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Dissociative identity disorder : features, etiology, and treatment

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Abstract

Dissociative Identity Disorder appears to be diagnosed more frequently in the current clinical arena. This may be connected to increased awareness of how people respond and cope with traumatic events, both singular and prolonged or serial. This increase in diagnoses may also correspond with new associations between childhood abuse and trauma, as well as research into how trauma is coded in memory.

Dissociation can be viewed as a natural phenomena that, when overly utilized as a defense against trauma and its impact, may develop in some persons into DID. Treatment of DID tends to progress through four phases: initial, middle, preintegration, and integration-postintegration. However, these stages frequently do not follow in order and may need to be revisited as the therapist and client encounter new parts in the client's system. Accurate diagnosis, informed consent, and a strong therapeutic alliance that explicitly conveys trust and safety seem to be the most important elements in successful treatment of DID.

DISSOCIATIVE IDENTITY DISORDER: FEATURES, ETIOLOGY, AND TREATMENT

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Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder (MPD), has received increasing attention by the media in recent years. Films such as “Sybil” and “The Three Faces of Eve” and various media reports and documentaries have offered the general public a sometimes sensationalist glimpse into the lives of people who suffer from DID. Until recently, clinicians have tended to consider the actual occurrence of DID rather rare (Baldwin, 1990; Higdon, 1990; Kluft 1987, 1996; Marmer, 1996; Ross, 1989, 1997). However, the perception of DID as being clinically rare has started to change somewhat in the last fifteen years (Fike, 1990a; Higdon, 1990; Kluft, 1987; Ross, 1989).

In the last decade or so, clinical and public awareness of childhood sexual abuse has increased, as has awareness of Posttraumatic Stress Disorder (PTSD) and its symptomatology, particularly as represented in the Vietnam veteran population. This heightened awareness of trauma and abuse has led to greater education and understanding of how trauma and abuse affect victims’ lives. During this time of increased awareness and education, there has also been a marked increase in DID diagnoses (Fike, 1990a; Higdon, 1990; Kluft, 1987; Ross, 1989). Whether this is due to current cultural trends or previous misdiagnosis is not certain (Fike, 1990b; Higdon, 1990). With the rising acknowledgment of childhood abuse and PTSD, there appears to be a similar, if slower, increase in the acceptance of DID as a legitimate diagnosis (Baldwin, 1990; Kluft, 1987).

At the current time, it is generally accepted that DID tends to originate in childhood as the result of experiencing trauma, usually in the form of some kind of abuse (Baldwin, 1990; Fike, 1990a; Kluft, 1987; Marmer, 1996; Peterson, 1996; Ross, 1989; Siegel, 1996; Spira, 1996). The trauma may be a one-time incident or may be on-going, as is frequently the situation with childhood sexual, physical and emotional abuse. In either case, the definition of a traumatic event in reference to DID is the same as offered in the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychological Association, 1994) for the description of PTSD. This means that the person must experience the trauma as somehow life-threatening to either himself or herself or others, and his or her reaction must be one of intense fear, helplessness, or horror.

Clinical Features of Dissociative Identity Disorder

The criteria for the diagnosis of DID as defined by the DSM-IV (1994) reads as follows:

- A. The presence of two or more distinct personalities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).
- B. At least two of these identities or personality states recurrently take control of the person's behavior.
- C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). **Note:** In children, the symptoms are not attributable to imaginary playmates or other fantasy play. (p. 487)

Criterion “A” of the diagnosis is “the presence of two or more distinct identities or personality states” (p. 487, APA, 1994). Many clinicians, as well as clients diagnosed with DID, refer to these personality states as parts, alters, or personalities (Fike, 1990a; Goulding & Schwartz, 1995; Ross, 1997; Spira, 1996).

Parts of Self

While each person with DID is unique and thus has a unique combination of alters, there are several kinds of parts frequently associated with DID: the host, child parts, protector parts, persecutors or perpetrator alters, and internal self-helpers (Dawson, 1990; Fike, 1990a; Ross, 1989, 1997). Each part generally has its own name and personality characteristics which reflect its particular world view (Spira, 1996). The entire combination of parts and host is often referred to as the system (Goulding & Schwartz, 1995; Ross, 1997; Smith, 1996).

The part generally referred to as the host is often the one who initiates therapy (Fike, 1990a; Peterson, 1996). Frequently, the host is also considered to be the original personality or core self, but not always, and may have no conscious knowledge of the other alters (Ross, 1997). It is usually the one who

claims the person's legal name and tends to have the most prolonged engagement with the outside world.

Child parts are those alters that often hold the memories of the actual traumatic event(s) (Goulding & Schwartz, 1995; Ross, 1997). They frequently are the age the child was when the event(s) occurred and do not necessarily mature along with the physical body; they often remain locked in time at the point of the trauma (Ross, 1997). Possibly as a result of being "frozen" in the time of the traumatic event(s), child parts may initially be very frightened and untrusting of other alters as well as external people such as therapists (Ross, 1997).

Protector parts are those who act to protect both the host from the memories of the younger child parts and the child parts themselves from emerging and possibly suffering further harm (Goulding & Schwartz, 1995). Protectors may deliberately cause crises in the host's life in order to distract the host from uncomfortable memories or associations to past traumatic events (Goulding & Schwartz, 1995; Ross, 1997). They may also divert the host personality by devoting the system's energies to work or particular hobbies, keeping the focus on things other than internal reactions and processes.

Persecutors or perpetrator alters are often introjects of the actual perpetrators (in the cases of childhood abuse) and may serve to punish perceived mistakes and errors the host or any other part might make in daily living (Ross,

1997). Sometimes persecutors also serve as enforcers of rules. These rules are also often the introjected threats, statements, and behaviors of the external abusers (Fike, 1990a; Ross, 1997). Some of these statements might include: “you can’t talk about this to anyone,” “no one will believe you,” “you want this,” “you are bad and deserve this” and other comments such as these.

Finally, internal systems of persons with DID usually contain self-helpers. These parts appear to be those that are perhaps more introspective and willing to examine issues and concerns stemming from past trauma. They often serve as observers or hold knowledge that they can share with the other parts. This knowledge is often dissociated from any emotions or physical experience (Fike, 1990a; Ross, 1997). They also may be willing to help comfort younger parts or child alters and help establish communication among parts and with the host personality (Fike, 1990a; Ross, 1997).

Along with these more common alters, many persons with DID report other kinds of personalities. Some of these include alters who are of the opposite sex or sexual orientation as compared to that of the host, alters of different races, and nonhuman alters who often present as animals and sometimes as mythological or demonic beings (Fike, 1990a). While these parts may appear strange and vastly different from the host, they too can often be generally categorized into helpers, protectors, persecutors, and child alters after the clinician and host garner the parts’ histories and prescribed roles or purposes.

Switching

The second criterion of the DSM-IV (1994) states that “at least two of these identities...recurrently take control of the person’s behavior” (p. 487). In the language of those with DID, this is often described as another part “coming out” or “switching” (Kluft; 1987; Peterson, 1996; Ross, 1989, 1997; Smith, 1996; Spira, 1996). When each alter was “born” (created by the host), it was most likely during a time of extreme stress for the person. The host could not cope with the situation and so split off a part of himself or herself to contain the experience. In the case of DID, this process apparently becomes quite successful for the person and, as he or she experiences other stressful events, the person may continue to use this splitting process as a means of dealing with them. So, the person essentially conditions himself or herself to flee into another personality state when he or she deems the situation is too intense or stressful to cope with as himself or herself (Kluft, 1988).

As DID frequently has its origins in childhood, this process, while disruptive at times, is an effective way of surviving until the child becomes old enough to take himself or herself out of the traumatic environment. However, the consequence of this utilization of natural dissociation is that those parts created during specific times of duress are likely to “come out” when the person experiences similar distress or perceives a situation as somehow like past traumatic events (Albach, Moormann, & Bermond, 1996; Kluft, 1988). This is

what is described by Criterion “B” in the DSM-IV (1994): the host feels threatened in some way, or the alter itself perceives a situation as threatening and pushes aside the host, so to speak, and takes control of the person’s behavior for a period of time. The personalities “switch.”

Amnesiac Experiences/Loss of Time

Criterion “C” (APA, 1994) is closely linked to “B” (APA, 1994) in that when an alter takes control of the person, the host personality is temporarily displaced and is often unaware of what transpires during the time that the alter is “out” and functioning in the world. This temporary amnesia is frequently referred to as “losing time” and may vary from a few minutes to days or weeks (Ross, 1997). This is a function of the original defense mechanism: to protect the core or host personality from intolerable stress by containing the experience in a part of self that is disconnected from the host’s consciousness. However, during the time that the host is amnesiac, another part with its own personality characteristics has come out and is interacting with the external world.

Just as Criterion “A” (APA, 1994) states, each alter has specific patterns of relating to and perceiving the world. Frequently this means that each alter has a preferred social group, a preferred manner of dress and speech, and a preference as to how it accomplishes meeting its needs and fulfilling its perceived role. So, when the host is returned to consciousness, the person may find that he or she has a new wardrobe, messages on the answering machine from strangers who seem to

know him or her, unexplained bills, and so forth. This is a potential consequence of utilizing DID as a primary defense: the person may no longer consciously experience the majority of his or her life and may be left with mysterious fragments that must remain unaccounted for as long as the person refuses to acknowledge those dissociated parts of self.

This loss of time must be unrelated to any kind of substance use or medical condition (Criterion “D”) (APA, 1994). If the host has come to realize that he or she has different parts, the person may be able to achieve some level of co-consciousness during the time that another part is out (Peterson, 1996; Ross, 1997). An analogy for co-consciousness might be watching someone from behind a two-way mirror. The person watching can observe the external events occurring beyond the mirror, but cannot necessarily interact with or impact those events. Nor can anyone in front of the mirror directly interact with the person observing behind it. Co-consciousness itself tends to be a step toward achieving a more equal level of system cooperation where both the host and another part or parts would be able to interact with the external environment. However, until the person realizes and accepts that he or she has various other parts of himself or herself and begins to make contact with those parts, the person will continue to lose time when other parts of self emerge to take control.

Physiological Features and Comorbid Disorders

Along with the criteria listed in the DSM-IV (1994), there are other physiological features that often occur with DID. Headaches, especially migraines, are a frequent somatic complaint of persons with DID. The headaches appear to be a side-effect of switching, but this has not been conclusively proven (Kluft, 1987; Peterson, 1996; Ross, 1989, 1997). Other physiological phenomena that occur with some regularity in persons with DID are blood types, blood pressures, and body temperatures that vary with alters, along with handwriting styles unique to specific alters (Fike, 1990a; Kluft, 1987; Ross, 1989). While these phenomena have been documented in persons with DID, not every person with the disorder exhibits them, nor do these curiosities appear to have a medical explanation as yet.

In addition to physiological features that frequently accompany a DID diagnosis, there are also several psychological disorders that often appear in conjunction with DID. Substance abuse, anxiety, mood, eating, and somatoform disorders, as well as personality disorder traits and personality disorders themselves, may be presented by persons with DID (Dawson & Higdon, 1989; Kluft, 1987; Marmer, 1996; Peterson, 1996; Ross, 1989, 1997). Posttraumatic Stress Disorder is also commonly diagnosed along with DID (Ross, 1997). The most recent trend in research into PTSD and DID is reflecting a new conceptualization of DID, PTSD, and other anxiety disorders which includes

them as part of one continuum in regard to how the mind and body adapt to stress and trauma (Ross, 1997; van der Kolk, 1996; van der Kolk, van der Hart, & Marmar, 1996). This is a new theory and has yet to be fully researched or tested, but, if accepted by the clinical arena, it may further the acceptance of DID and PTSD as legitimate diagnoses that can occur outside the horrors and rigors of war.

There also exist phenomena in DID that resemble personality disorders and other psychiatric disorders. Persons with DID tend to hear voices conversing, singing, or generally making some sort of noise in their heads (Kluft, 1987; Ross, 1989, 1997; Spira, 1996). In DID, these noises and conversations generally are the parts talking to or among themselves or offering commentaries on what they see the host doing. Not only does this tend to cause the person to think he or she is “crazy,” but it also makes it increasingly difficult for clinicians to make an accurate diagnosis (Ross, 1997). The difference between the voices a person with DID “hears” and the voices a person with schizophrenia “hears” is that the person with DID experiences the voices as internal where the latter person experiences them as external (Ross, 1989). One is classified as psychotic phenomena and the other is not. This can become a very fine diagnostic line.

Another confusing diagnostic concern is the frequency of self-mutilation, unstable relationship patterns, and suicide attempts among persons with DID. A history replete with these issues often leads a clinician to diagnose Borderline

Personality Disorder in a person who actually has DID (Kluft, 1987; Ross, 1989, 1997). In persons who have DID, suicide is often a tool for coping, an ultimate guarantee for escaping an untenable situation. Self-mutilation and other forms of self-injury in persons with DID tend to be done by persecutor parts who are punishing the host or other parts for actions that are perceived as mistakes or “bad.” Neither suicide attempts or self-mutilation are likely to be attention-seeking behaviors in the person with DID as compared to a person with Borderline Personality Disorder (Fike, 1990b; Ross, 1989, 1996, 1997). With regard to unstable relationships, the fact that the personality is split into various parts with distinct personality styles and traits can make maintaining healthy relationships difficult (Ross, 1989).

Accurately uncovering and connecting all of these issues can make it very challenging for the clinician to correctly diagnose a person with DID. Compounding this difficulty are clients who do not know they have DID or choose not to disclose their suspicions of having alters (Kluft, 1986, 1987). These people may instead present with symptoms of anxiety or depression. Indeed, clients who tell clinicians they think they may have DID are frequently not believed (Baldwin, 1990; Dell, 1988; Kluft, 1986, 1987; Ross, 1989). It is estimated that persons with DID spend an average of six to seven years in the mental health system before they are correctly diagnosed (Fike, 1990b; Kluft,

1987; Ross, 1989, 1997). However, a correct diagnosis is critical for effective treatment of this disorder.

According to Ross (1997), the treatment of DID, as well as the treatment of other trauma-induced disorders, ought to be done hierarchically. This means that the root disorder, be it PTSD or DID, needs to be accurately diagnosed so it can be the focus of treatment. Comorbid disorders such as eating, mood, and somatoform disorders may, depending upon their severity, need to be treated concurrently. However, Ross (1997) offered that treating the primary disorder is most effective, and progress in treatment of that disorder tends to diminish comorbid symptomatology.

An example of this is a person with DID who is presenting with symptoms of severe and resistant major depression. Eventually, electroconvulsive therapy (ECT) is prescribed as no other medicinal regime has been successful in alleviating the client's depression. Electroconvulsive therapy is expressly contraindicated for the treatment of DID, as a potential side-effect of ECT is permanent memory loss. This may serve to further complicate the integration of parts (one goal in the treatment of DID) if the person has permanently lost access to parts of his or her memory (Kluft, 1987; Ross 1989, 1997). Frequently, disorders that appear comorbidly with DID are resistant and difficult to treat, as oftentimes they may be symptoms of DID rather than disorders that are generalized across the person's entire internal system (Kluft, 1987; Ross, 1989,

1997; Spira, 1996). In cases such as this, it appears crucial to treat the DID first and offer supportive therapy for the comorbid disorder, understanding that improvement in the primary disorder may instigate a corresponding improvement in the second (Ross, 1997).

Etiology of Dissociative Identity Disorder

According to clinicians who have researched DID, dissociation is actually a naturally occurring phenomenon experienced by people in their every day lives. Highway-hypnosis, day-dreaming, and becoming involved in a book or movie to the exclusion of all else are examples of commonplace dissociation (Ross, 1989, 1997; Spira, 1996). Persons who develop DID appear to have a proclivity for dissociation and abstract thinking (Kluft, 1987; Siegel, 1996; Spira, 1996). They tend to utilize these abilities as defense mechanisms in increasingly complex ways (i.e., the splitting of the personality into various alters) according to the duration and frequency of the stressors from which they are protecting themselves (Marmer, 1996; Ross, 1997; Siegel, 1996). Thus, DID occurs when a person utilizes naturally-occurring dissociation as a primary defense mechanism that splits the person's core personality into various alters. Dissociation becomes an actual disorder when that defense is no longer useful for the person's survival and interferes with the person's functioning (Kluft, 1987; Ross, 1989, 1997; Siegel, 1996; Smith, 1996; Spira, 1996).

Kluft's Four-Factor Theory

According to Kluft (1987), there are four factors which contribute to the development of DID. The first is that the child has the capacity to dissociate. This means the child has the ability to lose himself or herself in fantasy or abstract imaging to the point of creating a break in consciousness and reality (Spira, 1996). This talent for losing oneself in the realm of fantasy and abstract thought is not altogether common. Only about twenty to twenty-five percent of people have the ability to undergo dissociative or amnesiac experiences (Dell, 1988). This means that they are able to utilize imagery as their primary thought process (the tendency to create an internal representation or image of an outside event or experience) at will (Dell, 1988; Spira, 1996).

The second factor for developing DID requires that the child be subject to overwhelming stimuli (trauma) which force him or her to use normal, or healthy, dissociation as a defense to keep from being completely overwhelmed. The child splits off a part of himself or herself. That part then experiences and stores the memories of the abuse, leaving the core personality of the child free to continue on with his or her life unaware of the trauma (Marmer, 1996; Ross, 1997).

Kluft (1987) suggested that when the child splits off in this fashion, dissociation moves from normal fantasy to a necessary and increasingly complex defense mechanism that also serves to shape personality development (factor three). An example of "normal fantasy" might be having imaginary playmates.

In the case of a child presented with unendurable stress (trauma), the child might make that imaginary friend endure the traumatic event rather than the child himself or herself. This creation of separate entities that experience and contain negative events is what ultimately may shape the child's personality development in areas such as bonding, individuation, and exploration (Spira, 1996).

Finally, if the child cannot find support, safety, or relief from the trauma the child continues to use dissociation as a survival tool, which can potentially result in the development of DID (Kluft, 1987; Spira, 1996). In many cases, the child is subjected to repeated traumatic or abusive events by his or her family members or care-takers (Kluft, 1996; Peterson, 1996; Ross, 1997; Spira, 1996). In such cases, the child is dependent upon those family members or care-takers for his or her survival (Ross, 1997). This sets up a situation in which the child is faced with separating itself from the care-taker. Physical detachment from the care-taker would likely result in a failure to thrive and eventual death (Ross, 1997). So the child must create a different solution that allows him or her to remain attached to the perpetrator but achieve detachment from the abuse. In the development of DID, this results in the creation of a split in the child's personality (Kluft, 1987).

The child quickly learns that dissociating the events into separate parts of self is an effective means of living in a situation that is inherently unsafe.

However, because dissociation is indeed so effective, the child continues to use

this as a defense in situations that are not necessarily life-threatening but are perceived by the child as being somehow dangerous and distressing. This proclivity for dissociation tends to follow the child through his or her development into adulthood, thus creating a personality and world view that centers around dissociation (Spira, 1996).

Treatment of Dissociative Identity Disorder

Many authors suggest that integration or fusion be the ultimate goal in the treatment of DID (Allers & Golson, 1994; Kluft, 1987, 1988; Marmer, 1996; Ross, 1989, 1997; Spira, 1996). Proceeding toward this goal in the treatment of DID generally requires movement through four basic phases: (a) the initial phase, (b) the middle phase, (c) the preintegration phase, and (d) the integration-postintegration phase of treatment (Ross, 1997). The last phase of treatment can take about two years depending upon the client's ego strength in his or her newly unified state (Kluft, 1988), while the first three phases generally require anywhere from two to five years of consistent psychotherapy (Kluft, 1987; Ross, 1997).

Initial Phase

The initial phase in the treatment of DID follows, in many respects, the treatment of most psychiatric disorders. It consists of assessment and diagnosis, gaining informed consent from the client, and initializing the therapeutic alliance with the client and client's system (Braun, 1984; Kluft, 1987; Ross, 1997). While the initial phase of treatment may be the briefest of the four, the basic

components of respect, trust, and safety that are established within its parameters can determine whether the treatment is a success or a failure.

Assessment and Diagnosis

Assessing and accurately diagnosing DID is often quite challenging for clinicians. Frequently, there are comorbid disorders which may appear to be generating the client's presenting symptomatology (Dawson & Higdon, 1989; Kluft, 1987; Marmer, 1996; Peterson, 1996; Ross, 1989, 1997). The client may also either not be aware of the other alters in his or her system or may simply choose not to disclose that knowledge to the clinician (Kluft, 1986, 1987). Frequently, the client only exhibits behavioral symptoms during times of extreme stress and deterioration (Kluft, 1987). Therefore, the resulting diagnostic window can be quite small.

Correct diagnosis, however, is crucial to the effective treatment of the disorder. Assessment tools such as the Dissociative Disorders Interview Schedule (Ross, Miller, Reagor, Bjornson, Fraser, & Anderson as cited in Ross, 1997) and the Dissociative Experiences Scale (Bernstein & Putnam as cited in Ross, 1997) can be useful in helping the clinician determine what specific dissociative symptoms the client may be experiencing in his or her life (Ross, 1997). Additional diagnostic clues for DID include: (a) the client having a long psychiatric history replete with failures to respond to orthodox treatment methods, (b) several prior diagnoses, (c) fluctuation of symptoms and level of

functioning, (d) a history of time lapse or distortion, (e) auditory hallucinations, (f) the client's use of the plural pronoun "we" when describing himself or herself, (g) a history of trauma or abuse, (h) severe headaches and other somatic complaints, (i) and the client having been told by others of activities which the client cannot recollect (Kluft, 1987). Utilizing these assessment tools and this checklist can aid the therapist in correctly diagnosing DID in clients.

Informed Consent

After the clinician is reasonably certain that the client has DID, he or she must explain the diagnosis and the likely course treatment of the disorder could take to the client (Kluft, 1987; Ross, 1997). This is especially important in the treatment of DID, because DID therapy often results in temporary but severe periods of dysfunction in the client (Fike, 1990b; Kluft, 1996; Ross, 1997; Spira, 1996). Therefore, it is the therapist's duty to explain carefully to the client what benefits and risks treatment may entail. In this way, the client and the therapist together can decide if it is appropriate to begin treatment for the client at that particular time (Ross, 1997). Gaining informed consent from the client is also a means of conveying respect for the client, which can begin to establish trust and the therapeutic alliance.

Establishing Trust and the Therapeutic Alliance

Successful treatment of DID appears to hinge upon establishing trust and safety within the therapeutic alliance (Braun, 1984; Ross, 1997). These clients

tend to present with a distinct lack of trust in others, particularly with those the clients perceive as authority figures (Kluft, 1987; Ross, 1989). Often authority figures in the client's past (offenders and past therapists alike) have fed into the client's belief that he or she is "crazy." As one of the earliest signs of co-consciousness or greater awareness is the client hearing conversations, comments, or voices inside his or her head, it is fairly apparent why these clients may believe they are losing their sanity (Peterson, 1996; Ross, 1997). Frequently, these clients have not been believed or have been dismissed as "making it up" by friends, relatives, and even therapists when they have previously described their experiences (Baldwin, 1990; Dell, 1988; Kluft, 1987; Ross, 1989, 1997). Respectful exploration of the reported symptoms by the clinician without a quick dismissal as psychotic, borderline, or other diagnostic features that are easily mistaken for DID can be the beginning of a trusting relationship between therapist and client.

A somewhat unique aspect of establishing the therapeutic alliance with clients who have DID is the necessity to re-establish that alliance with each part in the client's system (Dawson, 1990; Kluft, 1987; Marmer, 1996; Ross, 1989; Spira, 1996). Some parts may have "observed" the therapist prior to meeting him or her, while some may not know the therapist when the parts first come out. Therefore, it is important that the therapist introduce himself or herself to each

part and explain the role of the therapist in relation to the part and therapy in general (Ross, 1997).

Middle Phase

The middle phase of treatment of DID has three primary components. The first is establishing safety within the therapeutic arena. The second aspect of the middle phase concerns the clinician contacting the client's alters and mapping the client's system. The final point of the middle phase is generally where most of the client's traumatic memories are accessed and processed, frequently through abreaction and hypnotic interventions (Braun, 1984; Kluft, 1982; 1987; Ross, 1997).

Establishing Safety

It is essential to establish a sense of safety and trust within treatment (Braun, 1984; Fike, 1990b; Kluft, 1987; Ross, 1997). Much of this process centers around creating boundaries and limitations both for the therapist and for the client. These can be stated in a client-counselor therapy contract (Ross, 1997). The therapist must be very clear in describing to the client his or her personal boundaries as a therapist. One issue to be made clear might be the degree of accessibility the therapist will agree to have with the client outside of therapy appointments. This could include whether the client may call the therapist at home or at the office, the number and length of phone calls, and how soon the therapist would agree to answer client-phone calls and messages. It may

also be important to emphasize the specific length of therapy appointments and keep to those limits. This demonstrates respect for the client's time, the therapist's time, and for those other clients who are waiting for their appointments with the therapist. Additionally, it is important for the therapist and client to delineate when it is appropriate for unilateral termination of treatment. This may be if the client threatens to harm the therapist or the therapist's family, or if the client continues to disrespect specified therapeutic boundaries despite repeated discussions in treatment about those infractions (Ross, 1997).

It is also important that the therapist work to ensure that the therapy sessions themselves are physically safe for the client (Ross, 1997; Smith, 1996). This may entail light-to-moderate restraint of the client if an alter is abreacting (appearing to be re-experiencing the trauma in the present) (Ross, 1997). It may also be necessary to ensure that the clients are not bringing any weapons into the therapy sessions. This is for the protection of both the counselor and the client (Ross, 1997).

It is also helpful if the therapist can assist the client in establishing an internal Safe Place for parts. A Safe Place is an internal space that can be created through visualization, drawing, or writing and offers the parts a place to go when they need to feel secure and safe (Shirar, 1996). It may be helpful to ask individual parts what they would like to have in their particular "corner" of the Safe Place, things that would give them comfort or pleasure such as stuffed

animals, pets, and activities like books, music, writing paper, and/or drawing utensils. Establishing a Safe Place allows an internal area where parts can go or be asked to go when it is time for the host to return or if the content of the session might be too distressing for particular parts (Shirar, 1996).

An additional tool is the creation of a safety contract with the client. This is a contract that is drawn up with the host and signed by the therapist, host, and as many alters as possible, with the highest goal being a system-wide agreement to “do no harm” (Kluft, 1996; Ross, 1996). While this contract is not legally binding, it communicates the message that the therapist believes the client does not deserve to be abused or harmed and that abuse in the therapeutic arena will not be tolerated.

It is the client’s responsibility to abide by the contractual agreements decided upon by both himself or herself and the therapist. It is also important that the client take responsibility for his or her actions regardless of which alter is present (Ross, 1997). This process of informed consent, negotiation, and semi-formality of either a verbal or written contract is intended to offer a sense of validity and commitment to the client and therapist regarding treatment. A contract also can connote a sense of responsibility as well as a sense of security that has often been lacking in the lives of clients with DID (Kluft, 1987; Ross, 1997). It may also be the beginning of dissolving the amnesiac barriers between

alters, since almost any therapeutic contract is likely to be regarded very differently by various parts (Fike, 1990b; Kluft, 1987).

Safety in treatment may also ultimately result in hospitalization, which is not uncommon, particularly in the middle phase of treatment (Fike, 1990b; Kluft, 1996; Ross, 1989, 1996, 1997; Spira, 1996). The possibility and even likelihood of brief hospitalizations must be discussed with the client at the beginning of treatment (Ross, 1997). It is most helpful if the therapist and client can discuss potential criteria for hospitalization and agree on a hospital and protocol for getting there; this is less traumatic for both the clinician and the client, and results in greater empowerment for the client (Kluft, 1991).

Ultimately, establishing safety within therapy sessions conveys the message that abuse of the client or the counselor will not be tolerated. This also serves to model to the client that healthy relationships do not contain abuse and helps convey the message that no person is deserving of abuse regardless of his or her age or gender (Ross, 1997). Additionally, a firm stance on creating a non-abusive and safe atmosphere in therapy can help convey a sense of safety, trust, and security to the various alters in the client's system.

Contacting Parts

Establishing trust with the client's alters is often an on-going process throughout therapy, but tends to begin in the middle phase of treatment (Braun, 1984; Kluft, 1987; Ross, 1997). This contact with the alters often occurs

naturally within the context of DID treatment: either the alters come out spontaneously or the therapist calls them out for a specific therapeutic purpose (Braun, 1984; Fike, 1990b; Kluff, 1982; Ross, 1997). Initially, the therapist may ask to speak with various alters in order to “map” the client’s system (Allers & Golson, 1994; Braun, 1984; Dawson, 1990; Dawson & Higdon, 1996; Kluff, 1982; Marmer, 1996; Ross, 1989, 1997; Siegel, 1996; Smith, 1996). This usually entails asking the host what he or she knows about the system as a whole, as well as seeking information about specific alters (e.g., names, purposes, personality traits). Then the therapist may ask to speak with individual alters in order to garner their specific histories, perceptions, and knowledge of the system (Ross, 1997). One result of this process is that the therapist tends to introduce himself or herself repeatedly throughout the course of therapy.

As the parts are introduced into therapy, they tend to vary in their cooperation and resistance to the therapist and to treatment (Dawson, 1990; Kluff, 1987; Ross, 1997). Particular pitfalls are associated with persecutors and child alters. The possible problem in working with child alters is that they tend to elicit a care-taking or parental response in the treating clinician. These parts tend to be engaging, charming, and generally interesting (Fike, 1990b; Ross, 1997). It may become difficult for the clinician to maintain his or her objectivity and refrain from being pulled into a protector or rescuer role in relation to these parts (Ross, 1997). It is helpful for clinicians to remain aware of the fact that DID child alters

are not “true” children. Often these parts function at cognitive levels far beyond what a physical child could do at a similar age in spite of their child-like demeanor (Ross, 1997).

Persecutors and protector alters also tend to pose some specific challenges in the treatment of DID. These parts may be adolescents, introjected abusers, or mythological beings and demons. Frequently, they interpret the therapist’s interventions as interference and are often resistant or directly hostile in relation to the counselor and treatment (Fike, 1990a; Ross, 1997). It may be advisable for therapists to simply avoid power struggles with these parts. In fact, if it is at all possible, it can be useful to join with these parts and utilize them as consultants in the treatment of the host (Ross, 1997). When this is accomplished, these parts are often revealed to be sad and exhausted younger parts who have used a defense of anger to protect and keep the host amnesiac regarding past abuse and trauma (Ross, 1997). There may be times, however, when parts who are vital to treatment resist every attempt to be contacted or to participate in therapy. In these cases, hypnosis may be a useful for contacting and engaging those parts in the therapeutic process (Braun, 1984; Kluft, 1982, 1987; Ross, 1997).

Use of hypnotic interventions.

There are many uses for hypnotic interventions in the treatment of DID. There are also a number of clinicians who believe that DID can be an iatrogenic

construct and state that hypnosis is the primary method of inadvertently “creating” a false case of DID in a client (Kluft, 1982; Ross, 1997). It is also suggested that because persons with DID tend to be very easily hypnotizable, iatrogenic DID can become a serious concern when using hypnosis for the recovery of traumatic memories (Ganaway, 1989). Other authors argue that the nature of traumatic memory and the subsequent development of dissociative identity disorder is such that it cannot be exogenously created (Bowman, 1996; Braun, 1984; Kluft, 1982; Smith, 1996). As there appears to be relatively wide dissent among researchers as to the ethical use of hypnosis in garnering diagnostic information, the use of hypnosis in the treatment of DID might best be reserved for interventions that do not include memory-retrieval (Ganaway, 1989).

This does not, however, preclude other uses of hypnosis in the general treatment of DID. One such use is accessing parts that may be reluctant or unwilling to speak to the therapist or host (Braun, 1984; Kluft, 1982, 1987; Ross, 1997; Smith, 1996). It may be advisable for the clinician to try contacting these reclusive parts via other parts (asking a part to serve as a kind of translator or relater of messages between the reluctant part and the therapist) or through writing, drawing, or other media. However, if these parts remain resistant, it may be beneficial to contract with the host to utilize some hypnotic interventions in therapy (Braun, 1984; Fike, 1990b; Kluft, 1982, 1987; Ross, 1997). The rationale

for this is that frequently these parts may be sabotaging therapy or erecting blockades in treatment (Kluft, 1982).

Another use for hypnosis is in symptom relief. Somatization is common in clients with DID; judicious use of hypnotic suggestions can help to minimize somatic discomfort (Kluft, 1982; Smith, 1996). Hypnosis can also be utilized to help challenge and change cognitive errors in various parts (Kluft, 1982; Ross, 1997). It can also be used to help contain hostile, violent, self-abusive, or abreacting alters. Introducing hypnotic suggestions for sleep, calm, or even an order to physically “freeze” can be a temporary aid for reducing potentially dangerous situations for both the client and therapist inside and outside of the session (Braun, 1984; Kluft, 1982; Ross, 1997).

Finally, hypnosis can be used in facilitating integration among parts (Braun, 1984; Fike, 1990b; Kluft, 1982; Ross, 1997; Smith, 1996). This may take the form of creating a visualization of joining which emphasizes a creation of a whole in which nothing is lost (Kluft, 1982). It is important that parts realize that they will not “die” or “disappear” when they integrate. Rather, they will merge with other parts forming a whole in which their knowledge, skills, and experiences will remain and be accessible as one entity.

In general, the use of hypnosis in the treatment of DID can serve to increase communication within the client’s system (Braun, 1984; Kluft, 1982, 1987; Ross, 1997). A possible result of increased communication may be that

memories of past events that were previously dissociated from the host become accessible. This usually occurs in the middle phase of treatment, after trust and contracting have been basically established and the process of understanding the client's system has begun (Braun, 1984; Ross, 1997).

Processing Memories and Abreaction

The initial processing of memories may be done primarily with the clinician working with a specific part holding the memories of a particular event (Ross, 1997). This requires having already mapped the client's system so that the therapist has an idea of which parts might be involved in which traumatic memories. The therapist should have also worked with those parts on increasing their chronological awareness. This means that the parts have at least a basic understanding of the fact that several years (in most cases) have passed since the traumatic incident, the body is older and bigger, the alter and host are safe and, if appropriate for the specific memory, the abuser is no longer present (Ross, 1997).

To process a memory with a client, the clinician first asks for the part holding the memory to come out. The therapist may then begin asking the part about the memory in a general, non-suggestive manner (Ross, 1997). During the actual processing, the clinician may witness a part abreacting. When a part abreacts, it believes it is experiencing the traumatic event in the present and will often respond physically and verbally as if the event were actually occurring in the therapist's office (Fike, 1990b; Higdon, 1990). It is important for both the

therapist and client to understand that what is occurring is a memory and not the actual event. If the therapist forgets this, it can lead to him or her eventually developing secondary posttraumatic stress disorder; if the client forgets this, the energy poured into the abreaction is essentially wasted as the memory is not processed but merely re-experienced (Ross, 1997).

Abreaction, when therapeutic, is a relatively controlled event (Fike, 1990b; Kluff, 1991; Ross, 1997; Smith, 1996). As the part begins to relate the memory, it may start to use the present tense; it is useful for the therapist to continue using past tense as he or she addresses the alter. The clinician may continue to prompt the alter, asking what the alter is seeing, feeling, hearing, and so forth, all the while reiterating that this is a memory, that the alter is in a safe place now, the client has an adult body, and that the abuse occurred in the past (Ross, 1997; Smith, 1996).

Generally, a therapeutic abreaction will follow a curve, peaking for about ten minutes before starting to ease (Ross, 1997). After the alter again has a sense of being in the present in the therapist's office, it is important that the therapist and alter debrief the event (Ross, 1997; Smith 1996). This may entail a great deal of reassurance on the therapist's part that the alter is safe now, that it did not deserve what occurred, and that the event is in fact over and in the past (Fike, 1990b; Ross, 1997). An additional part of this debriefing is beginning to challenge whatever cognitive errors the alter may have regarding the incident

(Ross, 1997). Frequently, the alter believes he or she caused the event or was somehow responsible for it. Beginning to challenge and help correct this belief is essential in the effective processing and integration of the event.

Prolonged abreaction and abreaction without debriefing or processing is generally untherapeutic and only serves to increase feelings of shame and powerlessness in the client (Kluft, 1991). Additionally, prolonged abreactions with frequent switching during them may be indicators that something is not going well in therapy. If the clinician and client cannot identify the underlying reasons for the abreactions, and if they continue to escalate in frequency and intensity, consultation with another clinician and possible hospitalization of the client may be necessary (Kluft, 1991; Ross, 1997). It is often during this phase in treatment that suicidality, along with a pervasive sense of treatment “not being worth it,” increases in clients (Kluft, 1991; Ross, 1997). In the short term, that may be an accurate assessment on the client’s part, as decreasing the amnesiac barriers and reclaiming lost parts of self tends to be emotionally, physically, and mentally draining, often impairing daily functioning to various degrees (Fike, 1990a). This tends to be the most difficult time in treatment (Ross, 1997). Fortunately, this phase eventually ends, and treatment begins to focus primarily on increasing communication within the client’s system.

Preintegration Phase

The third phase or preintegration phase of treatment is mostly concerned with increasing communication and negotiation within the client's system in an effort to essentially eliminate amnesic barriers and establish cooperation in shared tasks and responsibilities (Ross, 1997). It is not uncommon during this time for the therapist and client to uncover a sublayer of alters (Ross, 1997). This requires essentially starting with the initial phase of treatment (building the therapeutic alliance, establishing safety and limits, beginning the mapping process) and bringing those alters up to speed with the alters previously worked with in treatment.

This may seem like a setback to both therapist and client; both may feel doubtful of ever seeing an end to therapy. It is useful to note that this seeming repetition of treatment interventions in DID therapy is fairly common: treatment of DID rarely occurs in a linear fashion. As new alters are discovered during therapy and as the client encounters differing stresses in the outside world, past phases of therapy may need to be revisited (Ross, 1997). It may be helpful for both the therapist and client to remember that such repetition generally ought not be perceived as a failure or regression in treatment, but, rather, a fairly normal occurrence during DID therapy.

As eventual integration, or fusion, is generally considered to be the ultimate goal in the treatment of DID (Allers & Golson, 1994; Kluft, 1982, 1987,

1988; Marmer 1996; Ross, 1989, 1997; Spira, 1996), it is important to begin dissolving the amnesiac barriers that exist between the host and alters (Fike, 1990b; Ross, 1997). Alters may resist this. Frequently, protector parts, in particular, will protest that the host cannot cope with the memories that they or other alters in the system may hold (Ross, 1997). Also, some alters may be afraid of other parts or hold other parts in derision (Dawson, 1990; Fike, 1990a). Some alters may also protect or hide other parts, making it almost impossible for the host or therapist to make contact with those exiled or secluded personalities (Fike, 1990b; Ross, 1997). These general considerations, as well as problems idiosyncratic to particular clients, can make establishing connections and communication within the client's system very challenging.

A useful way to increase communication among alters is to ask them to join together in completing a task designed to utilize the combination of the parts' particular skills (Dawson, 1990; Dawson & Higdon, 1996; Higdon, 1990). In this way, parts become increasingly accustomed to sharing responsibilities, perceptions, feelings, and expectations with other parts. With the aid of mediation from the therapist and host, the parts learn to negotiate wants and needs in an increasingly collaborative and democratic fashion (Kluft, 1982; Ross, 1997). Shared tasks can also help parts develop respect for other alters' levels of competency, as well as empathy between previously hostile alters (Dawson, 1990;

Dawson & Higdon, 1996). Hypnotic interventions, as described previously, can also facilitate increased cooperation among parts.

This phase of treatment often demands the most tenacity, as it is frequently difficult to break down amnesiac barriers and increase internal communication and cooperation within the client's system (Ross, 1997). Therapists can generally expect to encounter a great deal of resistance to the concept of collaboration and integration from the host as well as internal parts (Ross, 1997). During this phase of treatment, it becomes important that the client and counselor assess whether it is in the client's best interest to integrate his or her system. In some cases, integration may not be a needed or desired goal, but rather collaboration and a consistently high degree of functioning may be the most important treatment outcome (Caul as cited in Kluft, 1987; Goulding & Schwartz, 1995; Ross, 1997).

One possible way of determining a client's readiness and/or need for integration is to propose a temporary fusion in which the parts of the system agree to integrate for a specific amount of time, split again at the end of that allotted time, discuss the pros and cons of integration, and make a decision as to whether they want that to be the goal for the system at that time (Smith, 1996). Some clients may never choose to integrate and may go on to lead productive, functional lives (Ross, 1997). Others, however, may decide that

integration is their ultimate goal. For these clients, there is yet another stage in treatment.

Integration-Postintegration Phase

Kluft (1982) offered six criteria that must be present for a period of three consecutive months to meet the definition of integration or fusion: (a) the client must not experience any amnesic episodes or loss of time; (b) there is no observable switching or other behavioral phenomena associated with DID; (c) the person reports experiencing an internal sense of unity; (d) the therapist can find no presence or evidence of alters when using hypnotic re-exploration; (e) transference in treatment is consistent with one integrated personality; and, (f) there is clinical evidence that the person exhibits acknowledgment of attitudes and awarenesses that were previously separated in specific alters. Kluft (1982, 1988) noted that integration tends to occur only after several tries and false starts. These may have to do with pleasing the clinician, a flight into health, or simply that the client, after experiencing integration, decides that returning to a dissociative method of coping is more effective for him or her in life than being integrated (Kluft, 1982; Ross, 1997).

Postintegration work is essentially the same as treating any client without DID (Ross, 1997). Integration is frequently quite difficult for the client, especially during the first year. The client has chosen to cope directly with his or her current life experiences instead of retreating into himself or herself and

allowing another part of self executive control and may feel raw and unprepared for dealing with life's events (Dawson & Higdon, 1996; Kluft, 1988; Ross, 1989, 1997). This is often frightening and daunting for clients. During this time, it is important to help the client establish a firm support system as well as aiding him or her in developing common skills such as social skills, assertiveness, and learning how to access and utilize community resources (Dawson & Higdon, 1996; Kluft, 1988; Ross, 1989). Postintegration therapy may last for as long as two years or be brief in nature, depending upon the client's natural resilience and ego-strength (Kluft, 1988).

It is also important to realize that some secondary diagnoses may not be entirely alleviated by successful treatment of DID (Ross, 1997). Clients still may have mood or anxiety disorder that become the focus of treatment. They may still exhibit posttraumatic stress symptoms or personality disorder traits that might need to be addressed. However, treating these issues in fully integrated DID clients is typically the same as treating any person with similar issues who never struggled with DID (Kluft, 1988; Marmer, 1996; Ross, 1989, 1997).

Conclusion

Dissociative Identity Disorder appears to be diagnosed more frequently in the current clinical arena. This may be connected to increased awareness of how people respond and cope with traumatic events, both singular and prolonged or serial. This increase in diagnoses may also correspond with new associations

between childhood abuse and trauma, as well as research into how trauma is coded in memory.

Dissociation can be viewed as a natural phenomena that, when overly utilized as a defense against trauma and its impact, may develop in some persons into DID. Treatment of DID tends to progress through four phases: initial, middle, preintegration, and integration-postintegration. However, these stages frequently do not follow in order and may need to be revisited as the therapist and client encounter new parts in the client's system. Accurate diagnosis, informed consent, and a strong therapeutic alliance that explicitly conveys trust and safety seem to be the most important elements in successful treatment of DID.

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