Steele, K. (2013). Six reasons to understand and treat dissociation. *Paradigm*, *18*, 12-15

Six Reasons to Assess and Treat Dissociation

Kathy Steele, MN, CS

Susan, an experienced psychotherapist, sits in her consultant's office discussing a troubling new case, a 38 year old woman named Caroline. Caroline is intelligent, has a wonderful sense of humor, is willing to work hard in therapy, and functions reasonably well at work. But she lacks close relationships, and spends much of her time alone. She has a long history of multiple diagnoses, including borderline personality disorder, Complex PTSD, bipolar disorder, major depression, panic disorder, periodic substance abuse, and bingeing and restricting. Caroline is a relatively poor historian; she has trouble giving a linear narrative, sometimes beginning a sentence with one topic and meandering around to another by the end. Susan often feels confused during sessions, so much so that she has begun writing notes during the session to keep herself and her client on track. Even after several meetings she does not have a clear sense of Caroline's history or who she is. It does seem clear that Caroline has a history of chronic childhood abuse and neglect that she hints at, but avoids talking about.

Some of Caroline's behavior was puzzling to Susan. She would often stop in mid-sentence and stare into space or look to the side, appearing frozen and unresponsive. Several times she clamped her mouth shut in the middle of word and would say no more. Occasionally she seemed to have trouble following the conversation and would ask Caroline, "What were we just talking about?" When talking about a painful subject, she would curl up on the sofa, yawning profusely, looking sleepy and shutdown. Often she would cry, but seemed genuinely puzzled, saying, "I have no idea why water is coming out of my eyes!" Twice in sessions she stood up and looked frantically around the room during session as though she was terrified and did not know where she was, and had trouble responding to Susan. It took a while to get her

grounded afterwards. Caroline reluctantly admitted that she heard a terrifying voice threatening to hurt her if she continued to come to therapy, and was convinced she was "crazy." She would wake up in her closet occasionally, and assumed she had gone there in her sleep, but seemed to have no real explanation as to why she might have done so. Heavy bruises would sometimes appear on her thighs, or a couple of times cuts on her forearms, and knew she must have hurt herself, but had no idea how or why. She also reported that she felt no pain from her injuries. She would go shopping and wander around for several hours without noticing the passage of time, sometimes having trouble finding where she parked her car. Susan suspected that Caroline was dissociative, but wasn't sure exactly how to assess her more thoroughly or how to treat her. Susan is not alone; many therapists are in the same boat.

Dissociation often seems like a neglected and misunderstood step-child in many corners of the mental health field. Its existence is acknowledged, but that is about as far as it goes. And even when it is acknowledged, it has many different meanings. Yet, it is likely that many therapists see clients who dissociate, particularly if they are working with individuals who have a history of childhood trauma and neglect. However, unless they have sought out specialized training, most therapists do not know how to assess or treat dissociation, since it is not typically included in basic training in universities. Some therapists are skeptical of dissociation; some are intimidated; others are overly fascinated with it. All of these countertransference positions can be alleviated by understanding the neurobiology and psychological underpinnings of dissociation, and how to treat it rationally and sequentially.

Reason #1: Serious dissociation is more common than you might imagine.

Dissociation is a common symptom in trauma-related disorders. There is now a subtype of PTSD that is dissociative and which involves hypo-arousal (APA, 2013, p. 271). One of the

major hallmarks of Complex PTSD is dissociation (Courtois & Ford, 2012). And of course, it is the central problem in the Dissociative Disorders, including Dissociative Identity Disorder (DID), and its lesser form, Dissociative Disorder, Not Otherwise Specified (DDNOS). The most extreme form of dissociation is Dissociative Identity Disorder, which has a prevalence rate of 1.5%, which is more than twice as common as Schizophrenia at 0.7% (APA, 2013). Up to 10% of the general psychiatric population has DID or DDNOS (Şar, 2011). Of course, in those who have a history of prolonged and severe childhood disruptions, neglect and abuse, the rates are even higher. Most therapists in private practice are treating at least a few clients who have a serious childhood trauma history, so the likelihood of coming across clients with dissociative disorders in relatively great.

Reason #2: Dissociation is not just about spacing out and shutting down; it involves a division of personality or self that must be directly addressed in treatment.

Dissociation is a concept that suffers from multiple meanings. When Susan's consultant asked if she had considered that Caroline might be dissociative, Susan readily answered. "Sure," she said, "She can really shut down in sessions, and I can hardly get a response out of her, and I know she spaces out a lot at home. She doesn't seem to remember her childhood very well, either." Therapists most commonly understand dissociation as a kind of spaciness and forgetfulness, inattention, or daydreaming –types of absorption -- which have been referred to as "normal" dissociation because we all experience it. This involves a narrowing and/or lowering of the level of conscious awareness, and can happen when we are tired, ill, preoccupied, stressed, or so focused on one thing (for example, reading an interesting book or working on the computer) that we do not notice others. Most trauma survivors experience this lowering of the level of consciousness on a regular basis, some to the degree that it interferes with their functioning, so in

this sense it may not be "normal" at all. Caroline humorously described herself as "a space cadet," and told Susan that she "lived her in head a lot."

Dissociation is also described as a *physiological shutdown* or extreme hypo-arousal due to parasympathetic activation. This is an innate defense reaction that results in rapid loss of energy and movement ("flag") and ultimately in total collapse or death feignt ("faint") when confronted with life threat (Porges, 2011; Schauer & Elbert, 2010; Van der Hart et al., 2006). Many trauma survivors have a tendency to shut down automatically, especially when they feel threatened in relationships, or by inner conflicts or overwhelming emotions. Caroline also had these symptoms, times when she felt shut down and unable to move, such as when she curled up on the couch and got very sleepy and unresponsive in sessions.

However, in cases involving trauma, especially in childhood, dissociation is much more, and involves what is sometimes called "pathological dissociation" (Waller, Putnam, & Carlson, 1996). This is actually a misnomer, since there is significant evidence that these severe symptoms of dissociation are not completely on a continuum with normal changes in conscious awareness, the so-called "normal" dissociation (Steele, Van der Hart, & Nijenhuis, 2009). It appears absorption and lowering of the level of consciousness are necessary but not sufficient for the development of "pathological" dissociation. We can better understand dissociation not as extreme absorption or shutdown, but as a particular underlying organization or structure of personality and self that involves unusual degrees of separation. This has been called *structural dissociation*, as it involves a particular organization (structure) of the individual's personality (Steele, Van der Hart, & Nijenhuis, 2004; Van der Hart, Nijenhuis, & Steele, 2006; Steele et al., 2009).

Structural dissociation is a complex developmental deficit in which traumatized children have been unable to adequately integrate their personality and sense of self into a cohesive organization that is stable across time and situations. Dissociation is the ultimate failure of integration, the inability to be here and now and to be *me, myself, and I*. It is a fragmentation or division between being stuck in the traumatic past, and attempts to avoid the past in order to move on with daily life. Normal integration of self and personality is not present at birth, but rather is a developmental achievement over time. That is because our "self" needs constant updating and adaption (Damasio, 1999; Schore, 2003). In structural dissociation, the client has already developed dissociative parts in childhood. Over time these become increasingly rigid, not very open to updating. Each part is organized around fixed and rather limited way of thinking, feeling, and behaving, impervious to almost anything that invites change. A hallmark of many dissociative parts is their stuckness in trauma-time in the past and in animal defenses of freeze, flight, fight, flag, and faint. Other parts are overly focused on functions of daily life and strenuously avoid parts stuck in trauma-time (Van der Hart et al., 2006). This fixation results in scared parts that are always scared and expecting to be hurt, in angry parts that are perpetually angry and trying to fight, in clinging parts that are always anxious, constantly needing reassurance, but never seeming to get enough, and so on.

Reason #3: Dissociative parts are different from "normal" ego states in fundamental ways that have treatment implications, so "treatment as usual" will not be adequate.

Ego State Therapy (EST) and recent studies in neurobiology indicate that everyone normally has multiple self-states, and that consciousness and self are never completely unitary constructs. The founders of EST, John and Helen Watkins, noted that ego states are "covertly segmented personality structures" that exist on a continuum of less to more discrete (Watkins &

Watkins, 1997, p. ix). We can easily understand dissociative parts in these terms of an underlying structure. Normally ego states are relatively connected and cohesive in a healthy self and personality. This does not happen in dissociation, so that dissociative parts are much less connected and take on a life of their own to some degree. But, of course, neither personality nor self are things or entities. These terms are merely short-hand language for our inner organization of attitudes, expectations, feelings, and meanings (Sroufe, 1990), and for our enduring ways of being across time and situations.

Many therapeutic approaches use the concept of ego states, which can be quite useful in working with dissociative clients. However, the amnesia, phobic avoidance, and high levels of conflict among dissociative parts require additional interventions. Normal ego states have quite permeable boundaries and are still experienced as "me." Not so in dissociation. The boundaries between parts may be so strong that there is lack of awareness of one part for the other, and lack of realization that all parts make up "me." The client may not be aware of dissociative parts that have taken on some autonomy, operating "on their own," though always only to a degree. It is these kinds of problems that require additional interventions in therapy, or they will continue, at least under the surface.

Ego states, although they may not be completely owned or liked by a person, are still considered by the person to be "*me*." Dissociative parts have their own first-person perspective, that is, they have their own sense of self, of "*me, myself, and I*." This perspective has quite a wide range, from very limited and rudimentary, to very autonomous and elaborate, such as in some cases of DID.

Dissociative parts, particularly those stuck in trauma-time, are often disoriented to time, place, and even person. This can happen with ego states, but is less profound. The therapist can

encourage “all parts” or “all parts of the mind” or “all parts of you” to focus on present experience in the room with the therapist. The therapist can first orient parts to time and place: “You are in my office, safe, and it is (date). Let all parts of you look around the room and see where you are. Can you notice something that can be a reminder to your whole mind of the safe present?” Parts more oriented to the present are encouraged to inwardly remind other parts of the present.

Finally, normal ego states do not involve the presence of symptoms of structural dissociation, but many clients with trauma-related disorders may. These symptoms are briefly described in the next section.

Reason #4: Symptoms of dissociation are often subtle, confusing, and not what you might expect.

A common misconception about dissociation is that the major manifestation is obvious switching between one part and another, as in well-publicized cases like Sybil or Eve. In fact, this is a quite rare presentation. Dissociation is an inner organization, often hidden under the surface, so it may not include overt symptoms of switching. Amnesia for past events or for present-day experience is common but not universal, but many clients may not realize how much they do not remember until they begin to try to consciously piece together their history in therapy. So asking a question such as, “Do you have significant gaps in your memory?” may not be sufficient. Usually symptoms of dissociation are much more subtle and puzzling, and can be physical or mental. Physical symptoms include numbing or (often temporary) paralysis, unexplained intrusive pain or other sensations, conversion symptoms, and pseudoseizures.

The typical presentation of a complex dissociative disorder is the outward manifestations of dissociative parts that function in an internally constructed world, working “behind the

scenes" to influence the part of the client that is functioning in daily life. Thus it is quite common for dissociative individuals to experience their emotions or thoughts or bodies as being "controlled" by some outside force. Many dissociative clients also hear auditory hallucinations, the voices of other parts arguing and commenting internally, sometimes leading to the misdiagnosis of psychosis. Often, clients will not reveal these symptoms unless respectfully asked by the therapist. These voice can typically be distinguished from psychotic auditory hallucinations (Dorahy et al., 2009) in the following ways: (a) they usually begin before the age of ten; (b) include voices of children and adults; (c) include voices of people from the client's past; (d) are heard regularly or constantly instead of intermittently; (e) comment about the person or have conversations about him or her that are "overheard" by the client; (f) can be engaged in dialogue with the therapist and the client; and (g) have their own sense of self, even if very limited. Caroline heard a terrifying critical voice, which is very common. She also heard "murmurings" that she could not quite make out, and in truth, did not really want to try to understand.

Susan learned she could "talk through" Caroline to these voices simply by saying, "As we are working together, I'd like to ask that all parts of you, of your mind, listen and have input, Caroline. Every aspect of you is important, even though you may feel frightened of your experiences right now. As we both begin to accept and understand these voices as parts of you, I have every confidence that they have very important input that will help you, and working with them safely is important to your success in therapy." Caroline was encouraged to "check in" with parts of herself regularly, to consult with them to prevent conflicts, especially as she considered doing something that might create stress, for example, going home for the holidays to an abusive family.

On the surface, dissociation may appear to mimic other problems. For example, Caroline cuts herself, so she is labeled as self-harming. This behavior is normally understood as a symptom of dysregulation. And, of course, interventions that support regulation and distress tolerance are helpful for self-injury. However, in Caroline's case, the self-injury is also a manifestation of her inner dissociative world, since one part is experienced as cutting another as punishment. Thus, an essential intervention in treating Caroline's self-injury is helping her improve the intrapsychic relationships between parts, decrease inner conflicts, and support regulation of specific parts as steps towards regulation of the whole person, key concepts in treating dissociative disorders. In Caroline's case, an "adolescent" part was punishing Caroline by cutting for not stopping the abuse. Susan learned to understand and empathize with the rage and helplessness of the adolescent part, and facilitated that part in establishing a more empathic and helpful relationship with Caroline, as the adult. Caroline also had to learn to appreciate the strengths of the adolescent part instead of being afraid and avoiding these experiences, and gradually learned that this part actually wanted the abuse to stop, just as she did. Susan learned to take the usual interventions for dysregulation (for example, DBT skills) and help all parts practice, and support each other in learning and cooperating more effectively with each other.

Caroline was showing a number of symptoms that might provide clues to the presence of structural dissociation, including amnesia for the past, time loss in the present, self-puzzlement, auditory hallucinations, and physical numbness. Resources for assessment include Brand & Loewenstein, 2010; Loewenstein, 1991; Dell, 2006; Dell & O'Neil, 2009; Steinberg, 1995; Kluft, 1987; and Van der Hart et al., 2006).

Reason #5: Dissociation does not resolve by itself and will continue to cause problems.

Over 70% of clients with complex Dissociative Disorders have made at least one suicide attempt (APA, 2013). Most, if not all, have serious episodes of anxiety, depression, sleep problems, relational problems, and other symptoms, such as self-harm, substance abuse, sexual problems, and eating disorders. Obviously, these clients have a high degree of chronic suffering and dysfunction. Many clients have had a number of therapies without sufficient relief because their dissociation was untreated. In fact, the average time most of these individuals spend in mental health treatment before receiving a correct diagnosis of a dissociative disorder is 7 to 8 years. That is a tremendous and sad waste of resources for both clients and therapists.

Clients who are dissociative have a strong degree of avoidance—and sometimes amnesia between parts of self that prevent usual interventions from being completely effective. For example, insight in one part does not necessarily translate into insight and change in other parts. And an intervention may be helpful to one part, but is aversive to another. For example, touching a client in a supportive, comforting way may seem helpful in the moment, but is perceived as a direct threat by particular part, and unleashes overwhelming dependency yearnings in another part.

Why doesn't dissociation resolve by itself over time? Dissociation is an underlying organization, not just a symptom. This organization is maintained by a series of trauma and attachment-related phobias that are self-perpetuating. Originally in the child, dissociation was not a defense, but rather the result of inadequate integrative capacity. This is why skills building is an essential part of the first phase of treatment, so that the capacity to function and integrate is strengthened as much as possible (Boon, Steele, & Van der Hart, 2011). But because integrative capacity has been lacking for so long, clients have developed major avoidance strategies to

prevent confrontation with what has been dissociated. This leads to a series of inner-directed phobias that prevents the natural progression of integration.

Trauma-related phobias may be triggered strongly in relational contexts. They include the overarching phobia of inner experience, and others such as the phobia of dissociative parts; the phobia of traumatic memory; the phobia of attachment and attachment loss; and the phobia of healthy risk-taking and change (Steele et al., 2005; Van der Hart et al., 2006). Each dissociative part is relatively isolated from other parts by these phobias, which involve painful conflicts, defensive strategies, and resistances. For example, an angry part might feel disgusted by a needy part and punish the client when needs are expressed, while the needy part feels overwhelmed, criticized, and afraid of the angry part.

Reason #6: Dissociation is most often triggered by relationship disruptions, involves a particular type of insecure attachment style, and thus chronically interferes with the formation of healthy relationships.

Dissociation is not only an intrapsychic phenomenon, but an interpersonal one, being highly reactive to what is happening in relationships in the present (Liotti, 2009). Dissociation related to childhood abuse and neglect can perhaps be best understood in the context of attachment and threat. Dissociative clients invariably have a particular type of insecure attachment pattern called *disorganized/disoriented* or *D-attachment*. D-attachment involves an insoluble conflict between the need for defense and attachment with the same person. It is strongly correlated with chronic dissociation and dissociative disorders (Liotti 2004, 2009; Ogawa et al., 1997; Steele, Van der Hart, & Nijenhuis, 2001). As a child, the client is caught in a dilemma between needing an abusive caregiver, while also needing to defend against danger with the same caregiver. Dissociation occurs between parts that involve engagement in daily life

and attachment strategies, and parts that are rigidly fixed in innate animal defenses against threat (attachment cry, freeze, flight, fight, flag, and faint). As Liotti (2009) noted, chronic threat from a needed caregiver "exceeds the limited capacity of the infant's mind for organizing coherent conscious experiences or unitary memory structures" (p. 55).

D-attachment requires a careful balance by the therapist of consistent, predictable presence that is neither too warm and close, nor cold and distant. If the therapist works with child parts and ignores angry parts, or does not include the adult self of the client in learning to relate to child parts, the client's delicate balance is upset. The therapist should recognize that both attachment and attachment loss are simultaneously feared, and therefore must find a balance between enmeshment and distancing emotions and behaviors (Steele et al., 2001).

Behavioral manifestations of attachment cry, which involves panic rather than fear, typically include difficulty ending and leaving sessions, crisis calls in between sessions, panic when the therapist goes away, frantic expression of need, and other attempts at frequent contact with the therapist outside of sessions (Steele and Van der Hart, 2013; Steele et al., 2001) These behaviors are unfortunately often labeled as "manipulative," but actually represent efforts to attain safety via care taking and attachment, since these parts are dissociated from adult inner resources that could be soothing and helpful.

These "clinging and frantic seeking" behaviors may alternate with rage directed at the therapist for not meeting needs. Treatment does not call for the therapist to meet every need and demand and be constantly available, but rather to be consistent and predictable (Steele et al., 2001). In fact, the therapist needs to set appropriate boundaries and limits on contact outside of session. This helps prevent too many dependency yearnings that can upset the equilibrium of the

patient, and allows him or her to bring dependency needs into the therapy room, and those dissociative parts can be accepted by the client.

Caroline was extremely phobic of a child part that cried all the time, calling out for help internally, and also of her inner critical part that was always telling the child part to "shut up." This inner conflict was so intense she began calling Susan frequently between sessions to get help with her anxiety. Susan first helped her verbalize more about her conflict about dependency on the therapist and addressed her concerns. Then she asked for permission to address the critical part and determined that the function of this part was to maintain safety by keeping the "crybaby" quiet so the child part would not "cry too much and get in trouble." This critical part was living in trauma-time, unaware of the present, and was well-defended by rage against dependency needs.

Susan helped Caroline orient the critical part to the present and agreed that she also did not want the child part (or any part of Caroline) to be in such a painful state. The therapist then encouraged Caroline to understand the functions of the critical part, as well as the dependency yearnings of the child part. She gradually became less phobic and more compassionate toward these parts of herself and could accept their functions. The therapist supported an alliance between the critical part and the adult part of Caroline, which in turn, supported the child part in being acknowledged and helped in appropriate ways. This significantly calmed the inner conflict.

A Brief Overview of Treatment

The standard of care for treating dissociative disorders is a phase-oriented approach (Boon, Steele, & Van der Hart, 2011; Chu, 2011; Courtois & Ford, 2012; Howell, 2011; ISSTD, 2011; Van der Hart et al., 2006). Phase-oriented treatment is based on the premise that early trauma and attachment disruptions limit integrative capacity and impede self and relational

regulation skills. Therefore, treatment begins with an initial phase of stabilization, safety, ego strengthening, and skills building. The second phase focuses on treatment of traumatic memory and resolution of traumatic bonds, and the final phase on a more adaptive integration of the individual's functioning across all domains of life. Within each phase, treatment of trauma-related phobias that maintain dissociation is essential. For Caroline, treatment consists of gradually helping her realize all her dissociative parts are aspects of her as a whole person.

In the first phase of treatment, Caroline needed to learn skills to stabilize her life: how to establish and maintain inner and external safety, effective use of self and relational regulation, the ability to reflect on experience, energy management, relational skills, skills to accept and work with dissociative parts, as well as other daily life skills (Boon et al., 2011). Susan learned that relational interventions should generally be preceded by those that address safety and collaborative cooperation of the adult self of Caroline, following the principle that attachment cannot occur as long as serious threat is perceived.

Treatment is *not* about working with each dissociative part as though they were separate people. Rather, it involves a sequenced approach that focuses on the *relationships and conflicts between dissociative parts* – how parts of the whole person relate to or avoid *each other*, how these rigid inner patterns maintain dissociation, and how they can be changed to be more adaptive and integrated. The ways in which dissociative parts interact often is a replication of the client's dysfunctional family, with shame, rage, terror, impulsivity, dysregulation, and lack of empathy central to the dynamics between parts.

Susan began to support Caroline in taking the normal developmental steps of accepting with compassion each way of being as her own, gradually resolving the many conflicts among parts. Then Caroline was gradually able to bring dissociative under the umbrella of one sense of

self, with attention focused on the present, not the past. Within a year, Caroline's self-harm abated and she no longer lost time, unless she was severely stressed. She was much less depressed and anxious, worked effectively with her parts, and felt times of inner peace and cohesion. Her narratives became more coherent and less avoidant. She could calmly leave sessions without anxiety, and was able to use the sessions to further her progress. Susan felt much more capable and confident of her ability to work with dissociation, and subsequently found that another of her clients also had a dissociative disorder.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, fifth edition.* Washington, DC: American Psychiatric Publishing.

Boon, S., Steele, K., & Van der Hart, O. (2011). *Coping with trauma-related dissociation: Skills training for patients and therapists*. New York: W. W. Norton.

Brand, B., & Loewenstein, R. (October, 2010). Dissociative Disorders: An overview of assessment, phenomenology, and treatment. *Psychiatric Times*, 62-69.

Chu, J. (2011*). Rebuilding shattered lives: Treating Complex PTSD and Dissociative Disorders*. (2nd ed.) New York: Wiley.

Courtois, C. A., & Ford, J. D. (2012). *Treatment of complex trauma: A relational sequenced approach*. New York: Guilford.

Dorahy, M. J., Shannon, C., Seagar, L., Corr, M., Stewart, K., Hanna, D., Mulholland, C. & Middleton, W. (2009). Differentiating auditory hallucinations in DID from Schizophrenics with and without a trauma history. *Journal of Nervous and Mental Disease, 197*, 892-898.

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

Kluft, R. P. (1987). First-ranked symptoms of schizophrenia as a diagnostic clue to multiple personality disorder. *American Journal of Psychiatry, 144*, 293-298.

Liotti, G. (2009). Attachment and dissociation. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 53-65). New York: Routledge.

Loewenstein, R. J. (1991). An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. *Psychiatric Clinics of North America, 14*, 567-604.

Porges, S. W. (2011). *The polyvagal theory: Neurophysiological foundations of emotions, attachment, communication, and self-regulation*. New York/London: W. W. Norton & Co.

Şar, V. (2011). Epidemiology of Dissociative Disorders: An overview. *Epidemiology Research International, vol. 2011*, Article ID 404538, 1-8. doi:10.1155/2011/404538.

Schore, A.N. (2003). *Affect dysregulation and disorders of the self*. New York/London: W. W. Norton & Co.

Putnam, F. W. (1997*). Dissociation in children and adolescents: A developmental perspective*. New York: Guilford Press.

Steele, K. (2009) Reflections on integration, mentalization, and institutional realization. *Journal of Trauma and Dissociation, 10*, 1-8.

Steele, K., Van der Hart, O., & Nijenhuis, E. (2005). Phase-oriented treatment of structural dissociation in complex traumatization: Overcoming trauma-related phobias. *Journal of Trauma and Dissociation, 6*, 11-53.

Steele, K., Van der Hart, O., & Nijenhuis, E. (2009). Dissociation versus alterations in consciousness: Related but different concepts. In P. F. Dell & J. A. O'Neil (Eds). *Dissociation and the dissociative disorders: DSM-V and beyond* (pp. 155-170). New York: Routledge.

Steele, K., Van der Hart, O., & Nijenhuis, E. (2001). Dependency in the treatment of Complex Posttraumatic Stress Disorder and Dissociative Disorders. *Journal of Trauma and Dissociation, 2*, 79-116.

Steinberg M. (2004). *Interviewer's Guide to the Structured Clinical Interview for DSM-IV Dissociative Disorders—Revised (SCID-D-R)*. 2nd ed., Washington, DC: American Psychiatric Press.

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

Waller, N. G., Putnam, F. W., & Carlson, E. B. (1996). Types of dissociation and dissociative types. *Psychological Methods, 1*, 300-321.

Watkins, J. G., & Watkins, H. H. (1997). *Ego states: Theory and therapy*. New York: W. W. Norton.