

Dissociative Identity Disorder: Adaptive Deception of Self and Others

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Dissociative identity disorder (multiple personality) is increasingly diagnosed, often follows childhood trauma, and is characterized by rigidification of phenomena that resemble hypnosis. To interpret dissociated aspects of selfhood as autonomous entities is a useful heuristic; but when taken too literally, it leads to three kinds of anomaly: (1) legal: dissociators remain culpable for misdeeds carried out beyond apparent awareness or control; (2) clinical: legitimization sometimes leads not to relief, but to escalating cycles of regressive dependency; and (3) scientific: the form of dissociated entities varies with how they are defined, in ways that are intrinsically motivated and clinically manipulable. These anomalies yield to an evolutionary perspective that views dissociative identity disorder as an evolved strategy of adaptive deception of self and others; e.g., a beaten subordinate avoids further retribution by “pleading illness.” Such a deceit best avoids detection when fully experienced; through its intensity and persistence, it becomes real at a new level. One’s basic competencies remain intact, however, and are the source of the anomalies described. They can be clinically accessed and empowered, providing the key to therapeutic change when dissociative processes are problematic. Overall, despite clear impairment in subjective awareness and volition, dissociative-disordered individuals are best held fully accountable for the consequences of their actions.

When deviant behavior becomes unacceptable, society classifies the offending agents in two groups. Those defined as “bad” (culpable, blameworthy) are subject to retribution. Others, defined as “mad” (sick, insane), are compassion-

ately excused and “treated.”¹ To be held liable for retribution, transgressors must (1) know what they are doing and why, and (2) be able to choose otherwise. These attributions correspond to “consciousness” and “volition,” the sensory and motor aspects of subjective experience.² Their absence, by contrast, provides the cognitive and volitional prongs of the insanity defense,³ and also contributes to the defining features of the dissociative disorders.

Dissociative identity disorder (DID) relabels multiple personality in the new

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DSM-IV.⁴ Positive criteria are the characteristic symptom patterns: (a) presence of two or more "entities" (personality states), which can (b) "take control" of one's behavior, accompanied by (c) "inability to recall . . . too extensive to be explained by ordinary forgetfulness" (amnesia). If an alternate personality state takes over and commits a crime beyond awareness, control, or desire, three factors provide a *prima facie* case that afflicted patients should be excused from criminal retribution. Amnesia, a cardinal symptom of DID⁴ and hypothesized vehicle for dissociative barriers,^{5,6} negates our usual concept of conscious awareness. Nonvolition is implied whenever an alternate personality (alter) "takes over" beyond a subject's control. External victimization is believed to be a primary etiology in more than 95 percent of cases.⁷ Eminent treatability^{8,9} suggests a practical reason that dissociative-disordered offenders should be transferred from the criminal justice to the mental health system.^{10,11} Predictably, this occurs from time to time in the lower courts.¹²⁻¹⁴

When such pleas reach the appellate level, however, they uniformly fail.¹⁵⁻²⁰ Despite undisputed impairment in consciousness, volition, and recall, higher courts have consistently ruled that these patients remain legally responsible for the consequences of their actions.^{21,22} Although unfair from an intuitive perspective, there are also dominating psychotherapeutic reasons to enforce this responsibility rigorously.²³⁻²⁸ This paper explicates how such anomalies arise from the very nature of the dissociative

process: real, yet fundamentally deceptive. This further clarifies how excusing from responsibility paradoxically reinforces the condition, whereas accountability, by contrast, can lead to its successful resolution.

Multiple Personality as a Useful Approximation

There is little doubt that DID (multiple personality) exists as defined by operational criteria.^{4,29} It is increasingly diagnosed,⁷⁻⁹ and a standard of care has recently been proposed for its treatment.²⁸ Current consensus accepts a traumatic etiology, usually catastrophic child abuse or its equivalent. Thus, DID is a variant of posttraumatic stress disorder (PTSD).^{30,31} Although recent data suggest significant differences that remain to be clarified,³² posttraumatic dissociation remains closely linked with the dissociative phenomena of normal hypnosis.^{6,33} Trauma often leads to stable increases in hypnotizability,^{34,35} and spontaneous hypnosis occurs widely in patients with DID.^{21,36} Dissociative barriers are widely believed to be rigidified through the aversive push of traumatic affect.^{37,38}

Regarding other aspects of the disorder, controversy reigns. Among these are the questions of responsibility,^{21,23} iatrogenic artifact,³⁹ veracity of traumatic memories,⁴⁰⁻⁴³ examiner bias,⁴⁴ and potency of environmental shaping influences.⁴⁵⁻⁴⁷ Among experienced practitioners there is additional tension between whether to emphasize dissociative disorder as a pathological condition^{7-9,48} or as residing on a continuum with the

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complex consciousness of everyday living.⁴⁹⁻⁵³

However we conceive these dilemmas, to think of human mentation at least *as if* comprised of multiple part-selves has extensive heuristic value. It helps to make sense of otherwise inexplicable paradoxes in consciousness and volition^{2, 6, 21, 37, 49-53} and respects humankind's ubiquitous experience of inner dialogue and conflict. To validate part-selves' autonomous identities contributes to the efficacy of ego-state therapy,⁵³ configurational analysis,⁵⁴ gestalt,⁵⁵ and transactional analysis,⁵⁶ as well as treatment of multiple personalities *per se*.^{8, 9, 37, 51-53} These advantages hold, as long as we consider the concept of mental entities as either a useful approximation or a heuristic.^{2, 21, 37}

Reifying Part-Selves: Three Anomalies

When dissociated entities are taken literally, reified, or confused with substantive reality, anomalies arise at legal, clinical, and scientific levels. Because there is only one body that others can reward or punish, to allocate legal responsibility among part-selves is enigmatic.¹⁶ When alters number into the tens or hundreds, it can lead to a *reductio ad absurdum*.¹⁵ When therapists validate dissociative-disordered patients' impairments at the expense of coexisting strengths, we often see an escalating spiral of symptomatic distress, destructive behavior, and regressive unraveling of personality^{23, 25, 26, 37, 57-59} rather than the expected relief. Finally, scientific data from many diverse sources shows that

despite appearances of temporal stability, the *form* of psychological structures varies profoundly with the context in which they are defined.⁴⁵ Hypnosis research suggests that physiological parameters may also be context-dependent.⁶⁰ These anomalies will be discussed in turn, before a new synthesis that resolves them at another level of abstraction.

Legal Anomaly: Multiple Personalities are Culpable for their Misdeeds
Barring major psychosis, courts are traditionally reluctant to excuse wrongdoers from responsibility because of claimed amnesia or subjective nonvolition. These are simply too intangible and difficult to validate.²⁷ More important, if convincing subjective reports could consistently exonerate antisocial offenders, this would undermine criminal law's basic charge for the protection of society.⁶¹ Further, such claims are notoriously unreliable whenever high stakes reward skillful deceit.^{62, 63} When being accused, an almost universal human strategy is to claim lack of recall.⁴⁷ Surveys of homicide defendants indicate that 40 to 70 percent claim amnesia,⁶⁴ and we lack methods to differentiate reliably whether this is real or malingered.⁶⁵ Interview styles often used to uncover multiple personality disorder (MPD) are also known to bias naive subjects toward assuming a dissociative pattern.^{45, 46}

These issues led to extensive debate over the widely publicized "Hillside Strangler" case. Some experts argued that the accused committed homicide in a dissociated state beyond awareness or

control⁶⁶; others, that this was willful fabrication by an incorrigible psychopath.⁴⁷ The intensity of the debate partly reflected the tacit assumption that “real” dissociative disorder implies “not guilty,” and the reverse. This assumption does not hold. Even when diagnosis is affirmed, appellate case law holds patients with dissociative identity disorder accountable. This applies equally to pleas based on impaired consciousness (amnesia), nonvolition (alters “taking control”), and external victimization (coercion).

Amnesia is a known symptom of primary organic conditions (e.g., epilepsy, Alzheimer’s disease), substance abuse, and neurotic process (conversion and dissociative disorders), but is “easily fabricated by a criminal defendant.”⁶⁷ Although in principle it implies diminished responsibility,⁶⁸ courts usually dismiss it as irrelevant except when it is a symptom of some other condition.⁶⁹ Significant precedents reside in *U.S. v. Olvera* (1954): “Amnesia is—in and of itself—a relatively neutral circumstance . . . significant only as a symptom confirming other evidence that the accused did not know the nature and quality of his acts during the period for which he lacked recall.”⁷⁰ If epilepsy were established, one might be exonerated, but by “the epilepsy, not the amnesia.” If, on the other hand, an intoxicated rapist fled when the victim screamed, this shows “that he was conscious of having done something wrong.” Hence, *mens rea* is established. Only this, not the amnesia, is relevant to his guilt.

Amnesia has also been used to argue

incompetency to stand trial. An oft-cited law review article noted that “some amnesia is present in everyone,” with effects similar to the information gaps that always complicate jurisprudence; thus, amnesia is not a sufficient reason to interrupt the process.⁷¹ In *State v. Badger* (1988), a court noted that an MPD claiming incompetency “is only aware that he has ‘lost time.’ Yet, when one of his alternate personalities is in control, that ‘person’ can remember, quite clearly, what transpired during the time that ‘person’ was in control.”⁷² Each personality state was fully competent, and information sacrificed by dissociative amnesia for another state could be restored adequately with the attorney’s help. In summary, we have a paradox: even where global impairment is undisputed, *at other levels the competency remains*, and proves definitive.

Similar results follow claims of nonvolition due to contrary alters “taking over” beyond awareness or control. In *State v. Grimsley* (1982), an Ohio court found that “there was only one person driving the car and only one person accused of drunk driving. It is immaterial whether she was in one state of consciousness or another, *so long as in the personality then controlling her behavior, she was conscious and her actions were a product of her own volition*” (emphasis added).⁷³ In *Kirkland v. State* (1983), a Georgia court affirmed conviction for a robbery committed in a fugue state: “the personality, whoever she was, who robbed the bank did so with rational, purposeful criminal intent and with knowledge that it was wrong.”⁷⁴

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A Hawaiian court expanded this reasoning in *State v. Rodrigues* (1984), holding that multiple personality "can be examined in a similar fashion as other defenses of insanity. If a lunatic has lucid intervals of understanding he shall answer for what he does in those intervals as if he had no deficiency."⁷⁵ And affirming earlier decisions, "the law adjudges criminal liability of the person according to the person's state of mind at the time of the act; we will not begin to parcel criminal accountability out among the various inhabitants of the mind."

Similar reasoning applies to crimes committed because of external victimization. Discussing Patty Hearst and the few veterans courtmartialed for anti-American actions committed under duress, Lunde and Wilson explored the legal ramifications of coercion.⁷⁶ Insanity is rarely defensible, for similar reasons, and even diminished capacity is difficult to argue. They noted that mitigation of sentence is more appropriate, based on threefold criteria of a defendant's susceptibility, amount of coercion relative to severity of crime, and lack of opportunity to avoid reprisals.

Case law variably affirms mitigation of sentence. Death penalty cases are especially difficult,⁷⁷ and some states currently allow varying degrees of compassion for capital offenders who had themselves been severely abused. In *State v. Moore* (1988), *mens rea* was affirmed for a lesser felony. In this case, the victim's death was not intended, but the causative brutalizations were.⁷⁸ Variably, the pleomorphic diagnosis of PTSD

has also been used to support pleas for mitigation.⁷⁹

Two fundamental issues underlie the hard line that courts take in holding multiple personalities responsible. First, for practical reasons, it is only meaningful to deal with a single body. It is not possible to imprison one part-self while granting pardon or commendation to another.¹⁶ Second, it is not one's global mental state that determines culpability, but one's state *vis-à-vis* the offense committed, at the time of the offense. An offender is culpable *who knew what he or she was doing at that time, and that others would disapprove*. Only this is the *mens rea* that makes a crime a crime.

Using the multiple consciousness model, the impairment to consciousness and volition is only partial,^{21, 22, 26} it is applicable to perceived selfhood, but not the level at which an offense is committed. Only the second level is relevant to *mens rea*, and here, conscious intentionality is usually evident from the way a crime is planned and executed. Highlighting this point are a few contrasting cases in which intentionality is absent altogether, as in epilepsy. Two patients with PTSD, for example, charged with excessive use of force in self-defense, were exonerated on testimony that they may have entered dissociative "automatic pilot" when assaulted, truly unable to form the requisite intent at any level.⁸⁰ In DID, however, the fact that competent awareness and intentionality remain intact even when concealed is fundamental to the nature of the disorder.

Clinical Anomaly: Iatrogenic Regres-

sion Dissociative-disordered patients often present as living in constant fear of imminent catastrophe from within, due to overpowering traumatic affect and dyscontrol of dissociated alters, implying that, being so impaired, only a therapist can assume responsibility for their safety. To reify this implication as if objective truth is highly problematic from a therapeutic standpoint.

Facing such a patient can feel like seeing an abandoned baby in the street. Basic human instinct cries out to rescue and provide emotional nurturance. There is also real concern over the patient's safety, feared liability for failing to protect, and a prevailing ethic of playing safe. When a therapist does reach out to rescue or nurture, however, the patient is often not functionally relieved, but may enter a pattern of regressive dependency with increased emotional distress, ever more desperate pleas for rescue, and escalating invasion of the therapist's boundaries that can worsen the patient's condition, make treatment untenable, and/or aggravate the ultimate risk of tragedy.^{25, 26, 37, 57-59}

Experienced MPD therapists attribute iatrogenic regression to excessively nurturant countertransference;^{58, 81} others, to therapists' implying their own omniscience or omnipotence, treating patients as "special," or gratifying patients' dependency.^{82, 83} Halleck sees failing to hold patients responsible as a primary factor leading those with dissociative disorder²³ and other "disorders of will"⁸⁴ to regress rather than improve in treatment. All these factors share a common denominator: an implied threat to pa-

tients' autonomy. How this is problematic can be understood by again viewing patients' impairment as only partial.

Concurrent with seemingly insatiable dependency needs is an inviolable demand for autonomy.³⁷ the former, a probable manifestation of traumatic affect; the latter, an antithesis to the utter helplessness that many consider the most aversive aspect of trauma.⁸⁵ Therapeutic nurturance provides relief at the first level and impetus to continue in treatment. At the level of the already suppressed autonomous strengths, however, the dependency is perceived as a threat, increasing the perceived helplessness and leading to an escalating cycle. Acting out with transient tension relief can be seen as a misdirected assertion of autonomy,^{25, 37} or in biochemical terms like endogenous addiction.⁸⁶ Either way, the autonomous coping most needed for health is undermined.

The regressive cycle can be avoided in part by selectively reinforcing and building on the impressive autonomous strengths that virtually all dissociating patients possess but disavow.^{25, 51, 59} This can be facilitated by therapists' explicitly renouncing the role of indispensable agent of change,⁸⁷ which keeps the interpersonal boundary rigorously correct. Such treatment could not be conceived were we to take the impairment literally as the truth, the whole truth, and nothing but the truth. Thus, to optimize treatment requires that we look beneath surface appearances to validate and challenge the underlying competency, not threaten it. This is the same hidden competency that renders dissociators legally

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responsible for the consequences of their actions.

Scientific Anomaly: Context-Dependency of Psychological Structures From a purely scientific perspective, viewing dissociated part-selves as truly autonomous entities is also profoundly anomalous. Social psychological data show that although dissociative structures are found, their *form* varies with their psychosocial context far more than commonly believed. Spanos and colleagues replicated many earlier studies that had identified dissociated entities,^{6,66} but found that if they altered the subtle contextual cues in an otherwise unchanged design, the nature of the entities changed accordingly.^{45,46} Reviewing many such studies led Spanos to conclude that whenever the predictions of objective entity and context-dependency models conflict, the latter always prevail.⁴⁵ Like earlier skeptical investigators,^{60,88} he affirmed that dissociative phenomena like involuntary action are valid, subjectively, but must be intrinsically deceptive. Only through actions consciously planned and voluntarily implemented, at some level, can one create the (real but illusory) experience of subjective nonvolition.⁴⁵

Strategic therapists report successfully revising their patients' inner realities by skillfully redefining their interpersonal context.^{87,89,90} With dissociative phenomena so closely linked to hypnosis, we must keep in mind their enhanced potential for modulation through hypnotic-like transactions in the interpersonal environmental.^{21,91} Hypnotists channel subjects' attention and redefine

their focus in a context of enhanced affiliative bonding known as "rapport."^{91,92} When a hypnotic "state" is achieved, subjects experience new inner realities in response to suggestion, while hypnotists enjoy a corresponding illusion of control. Similar processes are widely believed to occur within psychotherapy.^{37,43,51,92,93} Each party's experience validates and reinforces the other's, much like a *folie à deux*.

The quasi-contractual nature of these transactions is betrayed by the fact that each party is often partially aware of an "as if" quality. The psychoanalytic interpretation of hypnotic phenomena as altered psychological structure^{92,94} becomes increasingly problematic, as new research refutes the validity of "trance" as a separable state.^{45,60} An alternative model is to view them as an experienced reification of a covert contract for reciprocally reinforcing illusions. These are then experienced so vividly that they become real, at a new level.^{2,91}

Adaptive Deception of Self and Others

These anomalies yield to another level of abstraction: the adaptive point of view, i.e., distinctions like conscious versus unconscious, voluntary versus involuntary, and defining boundaries of psychological entities are all inherently deceptive, having been shaped through natural selection both to avoid retribution and to promote social cooperation in the face of conflicting interests.⁹⁵⁻⁹⁹ Like hypnotic phenomena, these deceptions become real by virtue of how vividly they are experienced, stubbornly

maintained, and legitimized by significant others. They are real, but are not what they seem. Psychological structures masquerade as if substantive entities, but they follow the rules of motivated intentionality rather than those of physical substance.¹⁰⁰ Unlike objects, they vary with how they are defined and are validated by social consensus—the “reasonable person” test of common law.^{2, 91}

Their inherent intentionality has several important implications. In science, it contributes to the fundamental uncertainty that accompanies any attempt to apply the rules of physical causation.³⁷ In psychotherapy, the resulting context-dependence permits the therapeutic use of “reframing,” in which an otherwise invariant reality is simply redefined and the reality then changes.⁸⁷ In social intercourse, by tacit contract, what is hidden by self-deception as “unconscious” and “involuntary” is relatively off limits, reinforcing these deceptive attributes and providing coherence to what society rewards and punishes.^{2, 98} In social policy, what is excluded as “taboo” often returns to cause paradoxical effects.¹⁰¹

Posttraumatic Deception: The Root of Dissociative Identity Disorder

Deceptive elements are intensified and rigidified by psychological trauma. An evolutionary theory of neurosis postulates that traumatized individuals avoid further retribution by convincing dominants that they are ill, thus no threat.^{59, 99} If this charade is respected, it ensures both survival and face-saving with peers and intimates. Further, to

avoid betraying the lie by nonverbal slips, one must *actually experience* the impairment. One deceives oneself in order to protect adaptive deception of others from detection. This process is defended both internally and externally by traumatic affect, whose coercive force both protects against corrective self-scrutiny and helps to secure legitimization from significant others.¹⁰² When these processes are vividly experienced, maintained over extended time, and socially validated, they become real at a new level: “psychological realities” that can even acquire their own physiological substrates. By this means, a neurosis is born.

At the same time, it remains in traumatized organisms’ interest to retain maximum coping skill, as long as this is hidden from dominants. Autonomous competencies are preserved but “go underground,” into an “unconscious” from which their actions are experienced as “involuntary.”^{2, 59, 91, 98} One now controls others indirectly, through psychological “games”⁵⁶ or “symptoms as a power tactic.”⁹³ Supporting this hypothesis is that subjective impairment usually far outweighs any objective limitations in DID. Most patients experience their impairment as real, and their basic competency as but a “front,” in ironic contrast with the deeper truth that the competency is more real, but concealed.

Others are led to accept a patient’s self-definition,⁹¹ in part through the coercive effect of traumatic affect,¹⁰² and also through the benefits of reciprocity.⁹⁶ Legitimization helps to support a therapist’s own relative dominance, self-im-

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age as a benefactive healer, and economic livelihood.^{2, 91, 98, 103} As in hypnosis, this leads to “rapport.”^{91, 92} By these interdependent processes, patients’ competencies are successfully concealed but continue to exert their effects, manifest in the legal, therapeutic, and scientific anomalies described.

This is compatible with recent trauma research. Catastrophic stressors lead to predictable psychological effects that include dissociation; blurred interpersonal boundaries; and a variety of changes in cognition, perception, and recall⁸⁵ that closely resemble the hypnotic.^{21, 37} The resulting patterns are rigidified and driven by traumatic affect in two opposing directions, avoidance and re-enactment.^{85, 86} This model may also help to clarify the affect-laden controversy about the veracity of traumatic recall. The indelible quality of posttraumatic images may partly follow the rigidifying effect of traumatic affect, and its ability to evoke uncritical acceptance by so many significant others.⁴⁰⁻⁴¹ At the same time, their more fundamentally transactional essence is reflected in the many case reports that illustrate their malleability to therapeutic suggestion and contextual influence.⁴³ DID is one of several possible ways that these processes become manifest.³¹

The trauma response probably evolved to serve as “learned instinct” for adaptation to a particular ecological niche. Legitimization by others provided external reinforcement, and also served to promote interpersonal bonding in the face of outside common threats. Re-enactment provided internal rein-

forcement and rehearsal of defensive skills needed for emergencies likely to recur regularly but infrequently. The overall patterns are hypothesized to have been adaptive in the dangerous but stable environment of evolutionary adaptation, but progressively dysfunctional in a rapidly challenging milieu like the technological societies of today.¹⁰⁴

Implications for Mental Health Practice

Although inherently deceptive, dissociated part-selves are not fraudulent in the sense of a willful lie. Through their many interdependent reinforcers, they have become real at a new level. Thus, multiple consciousness can still provide a useful approximation or heuristic, valuable in many circumstances if not taken too literally. When problematic, anomalies can be avoided by returning to a unitary “whole person” perspective, but in a way that fully validates the subjective reality of psychological entities and their profound role in the regulation of interpersonal behavior. Which approach or what combination will prove most fruitful will vary for different clinical situations.

Traditional “MPD therapy”^{8, 9, 28, 36} can be interpreted in these terms.⁹¹ Achieving a shared diagnosis, e.g., the number of alters, relative permeability of amnesic barriers, and subjective levels of control, is interpreted not as a substantive truth, but a quasi-contractual *agreement* on how reality is to be defined—one that validates the patient’s pre-existing reality, but has already changed it in a direction of greater spec-

ificity. Concretization allows one to better grasp and gain control of processes otherwise too diffuse. Like Erickson's famous case of experimental neurosis⁹⁰ and Freud's transference neurosis,¹⁰⁵ to resolve the newly modified condition then pulls the other one along with it toward therapeutic cure by transference mechanisms not yet understood.

What is known as the "working through" of objective content is viewed as the *renegotiating over definition of "self,"* a superordinate structure best understood in terms of its impact with what is beyond.⁴⁹ Successful "integration" represents the patient's having agreed to a new covert contract, in which case failure to subsequently uncover alters by hypnotic exploration³⁶ reflects the subject's steadfast commitment to adhere to his or her new self-definition. Without reifying the constructs, anomaly is avoided, and as long as there is a shift toward increased expectation of a patient's responsibility,²³ a therapeutic outcome is likely.

Shared reifications become problematic, however, when therapists even covertly undermine patients' autonomous strengths. This leads to peril in both clinical and legal spheres. Clinically, to reinforce perceived impairments at the expense of already suppressed autonomous strengths can fuel the regressive cycle described earlier. Legally, to accept excessive responsibility for another's state of being may also have contractual implications with heightened liability risk whenever illusory expectations can no longer be fulfilled. In addition, to grant violators exemption from retribu-

tive consequences can threaten society's fundamental charge for the protection of its citizens.⁶¹ All lead to iatrogenic reinforcement.

Alternative treatment recommendations can minimize these problems. It is safer and more effective to hold patients to their own essential duties,^{22, 23} challenging their autonomous strengths and thereby empowering rather than undermining their mastery and competency. Appreciating the context-dependence of dissociated structures also carries the potential to alter them at the very outset by how they are defined.⁵⁹

The disorder must be validated as real, both to gain rapport and respect the fact that dissociative processes had long been present, rigidified by traumatic affect and hypnotic-like transactions with numerous others. This does not require taking the disorder too literally, however. How therapists interpret it with their patients may well influence such parameters as number of alters, permeability to information flow, and patients' ability to control and redirect their impulses. This confers an obligation to define these parameters so as to imply maximum health to begin with—specifically, to imply maximum internal information flow, and to hold patients fully responsible for what they can literally do only for themselves.

The therapeutic "fine art" is how to validate the emotional pain, symptomatology, and subjective impairment in ways that lead patients to feel understood and respected, while at the same time reframing their essential responsibilities so that they appear self-evident.

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It often helps to clarify what the therapist *cannot* do: provide global nurturance or reparenting, or usurp patients' ultimate responsibility for their safety and life priorities. This boundary-setting avoids contextually reinforcing the impairment and respects patients' personal space.

Unitary "whole person" language also helps to ensure that contextual reinforcers operate in the desired direction. The new label of "dissociative identity disorder"⁴ facilitates this by accurately implying disordered personal identity with dissociative pathology, and no more. Knowing that hidden aspects remain aware (co-conscious) enables patients to work with them without abdicating executive control.^{25, 52} Patients can hold "internal board meetings" to hear out inner strivings, address inner discord, and establish common purpose. In essence, alters are treated as the potentially discordant aspects of selfhood that all humans possess.

Patients are expected to interdict their own destructive impulses voluntarily rather than shift this burden to others, and, if in danger of dyscontrol, to seek and accept emergency protection via known crisis resources. Violation can lead to temporary transfer to a more secure facility elsewhere, defined as protection rather than treatment. When the patient is once again able and willing to accept his or her primary responsibility, treatment *per se* can resume. In a similar vein, patients are also encouraged to identify and abstain from the quasi-addictive re-enactment behaviors that internally reinforce the disorder.^{85, 86}

With increasing confidence, there is

also less need for the external reinforcers of dissociation, i.e., being treated as special and avoiding responsibility. Toward this goal, patients are encouraged to enhance coping skills at all levels including maintaining health, learning useful information, and applying new strategies for personal advancement in the real world. Dissociation can also be used intentionally as an adaptive skill rather than a symptom.⁵¹ Attention shifts toward more unitary issues like defining who one is, value priorities, goals, perceived roadblocks, and plans for overcoming them in the context of everyday life. Self-acceptance and confidence in one's mastery then become reciprocally self-reinforcing.

Within these parameters, patients' defining and redefining of their conflicted sense of personal identity can be used as the primary vehicle for therapeutic change.²⁵ Regressive dependency is minimized by defining a therapist as a consultant expert, rather than a primary agent of change. Pilot data confirm the utility, safety, and cost-efficiency of holding dissociative-disordered patients solely responsible for their essential tasks of safety from destructive impulses and the direction and pace of therapeutic work.²⁵

In summary, despite severe degrees of subjective impairment and nonvolition, patients with DID retain their basic competencies at levels that are hidden, but accessible. Hence, they remain fundamentally accountable for their actions. To hold them responsible has the threefold advantage of better protecting society's citizens from offending behav-

ior, fostering a therapeutic outcome for disordered clientele, and, by interdicting retraumatization, helping to interrupt the transgenerational perpetuation of abuse. Hopefully, the legacy can be a less traumatizing society for our future.

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