p.8.

707 Fisher, *Healing the Fragmented Selves of Trauma Survivors,* ibid, p.8. Note that IFS distinguishes `manager', `firefighter' and `exile' parts (Schwartz, *Internal Family Systems Therapy,* ibid) which are also now widely known and potentially helpful in working with traumatised clients. Along with Van der Hart et al's theory of structural dissociation and the contrasting but also complementary approach of sensorimotor psychotherapy, Fisher affirms the influence of IFS on her own clinical work with trauma survivors, including clients with DID (Fisher, *Healing the Fragmented Selves of Trauma Survivors,* ibid, p.8). See

708 Robin Shapiro, *Easy Ego State Interventions: Strategies for Working with Parts*, ibid.

But the contrasting types of ego-state therapy approaches also need to be noted.[709] Some varieties may be conducive to working with structural dissociation including DID (i.e. those adapted for working with childhood trauma).[710] But `standard' ego state therapy is insufficient due to the distinctiveness of ego-states of the DID self-system.[711]

At the same time, valuable ego-state influenced approaches to treating dissociative disorders have been developed.[712] Robin Shapiro delivers a training which specifically includes in its learning criteria: `Review the Theory of Structural Dissociation', `Distinguish Healthy/Flexible and Dissociative Ego States (and map your own)', and Working with Dissociative Identity Disorder'.[713] Some integrationist approaches specifically attuned to dissociation in the treatment of trauma-related disorders are also available.[714]

The literature and resources specifically addressed to the psychotherapeutic treatment of DID continue to grow. The publications of Howell,[715] Kluft,[716] Chu,[717] van der Hart et al,[718] Bray Haddock,[719] Fisher,[720] Chefetz[721] and others are invaluable. Specialised comprehensive workbooks which include practical strategies for treatment of structural dissociation and material relevant to treatment of DID enable clinical translation of the `principles to practice'.[722]

The perspectives of people with lived experience of DID about the nature of their experience, and the treatment implications, are also important for clinicians to attune to. The Plural Positivity World Conference of 2019[723]– convened to coincide with the 2019 Annual Conference of the International Society for the Study of Trauma and Dissociation (ISSTD) – was a major pioneering contribution in

709 This means that this orientation cannot simply be transposed to working with DID where the internal world is more complex.

710 For a contemporary ego-state approach to treatment of clients who struggle with the impacts of childhood trauma, see Shirley Jean Schmidt, *The Developmental Needs Meeting Strategy (DNMS): An Ego State Therapy for Healing Adults with Childhood Trauma and Attachment Wounds* (DNMS Institute, Texas, 2009). www.dnmsinstitute.com

711 Kluft, `Dealing with Alters', ibid, pp.283-284; also see 3.6 (`Towards clinical treatment: ego state therapy, its potential and limits in contexts of chronic dissociation').

712 In this category is the approach known as `Fraser's Dissociative Table Technique' formulated by Canadian psychiatrist George Fraser in the early 1990s (G.A. Fraser, `The dissociative table technique: A strategy for working with ego states in dissociative disorders and ego-state therapy', *Dissociation,* 4, 1991, pp.205-213; G.A. Fraser, `Fraser's `Dissociative Table Technique', Revisited, Revised: A Strategy for Working with Ego States in Dissociative Disorders and Ego State Therapy', *Journal of Trauma and Dissociation,* (4, 4, 2003), pp.5-28). This technique has also been widely utilised and adapted (e.g. within the EMDR field as part of preparing clients for the processing of trauma; see Shirley Jean Schmidt, `Internal Conference Room Ego-State Therapy and the Resolution of Double Binds: Preparing clients for EMDR trauma processing' https://www.dnmsinstitute.com/doc/db-prep.pdf)

713 Dr Robin Shapiro, `Training in Ego State Therapy', promotional training for London training 17-19 January 2019. Note that Shapiro's training in ego-state therapy is not dependent on prior training in EMDR and that she caters to both groupings.

714 See Carol Forgash and Jim Knipe, `Integrating EMDR and Ego State Treatment for Clients with Trauma Disorders', in Forgash & Copley, ed. *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* (Springer, New York, 2007), pp.1-59.

715 Elizabeth Howell, *Understanding and Treating Dissociative Identity Disorder: A Relational Approach,* ibid.

716 As previously cited and see reference list. Also see Kluft's prior paper `An Overview of the Psychotherapy of Dissociative Identity Disorder', *American Journal of Psychotherapy*, 53, 1999,, pp.289-319,and Kluft & Fine, ed, *Clinical Perspectives on Multiple Personality Disorder* (American Psychiatric Press, Washington, DC, 1993).

717 James Chu, `The Rational Treatment of Dissociative Identity Disorder', ch.12 in Chu, *Rebuilding Shattered Lives,* ibid, pp.207-227.

718 Van der Hart et al, *The Haunted Mind,* ibid and see subsequent footnotes.

719 Deborah Bray Haddock, *The Dissociative Identity Sourcebook* (McGraw-Hill: New York, 2001).

720 Fisher, *Healing the Fragmented Selves of Trauma Survivors,* ibid.

721 Chefetz, *Intensive Psychotherapy for Persistent Dissociative Processes,* ibid.

722 Boon, Steele & Van der Hart, *Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists,* ibid; Steele, Boon, & Van der Hart, *Treating Trauma-Related Dissociation: A Practical Integrated Approach*, ibid.

723 Details of the 2019 Plural Positivity World Conference are available at https://pluralevents.org/Conference/Conference

this regard. The podcasts of System Speak,[724] which aim to help `bridge the gap between survivor and clinician' (and are about `fighting stigma, and adding substance and quality and rawness to the online conversation regarding trauma in general, and Dissociative Identity Disorder specifically')[725] are a valuable ongoing contribution.

Helpful introductions to the pioneering early work in the field are also available.[726] The *Journal of Trauma and Dissociation* and the recently established *Frontiers in the Psychotherapy of Trauma and Dissociation* publish pertinent conceptual, research and clinical papers.[727]

724 SystemSpeak www.SystemSpeak.org is presented and conducted by Emma Sunshaw (`Dr E'), who was diagnosed with DID in the wake of the death of her parents and after functioning well for nearly two decades as a doctoral level clinician: `Educational, supportive, inclusive, and inspiring, SystemSpeak documents her healing journey through the best and worst of life in recovery through insights, conversations, and collaborations' www.SystemSpeak.org

725 www.SystemSpeak.org Details of available podcasts are accessible via the SystemSpeak website.

726 See the initial chapters of Howell & Itzkowitz, *The Dissociative Mind in Psychoanalysis*, ibid. For earlier accounts, see Van der Hart. & Friedman, `A reader's guide to Pierre Janet on dissociation: A neglected intellectual heritage', *Dissociation* (2, 1, 1989, pp.3-16), and Van der Hart, Brown, & Van der Kolk, `Pierre Janet's treatment of posttraumatic stress', *Journal of Traumatic Stress (*2, 4, 1989, pp.379-396).

727 See, for example, Middleton, `The First Individual with Dissociative Identity Disorder (DID) That One Knowingly Diagnoses and Treats," ibid; McMaugh, `My First Case of DID: Learnings from Treatment Failure', ibid. Excellent, nuanced and accessible material – including notifications of conferences, webinars, and other relevant platforms for clinicians to engage, support and discuss - is also available to all members of the International Society for the Study of Trauma and Dissociation (ISSTD http://www.isst-d.org/) which has a growing Australian membership.

Chapter 3
Summary of key points and themes

1. In contrast to theories which see personality as `a set of fixed, persistent, and globally defining traits that pervade all of the person's interactions with the world', the `state model' defines personality as `the collective dynamics of a person's set of identity, emotional, and behavioral states' (Putnam, 2016: 159).

2. The state model of personality allows for `a wider range of disparate behaviors' and `can account for abrupt personality changes' (Putnam, 2016: 159). Personality changes and contrasting behaviours depend on activation of the collective dynamics of emotional and behavioural states at particular times in particular contexts.

3. `All of us are – always – in one or another state of being' (Putnam, 2016: 160); `We are all multiple to some degree' (ibid: 121). *(`It is how well we can `keep it together', how harmoniously we can bridge, coordinate and even integrate the different parts of ourselves that determines how functional we are'* Putnam, ibid: 121). Dissociation which does not meet clinical criteria can still affect well-being.

4. Trauma limits ease of access to diverse internal states. Severe dissociation generated by childhood trauma can produce self-states to which the person may lack access and conscious recall.

5. The most severe outcome of childhood trauma is DID, in which separate and distinct identity states `may have little or no awareness of each other and thus often behave in conflicting, contradictory, and self-defeating ways' (Putnam, 2016: 159).

6. Personality state-dependent measures for diagnosed DID and DID simulating controls establish that DID is a genuine disorder (Reinders, Willemsen et al, 2016; Schlumpf, Reinders et al, 2014). Research consistently supports the `Trauma', rather than `Fantasy' model of DID (Rydberg, 2017; Brand, Vissia et al, 2016).

7. A continuum of trauma-related symptom severity has been found across groups, *`supporting the hypothesis that there is an association between the severity, intensity, as well as age at the onset of traumatisation, and the severity of trauma-related psychopathology'* (Rydberg, 2017: 95).

8. Unintegrated self-states in which *`a part of psychic functioning …seems to operate independently from the other parts'* - may be more common than is recognised (Schimmenti & Caretti, 2016; ref. Van der Hart, Nijenhuis & Steele, 2006).

9. The concept of `ego states' is common in diverse psychotherapies and are widely considered to characterise the internal world of all of us (Watkins & Watkins, 1993; Phillips & Frederick, 2010).

10. Ego-state therapy is based on the `normal and adaptive' processes of integration and differentiation (Watkins, 1993). When the interaction of these processes `becomes excessive and maladaptive, it is usually called `dissociation' (Watkins, ibid: 233).

11. `[M]ultiple personality disorder [now called DID] represents that extreme and maladaptive end of the continuum that begins with normal differentiation. It is a matter of degree or intensity' (Watkins, 1993: 233).

12. The ego states of structural dissociation differ in significant ways from those which characterise psychological health *(`All alters necessarily fall under the rubric of ego states, but most ego states are not alters'*; Kluft, 2006: 284).

13. Diverse terms are used to describe the more specific ego states of DID (e.g. *`alters,'* Kluft, 2006) and of trauma-generated parts of the personality more broadly (e.g. *`dissociative parts of the personality'*; *`Apparently Normal Part' [ANP]; `Emotional Part' [EP]* (van der Hart, Nijenhuis & Steele, 2006); `front person' (Miller, 2014); *`different ways of being you'*; Chefetz, 2015). Whatever language is preferred, the distinctive ego states of a structurally dissociated personality need to be understood (as per Kluft, 2006).

14. Clients who have experienced trauma usually welcome the language of `parts', and *`generally find `parts of the personality' or `parts of yourself' an apt description of their subjective state'* (van der Hart et al, 2006).

15. While written prior to wider use of the term `dissociation', Bowlby's paper `On Knowing What You are Not Supposed to Know and Feeling What You are Not Supposed to Feel' (1979, 1988) delineates child-parent scenarios which Bowlby believed to be `seriously neglected as causes of information and feeling being excluded from consciousness' *(`Is there any wonder that in such circumstances feeling should become shut away?'*; Bowlby, ibid: 120).

16. Self-states of the DID system (called `alters' by Kluft, 2006) `may understand themselves to have all manner of relationships with one another' (ibid: 286). But they may also lack awareness of one another *(`It helps to bear in mind that alters regularly cannot or will not own the experiences of other alters of whom they may not be aware and for whose experiences they may have amnesia'*; Kluft, 2006: 293).

17. Clinicians who work with DID need to engage the clients' diverse self-states, lest the complexity of the client's inner world is underestimated and the `presenting self' is mistaken for the whole personality - *`The treatment of DID is facilitated by therapists being prepared to work directly with alters. Interventions that access and involve the alters in treatment are vital components of the successful treatment of DID'* (Kluft, 2006: 302).

18. The overall functioning of the DID client, as of all clients, is of primary importance, and safety and stabilisation are of the highest priority. At the same time, it is important that treatment of the DID remains an ongoing goal.

19. Standard `grounding', relaxation techniques and imagery may be contraindicated for the DID client *(`The usefulness of relaxation and imagery methods…may be compromised by unfavourable risk/benefit ratios…Many traumatized individuals struggling to keep control…feel threatened by relaxation approaches'*; Kluft, 2012: 146). Grounding techniques which may seem to be stabilising for the `presenting self' may also be problematic for other parts and states.

20. The `inevitability of encountering autohypnosis and spontaneous trance phenomena' in clinical work with dissociative disorders means that therapists who treat DID and OSDD will benefit from knowledge of and experience in the use of hypnosis (Kluft, 2012: 154).

21. Misconceptions about hypnosis have abounded since the Freudian era in which a perception of authoritarian suggestion bears little resemblance to the clinical methods and interventions of today (Kluft, 2013: 275).

22. Many techniques of hypnosis are amenable to utilisation outside of formal induction and especially in treating dissociative disorders which `have many hypnotic elements' (Kluft, 2013: 276; ref Bliss, 1986; Braun, 1983).

23. The publications and trainings of clinicians experienced in treating structural dissociation (e.g. van der Hart et al, 2006, 2011, 2017; Kluft, 2006, 2013, 2016, Chefetz 2015, Fisher, 2017, Danychuck & Connors, 2017) are invaluable in orienting to work with these cohorts.

24. Kluft's maxim of `*the slower we go, the faster we get there*' and important distinction between `*getting better and feeling better*' (Kluft, 2013) are invaluable for seasoned and less experienced clinicians alike. Key themes of the development of Kluft's clinical work with DID, including his clinical innovations of the `*rule of thirds*', `*fractionated abreaction*' method, and suggestions for the safe ending of sessions, are presented in a recent paper (Kluft, 2017: 18-44).

25. Dialectical Behavior Therapy (DBT), developed for BPD clients who differ from DID clients but also share some common features, is now widely available for diverse client populations. A recent publication by American psychiatrists suggests ways in which DBT groups may be adapted to better suit the needs of DID clients (Foote & Van Orden, 2016).

26. Knowledge of therapies informed by ego-state approaches (`parts work') may assist in working with structural dissociation. But standard ego-state therapies are not sufficient for effective work with the specific phenomenology and challenges of DID clients.

27. Medication is not a `treatment of choice' for DID and where necessary should be integrated within the psychotherapy treatment recognising that different self-states may respond differently to its effects (Kluft, 2006: 300; Chu, 2011).

28. Therapists should not begin to work with DID clients without knowledge and training in the dissociative disorders field (Kluft, 2006: 296).

29. The forum SystemSpeak www.SystemSpeak.org was founded to help `bridge the gap between survivor and clinician' regarding `trauma in general, and Dissociative Identity Disorder specifically' (ibid). It presents valuable podcasts which are available on its website.

30. Current research confirms previous research that when treatment consistent with the ISSTD expert guidelines for treating DID is provided https://www.isst-d.org/wp-content/uploads/2019/02/GUIDELINES_REVISED2011.pdf `DID patients show improvements in symptoms and functioning' (Brand & Brown, 2016: 246).

Appendices

Appendix 1

Features Of Complex Trauma Of Which All Health Professionals Need To Be Aware

Lack of a prior `felt sense' of safety

Impaired capacity to self-regulate is a hallmark of childhood trauma (Courtois & Ford, 2009).

Thus advice to focus on a safe/calming image or feeling may be destabilising (and even the invitation to `focus' per se; see final point below)

Pervasive sense of shame

A `core affect' of complex trauma, shame presents `not only as an acute emotional state', but as `a more fundamental and enduring aspect of…personality structure' (Frewen & Lanius, 2015:206)

Thus `exposure-based therapies may not be the treatment of choice' (ibid: 207).

`Symptoms' are the outgrowth of coping strategies which were initially protective

`The problem is the solution' (ACE Study, 1998; 2010); `adaptive yet symptom-generating emotional learnings' (Ecker, 2018: 6); `resilient strategies and maladaptive coping skills' may be `interlaced and occur simultaneously' (Bloom & Farragher, 2011:16).

Thus `targeting symptoms'- common to many short-term interventions- may be problematic in the absence of practitioner knowledge of possible underlying trauma

High levels of dissociation

*`Most people with complex PTSD have experienced chronic interpersonal traumatization as children' and `have severe dissociative symptoms' (*Van der Hart et al, 2006: 112). Often undetected by clinicians, dissociation (not being psychologically present) impedes the client's ability to focus.

Thus mindfulness exercises may be inappropriate and destabilising in the early stages of therapy as mindfulness and dissociation are rival brain activities (Forner, 2017).

Appendix 2

Self-Care For Therapists Who Work With Complex Trauma

`[T]he first line of care should be for the care-givers'
(Rothschild, 2011:134)

`...self-care is an ethical imperative for all therapists but especially for those working with complex trauma'
(Pearlman & Caringi, 2009:216; original emphasis)

Practitioner well-being is critical, and the risk of vicarious traumatization is especially high in complex trauma treatment (Coleman, Chouliara & Currie, 2018). Hence `[t]he need for good practice guidelines on self-care internationally (ibid). It is important to look after and maintain your own wellness and energy levels for you as well as your clients. The following basic points, questions, and tips can help safeguard your wellbeing:

DIMENSIONS OF WELL BEING:

- Physical
- Emotional
- Organisational (policies and health of the context in which you work)
- Consultation with colleagues
- Regular trauma-informed clinical supervision
- Structural and systemic support
- R&R (is time for rest and relaxation factored into your weekly schedule?)
- Ability to track your responses (attune to your body and to somatic cues which may challenge the rationalisation that you `feel fine' and can `carry on' without regular breaks)
- Your capacity to find meaning (important when ministering to human distress)

QUESTIONS TO CONSIDER:

- How do you currently care for yourself in light of the work that you do?
- Do you have a `wellness plan' to which you regularly refer?
- Are there dimensions of self-care that remain in need of addressing?
- To what extent do you track your own (as well as client) responses? (does consultation with colleagues help you with aspects of this?)
- Are your attitudes and assumptions to your work and life protective of your own health? (if not, how can you begin to address this?)
- From where do you derive your sense of meaning? (which is critical both to your own wellbeing and to effective practice)

For training to help safeguard you against the risks of Vicarious Trauma see https://www.blueknot.org.au/Training-Services/Training-for-your-organisation/Vicarious-Trauma

Glossary*

*See in conjunction with the more detailed Glossary contained in the updated *Practice Guidelines for Clinical Treatment of Complex Trauma* (2019)

Glossary

alter – *A particular kind of ego state; the term is commonly used to describe the inner world of people diagnosed with Dissociative Identity Disorder (DID). Reference to `ego states' is a helpful entry point for considering the chronic internal divisions, including structural dissociation of the personality, which can be generated by developmental disruption and early life trauma. But the ego states of structural dissociation (`alters') differ from the ego-states which characterise health and well-being: `All alters necessarily fall under the broad rubric of ego states, but most ego states are not alters' (Kluft, 2006). Kluft (2006) describes characteristics of ego states which are also alters but which `are not intrinsic to the ego state phenomenon per se' (Kluft, 2006). See `ego state', `dissociation', `dissociative disorder', `Dissociative Identity Disorder', `parts', `self -state', `self -system.'*

---

body – *Neuroscientific research is illuminating the inextricable relationship between physiological and psychological processes, with major implications for understanding and treating trauma (`Modern neural science clearly points to the central role of the body'; Siegel, 2007). To the extent that `talk therapy' takes insufficient account of bodily experience, current research suggests that traditional psychotherapeutic approaches need to attune more closely to physical experience and expression (van der Kolk, 2003; Ogden, 2006). See `somatisation', `expressive therapies', `traditional psychotherapy'.*

Borderline Personality Disorder (BPD) *– A diagnostic category which describes severe difficulty with integrating emotional states, in which extreme anger, emptiness and abandonment frequently coexist with volatile and self-harming behaviours. To the degree that this diagnosis masks underlying trauma, and the term `borderline' is applied in a derogatory way to people whose relational impairments make them challenging to be with, both the diagnosis and the label are contested by many. Ross & Halpern (2009) note that `[t]oo often, the mental health field inflicts more abuse, neglect, devaluation, and rejection on top of the life experience that gave rise to the borderline criteria to start with'. Also see `complex trauma', `neurobiology of attachment', `coping strategies', `Dialectical Behaviour Therapy', `trauma informed'.*

---

burnout – *`[A] collection of symptoms associated with emotional exhaustion and generally attributed to increased workload and institutional stress' (Bloom, 2011). Initially regarded in the 1970s and 1980s as a problem of individuals, the contextual role of the surrounding environment is now increasingly recognised. Thus burnout is increasingly seen as `the result of repetitive or chronic exposure to vicarious traumatization that is unrecognised and unsupported by the organizational setting' (Ibid). See `secondary trauma', `vicarious trauma', `supervision', `trauma-informed'.*

---

child sexual abuse (CSA) *– A pernicious form of child maltreatment which involves sexual violation and has pervasive negative impacts including and especially on mental health (Canton-Cortes, Cortes, et al, 2012; Mullen et al, 2000; Everett & Gallop, 2001). Repeated episodes of child sexual abuse comprise severe childhood trauma which, if occurring at critical periods of neural vulnerability, can impair not only general development but development of the self per se. See `early onset trauma', `survival brain', `developmental trauma', `Developmental Trauma Disorder' (DTD).*

clinical supervision *– A key component of ethical and professional practice in counselling, psychotherapy and psychology, whereby clinicians regularly consult a more experienced practitioner about their client work. Clinical supervision differs from `de-briefing', involving facilitated self-reflection, and support, psychoeducation, and encouragement of self-care. Also see `ethical practice', `supervision', `self-care', `risk management'.*

---

comorbidity *– A medical term for coexistence of more than one disorder or disabling condition. Complex trauma has high comorbidity (Ross & Halpern, 2009); `Many Complex PTSD presentations are so enmeshed in co-morbid factors that the traumatic antecedents can be readily neglected by clinicians' (Schwarz, Corrigan et al, 2017).*

---

compassion fatigue *– Formerly known as secondary traumatic stress disorder (Figley, 1995); refers to the negative though predictable and treatable psychological consequences of working with, and proximity to, suffering people (Bloom, 2011).*

***complex trauma – `****[A] subset of the full range of psychological trauma which has as its unique trademark a compromise of the individual's self-development' (Ford & Courtois, 2009). In contrast to `single-incident' trauma, complex trauma is cumulative, repetitive and largely interpersonally generated, and occurs in the context of the family and intimate relationships as well as within organisations.*

Complex trauma `usually involves a fundamental betrayal of trust in primary relationships, because it is often perpetrated by someone known to the victim'; Courtois & Ford, 2009). Unlike a one-off event, the cumulative impact of relational trauma involves compounded dynamics and entails pervasive effects. Complex trauma places the person at risk `for not only recurrent anxiety…but also interruptions and breakdowns in the most fundamental outcomes of healthy psychobiological development' (Ibid). Note that complex trauma is broader than the new diagnosis of Complex PTSD (CPTSD) in ICD-11: `[w]hereas continuous consciousness across states might be typical of complex PTSD, development of increasingly severe trauma-related disorders…increasingly becomes a risk the more prolonged and severe the traumatic events' (Fisher, 2017). See `complex post- traumatic stress disorder'.

Complex Post-Traumatic Stress Disorder *– Diagnosis first proposed in 1992 by psychiatrist Judith Herman to describe the range of clinical presentations of survivors of long periods of interpersonal violation. Complex traumatic stress reactions `are those that are most associated with histories of multiple traumatic stressor exposures and experiences, along with severe disturbances in primary caregiving relationships' (Courtois & Ford, 2009). The advantage of the concept `complex post-traumatic stress disorder' (CPTSD) is that it integrates in a single and coherent formulation `the consequences of prolonged and repeated trauma' (Herman, 2009). Note that `PTSD alone is insufficient to describe the symptoms and impairments that follow exposure to complex trauma' (Courtois & Ford, 2009; van der Kolk, 2003).*

In 2018 a formal diagnosis of Complex PTSD (CPTSD) was announced with release by the World Health Organisation (WHO) of the 11th revision of the International Classification of Diseases (ICD-11) effective January 2022: `Complex post-traumatic stress disorder (Complex PTSD) is a disorder that may develop following exposure to an event or series of events of an extreme and prolonged or repetitive nature that is experienced as extremely threatening or horrific and from which escape is difficult or impossible (e.g., torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse' (Cloitre, Garvert, 2013; https://icd.who.int/en/).

While it problematically requires all diagnostic criteria for single-incident PTSD to be met (note that `many individuals having suffered the most severe complex trauma do not describe core PTSD symptoms'; Schwarz, Corrigan et al, 2017) achievement of the formal diagnosis of CPTSD is a welcome and long overdue development. In contrast to ICD-11, the current edition of the Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) does not include the diagnosis of CPTSD. It does, however, now include a dissociative subtype of PTSD. See `dissociative subtype of PTSD', `complex trauma'.

complex trauma treatment *– In contrast to single-incident trauma (PTSD) in which the traumatised person has generally experienced a sense of safety prior to the onset of the trauma, the survivor of complex trauma does not start with this advantage. The radical impairments in self-regulatory capacity associated with complex trauma, particularly when it is early onset as in child abuse, present a different treatment starting point. This is as important as it is widely missed (i.e. when complex trauma is mistaken for, and conflated with, PTSD). Recommended treatment for complex trauma is* phased treatment*. See `complex trauma', `complex post-traumatic stress disorder', `phased treatment', `trauma treatment'.*

---

coping strategies *– methods for dealing with adverse experience/s. As the Adverse Childhood Experiences (ACE) Study establishes (Felitti, Anda et al, 1998) traumatic childhood experiences are highly prevalent even without overt markers of social disadvantage. As it also shows, there is a direct relationship between the coping strategies which initially serve a protective function and their conversion over time into active risks to emotional and physical health. Thus `personal solutions', i.e. coping strategies, become both individual health problems in adulthood and public health problems. See `neurobiology of attachment', `symptoms', `pathology', `trauma-informed'.*

---

countertransference *– The largely unconscious responses of a therapist to their client based on prior relationships and associations. Because psychotherapy involves power differentials which it is the responsibility of the therapist to manage, clinical supervision is a necessary and valuable forum in which to explore therapist countertransference to their clients. There is some evidence to suggest that therapists with trauma histories may have stronger countertransference responses than those who do not* (*Cavanagh. Wiese-Batista et al 2015). The phenomenon of abuse-related countertransference was elaborated in the early 1990s (Briere, 1992) and the prevalence of childhood trauma means it is possible that both the therapist and the client may have a trauma history. Subject to having addressed their own histories, personal experience of trauma does not preclude clinicians from conducting effective trauma therapy. See `implicit memory', `supervision'.*

---

developmental trauma *– A form of complex trauma which, occurring at early and critical periods of development, can radically compromise psychobiological, social and emotional development. In comprising threats not only to physical survival but to survival of the self (see `complex trauma') such threats are especially damaging to young children for whom the self is fragile because it is still developing. Also described as `developmentally adverse interpersonal trauma' (Ford, 2005) See `Developmental Trauma Disorder' (DTD), `early onset trauma', `neurobiology of attachment'.*

Developmental Trauma Disorder (DTD) *– A diagnosis proposed by van der Kolk (2005) for children who experience complex trauma. Criteria for DTD, which has not achieved inclusion in diagnostic manuals, stem from exposure to `developmentally adverse interpersonal trauma'. See `developmental trauma', `neurobiology of attachment'.*

---

diagnosis of trauma *– As complex trauma was not seen as a distinct entity within standard classificatory and diagnostic systems for a long time, often it was not recognised that trauma can underlie otherwise diverse client presentations (and can therefore receive multiple and contrasting diagnoses). Inclusion of the diagnosis of Complex PTSD in the 11th revision of the International Classification of Diseases, ICD-11 (but not in the current 5th edition of the Diagnostic and Statistical Manual of Mental Disorders, DSM-5) partially rectifies this anomaly.*

The diagnosis of Complex PTSD goes beyond the criteria of `standard' single-incident PTSD, and comes closer to acknowledging that trauma in its more complex forms represents `a defining and ongoing experience that forms the core of an individual's identity rather than a single discrete event' (Jennings, 2004). As Courtois & Ford (2009) highlight, `in the absence of a formal diagnosis for complex traumatic stress disorders, there is the potential for mis- or overdiagnosis of severe disorders (e.g. bipolar or schizophrenia spectrum disorders, BPD, conduct disorder)'. As they further underline, experts on complex traumatic stress disorders argue that `a sophisticated trauma-based approach to conceptualizing and classifying these disorders is essential to prevent complexly traumatised clients from being burdened with stigmatizing diagnoses and to provide these clients with treatment that is informed by current scientific and clinical knowledge bases' (ibid).

Current calls for 'trauma-informed' care and practice challenge formal diagnostic categories which fail to recognise the complex trauma that underlies a plethora of symptoms, health problems and conditions and which are `rarely captured by traditional diagnostic models' (Fisher, 2017). See `complex trauma', `post-traumatic stress disorder', `complex post-traumatic stress disorder', `Diagnostic and Statistical Manual of Mental Disorders', `International Classification of Diseases', `trauma informed'.

***Diagnostic and Statistical Manual of Mental Disorders (DSM)** – Widely cited publication of the American Psychiatric Association for classification and diagnosis of psychological problems and conditions. The current (fifth) edition is the DSM-5 (2013). Despite the proliferating number and nature of DSM diagnoses, complex trauma is not included in its own right. This contrasts to the International Classification of Diseases (ICD-11) which now includes the diagnosis of Complex Posttraumatic Stress Disorder (CPTSD). While the DSM-5 includes a dissociative subtype of PTSD which addresses the dimensions of depersonalisation and derealisation, the dissociative subtype is much less inclusive than the diagnosis of CPTSD. See `dissociative subtype', `diagnosis of trauma', `Complex Post-Traumatic Stress Disorder').*

***Dialectical Behaviour Therapy (DBT)** – A form of psychotherapy developed by American psychologist Marsha Linehan (1993, 2015) that is primarily used to treat borderline personality disorder (BPD). Dialectical Behaviour Therapy involves various stages of treatment, focuses on development of self-regulatory capacity and skills acquisition and training, and DBT groups are common. Note that an American psychiatrist and clinical psychologist have published a paper on adaptation of DBT for treatment of Dissociative Identity Disorder (DID); Foote & Van Orden (2016).*

***disorganised attachment** – A variety of attachment which occurs when the primary attachment figure on whom the child depends is also someone who engenders fear, such that the child is effectively unable to connect with them.. Disorganised attachment stems from `a collapse in coping ability' (Siegel, 2010). Note that a primary care-giver who is not actively abusive, but who is unable to manage their own responses (the frequent legacy of their own unresolved trauma) is frightening to the child (Hesse, Main, et al, 2003). Disorganised attachment is closely correlated with childhood trauma (Carlson et al, 1989; Siegel, 2010). Also see`neurobiology of attachment', `early onset trauma', `borderline personality disorder'.*

***dissociation** – Separation or disconnection from immediate experience: `In essence, aspects of psychobiological functioning that should be associated, coordinated, and/or linked are not' (Spiegel, Loewenstein et al, 2011). Dissociation varies in type and intensity and many believe it operates along a continuum. In the continuum model, dissociation may occur in unremarkable forms such as daydreaming and mild trancing. As a defensive response to overwhelming threat (`the escape when there is no escape'; Putnam, 1992) dissociation is commonly present as a dimension of trauma, and most people who have experienced chronic interpersonal traumatization as children `have severe dissociative symptoms' (van der Hart et al, 2006)*

Dissociation occurs beyond conscious awareness and control. As a protective response to the risk of being overwhelmed, it can also be reflexively deployed subsequent to the precipitating trauma in the absence of apparent threat (i.e. activated by seemingly innocuous cues which serve as `triggers' of the original trauma). Because of its prevalence as a feature of trauma (particularly in sexual abuse and complex trauma) effective trauma treatment requires knowledge of and ability to work with dissociative responses. Also see `dissociative disorder', `implicit memory', `right brain'.

---

dissociative disorder - *Persistent activation of dissociation for defensive purposes erodes health and well-being: `The most important distinction…to make is between mild dissociative experiences that are normal and experiences that range from moderate to severe' (Steinberg & Schnall, 2003). The core symptoms of dissociation are* depersonalisation *(sense of detachment from self),* derealisation *(sense of estrangement from surroundings),* amnesia, identity confusion *and* identity alteration*, and `different constellations of these five core symptoms define the particular dissociative disorder a person ha[s]' (Steinberg & Schnall, ibid). It is important for health professionals to be aware that `[m]ultiple lines of evidence support a powerful relationship between dissociation/DD [i.e. dissociative disorders] and psychological trauma, especially cumulative and/or early life trauma.…DD are common in general and clinical populations and represent a major underserved population with a substantial risk for suicidal and self-destructive behavior' (Loewenstein, 2018).*

Dissociative Identity Disorder (DID) *– Diagnosis for the most serious form of dissociative disorder which has its aetiology in early childhood trauma and in which, commensurate with the severity of the trauma, the person exhibits separate and distinct identity states.. In DID, alternate identity states are dominant at different times, and a degree of amnesia occurs between the different self-states which `cannot be explained by imaginary companions, alcohol blackouts or medical conditions' (Ross & Halpern, 2009). Neuropsychological data confirms different brain activity between individuals with DID and simulating controls (Schlumpf, Reinders et al, 2014; Reinders, Willemsen et al, 2016). These findings are consistent with the theory of structural dissociation of the personality `and inconsistent with the idea that DID is caused by suggestion, fantasy-proneness and role-playing' (Schlumpf, Reinders et al. ibid). Recurrent myths about DID are addressed in an Open Access paper published in the Harvard Review of Psychiatry (Brand, Sar et al, 2016) accessible at the following link:* https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction___An_Empirical.2.aspx *See `structural dissociation', `alters', `parts', `self-state', `self-system', `implicit memory', `Trauma Model'.*

---

dissociative subtype of PTSD *– subtype of PTSD introduced in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) which addresses depersonalisation (sense of self-estrangement) and derealisation (perception of the external world as strange or unreal). In so doing, it comes closer to addressing characteristic features of complex trauma but is insufficiently inclusive. In contrast to the International Classification of Diseases (ICD-11), the DSM-5 does not yet include the diagnosis of Complex Post-Traumatic Stress Disorder (CPTSD). The dissociative subtype of PTSD is also regarded by some as a problematic conceptualisation. For example, Ross argues that `[t]here does not appear to be any sound conceptual reason for excluding amnesia and flashbacks from the criteria for dissociative PTSD', in which case `most cases of PTSD would be dissociative in nature, and non-dissociative cases would be a minority subtype' (Ross, 2018).*

DSM *– See Diagnostic and Statistical Manual of Mental Disorders*

---

dual awareness- *the ability to attend to two experiences simultaneously and to observe internal sensations while retaining awareness of surroundings (`Noticing' as in mindful awareness allows the client to achieve `dual awareness', the ability to stay connected to the emotional or somatic experience while also observing it from a very slight mindful distance'; Fisher, 2017). Also known as dual presence, dual awareness is central to self-regulation and thus a skill to be cultivated in therapy as early as possible. It is also essential for trauma processing, `allowing us to explore the past without risk of retraumatization by keeping one `foot' in the present and one `foot'* in *the past' (Fisher, 2017). See `mindfulness', `implicit memory'.*

---

early onset trauma *– Trauma which is experienced in childhood. Current research on the developing brain in the context of early attachment relationships substantiates that early onset trauma – particularly when it is prolonged, repetitive, and unrepaired – is highly damaging. In light of increased understanding of the centrality of the right brain hemisphere to social connectedness, self-regulatory capacity, and development per se, parental attunement to the emotional needs of the infant is as vital as meeting physical needs (i.e. in fostering the ability to manage emotion, which is crucial to healthy development). See `developmental trauma', `Developmental Trauma Disorder'.*

---

earned autonomy – *See `earned security'*

---

earned security *– The conversion of `insecure' attachment to `secure' attachment via the working through, processing, and resolution of adverse childhood experience. The exciting corollary is that when earned security takes place (via attainment of a coherent perspective on childhood experience) this also benefits the next generation in terms of positive modifications of parenting styles (`These are adults who appear to have had difficult childhoods, but… have made sense of their lives. The children attached to these adults have secure attachments and do well! History is not destiny – if you've come to make sense of your life'; Siegel, 2003). The possibility and many positive effects of earned security (sometimes called `earned autonomy') powerfully attest to the neuroplasticity of the brain. See `neuroplasticity', `neurobiology of attachment', psychotherapy'.*

---

ego state - *`one of a group of personality states that is relatively stable across time' and which `is distinguished by a specific role, emotion, behavioral, memory, and/or cognitive function' (Phillips & Frederick, 2010). An ego state is an `organized system of behaviour and experience whose elements are bound together by some common principle but that is separated from other such states by boundaries that are more or less permeable' (Watkins & Watkins, 1997). While described in different ways (e.g. parts, self-states; see relevant listings) ego states are widely regarded to characterise the internal world of all individuals: `Ego states exist as a normal aspect of personality development. Every individual has a number of different ego states, each of which is designed to assist the personality in important ways. Ego states evolve as creative ways of coping with the demands of external environments, allowing us to master developmental challenges such as distinguishing between acceptable responses in social, home, and school situations' (Phillips & Frederick, 2010).*

Ego state therapy *– `a psychodynamic approach in which techniques of group and family therapy are employed to resolve conflicts between various `ego states' that constitute a `family of self' within a single individual' (Watkins, 1993). Internal Family Systems (IFS) developed by Richard C. Schwartz (1995) is the most well-known and popular variety of ego state therapy. Many clinicians working with complex trauma draw on IFS (e.g. Fisher, 2017). Note, however, that diverse psychotherapeutic modalities recognise diverse inner states (`ego states') regardless of approach and nomenclature: `Every major school of psychology recognizes that people have subpersonalities and gives them different names' (van der Kolk, 2015). See `ego state', `self', `self-states', `self-system', `parts', `alters'.*

endogenous opioids *– Neurochemicals which relieve pain in `fight or flight' situations, and which are also implicated in maladaptive coping strategies in post-traumatic reactions. Endogenous opioids are now recognised to be potentially operative in dissociative responses (Cozolino, 2002), the self-harm often enacted by adults who have experienced child abuse (van der Kolk, 1994) and in relation to eating disorders (Middleton, 2007). Enhanced understanding of the operation and function of endogenous opioids strengthens the case for a revised understanding of post-traumatic `symptoms' as post-traumatic `coping strategies'. See `symptoms', `coping strategies', `somatisation', `Medically Unexplained Symptoms'.*

epigenesis *– The process whereby early experiences can alter the long-term regulation of genetic functioning within the nuclei of neurons – `If early experiences are positive… chemical controls over how genes are expressed in specific areas of the brain can alter the regulation of our nervous system in such a way as to reinforce the quality of emotional resilience. If early experiences are negative, however, it has been shown that alterations in the control of genes influencing the stress response may diminish resilience in children and compromise their ability to adjust to stressful events in the future' (Siegel, 2010).*

ethical practice *– the code of conduct, both implicit and explicit, by which responsible and professional practice is carried out. Ethical practice in psychotherapy requires several dimensions, which include clinical supervision and self-care as well as adherence to such principles as client confidentiality (subject to some exceptions) and informed consent. Ethical practice can also be regarded as a component of effective risk-management. See `risk-management', `self-care', `supervision'.*

evidence-based treatment and practice *– A description and endorsement accorded to the application of treatments and therapies which have undergone scientific testing and research. While seemingly unexceptionable, the requirement that treatments be `evidence-based' is problematic in a number of respects (for example in privileging a scientific paradigm the applicability of which is not questioned). Absence or paucity of research into a particular treatment does not of itself mean that a therapy `doesn't work', as research in relation to it may not have been carried out. This is an important point to underline in a culture in which `lack of evidence' (which routinely equates to scientific evidence) can wrongly imply a treatment approach to be ineffective. By contrast, `practice-based evidence' suggests a different reading of what `evidence' comprises.*

Currently existing treatment methods are known to be ineffective for 25-50% of patients enrolled in clinical trials (Thal & Lommen, 2018, citing many sources). Official evidence-based treatments have also been criticised as `protocolised and affect-phobic, with most trauma memory dismissed as irrelevant and any strong affect regulated by top-down control' (Schwarz, Corrigan et al, 2017). Thus people `unable to make use of time-limited evidence-based strategies may face rejection and labelling, feeling blamed for their lack of improvement and treatment resistance' (Schwarz, Corrigan et al, ibid). In fact `the evidence indicates that modalities tested in randomised controlled trials (RCTs) are far from 100% applicable and effective and the RCT model itself is inadequate for evaluating treatments of conditions with complex presentations and frequently multiple comorbidities' (Corrigan & Hull, 2015).

Requiring all treatments to be `evidence-based' is unrealistic and ill-advised given the many problems associated with this `standard', and its more specific limitations for complex trauma. For example, restricted entry criteria (a `norm' which is beginning to change in some instances) continue to preclude complex trauma clients from participating in trauma method outcome studies (Rothschild, 2011). Calls for 'trauma-informed' care and practice also highlight the limits of the imprimatur of `evidence-based' as a necessary and sufficient measure of treatment effectiveness: `Without such a shift [towards trauma-informed care]… even the most `evidence-based' treatment approaches may be compromised' (Jennings, 2004). Note that the neurobiology of attachment now comprises a strong evidence base. See `exposure therapies', `practice-based evidence'.

exposure therapies – *Psychotherapies, generally short term and cognitive based, which eschew the `stabilisation' phase recommended by the phased treatment approach to complex trauma in favour of early confronting of the client with the distressing material being avoided. Notwithstanding the imprimatur of `evidence based' and some studies which suggest otherwise, exposure therapies are problematic for complex trauma clients and especially in relation to the risks of dissociation (Spiegel, 2018, Herman, 2009; and see ch.3 in Practice Guidelines for Clinical Treatment of Complex Trauma, 2019). See `trauma treatment', `evidence-based treatment and practice', `prolonged exposure', `phased treatment'.*

---

expressive therapies *– Neuroscientific research which shows the centrality of physiological processes to emotional experience also suggests the limits of psychotherapeutic approaches which privilege `talk' and the spoken word (`To make meaning of the traumatic experience usually is not enough. Traumatised individuals need to have experiences that directly contradict the emotional helplessness and physical paralysis that accompany traumatic experiences'; van der Kolk, 2003). For this reason, and in contrast to both cognitive and insight-based approaches, `expressive' therapies which can engage right-brain processes and physicality may be highly beneficial. Expressive therapies are numerous and varied, and include bodywork, art therapy, and sandplay. See `body', `right brain'.*

---

exteroception *– attunement to stimuli originating outside of the body*

Eye Movement Desensitization and Reprocessing (EMDR) *– A therapeutic form of bilateral stimulation effective in treating a broad range of trauma, and which, subject to the client's ability to tolerate affect, can achieve dramatic results in a single session (Shapiro, 2010). Note that while directed to the eyes, other forms of bilateral stimulation (e.g. alternating hand taps or headsets playing alternating tones or music) are also found to be effective (Ibid). In 2018, three decades after its initial formulation, the third edition of Shapiro's Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures became available. In prefatory comments, Shapiro notes that `[s]ince the early days of controversy' over thirty randomised studies have verified the approach, and `hundreds of published peer-reviewed articles have documented positive treatment effects for a wide range of populations' (Shapiro, 2018).*

In relation to complex trauma and dissociation, however, a 2009 review recommended `a phase oriented EMDR model' which emphasises `the role of resource development and installation (RDI) and other strategies that address the needs of patients with compromised affect tolerance and self-regulation' (Korn, 2009). Shapiro is explicit in the 2018 reiteration of her landmark text that `[n]o clinician should use EMDR therapy with a client suffering from a dissociative disorder unless he is educated and experienced in working with this population…The clinician should also have a clear understanding regarding strategies for assisting the client in managing intense affect during EMDR processing, the client's dissociated system, and the client's defensiveness and resistance. The potential for harm with this type of client is great if EMDR reprocessing is used inappropriately or injudiciously' (Shapiro, 2018).

Fantasy Model - *Also known as the sociocognitive, iatrogenic or non trauma-related model, the `Fantasy Model' contests that Dissociative Identity Disorder (DID) is a disorder with its aetiology in childhood trauma. This is in contrast to proponents of the `Trauma Model': `Skeptics counter that dissociation produces fantasies of trauma, and that DD [i.e. dissociative disorders] are artefactual conditions produced by iatrogenesis and/or socio-cultural factors' (Loewenstein, 2018). This is notwithstanding that `[a]most no research or clinical data support this view' (Loewenstein, 2018).*

Evolving psychobiological, psychophysiological, and other data supports the Trauma Model rather than the Fantasy Model: `[c]omparisons of neural activity for individuals with DID and non-DID simulating controls suggest that the resting-state features…in DID are not due to imagination'* (Schlumpf, Reinders et al, 2014). *These findings are `inconsistent with the idea that DID is caused by suggestion, fantasy-proneness and role-playing', and correspondingly are `inconsistent with the sociocognitive model of DID' (Schlumpf, Reinders et al ibid). Yet while confirmed to have little empirical support (Dalenberg et al, 2014; Reinders, Willemsen et al, 2016; Schimmenti, 2017) the claims of the Fantasy Model, like the many myths about DID, continue to circulate. See `Trauma Model', `dissociative disorder', `Dissociative Identity Disorder', `implicit memory' `recovered memory'.

---

flashbacks *– Intrusive and disturbing memories in the form of images and/or sensory inputs which are indicators of unprocessed traumatic experience. See `post-traumatic stress disorder' (PTSD), `implicit memory'.*

---

hyperarousal *– Physiological and psychological agitation which stems from over activation of the central nervous system and which can be a key indicator of trauma. See `trauma treatment', `window of tolerance'.*

---

hypnotherapy – *the clinical application of hypnosis for therapeutic purposes. As an inclusive, facilitative orientation to health and well-being, hypnotherapy is very different from `stage' hypnosis and authoritarian directives. It also has an evidence base in relation to a range of psychological issues (Spiegel & Spiegel, 2004; Brann, Owens et al, 2015; Lynn, Rhue & Kirsch, 2010). Hypnosis is `a facilitator of treatment interventions, not a therapy or treatment in itself' (Kluft, 2017). In its demonstrated capacity to gain access to the subconscious mind, there are also many ways in which it may facilitate treatment of complex trauma and can be integrated into a phased treatment approach (Phillips & Frederick, 1995; Schwarz, 2002). See `phased treatment', `self-state', `dissociation', `complex trauma'.*

---

hypoarousal *– Emotional numbing or `shut down'. In contrast to the generally visible signs of hyperarousal, hypoarousal is also an indicator of trauma (`Emotional numbing alternating with periods of high arousal is characteristic of PTSD'; Bloom, 2011). It is extremely important that hypoarousal is identified as a trauma response. This is because it can be misperceived as a simple lack of expressiveness which risks being challenged to elicit a visible reaction (a major error which can lead to re-traumatisation; also note that it is possible for a person to be behaviourally active while dissociated). See `trauma treatment', `window of tolerance'.*

---

implicit memory *– Non-verbal and largely non-conscious recollection which relates to neural networks central to organisation of sensation, emotion and behaviour (Levine, 2015). Much implicit memory derives from early attachment experience with caregivers (Cozolino, 2002; Schore, 2003). Because early life experience occurs when the right brain hemisphere is dominant, it is remembered implicitly as `schemas' rather than explicitly (i.e. in contrast to conscious memory which is linked to subsequent development of the left brain hemisphere). Since it is `stored' as implicit rather than conscious memory, early attachment experience tends to be enacted and embodied rather than expressed in words. Also note the role of autonomic responses and the subcortical process of threat detection in the environment (i.e. neuroception; evaluation of risk without awareness) which `range from adaptive protection to social connection', and which register implicit memory which, `depending on past experiences, produces experiences of ventral vagal flow, sympathetic mobilization, or dorsal vagal immobilization' (Dana & Grant, in Porges & Dana, 2018). See `neuroception', `neurobiology of attachment', `Polyvagal Theory', `re-enactment', `recovered memory'.*

---

integration *– Coherence between different levels of functioning, which requires the linked operation of neural pathways in the brain. Neuroscientific research reveals that integration is the hallmark of wellbeing (Siegel, 1999, 2010; Cozolino, 2002). Basic requirements of integration are linked activity between the brain stem, limbic region and cortex (`vertical integration') and between the left and right brain hemispheres (`horizontal integration'). Trauma profoundly disrupts integration. In neuroscientific terms, effective trauma therapy entails repair and realignment of disrupted neural pathways (Cozolino, 2002).*

Note that the term integration has more specific connotations in the context of treatment for DID, and that the extent to which full integration of the diverse self-states or alters of the internal world of DID clients is necessary (i.e. as distinct from increased communication and cooperation between them) is now somewhat contested.

---

intergenerational trauma *– See transgenerational trauma*

International Classification of Diseases (ICD) – *The international diagnostic compendium for classification of health and disease. Unlike the American Diagnostic and Statistical Manual of Mental Disorders (DSM; current edition DSM-5, 2013) the current edition of the ICD (ICD 11) now includes a diagnosis of Complex Posttraumatic Stress Disorder (CPTSD). See `Complex Posttraumatic Stress Disorder', `complex trauma', `Diagnostic and Statistical Manual of Mental Disorders'.*

---

interoception *– sensitivity to stimuli from within the body*

---

interpersonal neurobiology *The processes by which experience activates neural mechanisms in the formation of mind and self (`the structure and functioning of the mind and brain are shaped by experiences, especially those involving emotional relationships'; Siegel, 2003). Also see `neurobiology of attachment', `social brain'.*

---

learning brain *– Development of neural networks in infancy fosters what has been called the `learning brain' (Ford 2009). Necessary for the developmental task of self-awareness, the learning brain requires sufficient support from caregivers and the external environment to sustain it. In the absence of such support, there is a shift to a `survival' brain, which is highly damaging in impeding both learning and development. Also see `interpersonal neurobiology', `neurobiology of attachment',`survival brain'.*

Medically Unexplained Symptoms (MUS) - *Symptoms for which there is no apparent organic cause. The dysregulation of unresolved trauma has physical as well as psychological impacts; impaired capacity to integrate and cognitively represent bodily states can lead to `distressing somatic complaints, concerns and symptoms' as well as to distressing feelings and thoughts (Schimmenti & Caretti, 2016). Many clients who experience the impacts of complex trauma consult a `psy' practitioner when medical tests are inconclusive and the sources of `physical' pain are unclear (`every physician will see several patients with high ACE scores each day'; Felitti, 2010). `Somatization is a dissociative process… and we pay a steep price when this possibility is overlooked in the medical investigation of chronic pain'; Chefetz, 2015; ref Nijenhuis, 2000). See `somatisation', `symptoms', `endogenous opioids', `trauma screening'.*

mindfulness *– A state of focused attention. Inspired by Buddhist and other spiritual traditions, the benefits of cultivating attuned awareness are now widely endorsed not only for spiritual practice but for general health and well-being. A mindful approach to experience fosters inner coherence and integration, and is currently encouraged by diverse schools of psychotherapy. The challenge for complex trauma clients is that mindful awareness and dissociation are rival brain activities (Forner, 2017) and dysregulated people are often destabilised by attempts to notice their physical sensations. Hence the importance of appropriate resourcing and `Phase 1' of complex trauma treatment. Also note that mindfulness in the sense of non-judgmental `noticing' is different from mindful meditation. Clients should not be encouraged to meditate unless or until they have acquired the ability to self-regulate. See `dual awareness', `phased treatment'.*

MUS: *See `Medically Unexplained Symptoms'*

---

neurobiology of attachment *– Convergent findings from the fields of affective neuroscience and attachment theory, which show `how the developing mind is shaped by the interaction of interpersonal experience and neurobiological processes in the creation of the human mind' (Siegel, 2003). See `interpersonal neurobiology', `neuroplasticity'.*

---

neuroception – *term coined by Stephen Porges to describe the subcortical process of threat detection in the environment; i.e. `the nervous system's capacity to evaluate risk without awareness' (Lindaman & Makela in Porges & Dana, 2018). Consistent with the principles of Polyvagal Theory, `[t]he vagus knows before cognition, and this means neuroception precedes cognition' (Theede, 2018). See `Polyvagal Theory', `Polyvagal Therapy', `implicit memory'.*

---

neurosplasticity *– The capacity of the brain to reorganise and form new neural connections in light of environmental stimuli. Contrary to long-standing belief that the brain is `hard-wired' or `fixed', neuroscientific findings show that it is malleable, and that it changes both structurally and functionally with social experience (Siegel, 1999: Cozolino, 2002; Doidge, 2007). This fundamental and pathbreaking recognition has implications for a wide range of fields and practices, and notably in mental health. Neuroplasticity means that experience changes the brain, and this goes both ways – just as damaging experiences change the brain in ways that impair subsequent functioning, different and positive experiences also change the brain in ways that are conducive to health. Studies now show that it is possible for trauma to be resolved, and that `experience in later relationships can actually change the future development of the mind' (Siegel, 2003). See `neurobiology of attachment', `interpersonal neurobiology'.*

OSDD *– see `Other Specified Dissociative Disorder'*

Other Specified Dissociative Disorder (OSDD) –*Diagnostic category which in DSM-5 has replaced the previous classification of Dissociative Disorders Not Otherwise Specified (DDNOS), and `applies to presentations in which symptoms characteristic of a dissociative disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the dissociative disorders diagnostic class' http://traumadissociation.com/osdd See `Diagnostic and Statistical Manual of Mental Disorders' (DSM), `International Classification of Diseases' (ICD), `Complex Posttraumatic Stress Disorder'.*

oxytocin *– Hormone which plays a significant role in childbirth, and which is important in the physiology of early attachment with respect to experiencing safety and developing empathy and trust (Carter & Ahnert, 2005; Churchland, 2011).*

---

parallel process – *A psychoanalytic concept which has traditionally been applied to the psychotherapy supervisory relationship when it mirrors what is occurring in the relationship between therapist and client. Bloom (2011) extrapolates this concept to the context of organisations, which she argues can become dysfunctionally `trauma-organised' in relation to the trauma experienced by their clients. See* `organisational trauma', `trauma-informed'.

---

part/s - *It is widely accepted that what we call `self' is not fixed or unified but rather consists of fluctuating states: `The self is characterized by a complex multiplicity of subunits and subselves and even the multiple parts themselves have parts' (Howell,2005; ref Erdelyi, 1994); `It is the nature of the human mind to be subdivided…Parts exist from birth… multiplicity is inherent in the nature of the mind' (Schwartz, 1995); `Modern neuroscience has confirmed this notion of the mind as a kind of society'; `The mind is a mosaic'; `We all have parts' (van der Kolk, 2015). Yet standard theories of personality continue to emphasise `fixed, persistent, and globally defining traits' (Putnam, 2016).*

It is important to be aware that `[p]arts are not just feelings but distinct ways of being, with their own beliefs, agendas, and roles in the overall ecology of our lives' (van der Kolk, ibid). In healthy functioning we can move flexibly between states and parts of the self, where `the important issue is not how many parts there are, but how they hang together' (Howell, 2005). Trauma and problematically unintegrated self-states impede internal flexibility, and can lead to internal configurations in which `a part of… psychic functioning… seems to operate independently from the other parts' (Schimmenti & Caretti, 2016; ref Steele, Van der Hart & Nijenhuis, 2006).

To the extent that `we all have parts' (van der Kolk, ibid) using the language of parts in therapy is realistic for all clients. It also reduces stigma for clients who experience the impacts of trauma (`traumatized patients generally find `parts of the personality' or `parts of yourself' an apt description of their subjective experience'; van der Hart, et al, 2006). Utilisation of the language of parts is also helpful in reflecting `how the mental and behavioural actions of survivors shift with the type of dissociative part that exerts executive control' (van der Hart et al, 2006) See `self', `self-state/s'; `self -system', `ego state/ therapy', `alter'.

---

pathology *– Commonly defined as the opposite state to health, the notion of pathology is intrinsic to biomedical frameworks of understanding, which when not acknowledging `biopsychosocial' factors, locate pathology within the individual. In establishing the unequivocal relationship between human growth and development, neuroscientific findings about `the social brain' pose challenges to individualist readings of health and pathology. See `neurobiology of attachment', `symptoms', `trauma-informed'.*

---

phased treatment *– Effective trauma treatment cannot proceed if the client is unable to tolerate affect. Since complex trauma impairs the capacity to regulate affect, graduated or `phased' treatment is recommended for treatment of trauma in its complex forms (The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults, 2012*) https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf *These guidelines remain the standard for complex trauma treatment despite some critiques of the phased based approach (see `Revisiting Phased Treatment for Complex Trauma', ch.3 in Practice Guidelines for Clinical Treatment of Complex Trauma, 2019). Also see `complex trauma treatment', `early onset trauma'.*

politics of trauma *– The relationship between trauma and politics, articulated by Judith Herman in her classic text Trauma and Recovery (1992, 1997) was rearticulated more recently by Bessel van der Kolk in The Body Keeps the Score (2015). It can also take many forms, e.g. failure to recognise and respond to the prevalence of trauma and to prioritise it as a public health problem. Middleton (2012) criticises the `rebadging' of a range of psychiatric problems to effectively conceal the trauma which underlies them.*

`Inability to see' the prevalence of trauma can be unconscious (as the concept of `social defence mechanisms' conveys; Bloom, 2011). Additionally, diverse and powerful interests are safeguarded when the pervasiveness of trauma is not confronted; vested interests which may operate unconsciously are protected by such myopia. Neuroscientific findings have radical implications for a range of areas, especially the mental health field. They also extend beyond `social model of health' frameworks which have challenged the individualist paradigm since the 1970s. If subjectivity is inherently relational – and the brain itself is `social' – this requires reconceptualisation of the very categories by which we structure our perceptions. Correspondingly, it requires recognition of the extent to which problems conventionally described as `personal' and `individual' are also social and political. This has major implications for the ways in which social policy is constructed and funding is allocated. See `social brain', `social defense mechanisms', `violence', `trauma-informed'.

Polyvagal Theory – *Account of the neurophysiological underpinnings of the experience of safety, and the emotions and cognitions which support and erode it. Developed by American psychiatrist Stephen Porges, The Polyvagal Theory (2011) was hailed as ground-breaking and its implications continue to reverberate. For example, it explains why `[i]t is not language, it is our biology that communicates safety' (Gray, 2018) and why thoughts, feelings, and verbalisations are actually `epiphenomena, all driven by body-based, nonverbal data' (`the story arises from the autonomic state first, and then the top down cognitions and narrative helps to solidify the experiential state'; Schwarz, 2018). The implications for effective trauma treatment are major. See `Polyvagal Therapy'.*

Polyvagal therapy *– Application of the principles of the Polyvagal Theory (2011) to psychotherapeutic practice. Publication of Clinical Applications of the Polyvagal Theory (2018) builds on the recognition that `[i]t is not possible to shift emotional and psychological states without shifting physiological states' (Gray, 2018). This understanding has major implications for psychotherapy in general and for trauma treatment in particular. In order to feel safe, sympathetic or dorsal vagal reactivity needs to be reduced via ventral vagal regulation (Porges, 2011). Methods which can assist this process become critical; indeed `[c]ues of safety are the treatment' (Porges, 2018).*

Extension of the Polyvagal Theory to clinical practice introduces the notion of polyvagal therapies. It also offers a sound rationale from which to potentially integrate somatic based interventions with `talk therapy'. For example, Bessel van der Kolk highlights the extent to which the principles of Polyvagal Theory seem to support `disparate, unconventional techniques' from a range of `age-old, nonpharmacological approaches that have long been practised outside Western medicine' (van der Kolk, 2015). Also see `New' and Emerging Treatments', ch.4 in Practice Guidelines for Clinical Treatment of Complex Trauma (2019).

---

post-traumatic stress disorder (PTSD) *– A disabling condition of unresolved trauma which can follow experience or witnessing of an event or events involving actual or threatened death or serious injury to oneself or others or threat to the physical integrity of oneself or others. Symptoms need to have been present for at least one month and include persistent hyperarousal, avoidance of reminders of the traumatic event, involuntary recall of the incident (e.g. via intrusive images or flashbacks) and compromised quality of life. It is estimated that approximately 20-25% of people who experience traumatic events go on to develop PTSD (Rothschild, 2011).*

`Standard' or `single-incident' PTSD might follow a motor vehicle accident, natural disaster, combat experience or single incident of assault. This is in contrast to `complex' trauma, which is multiple, cumulative and often interpersonally generated (such as experience of recurrent abuse). People who experience complex trauma are at higher risk for development of `standard', `single incident' PTSD. The current iteration of the International Classification of Diseases includes a diagnosis of Complex Post-Traumatic Stress Disorder (CPTSD) but the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) does not (although does include a dissociative subtype of PTSD). See `Complex Post-Traumatic Stress Disorder', `complex trauma', `diagnosis of trauma', `Diagnostic and Statistical Manual of Mental Disorders', `dissociative subtype of PTSD'.

---

practice-based evidence *– An inversion of, and alternative to, the paradigm of `evidence-based practice'. In contrast to the latter, `practice-based evidence' gauges treatment effectiveness with reference to client feedback which in turn guides the treatment (Miller, 2005). Correspondingly, it recognises the input of the clinician to the therapies being applied. Practice based evidence converges with the view that the most valuable measure of treatment effectiveness is* client outcomes *(on which there is comparatively much less emphasis when evidence-based practice is regarded as definitive). Also see `evidence-based treatment and practice'*

---

prolonged exposure (PE) – *an evidence-based psychotherapy whereby the client is encouraged to repetitively retell their trauma experience with a view to systematic desensitisation to its distressing impact. Regardless of its adherents and its status as an evidence-based treatment, the benefits of this approach for complex trauma which involves interpersonal violation and betrayal have been questioned (i.e. complex trauma is unlike simple phobias; to what, in the context of relational trauma, should clients be `exposed'?) Questions also arise about the benefits of PE for severely dissociative clients. A study of the effectiveness of PE for treatment of complex trauma (i.e. as well as of standard PTSD) found that it was less efficacious than anticipated: `It is arguable the most surprising result in our study was the poor performance of prolonged exposure therapy process….PE is often touted as the first-line treatment for distressed trauma survivors (Foa, 2009), but we found little evidence that PE was helpful for these clients, and some evidence of adverse effects' (D'Andrea & Pole, 2012: 444; also see Emerson & Hopper, 2011:15-16). Peter Levine is explicit that `prolonged exposure types of therapies …. though they undoubtedly do help some… harm others' (Levine, 2015). See `exposure therapies', `complex trauma treatment', `evidence-based treatment and practice', `phased treatment'.*

---

psychotherapy *– The practice by which a trained professional assists clients to address emotional and psychological problems. Following the initial dominance of psychoanalysis (the original `talking cure' pioneered by Freud in the late nineteenth century) psychotherapy has become a diverse field which includes an expanding range of approaches and modalities. It is also a field undergoing reappraisal and renaissance as its central tenets have been found to correlate with neuroscientific principles (Cozolino, 2002; Doidge, 2007; the latter describes psychotherapy as `a neuroplastic therapy').*

Psychotherapy is now regarded as `an enriched environment that promotes the development of cognitive, emotional and behavioural abilities' (Cozolino, 2002). Cozolino argues that `all forms of psychotherapy – from psychoanalysis to behavioural interventions – are successful to the extent to which they enhance change in relevant neural circuits' (Ibid).

Note, however, that current research in the physiology and psychobiology of trauma also suggests `the limits of talk' to resolve trauma (Ogden et al, 2006; van der Kolk, 2003; Porges, 2011). This in turn suggests the need to supplement traditional psychotherapeutic orientations with approaches which can directly engage somatic and `right brain' processes. See `body', `expressive therapies', `right brain', `traditional psychotherapy'.

---

psychodynamic psychotherapy *An interpretive and insight-based variety of psychotherapy which is directly traceable to Freudian psychoanalysis. Psychodynamic psychotherapies (which differ from the classical Freudian period of psychoanalysis and following `the relational turn') can be very valuable in working with the unconscious processes and self-states of complex trauma. Yet neuroscientific research also suggests the limits of psychotherapies which fail to attend to bodily experience, and there are now a range of therapeutic approaches which focus on areas which psychodynamic approaches do not (`It is possible that some of the newer body-oriented therapies, dialectical behaviour therapy, or EMDR may yield benefits that traditional insight-oriented therapies may lack'; van der Kolk, 2003). See `self state', `parts', `self-system', `body', `expressive therapies', `traditional psychotherapy', `body', `expressive therapies', `traditional psychotherapy'.*

---

recovered memory – *Delayed conscious recall of experience too overwhelming to be assimilated at the time of the original trauma. Overwhelm limits the functioning of the hippocampus, the part of the brain which is central to the encoding of memory and to conscious recall. Fragments of memory of the traumatic experience are stored somatically, and are reactivated - sometimes years later - by sensory stimuli which serve as `triggers' to conscious recall (`Contrary to the widespread myth that traumatic events are seldom if ever forgotten, much trauma is not remembered until something happens to bring it to mind'; Brewin, 2012).*

Traumatic memory relates to implicit (non-conscious) rather than explicit (conscious) memory and is expressed in `physical sensations, automatic responses and involuntary movements' (Ogden et al, 2006) rather than spoken language. The book titles The Body Remembers (Rothschild, 2000) and The Body Keeps the Score (van der Kolk, 2015) are illustrative. Recovered memory occurs in relation to diverse types of trauma (van der Hart et al, 1999) but its reliability is usually only contested in relation to child sexual abuse. It is important to be aware that research `has firmly established the reliability of the phenomenon of recovered memory' (Dalenberg, 2006). It is also important to be aware that studies show that recovered memories `can often be corroborated and are no more likely to be confabulated than are continuous memories' (Chu, 2011: 80; Barlow et al, 2017). See `implicit memory', `explicit memory', `re-enactment'.

---

recovery *– As applied in the field of mental health, the belief that impaired psychological functioning `is based on more than diagnosed pathology or the intensity of symptoms, [and] is the product of interactions between the individual and the environment' (Anthony, Cohen & Farkas, 1990, in Jacobson & Curtis, 2000). In contrast to physical illness (also recognising the interconnections) the term `recovery' has only recently been applied to psychological conditions. It also contains an implicit critique both of longstanding assumptions that recovery from mental illness is not possible, and of the systems and institutions organised around this belief.*

In the language of psychiatric rehabilitation, `recovery' refers primarily to functional ability. But for those who identify with lived experience of emotional and psychological challenges, the concept has both personal and political implications – `to recover is to reclaim one's life, to validate one's self in order that one may be validated as an autonomous, competent individual in the world' (Ibid) Thus recovery is centrally related to the concept of empowerment, which is also an underpinning principle of trauma-informed care. See `resilience', `trauma-informed care'.

---

re-enactment *– The repetition of prior experience which is an expression of implicit memory and which is particularly marked in the context of trauma. Traumatic re-enactment has long been observed as a response to trauma, and was described by Freud (1920) as `the compulsion to repeat'. It is also increasingly recognised to have strong biological foundations, and to be `part of the innate and programmed behavioral repertoire of the traumatised person' (Bloom, 2011). It is for this reason that contemporary research suggests the need for traditional psychotherapy to take more direct account of physical movement and the body, as in sensorimotor approaches (van der Kolk, 2003, 2007).*

The relationship between traumatic re-enactment and unresolved grief is emphasised by some – `The person continually re-enacts what he or she has not been able to resolve… unresolved loss becomes another dynamic that keeps an individual stuck in time, unable to move ahead, and unable to go back. Compounded and unresolved grief is frequently in the background of lives based on traumatic reenactment' (Bloom, 2011). See `trauma', `complex trauma', `recovered memory', `body'.

***relational trauma** – Interpersonally generated trauma which is not necessarily the product of experience within the family or with people to whom one is interpersonally attached (Shapiro, 2010). Examples of relational trauma include bullying, humiliation and shaming, rejection by a love object, having to keep a secret which sets one apart, and having one's needs ignored at any age – `All of these situations can create trauma. Any of them, chronically experienced, can root deeply into human neurology, creating a distorted view of the self (`I'm not worth caring about'; `I'm bad'; `Anything I try to do is futile.' (Ibid) See `complex trauma'.*

***resilience** – The capacity to sustain and respond positively to life stress, setback and difficulty. While initially conceptualised in individualistic terms, recent research emphasises the importance of social, cultural and environmental processes in fostering and supporting this capacity (Liebenberg & Ungar, 2009). While strengths-based rather than deficit-based, it is important that resilience is not celebrated at the expense of recognising difficulties. For example, compartmentalised functioning may mean that a client seems to `tick all the boxes' of health according to external criteria (e.g. in employment, intimate relationship etc) but may also experience compromised quality of life. See `coping strategies', `dissociation', `Medically Unexplained Symptoms'.*

***resources –** assets and strategies, both internal and external, which can be drawn upon to support well-being. The ability to access supportive resources is central to self-regulation and healthy functioning and is radically impeded by unresolved trauma. Complex trauma, particularly if it relates to childhood experience, can also damage the* capacity *to access resources, which means that the therapeutic challenge of `resourcing' the complex trauma client is itself more complex than for clients who do not have trauma histories. See `complex trauma', `expressive therapies', `implicit memory'.*

***retraumatisation –** Recurrence and re-experience of trauma. Research shows that re-traumatisation of clients takes place within the mental health system itself (Jennings, 2004; Fallot & Harris, 2009). It further shows that service practices which contribute to re-traumatisation rather than recovery are not exceptional, but pervasive and deeply entrenched. This underlines both the limits of individualist frameworks, and the need for introduction of care and practice which is `trauma-informed'. See `reenactment', `trauma-informed'.*

***right brain** – The right brain hemisphere, also known as the `emotional' brain, is critical to the processing of emotion and the regulation of affect. In contrast to the left or `cognitive' brain, the right brain is dominant in infancy, `indicating the essentially affective nature of mental functioning in the first years of life' (Fosha, 2003). See `neurobiology of attachment', `early onset trauma'.*

***risk-management** – The suite of policies, strategies and methods by which professional practice is safeguarded and maintained. Effective risk management in psychotherapy entails several components, of which respect for and implementation of boundaries, professional indemnity insurance, regular clinical supervision, and attentiveness to self (i.e. as well as client) care are some. Compliance with the relevant ethics codes and ethical practice are also part of risk-management. In organisational settings, risk management entails maintenance of a context which is conducive to conducting ethical practice at all times. See `ethical practice', `self-care', `supervision'.*

---

safety *– The foundational principle of complex trauma treatment, which may need to be actively facilitated as people with complex trauma histories might not previously have experienced it. A sense of safety is prerequisite to the ability to regulate affect, which is itself critical to the capacity to process and integrate trauma. Safety is also a key concept of trauma-informed care and practice (the others being trustworthiness, choice, collaboration and empowerment; Fallot & Harris, 2009). See `trauma-informed', `phased treatment'.*

---

secondary trauma – *A variety of `indirect' overwhelming experience which can stem from proximity to trauma; and which includes `the parallel trauma symptoms that helpers may develop in working with traumatised clients' (Pearlman & Caringi, 2009). Also previously known as secondary traumatic stress disorder (Figley, 1995) it is commonly now known as compassion fatigue. See `compassion fatigue', `burnout', `risk-management'.*

---

self *– the concept of `self' has long been problematic and difficult to define. What is increasingly clear is that mental life is `full of discontinuities' (Spiegel, 2018). Neuroscientific research reveals that `[t]he concept of a single, unitary `self' is as misleading as the concept of a single unitary `brain' (Schore, 2011). Research in the neurobiology of attachment also confirms that `self' is not a `given'. Rather, it is constructed over time in the context of early and subsequent experience in interpersonal relationships. When seen in this light, it becomes easier to understand how disturbances of self occur in interactions with others, that traumatic interpersonal experiences can disrupt self-coherence, continuity and identity (especially if trauma occurs early in life) and that resolution of trauma is necessary for self-regulation, self-development and healthy functioning. See `self-state/s', `ego state/s', `neurobiology of attachment', `complex trauma', `social brain'.*

---

self-care *– Attentiveness to one's own needs, especially for rest and relaxation, and to the general `looking after' of self. Ability to self-care is an indicator of healthy self-respect, and is very different from `selfishness'. Self-care is a key component of professional and ethical therapeutic practice, both in fostering the therapist's well-being in light of the intensity of psychotherapeutic work, and in modelling this ability for clients. See `ethical practice', `risk management' and `supervision'.*

---

self-harm *– Harm inflicted on the self which can take a number of forms but which frequently describes direct and intentional injury to body tissue. Self-harm is a frequent response to trauma, particularly when the trauma is sexual and early onset. Rather than indicating suicidal intent, self-harm more often serves a self-regulatory function and `is most often performed with intent to alleviate negative affect' (Klonsky, 2007). See `adaptation to trauma', `blaming the victim', `coping strategies', `early onset trauma', `endogenous opioids', `trauma-informed'.*

---

self-soothing – *Management of emotion; particularly the ability to establish or restore inner calm when experience is stressful. The capacity to self-soothe is a vital precondition to processing and integration of trauma. See `neurobiology of attachment', `phased treatment', `right brain', `safety'.*

---

self-state/s – *What we call `self' is not unitary (see listing for `self') but rather comprises diverse states. These are variously described as self-states, ego states, and/or `parts' (see listings for these terms). We are all subject to state change/s and fluctuations. In this sense multiplicity is the norm and `[w]e are all multiple to some degree' (Putnam,2016). Standard theories of personality, in their emphasis on `fixed, persistent, and globally defining traits', do not assist us to comprehend this (Putnam, 2016). By contrast, the `state model' defines self and personality as `the collective dynamics of a person's set of identity, emotional and behavioural states' (Putnam, 2016). See `self', `self- system', `ego states', `parts'.*

---

self-system –*The configuration of self-states which comprises the multiplicity of the mind: `The left and right [brain] hemispheres process information in their own unique fashion and represent a conscious left brain self system and an unconscious right brain self system' (Schore, 2011). Severe traumatic disruption in early life can generate many diverse self-states and an extremely complex self-system of which Dissociative Identity Disorder (DID) is the most severe outcome: `Scepticism about numbers of self-states is a potential intellectualization and deflection of the sad reality…an intolerance of the reality of severe abuse' (Chefetz, 2015). See `self', `self-state/s', `ego states', `parts'.*

---

shame *– While guilt relates to feelings of culpability for* actions*, shame applies to feelings about* the self*. In complex trauma, inability to self-regulate and to regain self-integrity in relationships (Courtois & Ford, 2009) means that shame frequently assumes an extreme (or `toxic') form. It can present `not only as an acute emotional state', but also as `a more fundamental and enduring aspect of an individual's personality structure; in many traumatized persons the experience of shame essentially defines who they are' (Frewen & Lanius, 2015). Deep-seated beliefs of lack of self-worth and inherent defectiveness are of a different order than the fear and anxiety that characterise standard PTSD. This can also have treatment implications: `when a person's past traumatic experiences are more associated with an experience of shame than they are with anxiety or fear, exposure-based therapies may not be the treatment of choice' (Frewen & Lanius, ibid).*

---

single-incident trauma *– See post-traumatic stress disorder (PTSD)*

---

social brain *– Term which reflects neuroscientific findings that social and environmental factors impact brain development and functioning. In highlighting the critical role of social experience in activating neural mechanisms and processes, findings from affective neuroscience transcend longstanding debates about `nature' and `nurture'. Humans are inherently relational. From the moment of birth, experience not only* influences *the self (which implies the effects of `external' environment on already intact subjectivity) but actively shapes and formulates it. Experience has `psychobiological correlates' in the organisation of our brains (Castillo, 1997; Cozolino; 2002; Doidge, 2007).*

---

social defence mechanisms *– While defence mechanisms are widely regarded as the preserve of individuals (i.e. in protecting from recognition of an unpalatable reality) they serve a similar function collectively (Herman, 1992). Bloom (2011:11) argues that basic assumptions underlie and reassure groups and organisations as much as for the individuals which comprise them. Thus `challenges to these basic assumptions… are likely to give way to anxiety and to `social defense mechanisms' (Bloom, Ibid). A powerful illustration of a `social defence mechanism' is the medicalisation of what are actually social problems (Ibid) See `blaming the victim', `politics of trauma', trauma-informed'.*

---

somatisation *– Expression of psychological states and processes as physical symptoms. Implicit memories of trauma can emerge as bodily ailments and pain (Cozolino, 2002; Siegel, 2010). In some cases, surgery is sought or recommended because the emotional and psychological sources of somatic symptoms are not recognised. See `symptoms', `coping strategies', `screening for trauma', `Medically Unexplained Symptoms'.*

soul murder - *A form of interpersonal trauma which entails damage to self, identity, and relationships with others, and in which survival comes at the cost of subjugation of the spirit. Prior to Freyd's elaboration of `betrayal trauma' in the late 1990's, betrayal of trust was described as a form of `soul murder' by Edward Shengold MD in relation to child sexual abuse (Shengold, 1989, 2000). The term was first used in the nineteenth century by Scandinavian playwrights August Strindberg and Henrik Ibsen; the latter described 'soul murder' as 'the destruction of the love of life in another human being' (Shengold, ibid).*

structural dissociation *– `[A] division of the personality as a biopsychosocial system into two or more subsystems of personality that should normally be integrated' (Steele & van der Hart, 2009). Also see `Dissociative Identity Disorder' (DID) and `dissociation'.*

supervision *– A process of oversight and monitoring which takes different forms depending on the diverse contexts to which it is applied. In the context of counselling and psychotherapy, it takes the form of `clinical supervision', is not authoritarian, and generally assumes the form of a conversation. Supervisees also generally select their own supervisor.*

Clinical supervision is a key component of professional and ethical practice, whereby (usually) less experienced practitioners consult about their client work with a more senior clinician on a formal but also democratic basis. Ethical psychotherapeutic practice requires all practising therapists to undertake clinical supervision, irrespective of their level of experience. Therapists who work in the area of complex trauma face particular challenges to which the supervision they access needs to be attuned (Coleman, Chouliara et al, 2018). See `clinical supervision', `ethical practice', `trauma informed', `self-care', `risk management'.

See `clinical supervision', `ethical practice', `self -care', `risk management'.

survival brain – *In contrast to the `learning' brain (which develops naturally under conditions of adequate care-giving and environmental support) the `survival' brain is suboptimal. Rather than being open to experience and new learning, it becomes `fixated on automatic, nonconscious scanning for and escape from threats' (Ford, 2009). The shift from a `learning' to a `survival' brain radically impedes the developmental task of self-awareness, and is particularly prevalent in child abuse (Ibid). See `early onset trauma', `developmental trauma', `learning brain', `Developmental Trauma Disorder'.*

symptoms – *Physical or mental indicators of unwellness according to which health problems are classified and diagnosed. To the extent that a range of diverse symptoms can stem from adaptations to trauma, a `trauma-informed' approach challenges the conventional understanding of symptoms, which is linked to a medical model and which is implicitly pathologising. By contrast, a trauma-informed perspective is strengths-based, and regards symptoms as the outgrowth of coping mechanisms which are adaptations to trauma and which can be utilised as resources in the process of recovery. See `coping strategies', `pathology', `trauma informed'.*

TOP DD *– See `* ***Treatment of Patients with Dissociative Disorders (TOP DD) Study'***

traditional psychotherapy – *As the original `talking cure', psychoanalysis emphasised verbal articulation which shaped the many psychotherapeutic modalities which followed. Approaches as diverse as psychodynamic and cognitive behavioural therapy privilege spoken language at the expense of physicality (`[n]either CBT nor psychodynamic therapeutic techniques pay much attention to the experience and interpretation of physical sensations and preprogrammed physical action patterns'; van der Kolk, 2007). Current neuroscientific research suggests the need to `put the body back' in the practice of psychotherapy, that optimal trauma treatment needs to engage right-brain processes, and that physical as well as cognitive and emotional experience needs to be attended to (Ogden et al, 2006). See `body', `right brain', `somatisation', `expressive therapies'.*

---

transference – *The unconscious responses of a client to their therapist, based on past relationships and associations which are evoked in the therapy session. Because complex trauma clients have often experienced betrayal and abuse from caregivers, their transference to therapists can be strong (e.g. negative, idealising, or a combination of the two). This means that therapy with such clients can be particularly intense for both parties, and therapists need regular clinical supervision to ventilate and explore the range of their responses to their clients (i.e. the `countertransference') See `complex trauma', `countertransference', `supervision'.*

---

transgenerational trauma *– The process by which trauma is transmitted to the next generation via the attachment style associated with unresolved parental trauma. Studies now show that it is possible for traumatic childhood experience to be resolved, and thus for the negative effects on parenting and the next generation to be positively intercepted. See `epigenesis', `disorganised attachment', `earned security'.*

---

trauma *– `[A] state of high arousal that impairs integration across many domains of learning and memory' (Cozolino, 2002). Trauma stems from activation of the instinctive `fight-flight' response to an overwhelming threat. Mobilisation of this biological `survival' response leads to a `freeze' response when the danger cannot be escaped, and the normal impulse for action is arrested. Experience need not literally be life-threatening to be traumatic. Neuroscientific research also establishes the vulnerability of the developing brain to early experience of caregivers. Repeated and unrepaired parental misattunement to infants can itself be traumatic, and can lead to significant developmental compromise. See `complex trauma' `developmental trauma'.*

---

trauma diagnosis – *See `diagnosis of trauma'*

---

trauma-informed – *A reconceptualisation of traditional approaches to health and human service delivery whereby all aspects of services are organised around the prevalence of trauma in society (and where complex trauma is not necessarily apparent from diverse diagnoses and client presentations). Services which are `trauma-informed' are attuned to the dynamics of trauma and all facets of service delivery, formal and informal, and `do no harm'. This is as distinct from directly treating trauma per se which is the role of clinicians (the appropriate term in the latter case is `trauma specific'; note that there can also be overlap between the two).*

Trauma-informed services are alert to the possibility of the existence of trauma in the lives of all clients/patients/consumers, irrespective of whether it is known to exist in individual cases. The contrast with `traditional' health and welfare settings is profound: `Changes to a trauma-informed organizational service system environment will be experienced by all involved as a profound cultural shift in which consumers and their conditions and behaviours are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently' (Jennings, 2004). Key principles of trauma informed care include safety, trustworthiness, choice, collaboration and empowerment (Fallot & Harris, 2009).

Trauma Model – *The perspective of trauma clinicians and researchers regarding trauma-related dissociation who see DID as `at the far end of the spectrum of trauma-related psychiatric disorders and related to a combination of factors such as chronic emotional and physical abuse and neglect and/or sexual abuse from early childhood, insufficient integrative capacity, and lack of affect regulation by caretakers' (Rydberg, 2017). This reading is contested by proponents of the so-called `Fantasy Model': `Supporters of the opposed trauma and fantasy models…of DID are engaged in a debate regarding the validity of DID as a mental disorder and its causes (i.e. traumatization or fantasy proneness, suggestibility, suggestion, and simulation' (Reinders, Willemsen et al, 2016). Research consistently supports the `Trauma' rather than `Fantasy' model of DID (Schlumpf, Reinders et al, 2014; Brand, Vissia et al, 2016). See `dissociative disorder', `Dissociative Identity Disorder', `complex trauma', `Fantasy Model').*

---

trauma screening *– The process by which questions are posed, whether spoken or written, for the purpose of gaining a sense of whether unresolved trauma is experienced by a client. Trauma screening is not common within health services and settings; Bloom (2011) argues that trauma is not only not screened FOR it is actively screened OUT. While the prevalence of trauma in its many forms indicates the need for its early detection, screening for trauma is problematic and can precipitate re-traumatisation in the absence of appropriate safeguards and sensitivity. For this reason, all trauma screening should be conducted in a context which is trauma-informed. See `trauma-informed'.*

---

trauma-specific *– Treatment approaches and services which are directly addressed to the clinical treatment of trauma in its various forms.*

---

trauma treatment *Effective trauma therapy entails facilitation of neural integration (Solomon & Siegel, 2003; van der Kolk, 2003). The importance of the capacity to manage emotion (affect regulation) is a precondition to the capacity to process and integrate trauma. In contrast to standard (single-incident) PTSD, the cumulative impact of complex trauma is severely disruptive of self-regulatory capacity which has implications for appropriate trauma treatment.*

Studies show that people who experience complex trauma `may react adversely to current, standard PTSD treatments, and that effective treatment needs to focus on self-regulatory deficits rather than `processing the trauma' (van der Kolk, 2003). It is for this reason that the recommended treatment for complex trauma is phased *treatment. See `complex trauma treatment', `exposure therapies', `phased treatment', `evidence based'.*

---

treatment of complex trauma – *See `complex trauma treatment'; `phased treatment'*

Treatment of Patients with Dissociative Disorders (TOP DD) Study*: Prospective, naturalistic study of treatment outcome for patients with dissociative disorders. The TOP DD involves 19 countries and data was collected at four points across 30 months of treatment. Findings were that the phased treatment delivered, on which the participating therapists reported at various points, led to reduced depression, dissociation, PTSD, and general distress, as well as fewer suicide attempts, self-harm behaviors and hospitalizations over the 30 months of treatment* https://www.towson.edu/cla/departments/psychology/topdd/ *The TOPP DD has generated a number of publications including a paper on its web-based educational program in the Journal of Traumatic Stress (Brand, Schielke, et al, 2019).*

---

treatment of trauma – *See `trauma treatment'*

vicarious trauma (VT) – *`[T]he negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment or responsibility to help them' (Pearlman & Caringi, 2009). Vicarious trauma is situationally inherent in exposure to traumatic material over time, and does not reflect weakness or fault on the part of the helper (`VT goes with the territory'; Ross & Halpern, 2009). Thus the challenge is one of recognition and appropriate addressing, where both ongoing clinical supervision and ongoing therapist self-care are protective factors. See `supervision', `self-care'.*

---

window of tolerance – *The threshold at which emotion can be tolerated without the person becoming either agitated and anxious (hyperaroused) or `shut down' and numb (hypoaroused) [Siegel, 1999]. It is essential that trauma therapy is conducted within `the window of tolerance', which, if exceeded, can precipitate re-traumatisation. See `affect regulation', `complex trauma', `phased treatment'.*

References

References

Aron, L. (1990) `One-person and two-person psychologies and the method of psychoanalysis', *Psychoanalytic Psychology* (7, 4), pp.475-485.

Bahadir, B., Baran, E. et al. (2016) `Comparison of the Patient Groups with and Without Dissociative Disorder Comorbidity among the Inpatients with Bipolar Disorder', *Family Practice and Palliative Care* (1, 2), pp.35-42.

Bahadir, B., Karamustafalioglu. K.O. & Ozer, O.A. (2012) `Comparison of Bipolar Patients with and Without Comorbid Dissociative Disorder', *European Neuropsychopharmacology* (Vol 22, Supplement 2), S299.

Barker, V. Gumley, A. et al. (2015) `An Integrated Biopsychosocial Model of Childhood Maltreatment and Psychosis', *The British Journal of Psychiatry* (206, 3), pp.177-180. https://doi.org/10.1192/bjp.bp.113.143578

Barlow, M.R., Pezdek, K. & Blandon-Gitlin, K. (2017) `Trauma and Memory', ch.16 in Gold, S.N., ed. *APA Handbook of Trauma Psychology: Foundations in Knowledge* American Psychological Association, pp.307-331.

Barrett, D. (2015) `Hypnosis: Statehood at Last' (Commentary on the APA Division 30 Definition of Hypnosis), *American Journal of Clinical Hypnosis* (57, 4), pp. 456-458.
https://www.tandfonline.com/doi/full/10.1080/00029157.2015.1011502

Benatar, M. (2018) *Emma and Her Selves: A Memoir of Treatment and a Therapist's Self-Discovery* New York, IPBooks.

Berne, E. [1961] (2015) *Transactional Analysis in Psychotherapy: A Systematic Individual and Social Psychiatry* CT, Martino Fine Books.

Bloom, S.L. & Farragher, B. (2011) *Destroying Sanctuary: The Crisis in Human Service Delivery Systems* Oxford: OUP.

Boehm, R. (2012) `The Enduring Effects of Child Abuse', *Network*, 2 October.
https://network.crcna.org/safe-church/enduring-effects-child-abuse

Boon, S., Steele, K. & Van der Hart, O. (2011) *Coping with Trauma-Related Dissociation: Skills Training for Patients and Therapists* New York, Norton.

Bowlby, J. [1988] (2006) *A Secure Base: Clinical Applications of Attachment Theory* New York, Routledge.

Brand, B.L. (2012) `What We Know and What We Need to Learn About the Treatment of Dissociative Disorders', *Journal of Trauma & Dissociation,* 13:4, 387-396.

Brand, B.L. & Brown, D.J. (2016) `An Update on Research about the Validity, Assessment, and Treatment of DID', ch.21 in Howell, E. & Itzkowitz, S. ed. *The Dissociative Mind in Psychoanalysis* New York, Routledge, pp.241-252.

Brand, B.L., Loewenstein, R.J. & Spiegel, D. (2014) `Dispelling myths about dissociative identity disorder treatment: an empirically based approach', *Psychiatry* (77, 2), pp.169-89.
https://www.ncbi.nlm.nih.gov/pubmed/24865199

Brand, B., Sar, V. et al (2016) `Separating Fact from Fiction: An Empirical Examination of Six Myths about Dissociative Identity Disorder' *Harvard Review of Psychiatry* (24, 4), pp. 257-270. https://journals.lww.com/hrpjournal/Fulltext/2016/07000/Separating_Fact_from_Fiction___An_Empirical.2.aspx

Brand, B.L., Schielke, H.J. et al (2019) `An Online Educational Program for Individuals with Dissociative Disorders and Their Clinicians: 1-Year and 2-Year Follow-Up', *Journal of Traumatic Stress* (30 January) https://onlinelibrary.wiley.com/doi/full/10.1002/jts.22370

Brand, B., Vissia, E.M. et al (2016) `DID is Trauma-Based: Further Evidence Supporting the Trauma Model of DID', *Acta Psychiatrica Scandinavica* (134, 6), pp.560-563.

Brand, B.L. `The TOP DD Studies' https://topddstudy.com
`TOP DD Network Study' https://www.researchgate.net/project/TOP-DD-Network-Study
`Treatment of Patients with Dissociative Disorders [TOP DD] Study'
https://www.towson.edu/cla/departments/psychology/topdd/

Brann, L., Owens, J. & Williamson, A. ed. (2015) *The Handbook of Contemporary Clinical Hypnosis: Theory and Practice* Oxford: John Wiley & Sons.

Braude, S.E. (2014) `The Conceptual Unity of Dissociation: A Philosophical Argument', in Dell, P.F. & O'Neil, J.A., ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond* New York, Routledge, pp.27-36.

Brewin, C.R. (2012) `A Theoretical Framework for Understanding Recovered Memory Experiences' Nebraska Symposium on Motivation, in Belli, R.F. ed. *True and False Recovered Memories, Toward a Reconciliation of the Debate* New York: Springer, pp.149-173.

Bromberg, P. M. [2006] (2010) *Awakening the Dreamer: Clinical Journeys* New York, Routledge.

Bromberg, P.M. (2014) `Multiple Self-States, the Relational Mind, and Dissociation: A Psychoanalytic Perspective', in Dell & O'Neil, ed. *Dissociation and the Dissociative Disorders*, New York, Routledge, pp. 637-652.

Bromberg, P. M. [1998] (2001) *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation* New York, Psychology Press.

Bromberg, P.M. (2011) *The Shadow of the Tsunami and the Growth of the Relational Mind* New York, Routledge.

Brown, R. (2006) `Different Types of `Dissociation' Have Different Psychological Mechanisms', *Journal of Trauma and Dissociation* (7:4), pp.7-28.

Bruch, D. [2015] (2016) *Fractured Mind: The Healing of a Person with Dissociative Identity Disorder* Michigan, Bruwicked.

Bucci, W.S. (2016) `Divide and Multiply: A multi-dimensional view of dissociative processes', ch.16 in Howell, E. & Itzkowitz, S. ed. *The Dissociative Mind in Psychoanalysis*, New York, Routledge, pp.187-199.

Butler, C., Dorahy, M. & Middleton, W. (2019) `The Detachment and Compartmentalization Inventory (DCI): An assessment tool for two qualitatively distinct forms of dissociation', *Journal of Trauma and Dissociation* (20, 5), pp.526-547. https://www.ncbi.nlm.nih.gov/pubmed/31070513

Butler, L. (2004) `The Dissociations of Everyday Life', *Journal of Trauma and Dissociation* (Vol.5, No.2), pp.61-88.

Calati, R., Bensassi, I. & Courtet, P. (2017) `The Link between Dissociation and both Suicide Attempts and Non-Suicidal Self-Injury: Meta-analyses', *Psychiatry Research* (Vol 251), pp. 103–114. https://doi.org/10.1016/j.psychres.2017.01.035

Cardena, E. (2000) Review of Watkins, J.G. & Watkins, H.H. *Ego States: Theory and Therapy* [New York: Norton, 1997], *American Journal of Clinical Hypnosis,* 43, 2, p.159.

Chefetz, R.A. (2015) *Intensive Psychotherapy for Persistent Dissociative Processes: The Fear of Feeling Real* New York, Norton.

Chu, J.A. (2011) *Rebuilding Shattered Lives: Treating Complex PTSD and Dissociative Disorders* NJ, John Wiley & Sons.

Church, D. (2015) *Psychological Trauma: Healing its Roots in Brain, Body, and Mind.* CA: Energy Psychology Press.

Cloitre, Courtois et al (2012) *The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults* https://www.istss.org/ISTSS_Main/media/Documents/ISTSS-Expert-Concesnsus-Guidelines-for-Complex-PTSD-Updated-060315.pdf

Courtois, C.A & Ford, J.D. (2009) *Treating Complex Traumatic Stress Disorders: An Evidence-Based Guide* New York, The Guilford Press.

Cowen, L. W. (2013). `Clinical Hypnotherapy', Modality Profile, *The CAPA Quarterly* (2, 5) https://issuu.com/capansw/docs/cq_2013-2_ethics

Cowen, L. W. (2016) `Literature Review into the Effectiveness of Hypnotherapy', *Australian Counselling Research Journal* (10, 1), pp.1-55. http://www.acrjournal.com.au/resources/assets/journals/Volume-10-Issue-1-2016/Volume-10-Issue-1-2016-FULL.pdf

Cozolino, L. [2002] (2017) *The Neuroscience of Psychotherapy: Healing the Social Brain,* 3rd edit. New York, Norton.

Dalenberg, C. J. (2004) `Maintaining the safe and effective therapeutic relationship in the context of distrust and anger: Countertransference and complex trauma' *Psychotherapy: Theory, Research, Practice, Training* (41, 4), pp.438-447. http://dx.doi.org/10.1037/0033-3204.41.4.438

Dalenberg, C. J. (2006) `Recovered memory and the Daubert criteria: recovered memory as professionally tested, peer reviewed, and accepted in the relevant scientific community', *Trauma, Violence & Abuse* (7, 4), pp.274-310. https://www.ncbi.nlm.nih.gov/pubmed/17065548

Dalenberg, C., Brand, B. et al (2012) `Evaluation of the Evidence for the Trauma and Fantasy Models of Dissociation', *Psychological Bulletin* (138), pp.550-588. https://www.ncbi.nlm.nih.gov/pubmed/22409505

Dalenberg, C., Brand, B. et al. (2014) `Reality Versus Fantasy: Reply to Lyn et al (2014)', *Psychological Bulletin (*140, 3), pp.911-920.

Danylchuk, L. & Connors, K. (2017) *Treating Complex Trauma and Dissociation: A Practical Guide to Navigating Therapeutic Challenges* New York, Routledge.

Degun-Mather, M. (2006) *Hypnosis, Dissociation and Survivors of Child Abuse: Understanding and Treatment* West Sussex, John Wiley & Sons.

Dell, P.F. & O'Neil, J.A., ed. (2014) *Dissociation and the Dissociative Disorders: DSM-V and Beyond* New York, Routledge.

Diagnostic and Statistical Manual of Mental Disorders, fifth edit; DSM 5 (2013) Washington DC, American Psychological Association.

Dorahy, M., Brand, B. et al (2014) `Dissociative Identity Disorder: An empirical overview', *Australian and New Zealand Journal of Psychiatry* (48, 5), pp. 402 - 417. https://www.researchgate.net/publication/262025048_Dissociative_identity_disorder_An_empirical_overview

Dorahy, M.J. & Van der Hart, O. (2007) `Relationship between Trauma and Dissociation: An Historical Analysis', ch.1 in Vermetten, E., Dorahy, M. & Spiegel, D. ed. *Traumatic Dissociation: Neurobiology and Treatment* Washington DC, American Psychiatric Publishing, pp. 3-36.

Ecker, B. (2018) `Clinical Translation of Memory Reconsolidation Research: Therapeutic Methodology for Transformational Change by Erasing Implicit Emotional Learnings Driving Symptom Production', *International Journal of Neuropsychotherapy* (6, 1), pp.1-92.

Ellason, J. W., & Ross, C. A. (1995) `Positive and negative symptoms in dissociative identity disorder and schizophrenia: A comparative analysis', *Journal of Nervous and Mental Disease,* (183, 4), pp.236-241 http://dx.doi.org/10.1097/00005053-199504000-00009

Ellenberger, H. F. [1970] (1994) *The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry* London, HarperCollins.

Elliott, D.M. (1999) `Traumatic Events: Prevalence and Delayed Recall in the General Population', *Journal of Counselling and Clinical Psychology,* 65, pp.811-820**.**

Felitti, V.J., Anda, R.F. et al (1998) `Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study', *American Journal of Preventive Medicine,* 14, 4, pp.245-258.

Felitti, V.J. & Anda, R.F. (2010) `The Relationship of Adverse Childhood Experiences to Adult Medical Disease, Psychiatric Disorders and Sexual Behavior: Implications for Healthcare', Ch. 8 in Lanius, R.A., Vermetten, E. & C. Pain, *The Impact of Early Life Trauma on Health and Disease* Cambridge University Press, pp.77-87.

Fisher, J. (2017) *Healing the Fragmented Selves of Trauma Survivors: Overcoming Internal Self-Alienation* Routledge, New York.

Fonagy, P., Gergeley, G. et al (2002) *Affect Regulation, Mentalisation, and the Development of the Self* London: Routledge.

Foote, B. & Van Orden, K. (2016) `Adapting Dialectical Behavior Therapy for the Treatment of Dissociative Identity Disorder', *American Journal of Psychotherapy* (70, 4), pp.343-364.

Foote, B., Smolin, Y. et al (2008) `Dissociative Disorders and Suicidality in Psychiatric Outpatients', *The Journal of Nervous Diseases* (196, 1), pp.29-36 https://journals.lww.com/jonmd/Abstract/2008/01000/Dissociative_Disorders_and_Suicidality_in.6.aspx

Foote, B. MD, Smolin, Y. MD et al (2006) `Prevalence of Dissociative Disorders in Psychiatric Outpatients', *American Journal of Psychiatry,* 163, pp.623–629 https://ajp.psychiatryonline.org/doi/pdf/10.1176/ajp.2006.163.4.623

Forgash, C. & Copley, M. ed. (2007) *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* New York, Springer.

Forgash, C. & Knipe, J. (2007) `Integrating EMDR and Ego State Treatment for Clients with Trauma Disorders', in Forgash & Copley, ed. *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* New York, Springer, pp.1-59.

Forner, C.A. (2017*) Dissociation, Mindfulness and Creative Meditations: Trauma Informed Practice to Facilitate Growth* New York, Routledge.

Fosher, D., Siegel, D.J. & Solomon, M., ed. (2009) *The Healing Power of Emotion: Affective Neuroscience, Development and Clinical Practice* New York, Norton

Fraser, G.A. (1991) `The Dissociative Table Technique: A strategy for working with ego states in dissociative disorders and ego-state therapy', *Dissociation* (4), pp.205-213

Fraser, G.A. (2003) `Fraser's `Dissociative Table Technique', Revisited, Revised: A Strategy for Working with Ego States in Dissociative Disorders and Ego State Therapy', *Journal of Trauma and Dissociation,* (4, 4), pp.5-28.

Frewen, P. & Lanius, R. (2015) *Healing the Traumatized Self: Consciousness, Neuroscience, Treatment* New York, Norton.

Frischholz, E., Lipman, L., Braun, B. and Sachs, R. (1992) `Psychopathology, hypnotizability, and dissociation', *American Journal of Psychiatry,* 149: 1521–1525.

Gold, S.N. (2000) *Not Trauma Alone: Therapy for Child Abuse Survivors in Family and Social Context* New York, Routledge.

Gold, S.N. & Seibel, S.L. (2014) `Treating Dissociation: A Contextual Approach', in Dell & O'Neil, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond,* New York, Routledge, pp.625-636.

Goldman, D. (2016) `A queer kind of truth': Winnicott and the uses of dissociation', ch.8 in Howell, E. & Itzkowitz, S. ed. *The Dissociative Mind in Psychoanalysis,* New York Routledge, pp.97-106.

Gonzalez, A. (2018) `Eye Movement Desensitization and Reprocessing (EMDR) in Complex Trauma and Dissociation: Reflections on Safety, Efficacy and the Need for Adapting Procedures', *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 2), pp. 192-211.

Gonzalez, A. (2018) *It's Not Me: Understanding Complex Trauma, Attachment and Dissociation; A Guide for Patients and Therapists* North Charleston, SC: CreateSpace Independent Publishing Platform.

Gonzalez, A. & Mosquera, D. (2012) *EMDR and Dissociation: The Progressive Approach* Charlston, SC, Createspace.

Gonzalez, A, Del Rio-Casanova, L. & Justo-Alonso, A. (2017) `Integrating Neurobiology pf Emotion Regulation and Trauma Therapy: Reflections on EMDR Therapy', *Reviews in the Neurosciences* (28, 4), pp.431-440.

Goulding, R.A. & Schwartz, R. C. (1995) *The Mosaic Mind: Empowering the Tormented Selves of Child Abuse Survivors* New York, Norton.

Haddock, D.B. (2001) *The Dissociative Identity Sourcebook* New York, McGraw-Hill.

Hainer, M. (2016) `The Ferenczi Paradox: His importance in understanding dissociation and the dissociation of his importance in psychoanalysis', ch.5 in Howell & Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis* New York, Routledge, pp.57-69.

Herman, J. & van der Kolk, B.A. (1987) `Trauma Antecedents of Borderline Personality Disorder', ch.5 in van der Kolk, *Psychological Trauma*, American Psychiatric Publishing, VA, pp.111-126.

Hesse, E., Main, M. et al. (2003) `Unresolved States Regarding Loss or Abuse Can Have `Second Generation Effects: Disorganization, Role Inversion, and Frightening Ideation in the Offspring of Traumatized Non-Maltreating Parents', ch.2 in Solomon, M.F. & Siegel, D.J. ed. *Healing Trauma* New York, Norton, pp.57-106.

Hiltzik, M. (2014) `Cultural production of ignorance provides rich field for study', *Los Angeles Times,* 9 March http://articles.latimes.com/2014/mar/09/business/la-fi-hiltzik-20140307

Holmes, E., Brown, R. et al (2005) `Are there two qualitatively distinct forms of dissociation? A review and some clinical implications', *Clinical Psychology Review* (25: 1), pp.1-23.

Howell, E. (2005) *The Dissociative Mind* New York, Routledge.

Howell, E. (2011) *Understanding and Treating Dissociative Identity Disorder: A Relational Approach* New York, Routledge.

Howell, E. & Itzkowitz, S. (2016) *The Dissociative Mind in Psychoanalysis: Understanding and Working with Trauma* New York, Routledge.

Hunter, M. [2004] (2009) *Understanding Dissociative Disorders: A Guide for Family Physicians and Health Care Professionals* Wales: Crown House.

Hunter, E., Charlton J., & David, A. (2017) `Depersonalisation and Derealisation: Assessment and management' *BMJ Clinical Research* 356:j745 DOI: 10.1136/bmj.j745 https://www.bmj.com/content/356/bmj.j745

International Classification of Diseases, 11th revision (ICD-11) https://icd.who.int/en

International Society for the Study of Trauma and Dissociation (2011) *Guidelines for Treating Dissociative Identity Disorder in Adults*, 3rd Revision, *Journal of Trauma & Dissociation*, 12:2, 115-187 https://www.isst-d.org/wp-content/uploads/2019/02/GUIDELINES_REVISED2011.pdf

Kluft, R.P. (2014) `A Clinician's Understanding of Dissociation: Fragments of an Acquaintance', in Dell & O'Neil, ed. *Dissociation and the Dissociative Disorders: DSM-V and Beyond*, New York, Routledge, pp.599-623.

Kluft, R.P (1999) `An Overview of the Psychotherapy of Dissociative Identity Disorder', *American Journal of Psychotherapy*, 53, pp.289-319.

Kluft, R.P. (2006) `Dealing with Alters: A Pragmatic Clinical Perspective', *Psychiatric Clinics of North America* (29), pp.281-304.

Kluft R.P. (1987) `First-rank symptoms as a diagnostic clue to multiple personality disorder', *American Journal of Psychiatry,* 144, 3, pp.293-298.

Kluft, R.P. (2012) `Hypnosis in the Treatment of Dissociative Identity Disorder and Allied States: An Overview and Case Study', *South African Journal of Psychology* (42, 2), pp.146-155.

Kluft, R.P. (2013) *Shelter from the Storm: Processing the Traumatic Memories of DID/DDNOS Patients with the Fractionated Abreaction Technique* South Carolina: CreateSpace.

Kluft, R.P. (2000) `The Inevitability of Ego State Therapy in the Treatment of Dissociative Identity Disorder and Allied States', Peter B, Bongartz W, Revenstorf D, et al, editors. Munich 2000: the 15th International Congress of Hypnosis. Munich, Germany: MEG-Stiftung; p. 69–77.

Kluft, R.P. (2017) `Trying to Keep it Real: My Experience in Developing Clinical Approaches to the Treatment of DID', *Frontiers in the Psychotherapy of Trauma and Dissociation* (1, 1), pp.18-44.

Knipe, J. (2007) `Loving Eyes: Procedures to therapeutically reverse dissociative processes while preserving emotional safety', in Forgash, C. & Copeley, ed. *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* New York, Springer, pp.181-225.

Korn, D.L (2009) `EMDR and the Treatment of Complex PTSD: A Review', *Journal of EMDR Practice and Research*, 3, 4, pp.264-278. http://www.traumacenter.org/products/pdf_files/korn_jemdr_2009.pdf

Kumar, S.A., Brand, B.L. & Courtois, C.A. (2019) `The Need for Trauma Training: Clinicians' Reactions to Training on Complex Trauma', *Psychological Trauma: Theory, Research, Practice, and Policy,* Online First Publication, http://dx.doi.org/10.1037/tra0000515

Laddis, A. (2018) `A Simple Algorithm for Medication of Patients with Complex Trauma-Related Disorder', *Frontiers in the Psychotherapy of Trauma and Dissociation*, (1, 2,), pp.244-266.

Lane, R. D, Ryan, L. et al (2015) `Memory reconsolidation, emotional arousal, and the process of change in psychotherapy', *Behavioral and Brain Sciences*
https://www.coherencetherapy.org/files/Ecker-etal_2015_Minding-the-Findings.pdf

Lanius, U.F., Paulsen, S. L. & Corrigan, F.M, ed. (2014) *Neurobiology and Treatment of Traumatic Dissociation: Toward an Embodied Self* New York, Springer.

Lankton, S. & Hicks Lankton, C. (2008) *The Power Within: A Clinical Framework of Ericksonian Hypnotherapy* CT, Crown.

Levine, P. (2015) *Trauma and Memory: Brain and Body in a Search for the Living Past* Berkeley, North Atlantic Books.

Levine, P. A. (1997) *Waking the Tiger: Healing Trauma* Berkeley, CA, North Atlantic Books.

Linehan, M.M. (2015) *DBT Skills Training Manual,* 2nd edition New York, The Guilford Press.

Liotti, G. (1992) `Disorganized/disoriented attachment in the etiology of dissociative disorders', *Dissociation: Progress in the Dissociative Disorders* (5), pp.196-204.

Loewenstein, R. J. (1991) `An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder', *Psychiatric Clinics of North America* (14, 3), pp. 567-604.
https://www.ncbi.nlm.nih.gov/pubmed/1946025

Loewenstein, R.J. (1996) `Dissociative Amnesia and Dissociative Fugue', in Larry K. Michelson & William J. Ray, ed. *Handbook of Dissociation* New York, Plenum Press, pp.307-336.

Loewenstein, R.J. (2018) `Dissociation Debates: everything you know is wrong', *Dialogues in Clinical Neuroscience* (20, 3), pp.229-242. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6296396/

Lyssenko, L., Schmahl, C. et al. (2018) `Dissociation in Psychiatric Disorders: A Meta-Analysis of Studies Using the Dissociative Experiences Scale, *American Journal of Psychiatry* (175), pp.37-46.

`Me, Me, Me and My Therapist' *Opinionator, The New York Times* January 3, 2015

Meares, R. (2012) *A Dissociation Model of Borderline Personality Disorder* New York, Norton.

Meares, R. (2012) *Borderline Personality Disorder and the Conversational Model: A Clinician's Manual* Norton, New York.

Medford, N, Mauricio, S. et al (2005) `Understanding and treating depersonalisation disorder' *Advances in Psychiatric Treatment* (11, 2), pp. 92-100.

Middleton, W. (2019) `The First Individual with Dissociative Identity Disorder (DID) That One Knowingly Diagnoses and Treats', *Frontiers in the Psychotherapy of Trauma and Dissociation* (3, 1), pp.60-75.

Miller, A. (2014) *Becoming Yourself: Overcoming Mind Control and Ritual Abuse* New York: Routledge.
Mosquera, D. (2015) *Rough Diamonds: A Glimpse into Borderline Personality Disorder* CreateSpace.

Murphy, A., Steele, M. et al (2014) 'Adverse Childhood Experiences (ACEs) Questionnaire and Adult Attachment Interview (AAI): Implications for parent child relationships', *Child Abuse and Neglect* (38, 2), pp.224-233.
https://www.researchgate.net/publication/261137510_Adverse_Childhood_Experiences_ACEs_Questionnaire_and_Adult_Attachment_Interview_AAI_Implications_for_parent_child_relationships

McMaugh, K. (2019) `My First Case of DID: Learnings from Treatment Failure', *Frontiers in the Psychotherapy of Trauma and Dissociation* (3, 2), pp. 123–135.

Nemiah, J. (1989) `Janet Redivivus: The Centenary of *L'automatisme psychologique, The American Journal of Psychiatry* (146:12), 1527-1529.

Nijenhuis, E. (2017) *The Trinity of Trauma: Ignorance, Fragility, and Control – Enactive Trauma Therapy,* Volume 3, Goettingen, Vandenhoeck & Ruprecht GmbH & Co KG.

Noble, K. (2011) *All of Me* London, Piatkus.

Ogden, P., Minton & Pain, C. (2006) *Trauma and the Body: A Sensorimotor Approach to Psychotherapy* New York: Norton.

Ogden, P. & Fisher, J. (2015) *Sensorimotor Psychotherapy: Interventions for Trauma and Attachment* New York: Norton.

`Other Specified Dissociative Disorder' http://traumadissociation.com/osdd

Oxnam, R. B. (2005) A *Fractured Mind: My Life with Multiple Personality Disorder*, New York, hachett.

Oxnam, R. (2010) Interview Web Extra https://www.youtube.com/watch?v=C12QD4A5bDE

Ozturk, E. & Sar, V. (2006) `The `Apparently Normal Family: A Contemporary Agent of Transgenerational Trauma and Dissociation', *Journal of Trauma Practice* (4, 3), pp.287-303.

Paulsen, S. (2017) *When There Are No Words: Repairing Early Trauma and Neglect From the Attachment Period With EMDR Therapy* Bainbridge Island, WA: Bainbridge Institute for Integrative Psychology Publication.

Phillips, M. & Frederick, C. (2010) *Empowering the Self through Ego-State Therapy* E-book
http://reversingchronicpain.com/EmpoweringSelfEgoStateTherapy/EST_ebook.pdf

Phillips, M. & Frederick, C. (1995) *Healing the Divided Self: Clinical and Ericksonian Hypnotherapy for Post-Traumatic and Dissociative Conditions* New York, Norton.

Porges, S. & Dana, D. (2018) *Clinical Applications of the Polyvagal Theory: The Emergence of Polyvagal-Informed Therapies* New York: Norton.

Porges, S. (2011) *The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation* New York: Norton

Practice Guidelines for Clinical Treatment of Complex Trauma (2019) Sydney, Blue Knot Foundation https://www.blueknot.org.au/resources/Publications/Practice-Guidelines

Price, M. Kearns, M. et al. (2014) `Emergency Department Predictors of Posttraumatic Stress Reduction for Trauma-Exposed Individuals With or Without an Early Intervention', *Journal of Clinical Psychology* (82, 2), pp.336-341.

Putnam, F.W. (2016) *The Way We Are: How States of Mind Influence Our Identities, Personality and Potential for Change* New York, International Psychoanalytic Books.

Reinders, A., Marquand, A.F. et al (2018) `Aiding the diagnosis of dissociative identity disorder: pattern recognition study of brain biomarkers', *The British Journal of Psychiatry,* 1-9 https://www.ncbi.nlm.nih.gov/pubmed/30523772

Reinders, A., Nijenhuis, E. et al (2006) `Psychobiological Characteristics of Dissociative Identity Disorder: A Symptom Provocation Study' *Biological Psychiatry* (60, 7), pp.730-740. https://www.researchgate.net/publication/237465966_Psycho-biological_characteristics_of_dissociative_identity_disorder_rCBF_physiologic_and_subjective_findings_from_a_symptom_provocation_study

Reinders, A., Willemsen T.M. et al (2016) `The Psychobiology of Authentic and Simulated Dissociative Personality States', *The Journal of Nervous and Mental Disease* (204, 6), pp.445-459. https://www.researchgate.net/publication/301685740_The_Psychobiology_of_Authentic_and_Simulated_Dissociative_Personality_States_The_Full_Monty

Richards, D. G. (1990) `Dissociation and Transformation', *Journal of Humanistic Psychology*, http://journals.sagepub.com/doi/10.1177/0022167890303004

Ross C.A. (2018) `Problems with the Dissociative Subtype of Posttraumatic Stress Disorder in DSM-5', *European Journal of Trauma and Dissociation* https://www.sciencedirect.com/science/article/abs/pii/S2468749918300206

Rossi, E., Erickson-Klein, R. & Rossi, K. (2015) *The Collected Works of Milton H. Erickson, M.D.* Collector Edition.

Rydberg, J.A. (2017) `Research and Clinical Issues in Trauma and Dissociation: Ethical and Logical Fallacies, `Myths, Misreports, and Misrepresentations', *European Journal of Trauma and Dissociation* (1), pp.89-99.

Sar, V. (2014) `The Many Faces of Dissociation: Opportunities for Innovative Research in Psychiatry', *Clinical Psychopharmacology and Neuroscience* (12, 3), pp.171-179.

Schickedanz, A., Halfon, N. et al (2018) 'Parents' Adverse Childhood Experiences and Their Children's Behavioral Health Problems', *Pediatrics* (142, 2) e20180023; DOI: https://doi.org/10.1542/peds.2018-0023

Schimmenti, A. (2017) `The Developmental Roots of Dissociation: A Multiple Mediation Analysis', *Psychoanalytic Psychology* (34, 1), pp. 96-105 http://dx.doi.org/10.1037/pap0000084

Schimmenti, A. & Caretti, V. (2016) `Linking the Overwhelming with the Unbearable: Developmental Trauma, Dissociation, and the Disconnected Self', *Psychoanalytic Psychology* (33, 1), pp.106-128.

Schlumpf, Y.R., Nijenhuis, E.R.S., et al (2019) `Functional reorganization of neural networks involved in emotion regulation following trauma therapy for complex trauma disorders', *Neuroimage: Clinical* (23), 101807. https://www.sciencedirect.com/science/article/pii/S2213158219301573

Schlumpf, Y. R., Reinders, A.T.S. et al. (2014) `Dissociative Part-Dependent Resting-State Activity in Dissociative Identity Disorder: A Controlled fMRI Perfusion Study' PLoS One, 9(6) https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0098795

Schmidt S, J. (1998) `Internal Conference Room Ego-State Therapy and the Resolution of Double Binds: Preparing clients for EMDR trauma processing' *EMDRIA Newsletter*, 3(2), 10-12, 14 https://www.dnmsinstitute.com/doc/db-prep.pdf

Schmidt, S.J. (2009) *The Developmental Needs Meeting Strategy (DNMS): An Ego State Therapy for Healing Adults with Childhood Trauma and Attachment Wounds* Texas, DNMS Institute. www.dnmsinstitute.com

Schwarz, L., Corrigan, F. et al (2017) *The Comprehensive Resource Model: Effective Therapeutic Techniques for the Healing of Complex Trauma* New York, Routledge.

Schwarz, R. (2002) *Tools for Transforming Trauma* New York, Routledge.

Schwartz, R.C. (1995) *Internal Family Systems Therapy*. New York: The Guilford Press.

Shapiro, F. (1996) *Dissociative Disorders Task Force Position Paper,* Presentation at the International Society for the Study of Dissociation 13th Annual Conference (San Francisco, CA) https://emdria.omeka.net/items/show/22193

Shapiro, F. (2018) *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures,* 3rd edition Washington, DC: The Guilford Press.

Shapiro, R. (2016) *Easy Ego State Interventions: Strategies for Working with Parts* New York, Norton.

Shapiro, R. (2010) *The Trauma Treatment Handbook*: *Protocols Across the Spectrum* New York, Norton.

Shengold, L. [1999] (2000) *Soul Murder Revisited* New Haven: Yale University Press.

Siegel, D.J. (2003) `An Interpersonal Neurobiology of Psychotherapy: The Developing Mind and the Resolution of Trauma', in Solomon & Siegel, ed., *Healing Trauma,* Norton, New York, pp. 1-56.

Siegel, D.J. & Hartzell, M. (2004) *Parenting from the Inside Out* New York, Penguin.

Silberg, J. (2013) *The Child Survivor: Healing Developmental Trauma and Dissociation* New York, Routledge.

Smith, J. MD (2005) `Understanding DID Therapy: The Case of Robert B. Oxnam', Epilogue of Robert Oxnam, *A Fractured Mind: My Life with Multiple Personality Disorder* New York, Hachette, pp.261-285.

Spanos, N. (1994) `Multiple Identity Enactments and Multiple Personality Disorder: A Sociocognitive Perspective', *Psychological Bulletin* (116, 1), pp.143-165.

Spiegel, D. (2018) `Integrating Dissociation', *American Journal of Psychiatry* (175:1), p.4-5.

Spiegel, D., Loewenstein, R. J. et al (2011) `Dissociative Disorders in DSM-5', *Depression and Anxiety* 28, pp.824-852. https://www.ncbi.nlm.nih.gov/pubmed/21910187

Spiegel, H. & Spiegel, D. (2004) *Trance and Treatment: Clinical Uses of Hypnosis* 2nd Edit Washington DC, American Psychiatric Publishing, Inc.

Stavropoulos, P. & Kezelman, C. (2018) *The Truth of Memory and the Memory of Truth, Different Types of Memory and the Significance for Trauma* Sydney, Blue Knot Foundation. https://www.blueknot.org.au/resources/publications/trauma-and-memory

Steele, K., Boon, S.& Van der Hart, O. (2017) *Treating Trauma-Related Dissociation: A Practical Integrated Approach* New York, Norton.

Steinberg, M. & Schnall, M. [2001] (2003) *The Stranger in the Mirror: The Hidden Epidemic* New York, HarperCollins.

Stern, D.B. (2010) *Partners in Thought: Working with Unformulated Experience, Dissociation, and Enactment* New York, Routledge.

Stone, J. (2006) `Dissociation: What is it and Why is it Important?' *Practical Neurology* (6), pp.308-313.

SystemSpeak www.SystemSpeak.org

Tanner, J., Wyss, D. et al (2017) `Frequency and Characteristics of Suicide Attempts in Dissociative Identity Disorders: A 12-month follow-up study in psychiatric outpatients in Switzerland', *European Journal of Trauma and Dissociation* (1), pp.235-239.

Van der Hart, O. (2016) `Pierre Janet, Sigmund Freud, and Dissociation of the Personality', ch.4 in Howell & Itzkowitz, ed. *The Dissociative Mind in Psychoanalysis* New York, Routledge, pp. 44-56.

Van der Hart, O., Brown, P. & Van der Kolk, B.A. (1989) `Pierre Janet's treatment of posttraumatic stress', *Journal of Traumatic Stress*, 2(4), 379-396.

Van der Hart, O., Brown, P., & Graafland, M. (1999) `Trauma-induced Dissociative Amnesia in World War 1 Combat Soldiers', *Australian and New Zealand Journal of Psychiatry*, 33, 1, pp.37-46.

Van der Hart. & Friedman, B. (1989) `A reader's guide to Pierre Janet on dissociation: A neglected intellectual heritage', *Dissociation,* 2(1), pp.3-16.

Van der Hart, O. & Horst, R. (1989) `The Dissociation Theory of Pierre Janet', *Journal of Traumatic Stress* (2, 4), pp.397-412.

Van der Hart, O., Groenendjik, M. et al al. (2013) `Dissociation of the Personality and EMDR Therapy in Complex Trauma-Related Disorders: Applications in the Stabilisation Phase', *Journal of EMDR Practice and Research* (7, 2) pp.81-94.

Van der Hart, O., Groenendjik, M. et al al. (2014) `Dissociation of the Personality and EMDR Therapy in Complex Trauma-Related Disorders: Applications in Phases 2 and 3 Treatment', *Journal of EMDR Practice and Research* (8, 1) pp.33-48.

Van der Hart, O., Nijenhuis, E. & Steele, K. (2006) *The Haunted Self: Structural Dissociation and the Treatment of Chronic Traumatization* New York, Norton.

Van der Kolk, B.A. (2015) *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma,* New York, Penguin.

Vissia, E.M., Giesen, M.E. et al (2016) `Is it Trauma or Fantasy-based? Comparing Dissociative Identity Disorder, Simulators, and Controls', *Acta Scandinavica* (134, 2), pp.1-18. https://www.researchgate.net/publication/303536752_Is_it_Trauma-_or_Fantasy-based_Comparing_dissociative_identity_disorder_post-traumatic_stress_disorder_simulators_and_controls

Wallin, D. (2007) *Attachment in Psychotherapy* New York, The Guilford Press.

Watkins, H.H. (1993) `Ego State Therapy; An Overview', *American Journal of Clinical Hypnosis* (35, 4), pp. 232 – 240 http://www.clinicalsocialwork.com/overview.html

Watkins, J.G. & Watkins, H.H. (1997) *Ego States: Theory and Therapy* New York, Norton.

Watkins, J. & Watkins, H. (1993) `Ego-state therapy in the treatment of dissociative disorders', in Kluft, R, & Fine, C. ed. *Clinical Perspectives on Multiple Personality Disorder* Washington DC, American Psychiatric Press, pp.277-99.

Watkins, J. & Watkins, H. (1984) `Hazards to the Therapist in the Treatment of Multiple Personalities', in Braun, B. ed. Symposium on Multiple Personality, *Psychiatric Clinics of North America* (7), pp.111-119.

blue knot foundation

National Centre of Excellence for Complex Trauma

Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation*

*See in conjunction with Practice Guidelines for Clinical Treatment of Complex Trauma (updated; 2019).