**Howell Chapter 7 Dissociated Self-States**

Kluft “multiple reality disorder for which the alters are an embodied and personified delivery system. There is a need to disidentify with the unacceptable experience, [disconnection with one’s state of mind during the unacceptable experience] and formation of a boundary that maintains the disconnections above. Therefore a fantasized personified adaption that serves and maintains these adaptions is formed”.

Repeated traumas are likely to elicit repeated altered state. The more it happens the greater the hosts amnesia and greater the memory stored in altered state.

Building blocks of DID: trauma is complex and repeated over extended portion of child’s life, occurs repeatedly resulting in numerous altered states.

Trance logic doesn’t have to make sense ie) Nice and upsetting Mommy together.

1. Origins of Dissociative Identities: The Karpman Drama Triangle of Victim, Persecutor, Rescuer Redux.
	1. Child becomes the victim, persecutor and rescuer in relationship with the parents and knows these roles implicitly as a result.
		1. Victim of the frightening caregiver
		2. Rescuer and comforter of the frightened caregiver
		3. Child perceives himself to be the persecutor of the frightened, withdrawn or preoccupied caregiver.
	2. Victim Identity
		1. Inner children who continue to suffer from the abuse
		2. Attachment is disorganized, attachment figure is frightening/abusive.
		3. Host-Detached from the event, rising to the ceiling, may be analgesic to the pain, and able to enter into a state of calm to engage in the attachment relationship. Leaving the other self-state child who is utterly terrified.
	3. Persecutor
		1. Trance logic prevails making an unclear distinction between self and other. Because the child is intensely focused on the abuser they are likely to mimic the aggressor’s behavior. (Identification with the aggressor)
		2. Focused on predicting the aggressor’s behavior to avoid some harm by the aggressor themselves.
		3. Mirror neurons, baby imitates bus also anticipates.
		4. Child may behave like the abuser or even experience the self as the abuser in the internal world/”third reality”
		5. Child focuses on abuser’s postures, motions, facial expressions, words and feelings in a depersonalized ways learning how to do things with others.
		6. Traumatic learning does not provide opportunity for discussing perspectives
		7. Procedural process of identification with the aggressor to survive.
		8. Mimicking the aggressor along with a depersonalized state creates a situation for the aggressor identified alter to develop.
	4. Rescuer
		1. Protectors for survival, Fairbain’s position: the infant becomes his own imaginary parent in situations of danger.
		2. Inner protectors are experienced as real and frightened parts attach to them
	5. Third Reality
		1. Inner world, has own structure cast and characters.
		2. Playful and creative
		3. Psychic system that is relatively closed and can create problems in living and limits growth.
	6. Self-care System
		1. Self-protective and compensatory rather than relational. It’ can’t gain understanding from experience.
		2. Resists transformation because it functions to prevent retraumatizing.
		3. Only temporarily helpful and needs to be replenished.
2. Connecting Dissociated Self States
	1. Putnam explained personality must become integrated over time. Discrete behavioral and mental states are the building blocks of human behavior and consciousness.
	2. Trauma impedes expected linking of associated pathways among states is impeded.
	3. Bound by contest: child beaten by a tall man associates all tall men re-evoke terror and experience flashbacks, or switch where terrified part appears.
	4. When self-states become more aware and accepting of their interrelatedness to one another the self becomes more context independent and decrease vulnerability by the outside context. Dissociative barriers will then decrease.
	5. Example Little Denny working together with his parts to understand his rage and feel empowered by being less alone, experiencing himself as standing next to the host, who can comfort and protect him.
	6. Intercontextualization, promoted in the therapeutic relationship. Parts interact with the therapist to share their third reality.
		1. Therapist acts as a bridge for self-states to share their segregated experience with each other.
	7. Integration: making barriers between various alters more permeable, increase communication and cooperation, return of subpersonalities to the status of “covert” ego states.
		1. Parts don’t die, they lose their redundancy. Too many parts doing the same things without knowledge of others doing the same wasting time and destabilizing.
		2. Dissociative separation of self-states and affect schemas impairs current affect regulation.
		3. Important to utilize their connectedness to each other they are in a better position to bear their overwhelming affects.
		4. Harmonious interaction among the self-states plus appreciation of contextual interdependence.
		5. Integration means different things to different people.
		6. Contextualization might be a better goal. Looking for reorganization if internal relationships to other states change.
			1. Different self-states become increasingly aware of how they are contextually related to each other. They then become more independent of specific contexts and less vulnerable to those triggers.

**Chefetz Chapter 3 – Recognizing Dissociative Experience and Self-States**

1. Only 10-15% of clients who meet criteria for DID have obvious switching and a fully developed alter system (Kluft)
2. Some providers see the dissociative process as schizoid which does not account for amnesia (i.e. Seinfeld)
3. Chefetz stance – naming the dissociative process and identifying constellations of experience that fit a multiple self-states model of mind decreases anxiety and increases the feeling of being understood and heard
4. Consider teaching clients how to use self-hypnotic induction in a nonharmful way which promotes naturalistic affect regulation – with the trichotillomania example, he saw the client’s excitement as a self-regulatory affect script and replaced the hair pulling with self-hypnosis
5. ‘Different ways of being you’ is a way to phrase the dissociative experience that notices differences while remaining focused on the integrative ‘you’
6. As it relates to self-states, we need to know:
	1. The qualities of the self-states experience to experience
	2. How perception and experience shift
	3. How things might conflict
	4. Be curious about the absence of conflict between states when it seems like it should be present
	5. What resolves tension between self-states
	6. **Curiosity and combining emotional/transferential dimensions, cognitive schemas, behavioral scripts – it combines all of them, how they are organized and stuck together in enduring patterns that are held distinctively separate and seem not to inform each other**
	7. The dissociative process is not going to raise its hand and speak up, it has not intention of being recognized
	8. Much of the dissociative experience, i.e. depersonalization feels strange enough that it leaves the person feeling like they are going crazy, maintaining dissociative adaptation through persistent exclusion and deflection is part of remaining ‘normal’
	9. Clinicians need to notice OUT LOUD
		1. Small inconsistences
		2. Incongruences
		3. Interruptions in train of thought
		4. Intervening facial expressions
		5. Other disruptive flows of consciousness
7. Thoughts on comparison – dissociation v. schizoid (Winnicott/Guntrip)?
8. The compartmentalization of self-states erodes as familiarity with the content of the individual compartments increases
9. Discontinuity of experience in other psychiatric disorders
	1. ADHD – high overlap with PTSD
	2. Bipolar disorder – compare to self-states for rapid cycling
10. Some theoretical background on the formation of self-states
	1. Kluft
		1. The capacity to dissociation
		2. Occurrence of profound trauma
		3. Alternate personality development based on naturally occurring phenomena
		4. Failure of parents to take care of the child
	2. Braun and Sachs
		1. Predisposition
		2. Precipitation of dissociation as defense
		3. Perpetuation through repetition
	3. Putnam – argues MPD can be understood as arising from a traumatic disruption in the early acquisition and control of basic behavioral states coupled with the creation of highly discrete dissociated states organized around differences in sense of self
	4. Bowlby/Putnam – the impact of attachment, the best predictor of adult dissociation is emotionally unresponsive parenting
	5. BPD research dissociates the literature on dissociation

**Dissociative experiences and dissociative minds: Exploring a nomological network of dissociative functioning** Adriano Schimmenti, PhD, DClinPsych

1. Background information
	1. When dissociation is relied on as a person’s primary response to stress it can become pathological
	2. trauma attachment often represents disorganizing factor for psychological development of a child.
	3. attachment trauma can generate impairments in several psychological domains including affect regulation, attachment, cognition, dissociation and self-concept.
	4. Psychodynamic Diagnostic Manual suggested cognitive, somatic and relationship patterns of highly dissociative people tend to reflect the particular affective states involved in dissociation.
	5. This implies: highly dissociative people could feel and behave according to their dissociated internal states to the point they could disregard the external reality.
	6. Higher dissociative people could respond to lower levels would correspond to lower levels of affect regulation, mentalization and empathy.
	7. Beliefs about the self “I am small, weak and vulnerable to recurring trauma.” Suggests higher level of dissociation would be related to higher problems with attachment.

II. Current study explores how dissociative experiences are linked to mental and relational functioning of individual in a nonclinical adult sample

1. Hypothesis #1: Participants with a higher DES-II score will show lower levels of theory of mind than participants with lower DES-II scores.
	1. Theory of mind: ability to attribute and interpret mental and emotional states such as beliefs desires, intents and perspectives.
2. Hypothesis #2: Participants with higher DES-II scores will show higher levels of alexithymia then participants with lower DES-II scores.
	1. Alexithymia is connected with affect dysregulation, it describes difficulties identifying, describing feelings, using feelings as a guide for behavior and linked to dissociation.
	2. Alexithymia and dissociation could serve to ward off overwhelming affective states.
3. Hypothesis #3: Participants with higher DES-II score will show higher levels of difficulties with attachment relationships then those with a lower score.
	1. Children have difficulty integrating attachment representations into a consistent system of meaning.
	2. They show many incompatible internal working models that contain a negative view of self, other and/or self-other relationships and that could evolve into severe dissociative states.
	3. Issues with closeness and intimacy
	4. Preoccupation or fearful in adult attachment relationships because they may feel weak
	5. May see others and relationships as unpredictable and potentially dangerous.
4. Hypothesis #4: Higher DES-II scores will shower lower empathy than participants with lower DES-II scores.
	1. Capacity to understand what others feel is widely influenced by parents own use of empathy toward their children.
	2. Due to high levels of dissociation people may have a lower degree of relatedness to others.
5. Results
	1. No significant differences between males/females in DES-II scores
	2. Males showed higher secure attachment/dismissive attachment
	3. Females higher for theory of mind, empathy, preoccupied attachment, and fearful attachment
	4. DES-II scores correlated with 3 groups
		1. Nondissociative – 51.9% of participants; score 8.27 DES-II
		2. Mildly/moderately dissociative – 34.4% of participants; score 23.45
		3. Highly dissociative – 13.7%; score 45.53 with above 30 cutoff for dissociative disorders
			1. Lower Eyes Test scores
			2. Lower EQ scores
			3. Higher TAS (Toronto Alexithymia Scale)
			4. Less educated
6. Discussion
	1. Dissociative experiences are positively related to alexithymia scores confirming the proposed relationship between affect dysregulation and dissociation – may relate to difficulty integrating mental states related to these feelings
	2. Speculations that highly dissociative individuals may regulate overwhelming feelings by shifting to a self-state with a different affect or no affect
	3. When controls for covariates were applied – dissociation remained consistent with a fearful attachment style which involves a negative view of self and others
	4. Theory of mind, and empathy scores were normal in nondissociative group, lower in mild/moderately dissociative group, and even lower in highly dissociative group 🡨🡪 alexithymia scores varied in the exact opposite way = highly dissociative individuals may benefit from clinical interventions aimed at enhancing mentalized

affectivity.

* 1. Mentalized affectivity is the experiential discovery of the subjective meaning of one’s own feelings as well as those of others in a way that extends well beyond intellectual understanding and entails simultaneously feeling and think-about-feeling
	2. Higher scores on preoccupied attachment and fearful attachment suggest that even moderate levels of dissociation can entail fear of intimacy, fear of rejection, feelings of inadequacy in close and intimate relationships, and negative evaluation of self

Resource: <https://us02web.zoom.us/rec/play/OWPaL7lnp19Grc_C5jpFikcNS6S7Q1I-N4iqwACQXsFids88jTSoaeWbkyrRBpEXAHysp3t5PY56uart.aTaLFVVWEHi2QLqG>