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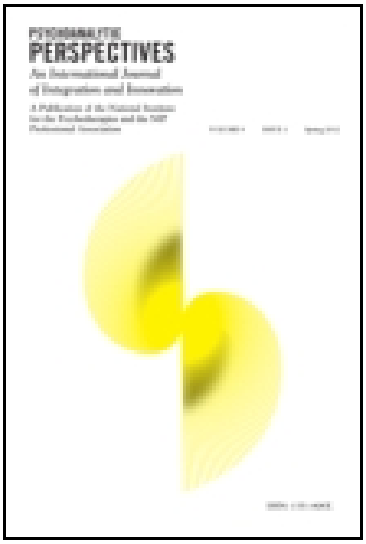

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EXPLORING DISSOCIATION AND DISSOCIATIVE IDENTITY DISORDER: A ROUNDTABLE DISCUSSION

SHELDON ITZKOWITZ, PhD, RICHARD A. CHEFETZ, MD, MARGARET HAINER, LCSW, KAREN HOPENWASSER, MD, and ELIZABETH F. HOWELL, PhD

In a lively and wide-ranging roundtable discussion, five seasoned clinicians versed in the treatment of dissociative disorders discuss the importance of recognizing dissociative phenomena: why they happen, how to recognize them, how to work with dissociation and Dissociative Identity Disorder. The panel emphasizes the point that dissociative processes are not exclusive to those suffering from an extreme dissociative disorder and can germinate from other experiences such as attachment trauma, for example. The case is made that dissociation has important implications for work with all patients, as it conveys a more experientially near conceptualization for a model of the mind.

Keywords: attachment, child abuse, consciousness, dissociation, Dissociative Identity Disorder (DID), self-states, trauma.

Prologue

The seeds of this roundtable were planted decades ago when I began working with a woman who was diagnosed with what was then called Multiple Personality Disorder (MPD). The tragic story of her life could fill the pages of this volume, and then some. Of the many aspects of her life that moved me, the treatment she received by therapist after therapist, hospital after hospital, was both tragic and shocking. For the extremely dissociated and DID patient, providing a coherent narrative of one's life is no easy or simple task. And it's understandable why well-intentioned mental health professionals, uninformed about the powerful impact of trauma-induced dissociation on the organization of consciousness, are beset with confusion and insecurity. Clinicians often find themselves at a loss about how to understand, diagnose, and treat someone who might be switching right before their eyes between different levels of consciousness and multiple self-states—that may reflect different ages, levels of cognitive sophistication, and even gender. But the repeated accusations of lying and manipulation, of not believing in the story this woman was able to tell, were unforgivable. Many an ER doctor had their turn suturing her bleeding, self-inflicted wounds, the cleanly divaricated skin made by

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the finely honed edges of razors and box cutters. Just a glance at these scars of self-hate carved into various parts of her body should have been enough to persuade anyone of the seriousness and severity of this woman's life circumstance.

At the time I began working with this woman, I had an appointment as a supervising psychologist at a Manhattan medical center. I quickly realized I needed help, so I began discussing this case with several of my colleagues at work, only to find that none of them had ever had experience treating a person with MPD/DID. In fact, some of them were taught that the diagnosis was fraudulent. I also came to learn that they, as well as several of my former supervisors and professors from my years of psychoanalytic training, held a jaundiced view of the very idea of MPD/DID. These views were based more on theoretical grounds rather than any real experience. Ultimately, I was confronted with their scorn and criticism of the diagnosis, my patient, and my work. I began feeling isolated, dismissed, and lost, unsure of where to turn for help in understanding how to be helpful to my patient—a parallel process, indeed.

Mindful of the gap in psychoanalytic thinking, I was very fortunate to find a supervisor experienced in treating dissociative and DID patients from an interpersonal-relational psychoanalytic perspective; her help was invaluable. Eventually I met more like-minded colleagues, and I continued working with two supervisors who have been at the forefront of writing about dissociation, multiplicity, and the dissociative mind. It was these experiences that motivated me to advocate to the editors of *Psychoanalytic Perspectives* for a roundtable discussion on dissociation and DID to appear in this journal; I am indebted to them for their encouragement and support. I am equally indebted to my fellow panelists, and friends: Rich Chefetz, Marg Hainer, Karen Hopenwasser, and Elizabeth Howell, for agreeing to be a part of "Exploring Dissociation and Dissociative Identity Disorder: A Roundtable Discussion."

—Sheldon (Shelly) Itzkowitz, PhD

Part 1: What Is Trauma?

Margaret Hainer (MH): So, we're delighted to be talking about this issue close to our hearts, dissociation in general and DID in particular. All of us have been working with patients with DID for over twenty years and, we owe them special thanks and acknowledgment. To paraphrase Guntrip (1971), the British object-relations analyst: Today's theory is what we learned from our patients yesterday.

With that thought in mind, I was thinking that a good place to start would be with a definition that you made in your first book, Elizabeth: Trauma is an event that causes dissociation (Howell, 2005). I wondered if you could tell us a little bit about why you made the formulation in that way, what you were trying to address with that, and then we can hear from other people about their feelings on the same topic.

Elizabeth Howell (EH): The reason that I came up with this formulation is that there are so many different views of trauma, so many differing assumptions. It gets very confusing, and then nobody really knows for sure what it means. The difficulty of the question is a real problem for the field of mental health, in which "trauma studies" have now proliferated, and in which the word "trauma" is so much a part of our discourse and is so essential to developing theories of how the mind works.

So one area in which we have entered murky waters has been with the attempts to define trauma as only "objective" or massive trauma, such as a devastating earthquake or events in which one had one's life threatened or witnessed that in another. *DSM-IV* and *DSM-IV-R* have tried to define trauma in such "objective" ways that are assumed to pertain to the overwhelming nature of the event. A notable problem with this "objective" view of trauma is the issue of resilience. Some people are very resilient to the kinds of events that many would be extremely harmed by, and others may suffer terribly under what would appear to be minor stress. This led to a subjective definition of trauma. The problem with this subjective view is that anything that a person finds unpleasant could be defined as traumatic. This overinclusiveness then can drain the word of any meaningful specificity.

In my book I defined trauma as "that which causes dissociation," as a way to transcend the problem of objective and subjective. My reasoning was related to going with a general understanding that psychic trauma is something that is overwhelming to the mind, something that is so terrible or so shocking that it cannot be assimilated by the mental frameworks, that it has torn the fabric of understanding. The mind dissociates, it develops fissures and/or blank spaces within itself to accommodate the trauma. This description of trauma as "that which causes dissociation," seemed to work as an answer to "What is trauma?" with respect to the objective versus the subjective points of view, or the designations of "big" or "little" trauma.

MH: Thank you. Other people have thoughts on this?

Richard Chefetz (RC): I think that Elizabeth's statement opens a lot of questions, like: *What really is a trauma?* To what extent is a trauma something that happens around us versus something that happens inside us? And what's the link between the two?

How do we understand the drive-by schoolyard shootings? The data from that suggest that there are some people who developed robust PTSD and weren't even in school the day of the shooting. So what the heck is that? There is something about the meaning of things, and the very personal experience of a trauma, that's different from one person to the next. When I lecture, I usually try to talk with the audience before my presentation to see who's there and who I'm going to be speaking with. I always ask if there are people from the VA hospitals, and

I have one question I always ask, and that is: "Is it true that your toughest cases of recalcitrant PTSD are in veterans with childhood trauma histories?" And the answer is always yes, so what is that about? So rather than elaborating on that, I just want to let those questions sit on the table, because I think they're really, really important. I'm not sure we have all the answers, but I'd be curious if somebody has some thoughts about that.

Karen Hopenwasser (KH): Well, this is earlier in our discussion than I thought that this topic would come up. We need to talk about intergenerational transmission of trauma, which speaks to not even needing to be in the room or near the traumatic event. The question is: How does this information transfer—not just in a narrative form, but in nonverbal or somatic transfer of information? There's work going on in the field of epigenetics that has to do with generational transmission of vulnerabilities. I have also seen dissociation that is not trauma based, because other things can cause dissociation. So perhaps we can discuss further the different feel and texture of dissociation that's caused by traumatic events as opposed to other sources, some of which are understandable and some of which are mysterious.

Shelly Itzkowitz (SI): If we talk about "big T" for big trauma versus "little t" for little trauma, then I think we have to think in terms of "big D" for big dissociation and "little d" for little dissociation. Just in terms of resiliency, when we think of trauma causing dissociation, we have to keep in mind the age of onset of the particular kind of trauma. Trauma happening to a 3-, 4-, or 5-year-old, for example, happens within a still developing cognitive structure. A child's understanding and appreciation of events and ability to cope with trauma is very different from that of an adult. I think that's something important for us to keep in mind.

MH: But even the question of resilience is complicated, right? I think that many people with DID are quite resilient in certain ways or in certain parts of themselves, and I guess for all of us, there are times that we pull through pretty well, and there are other times we kind of fall apart. Karen, what were you saying at the end of your remarks about some of those differences?

KH: Well, that brings us to one other issue that I think would be good to clarify at the beginning. We talk about DID as a diagnosis, so I just want to go on record to say that as far as I'm concerned, psychiatric diagnoses are at best 20th century, certainly not a 21st-century way of thinking about symptoms and problems in people's lives. We do need to clarify what we mean by DID. Some people with DID are more resilient and some people are less, because DID is not one thing. At the very least, if we see DID as a complex adaptation, then resilience is also determined by coexisting personality structures, other comorbidities and other relational influences.

Some people have dissociative symptoms with other diagnoses, and then we get into a debate: Is this person dissociative or is this person not dissociative? I think that's the wrong discussion, actually, with the exception being that chemical substances can cause dissociation—intoxication or drug use, or medication can cause dissociation. Metabolic disorders can cause dissociation. So there are times when we see a person who may have a history of trauma, but the dissociation may be something medical going on, so that all needs to get sorted out. But that is clearly different than what I assume we're going to clarify, which is what we mean by Dissociative Identity Disorder.

RC: I still think that this "What's a trauma" question is unresolved in our discussion in a big way, and I want to make it more complicated and more difficult for us by saying this: I think we're all aware of Martin Teicher's studies and his 2010 paper entitled "Hurtful Words: Association of Exposure of Peer Verbal Abuse with Elevated Psychiatric Symptom Scores and Corpus Callosum Abnormalities" (Teicher, Samson, Sheu, Polcari, & McGreenery, 2010) with his fMRI study of the brains of kids between about 3 and 16. He shows unequivocally that these kids have altered developmental structural signs as a result of ridicule and bullying. The hippocampus doesn't develop properly, the connections between the left and right hemisphere via the corpus callosum don't develop properly, and the executive function of precuneus doesn't develop properly. Now there are a bunch of people doing research and piggybacking on his results.

So we're talking about very profound neural changes from hurtful words, so I think there's a red herring in our literature with regards to "What's a trauma?" I think we all go "ooh, ahh" when we hear something horrible, and I'm not trying to say it's not horrible, but I think we underestimate the power of tapping on a nail a hundred thousand times versus hitting it once with a sledgehammer. If you tap on it a hundred thousand times, it's going into the wood. It takes longer, but it drives just as deep. When you have to deal with the consciousness for a hundred thousand taps that are relentless, there's a whole different process involving a kind of personal torture that goes on. So those kinds of traumatic experiences are extraordinary in their impact, but they don't have the gravity of an explosion. In *Psychiatric Clinics of North America* (2006), the volume that I know you were just looking at [*referring to Shelly Itzkowitz*], there's an article by Lyons-Ruth ("From Infant Attachment Disorganization to Adult Dissociation: Relational Adaptations or Traumatic Experiences?"; Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006), and she talks about the best predictor of adult dissociation being what I'll say is emotional unresponsiveness.

Now, there's an argument about what you need to create a dissociative disorder. How much trauma? How much emotional unresponsiveness? But I think we ought to ask the question differently, and that is: What produced the vulnerability that evokes or provokes the dissociative response? Take someone who's

traumatized, take a 16-year-old who's date raped and comes home with their clothing ripped and their hair undone, and they walk through the door of the house and Mom meets them and slaps them in the face and says, "You slut!" What's the trauma? I mean, the rape is enough of a trauma, but I would wager that it gets cemented in place by the mother's response, as opposed to "Oh my god! What happened to you, my baby! Who did that to you? Where's your father? Oh my god!" It's a whole different kind of experience. So what's a trauma?

EH: In the latter case, it isn't necessarily traumatizing, because the person can then connect the terror of what happened with something safe, with a safe attachment, and there is a likely possibility that the mind-splitting terror and decimation of the psyche can be repaired and healed. Your analogy about the nail is a beautiful one; a nail being hit a hundred thousand times, especially if we're talking about the texture of shame, of unremitting shame, is too much to take in. The person can't really take it in without developing a self-state that keeps the terror or the shame separated so that the person can continue to function. Not being able to process these terrible things weakens the person's ability to absorb information as part of who one is and what one expects.

KH: Just to reiterate or clarify that you're talking about this happening in childhood.

EH: Yes.

KH: That these repetitive taps or experiences of neglect while the brain is developing is really what is key.

SI: This addresses the issues and is also a theme of a Lyons-Ruth's (2002) article, and one by Liotti (1999) too, on attachment—the nature of attachment, and whether or not the mother–infant bond is one that allows the infant to survive and tolerate what would create a not-me experience. Emotional difficulties in a parent, one who is disorganized herself, along with infant-child maltreatment and failures in mentalization contribute to a disorganized attachment bond in the infant. The infant and young child become vulnerable to hyperarousal because two competing emotional states emerge simultaneously—the need for attachment and the fear of the traumatizing parent. The infant and young child can't deal with emotional overstimulation because there isn't a protective barrier, like having a parent who would say, "Oh my dear, my baby what happened?" and this makes the infant much more vulnerable and less resilient.

MH: Also, I was thinking of Winnicott's (1960) formulation about "going-on-being," the infant that has the experience of being contained in a holding environment that feels safe enough, so that the infant can have the experience of what he calls "going-on-being." It can be interrupted—not just with

neglect, not just with abuse, but also with intrusion, with too much stimulation, or nonattunement. This can disrupt a developing sense of self.

But I wonder: I'm interested in pursuing more about what is a trauma, or how we define that. I don't have any difficulty with what you said, Rich, but I think that sometimes, some of these things feel semantic to me in the sense that I think of it as how one responds to trauma as both the trauma *and* the aftermath. The aftermath is the environment, is what kind of recovery is offered, or not—whether it's chronic, or whether a one-incident—how the world can become safe again. All of those things determine what the trauma is, but I think if someone's been raped that there is some trauma even if there is a great response afterward.

KH: Oh, of course.

MH: Right.

KH: But I think what Rich is talking about is the development of an organization around it, so we maybe need to define trauma with the concept of organization. Bruce Perry (2006, 2009; Perry & Hambrick, 2008) has written extensively about the developing brain of children who were traumatized, and really gives you a feeling for how, whether you're looking at it neurobiologically, neurophysiologically, neuropsychologically, or intrapsychically, there is a complex system of organization around traumatic experience over time.

SI: It also underscores what you're both saying about how the trauma affects the body; it's not just the mind. That it actually changes physical structures in the brain.

EH: I'd just like to add to what everyone is focusing on, this issue about trauma and attachment and following up on things that Karen and Shelly and Rich have said. Liotti has done a lot of work on showing that disorganized attachment underlies later dissociative disorders, but when you look at that disorganized attachment, you are really talking about response to trauma. We're talking about a child who can't take in that the parents may be very different at different times—a rageful or a frightening parent (who may also be frightening because of being frightened) and a parent who can be approached as a haven of safety. So the child both wants to approach and to run away. The fear system and the attachment system don't cohere, and different models of attachment develop. The child is really forming different organizations of self/other. And that's certainly dissociative; and we call it attachment disorders or disorganized attachment, but really it starts out, to my mind, as trauma.

KH: Well, the other thing to add is the recognition that at one's physiological start there are differences in regulation of boundaries and stimuli that are not initially trauma based. That also is why you see such differences between individuals having the same experience and responding differently to it.

RC: I want to respond to two things that are on the table. I'll start with the attachment piece, and I'll just read what I wrote on the pad as I was thinking through what's been said: *Dissociation is a paradoxically resilient response to the disconfirmation and invalidation of insecure attachment situations that allows the child to maintain proximity to the parent.*

EH: I'm glad you wrote that down!

KH: Yeah.

MH: Really good!

RC: I think that we are always trying to make dissociation go away, make it conscious, and replace it with something more efficient and more useful. But frankly, if you're treating somebody who is still being abused and you try taking their dissociation away, you're really going to be clinically in a lot of trouble because you're taking away what they need.

The other thing, Marg, that I'm still thinking about is the problem of trauma as it's couched as "big T" versus "little t," dissociation, and the notion of semantics. Because there's a way in which I agree with you, and then there's a way in which I disagree with you. I'll leave the agreement part alone, but the disagreement comes from thinking about Putnam's early paper in 1986 on "The Clinical Phenomenology of Multiple Personality Disorder: Review of 100 Recent Cases" (Putnam, Guroff, Silberman, Barban, & Post, 1986). I think the numbers are pretty close to 85% of dissociators had a history of sexual abuse. If you added physical abuse, then the abuse score went up to something like 95%. But there was always the 5% in Frank's study that he couldn't explain as to why they had no abuse history. And that was in 1986. I think we're better at this discernment of dissociative process and dissociative disorderliness than we used to be, so we're seeing that 5%—my opinion, no study—we're seeing that 5% grow. Because in my practice, it's in the 20% range. It's in the subtlety of the histories. All these folks start with the statement, "Oh, I had a normal childhood," and it turns out to be not so normal.

MH: Or they can't remember half of it.

RC: But that's the script. That's the family mythology, and they carry that into the treatment. So I think that if we insist on defining trauma as in "big T," then we get in trouble in the mind-set that we have, the way we sit and listen. Because we're listening for big stuff when it's the little stuff that nails people again and again and again, and we could overlook that. I also think that the focus on trauma back in the '80s led to a lot of trouble in our field in assuming trauma and hunting for it, as opposed to naturalistically letting the narrative of somebody's life unfold.

MH: I agree with what you are saying. I, too, don't find the "big T, little t" formulation helpful, but what I was trying to talk about is a way of thinking about trauma within the context of a life. For example, a client whose mother was a Holocaust survivor and had gotten pregnant right out of a relocation camp was not prepared to be a mother. She was not enough recovered and was not a great mother to the child who came many years later. Her father was also a survivor, more intact, however he wasn't home much. It isn't that I think, well, the Holocaust did not literally happen to her, it's not her trauma; because in a way it did happen to her. So that's why I don't find "big T, little t" very helpful.

RC: I'm glad you don't.

MH: Yeah. But the transfer of that experience did happen to her.

KH: On that subject, there are two things that I wanted to add—one is cultural and one is physiological. One of my thoughts about the controversies that we experienced as clinicians treating people who were mistreated as children is that in some ways the word trauma distances us from what has actually happened, muting or softening the awareness of violence. To recognize dissociative processing in adult life is to recognize the level of violence in children's lives. There is a tremendous resistance in our society to acknowledging the level of violence within the family and within communities.

The other is that dissociation can be looked at in a number of different ways depending on what your model of the mind is. I was trained in a model that was pretty linear. That there's a self, and there's an ego and id, and a superego. But basically the mind really is a complex information processor. It used to be talked about as parallel pathways of processing. Now we're not talking so parallel, but basically that a lot of information is processing at the same time in the mind or brain—brain-mind. One of the things about dissociation that's particularly interesting to me is that it becomes a unique vehicle for understanding this complex processing because of the persistence of these separated parallel pathways, or shifting states of mind.

SI: Just as you were speaking, or just before you spoke, I wrote something down to address the 5% that you were talking about, Rich, the Putnam's studies and the 20% in your office. I was thinking about Elizabeth's book on dissociation, thinking about Philip Bromberg (1998, 2006, 2011) and all the work he's done, and the idea of dissociation as process versus dissociation as structure. When we talk about DID it feels like, maybe that 5% of Putnam's study had dissociative phenomena and dissociate, but when the nail gets hit a hundred thousand times, the child has to find a way to cope, and then that's when I think the mind develops dissociation as a structure and then splits self-experience. Getting to what you're saying, Karen, I think you're talking about the distinction between mind

as singular and bounded versus the way we tend to think about mind now as being multiple and discontinuous.

KH: Well, one thing to clarify: I would not say the mind develops dissociation; I would say that the ability of the child's mind to dissociate does not dissipate. That it's reinforced, and even enhanced as a result, and we could use other words too. Stress. Extreme stress will affect the development of a child's brain, which will affect the way in which dissociation is maintained—can be maintained.

MH: So this is the idea of it not starting off as a unitary mind.

KH: Right.

MH: But that the infant starts as much more fragmented than that, but under certain circumstances rigidifies in that fragmentation rather than develops.

KH: I would not use the word *fragmentation* and I wouldn't use the word *rigidifies*, and this is my own personal bias. I think there's a reason why so many of my dissociative patients are enormously creative and talented. I have files of amazing pictures, paintings and drawings, and poems—this is part of their dissociative experience—that indicate to me that we have, in my opinion, the wrong idea about the mind to begin with. People who have suffered this level of violence or mistreatment in childhood actually show us a more accurate picture of the mind. I don't entirely see DID as a disorder.

MH: Well, that seems like an important thing to explore. But before we do that . . .

KH: I may get in trouble for that.

MH: You may get in trouble for that! But before we do that, though, I want to know if there's agreement among us, because you were sort of moving us from dissociation in general more specifically to DID. So my question is: Do people agree upon the etiology of DID? Is it extreme persistent violence in childhood of one sort or another: physical violence, sexual violence, verbal abuse, or disorganized attachment, which can be or feel violent? Is that what we think creates DID?

EH: I'd like to come back to Rich's definition of invalidation and disconfirmed insecure attachment. Very important. The issue is much larger than only physical violence.

There is another distinction that needs to be made and that is that dissociation is a much larger concept than trauma, violence, mistreatment, torture. I think that's an important distinction to make. Dissociation can be a very adaptive ability that does not have to be rigid. The dissociation in hypnosis, in intense absorption in a problem to solve, absorption in a book, and so on, is

a larger category than trauma-related dissociation. So dissociation is an important human capacity. Even trauma-related dissociation can be thought of more in terms of its life-saving capacity. Because dissociation, as everyone has been pointing out, can be incredibly life saving and adaptive, and people who fall off mountain cliffs can survive in a cave with their heart rate lowered and their way of perceiving completely different, and it really is protective of survival, and so that, that has some bearing on your question.

MH: The 20%, you mean?

EH: Or the 5%, whether they would have had some kind of interpersonal invalidating experiences that made part of them "not me" that couldn't be accessed.

RC: I'm glad you asked the question that way, because I think I can pick up your question and go back to something you were saying, Karen. It has to do with model of mind, and what we as clinicians who understand dissociation maybe more than the average bear believe about how a mind forms. What I feel comfortable taking to the bank on that is Putnam's model, his discrete behavioral state model that he spells out in his 1997 book *Dissociation In Children and Adolescents*, and is based a lot on Peter Wolff's (1987) work about states. It's the notion that it's normal for infants to develop statehood on little islands that eventually bridge together and then do more than bridging in terms of filling in the land that's based on parental responsiveness to those states. Whether you invoke Christopher Bollas's (1989) transformational object paradigm, or you think about the work of Fonagy, Gergely, Jurist, and Target (2003) and I hope I didn't leave somebody out. . . .

MH: Well to paraphrase Winnicott (1960): There's no such thing as a baby, only a baby and its mother.

RC: Right. There needs to be parental responsiveness to the child's state-ness which validates reality but doesn't overdo it—doesn't fall prey to the child's fantasies of being a superpower—by using what Fonagy calls "markedness," in order to modulate the child's fantasies. But I think all these things, multiple self-states are normal as a developmental pattern in all humans and that the difficulty is in families where there isn't validation, confirmation, and responsiveness—the islands don't bridge. They don't knit. It's a problem, and with regards to Type D infant attachment there are a lot of clinicians who don't think of these infants as at risk of becoming dissociative adults. In the UK the tendency would be to call them borderline and here in the U.S. we'd more likely call them dissociative—depending on which religion you follow. But I don't think this is as important as the multiple self-state model itself. We might start there as normative, and I think

that may help you not feel so bad, Karen, about saying that you feel that the idea's sort of normal, that you don't see it as a disorder. [*Laughter*] I think I hear you. That it's not necessarily disorderly to have multiple self-states; it can be a creative solution.

KH: Actually, I'm really glad you brought up Putnam, because that was the beginning for me, reading Putnam's behavioral states model in 1997. It meshed with my study of nonlinear dynamics and complexity theory and the mind. He may have been the first person who put it together for me (Putnam, 1989). If you look at the early literature on consciousness studies, like the book by Daniel Dennett (1991) called *Consciousness Explained*, he actually says: What makes us think that having multiple personalities is any more unusual than having one personality? He was speaking not as a clinician but as someone who was putting forth a theory about multiple pathways of processing in the mind, which is one of the ways in which he's talking about consciousness. So I read that and Putnam around the same time, and I thought, "Oh! This is a whole other way to think about this!"

RC: So I'll pose you a question.

KH: Okay.

RC: Just to be responsive to your model, which I like, the question is: Okay, I agree, multiple self-states are normal, but what is it about this multiple self-states stuff that creates disorderliness and chaos and pain in somebody's life?

KH: As you were asking the question, I was thinking about a patient of mine, many, many years ago, a former patient, who called me from the entrance to the Lincoln Tunnel in a 5-year-old voice saying, "I don't know how to drive this car." So while shifting, dissociative states of mind may not be a disorder per se, the consequences can lead to dysfunction.

MH: But let's talk about that concretely for people who are more familiar with theories of the models of the mind and multiplicity and self-states but still don't have the experience of knowing that they are working with people with DID. If people could talk a bit about what it looks like, and the ways that DID is both a creative response to horrific situations and can be still quite creative in the present, and the liabilities and the disabilities like losing time, for example. And if people could also talk about the varieties of ways that it presents.

KH: Well, just to speak to Rich's question, and to backpedal on my saying that we shouldn't talk about rigidity, because in some ways I think that is correct**.** We all have multiple self-states that are fluid and in communication with each other most of the time. For those with DID, self-states are often not in communication with other self-states—what might be called a lack of co-consciousness. This lack

of co-consciousness between self-states can be difficult to discern in clinical work. So that one can work with a patient who does not bring into the session states of mind that they experience outside of the clinical work, and that is part of the reason why it can take a very long time to learn that somebody has states of mind that are not co-conscious. There was a literature review (see Kluft, 1985) that found it took an average of seven years for someone to be in the mental health system before a diagnosis, of what was then called MPD, was made.

MH: But it's not just a question of consciousness, right? This is speaking to the question of how people vary. I'm thinking of someone who is almost always conscious of other parts of her, and even when she's sequestered in her internal system, she is able to hear something or be somewhat aware. But she feels separate. She says that in the few moments when she doesn't have a cacophony of voices in her head, she feels very lonely, because her identity is based on having those different identities. So it gets hard to talk about, because it is not just a question of amnesia, although that is one distinctive variety, where people are not in touch with different parts of themselves at different moments.

RC: I think that a reasonable way to respond to this, Marg, is to talk about diagnosis. It is useful insofar as it holds in one place certain kinds of, if you'll pardon me, organizing principles for how to think about dissociative disorderliness, and those organizing principles are laid out nice and neatly in the SCID-D (see Steinberg, 1994). So the five main salient criteria are depersonalization, derealization, amnesia (as forgetting outside of the normal range of human experience), identity confusion, and identity alteration. Your patient who feels disconnected, the people who talk about feeling detached, the folks who say nothing has any meaning: "There's this odd distance I feel with the world"—they have depersonalization/derealization experience. The Kings College London website, from the depersonalization unit, says that 16% of people in the world have had depersonalization experience. That's a lot. You know, if 20% have major depression . . .

EH: Twenty years ago I read in the *Science Times* it was 30%. [*Laughter*]

RC: But let's talk for a moment about the subjective experience of dissociative process, and what that does to your marbles when you try to line them up in a row, because it makes a mess. What does a 4-year-old know about depersonalization experience? They're flying across the room, they're up on the ceiling, they're out in the neighborhood. They are certainly not on the floor being hurt. What does someone know about the fog of depersonalization? When you sit with someone and they tell you after 10 years of hard work, "God, you know, there's this. It's just so weird sitting here. You look so clear, and I can see the edge of the table. What's going on? And the colors are, like, bright. What happened?" Well,

they had an integrative experience. They tolerated, without noticing, that kind of perceptual disturbance forever and a day, until one day it was gone. So they don't notice, which is part of what's so insidious about these processes. There's no one saying that your actual perceptual experience is sort of off. We have to ask about it, which is a big problem if you don't understand these things. But I think the subjective experience really tells a lot of the story in terms of depersonalization, the five criteria that move things from normative kind of multiple self-states into the territory of trouble.

KH: Yeah, well, I partly disagree.

RC: What kind of partly? [*Laughter*]

KH: Right; is it contagious? [*Laughter*] If you look at depersonalization, for example, it is an experience that in my clinical observation is very, very painful. The patients that I've worked with who feel depersonalized are suffering terribly in that experience. Many dissociative patients that I've worked with do not complain about depersonalization, and some patients who, in my mind, clearly have dissociative symptoms do not complain about dissociative symptoms. Their presenting complaints are entirely different, and sometimes they have been in treatment for a long time, working on other things, and just to complicate it, for some people, the increased awareness of dissociation as an adaptation or maladaptation becomes a problem in itself. And there is a period, sometimes a prolonged period, in which actually there is more pain. So that's where I get into trouble with the disorder part of it. Because there are moments in long-term treatments where I feel in some ways that this person was better off before they ever met me, even though hopefully they'll be better off in the long run.

RC: Would you accept part of the title of the second chapter I'm working on of my book, which has the phrase "The orderly disorder of . . . " Because I think that is true, that there is an orderly disorderliness, just like some cardiac rhythms—it's my family doctor *alter* here—some cardiac rhythms are regularly irregular.

KH: Right.

RC: And I think that dissociative process works like that, too.

MH: But let's not go so fast by that question about whether they're better off before they met you, because they came to you for a reason, right? They came because of pain and distress. They came because things were breaking down and no longer functioning. So it's not just that the work, the treatment makes the pain greater—which it often does, I agree with you—but it's also that at some point, the system isn't functioning so well anymore, and so that brings them into our office in the first place.

KH: And I would say that this is the moment in treatment when it helps to have if not a psychoanalytic training, then to certainly be psychodynamically oriented. Because it's at that moment when you need to really hang in there and know that growth and healing requires mourning and grief and some suffering, and I am very grateful to have that background. With most of the people I've worked with, we've passed through those periods, and it takes a long time. But I think for anybody with less experience, I think it can be quite frightening to see the increased pain that comes with some, I don't use the word integration, but I do use the term co-consciousness.

SI: Increased awareness.

KH: Increased awareness.

EH: I'd like to add to the comments on depersonalization. I've often been amazed when people tell me, even though I know, "Oh, I'm always like this. I'm shut off from the feelings." Even though this is in itself troubling, it did save the person in the past, and perhaps the present, from being overwhelmed by affective arousal. But one of the things that happens here in the separation of these states is that there's a lack of an ability to place one's own mental emotional state in a context, in a kind of familiar or reliable context. There is also a lack of an ability to feel that there's a link, that there's a possibility to make a transition, that it's possible to know that there are other self-states, and this doesn't just apply to DID.

MH: I'm sorry to do this, but we had a request to have break for a few minutes. Oh, you're okay?

KH: I'm sorry, but I don't need it.

MH: Does anyone else need it?

EH: I want to stand up.

MH: Okay. Let's stand up and stretch for a minute.

RC: It's probably a good time to notice how important self-care is in doing this work.

MH: Oh, that's a very good point.

KH: Actually, you know what? I'm gonna take a break. [*Laughter*]

Part 2: How We Understand DID

MH: So, as we reconvene, let's talk more specifically about what we see presented in our offices, and how we understand DID in particular. Karen was suggesting we start off talking about the "me/not me" experience as one aspect.

RC: Well, there was a conversation that was going on earlier, before we started, about: *What's depression*? Someone comes to your office and they say they're depressed, and I think that it's useful to ask, "So what's it like when you're depressed?" because I want to know what the subjective experience is. I don't care about the terminology. I want to know what's happening. And I don't go out looking for dissociative disorders, but they come walking into my office and they slap me in the face. Like, when somebody says to me, "Well, I'm depressed when I feel so detached from myself, and so disconnected from the world, that it feels like I'm all alone." So what the hell is that? That's not depression, necessarily. But I ask, "When you feel detached from the world and so disconnected, what's your experience of your body?" They might say, *"Well, what do you mean?"* "Well, do you feel like you're connected to your body, or do you feel somehow not connected to your body? Or what goes on for you?" And people say, "Well, I never feel connected to my body, I mean, I don't understand what you're talking about. But it's like I have this suitcase that I carry around and I know I have to dress it up, and I know it's mine, but you know I just prefer not have it because it creates all sorts of problems for me."

Well, you know, that is not major depression. There might be a major depression, but that's something else. Then it's hell on wheels, because I've got this clinician out there who sent me a simple, depressed patient to prescribe an SSRI for, and I call him up and I say, "You know, have you ever talked to your patient about X, Y, Z?" *"Well, no."* Then I explain what I found and they go, *"Ohhhh my,"* and then they don't want their patient anymore. Too often it's because they get scared and they think they don't know enough about dissociative disorders, so they can't treat this person. They forget that they're a therapist.

MH: That, I think, is a very important and interesting point. I was talking to somebody this week who has DID, and I asked her what would she want people to come away with from this roundtable discussion. She's been hospitalized over a dozen times, often for six months at a stretch. She's had a lot of treatments, some of them horrific, some of them actually good, even in her own estimation. But what she said was, "When I'm treated like a person . . ."—and she was one who used DID as a creative response to horror—but she said, "When I'm treated like a person, recognizing that the way I experience the world is normal for me, and that I'm not actually crazy, and that there's a way in which everybody's experience is similar as well as different to mine, *then* I feel like I'm a human being and part of a discussion."

And I think the corollary is true, that other therapists who haven't worked with DID get scared in that way. She was saying, "I don't want people to be afraid of me. I don't want people to feel like I need to be medicated and shut up and marginalized, or given away by their therapist to somebody else."

That's what I say when therapists ask me if I'll take the patient that they already have an alliance with, because they have DID. I say, "Well I'm happy to supervise you, but you already have something going. Why would you want to abandon that person?"

KH: Well, it's a very complicated problem, because I, too, have that experience. Someone comes to me and says, "I have a patient who is dissociative. Can I have supervision?" And the first thing they say is, "Should I transfer this person?" Often I listen; I don't say anything until I hear, but often there's a good relationship between the therapist and the patient. So I tell them a little about what it was like for me at the beginning, because I agree that I didn't go out looking for dissociative patients.

MH: So what was it like at the beginning?

KH: I started off my career with a primary interest in women's mental health. I was very involved in women's mental health in New York City, and I started to get referrals of patients, women who had been victims of rape and domestic violence, and I started noticing that there was something going on that I hadn't learned about in my residency. I described in a book review that I wrote of Daphne Simeon's *Feeling Unreal* (Simeon et al., 1997; see Hopenwasser, 2007) that during my residency training I heard the word *depersonalization* once, and the word *dissociation* not even once.

MH: And the time frame? When were you in your residency?

KH: Yeah. *Ouch.* [*Laughter*]

RC: We won't tell; it'll just be published.

KH*:* Let's say this. In 1979, I treated two adolescents on the unit at Jacoby Hospital, both of whom were sexually abused. Neither of them were diagnosed with a dissociative disorder, nor was there any discussion about the sexual abuse, even though I was aware of it. That's a whole different issue, living with that awareness as a young resident, not recognizing there was anything I could do. Interestingly enough, one of those adolescent patients, almost 10 years later, tracked me down and wanted to come see me. But what was I saying?

MH: You were talking about changes over time in the field and what it was like when you were first beginning.

KH: I never learned about dissociation as a resident, and I started to notice something about patients that didn't fit into what I had learned, in a very good residency program. As a young attending I had a supervisor who I was telling about a patient who was having nightmares and vague memories of early abuse. He looked at me and he said, "Well, did it ever occur to you that this really happened?" And that was my turning point. It was 1982. I then joined a group, a small group of clinicians here in New York who were interested in peer supervision on dissociative disorders, and we met for many, many years. And once word gets out that this is what you do, you're set for life, because people are looking for help in this area. Over time I slowly came to understand this, and then discovered the International Society for the Study of Trauma and Dissociation (ISSTD), and discovered the writings of people such as Richard Kluft, Frank Putnam, Colin Ross, James Chu, none of whom were actually in New York.

MH: Yeah, almost exclusively not in New York.

KH: You know, so it was very interesting that in New York City there was very little in the academic institutions, actually none. Nothing.

RC: Do you have any speculation as to why?

KH: I do, but I don't think it's appropriate for this discussion. I will say this: As a young voluntary attending, for many years I taught residents a PGY-4 elective course on dissociative disorders and was supervising residents for dissociative patients on an inpatient unit, until a new unit chief decided he wouldn't allow that anymore. But my colleague and I who were doing the supervision, they would call us if they had an inpatient that they felt had a dissociative identity disorder, and we would come and we would work with the residents, and then we were banned from doing that.

SI: I'd like to jump in for a second. In a different way than you and Rich, it came knocking on my door. The unit chief in a hospital where I was a supervising psychologist approached me and said, "I have an interesting patient I think you might like to see," and it turned out that this woman had Multiple Personality Disorder; this was before the diagnosis was changed to DID. It was something that I had heard about but had never seen, and I'd been through a doctoral program, I'd been through training in psychoanalysis at NYU Postdoc. This never came up, which was remarkable; and I remember in college reading what was then a very popular abnormal psychology textbook called *The Abnormal Personality* by Robert White (1964), where he sort of says it's a very rare disorder, maybe a few times in a century will you see a patient with Multiple Personality Disorder. So I was very excited, thrilled even, and really wanted this experience.

RC: So for the record we should say it's more common than schizophrenia.

EH and SI: Yes.

RC: Schizophrenia has an incidence of 1%. Dissociative disorders have an incidence of somewhere between 1 and 6%. In the Wake Forest Bowman-Grey study (see Latz, Kramer, & Hughes, 1995) of about 500 consecutive admissions to their hospital, about 10% of those who agreed to be studied tested out as having a dissociative disorder, MPD at that time. This is a commercial message, my apologies. [*Laughter*]

KH: There are a lot of studies, too, that have come out in the last few years of consecutive admissions to the outpatient department, and also looking at psychiatric inpatients, and the numbers are 10, 15, 30%, which is also found internationally.

MH: Because if you can't or don't recognize it, you don't report it.

KH: Right.

MH: And it's going to be a bigger percentage than it was first believed to be, because people are beginning to recognize it.

RC: We interrupted Shelly.

SI: I was going to report a similar experience. At a time when I was working on an inpatient service and talking about my experiences with patients with Multiple Personality Disorder, I was met with—maybe not as harshly as what you experienced—disbelief and disapproval. But the irony was that whenever a patient was brought in and showed symptoms of dissociation or switching personalities—which over the years I was trying to inform the professional staff on the unit about—they would always ask me to come in. They wouldn't know what to do with the person. They'd say, "I think you know something about this."

They would still deny that it [MPD] was a legitimate diagnosis. There would be a grown woman on the floor under a blanket, whimpering in a 5-year-old girl self-state, speaking in a child's voice with a nurse standing with medicine in her hand, wanting to force her to take medicine, and it was right there for everyone present to see, but they still didn't want to believe it. "She's psychotic, she's borderline, she's just acting out, she's manipulating. . . ."

RC: She's regressed.

SI: She's regressed.

RC: What is regression, anyhow?

EH: I had an experience with a supervisee and with a colleague who told me two similar stories. Both patients had psychiatric hospitalizations, and the therapists called two different hospitals, separated by a couple of years. The therapist explained that their patient had DID, and the staff and the resident on call said, "No, this can't be." The attending then said, "This can't be, because I've never seen it." And the patient is then treated like an acting-out patient, and then in both cases the patient begins to visibly switch. Then all of a sudden the attending wants to film the patient and thankfully, in both cases the patient said no.

KH: I just want to reiterate one thought I have about one of the reasons why many people in psychiatry do not think that they've seen DID or think that it's extremely unusual. Dissociative disorders, if you recognize and understand them, significantly threaten the core body of knowledge in which people have been trained. I remember this experience for myself personally, of feeling in crisis as my way of understanding psychology and psychotherapeutic process changed as a result of learning from dissociative patients.

I sometimes think of dissociation like quantum mechanics versus Newtonian physics. If you're not ready to see it, you can't see it; it's conceptual. Once you see it, you can't ignore it; it's the way you think—and in a way that transcends the issue of whether it's a disorder or not. It can be a disorder, but it is a way of thinking. And it also makes me think of Sander's (2002) article "Thinking Differently," that appeared in *Psychoanalytic Dialogues*. Once you organize concepts in a particular way, you can't go backward.

MH: Well, I wonder though. [*Laughter*] Because yes, I know exactly what you mean from my own personal experience as a clinician. But I think there are two conflicting, countervailing tendencies within the field, especially within psychoanalysis. And the field did go backwards, because some of the roots of this way of thinking come from the past, from Janet, from Freud, from Ferenczi.

SI: Preanalytic Freud.

MH: Preanalytic Freud, but especially Ferenczi. If you read the *Clinical Diaries* (Dupont, 1988), there are the most beautiful, evocative expressions of what it's like from the inside out. He describes what DID looks like. He doesn't call it that, but that's what he's describing. There are also elements of an understanding in Fairbairn (1952) and in Sullivan (1953, 1965). So there were threads of understanding, and then there were complete disavowals. In the case of Ferenczi, he was repudiated, misunderstood, misrepresented, and then disappeared for more than half a century.

But I think that trend has shifted in this city, dramatically after 9/11, because all of a sudden, so many analysts were dealing with trauma and dissociation that they hadn't worked with before, or they hadn't recognized as such. There was

an interest and an aliveness about figuring all that out that hadn't existed, in my experience, prior to 9/11.

SI: Not only that, but we ourselves were traumatized.

MH: Yes, we ourselves were.

SI: It wasn't just the patients.

KH: Speaking of that, too, we need to acknowledge the emergence of trauma training programs, such as the ones at NIP, ICP, MIP, etc., that have really shifted awareness significantly—offering educational opportunities to clinicians.

MH: Right.

KH: Psychiatry is a little behind other disciplines in this field. Psychiatry is so embedded in a medical model of health and illness as well as evidenced-based research. Evidence-based medicine/psychiatry has to be limited to less complex, more homogenous problems.

MH: Last night I read some of my notes from a discussion in my group of trauma survivors, one of whom was a social worker whose parents were Holocaust survivors and whose brother had later committed suicide; she's had a lot of trauma in her life. She had gone to social work school in the '70s. In the group, in 2006, I mentioned your book, Elizabeth, soon after it had come out. She had begun to read it and came into group furious, "HOW COME NOBODY'S EVER SAID THIS TO ME?" She said, "I've heard it from you, Marg, but I hear a lot of things from you. I've never read this stuff. This was not taught to me. It's the first time I feel like I'm reading an experience that reflects something of what I know, what I have experienced."

Later in the group, somebody said, "Marg, you're just joining this person's intellectualization of the issues, and we should really get back to the emotional material," and this first person was able to say, "This *is* emotional for me! This is so central, and yet I've been deprived of this. There's a way of understanding that I've been deprived of."

SI: Speaking about psychoanalysis, and Elizabeth, I'd be interested to hear what you have to say about this. I think that 9/11 was a very important experience for all of us, but I think in terms of the psychoanalytic literature, there is a small group of people who have been writing about dissociation and trauma's impact on the mind. The people who comes to mind are Donnel Stern (1997, 2010), Philip Bromberg (1998, 2006, 2011), Jody Davies and Mary Gail Frawley O'Dea (1994), and yourself Elizabeth (see Howell, 2005, 2011).

EH: And Rich Chefetz.

SI: And Rich Chefetz. Sorry, my apologies.

RC: Who's not a psychoanalyst, by the way.

EH: Yes, he is.

RC: People tell me that, but the only psychoanalyst in my family is my wife. She's the one who did the training, but it's true I do speak the language.

SI: Maybe 9/11 helped to coalesce these ideas, bring us together to think about this in a different way.

EH: I go back to what Karen said about organizing ways of thinking, and I think that the Freudian paradigm has been hard to give up, and what you're saying about Ferenczi, that he came back to appreciating the importance of child abuse and of going with the patient's experience. Whether or not it was his disagreements in technique, or his disagreements about the etiology of psychopathology, he was said to be crazy. I mean I remember reading in my textbooks and in Ernest Jones's (1961) biography of Freud that he said Ferenczi was crazy; and then again Peter Gay (1998) in his biography *Freud: A Life for Our Time*, also said Ferenczi was crazy.

RC: Have you heard Warwick Middleton's (2009) presentation on Ernest Jones?

EH: Well I'm looking forward to it.

RC: But do you know why he said Ferenczi was crazy?

EH: Why?

RC: He was a pedophile. Ernest Jones was a pedophile. And Middleton has documented that and so there's a very checkered history.

MH: What I read says he was charged but not convicted of pedophilia, although also fired several times from jobs with children.

SI: Oh my God.

KH: Here we go again. [*Laughter*]

RC: I'm sorry, but there's a very checkered history in the history of psychoanalysis, and certain kinds of character assassinations were undertaken that were misguided, to be polite.

EH: But he was also Freud's "hit man," via media and gossip. His attacks on Ferenczi were especially vicious and false.

KH: Right. One of the things we're saying is that you can't really talk about this separate from the historical, social, political context.

EH: Yes.

MH: Culture.

KH: History, culture. You can't separate it out.

EH: And Freud's early renunciation of his first etiology of hysteria in which he linked child abuse to the symptoms of hysteria and then renounced it in favor of the Oedipal paradigm. That's been hard for people to give up on, even though people's experience might really be more with shifting mental states and with feeling traumatized.

Also, there's the issue of child abuse and pedophilia, that I think is also one of the driving forces in the hostility towards accepting the disorder (DID), because it's so often linked to a history of child abuse.

The existence of DID is so often linked to a history of child abuse, and many people who are pedophiles who have abused their children or been linked to child abuse are very much against the recognition of DID as something that is real.

RC: I have three things that I want to speak to, and I'll try to brief on each one of them. To add to the mess which you were speaking about to Elizabeth, Ken Pope (1988, 1990, 1994; see also Pope & Tabachnick, 1994; Pope & Vasquez, 2010) has documented the existence of sexual boundary violations among practicing clinicians as somewhere between 10 and 15%, which might be one reason why some people have such a hard time identifying dissociative disorders. Another problem is reminiscent of your comments about diagnosis. I think it's reasonable to say as an analogy that dissociative disorders are to psychiatry what syphilis was to internal medicine at the beginning of the 20th century. It is the great impostor. It shows up all over the place; with regards to diagnosis and psychiatry, psychiatrists are wedded to diagnostic nomenclature and criteria, and not all that switches is bipolarity.

The original bipolar construct that Bob Post worked on at NIMH (see Post et al., 2001) over the last 30 years was that a bipolar switch might occur as often as four times a *year* in order to qualify as rapid cycling. Most people don't know that definition, but that's what it is. Rapid cycling is not four switches a month, or a week, or a day, or an hour. The construct of bipolarity has been hijacked to include ultrarapid cycling as a way of explaining frequent switches, and there's a problem in Camelot, and it's a big one. It's especially a big one when, in

addition, no one in the ADHD area talks about the confounding diagnoses of ADHD patients who have trauma histories or dissociative symptoms.

I want to add that to the discussion and then return to your earlier question about what you see, how you recognize dissociative disorders. Just as a handle that's easy to hold, people would do well to look for discontinuity of experience that they have of their patient, and that their patient has of their own process in session. So if you are asking a question typical of the Adult Attachment Interview (see Hesse & Main, 2000), like "What kind of parent was your mom?" and you get back an incoherent response that you can't figure out what your patient has just said, *that* is pointing at dissociative process in the patient. So when you get confused, that may be an indication that there's some dissociative process in the patient.

Unfortunately, sometimes it can activate dissociative process in the therapist. Then you get a consultation where a therapist says, "I don't know what happened, but the session was over before it started, and I just have this big blank in the middle of the session." Then it becomes much more difficult and tender, because then you have two people with dissociative process, one more freshly discovered than the other. But it's the discontinuity that's the big thing to look for, and the other thing to look for is state change. State change shows up as sudden recognition of a change in temperature in the room, a sudden change in posture that doesn't make any sense, or there's suddenly a protective gesture, knees drawn in. . . .

SI: Or like, "It's getting darker; it's getting darker in here. Why aren't the lights on?"

RC: Right, right.

EH: Or the eyes look different.

KH: Well to add to that, including changes in muscle tension in the face. People can look younger than they looked before, or older. And there are very dramatic physical things that could happen.

MH: Or a delay in response to a question, as if they are listening to something you can't hear.

EH: Or handedness changes.

KH: But I wanted to highlight something you said that feels so, so important, which is that experience that a clinician can have after a session with someone who's dissociative in which it's difficult to remember what happened. You go to write your notes and you can't figure out what to write, and while there could be other explanations for that, often the explanation is that there was so much dissociation in the room that it actually interferes with organizing the

information, even in the other person who's not dissociative. What I focus on when I write about is this: If it's in the room, it's in you.

SI: And one thing to add to your list, and something you mentioned earlier, when a patient says she or he is hearing voices, people automatically think schizophrenia.

RC: That's because the *DSM* says you can make the diagnosis if you hear voices.

SI: Right, right. Voices inside of the head, voices that they're familiar with, voices that have names are indicative of DID. If the voice is coming from outside, the next-door neighbor, from down the street, from their pet, that's a different story altogether.

MH: Well, it's also the way they understand it.

EH: Yeah.

MH: Because I have someone who has DID who hears voices internally, but she also hears music as if it's coming from the outside and she can't turn down the volume. But she knows that that's weird. She doesn't think that somehow the Martians have taken over and they're pumping music into the room, or she doesn't have a fantastic explanation for it. She thinks that there is something odd about it, and she keeps it hidden for that reason.

KH: I also wanted to introduce the concept of the human connectome, which might be useful for us here, going forward. This concept challenges our phenomenological system of diagnosis. As I said earlier, the revision of the *DSM* is still not 21st century. The concept of the human connectome is that there are trans-diagnositic patterns of neural connectivity, that symptoms are a function of networked brain connectivity, and that these connective patterns overlap. Networks get activated differently at different times, and you cannot divide them into diagnoses. The whole idea when I think about the voices is that it is an experience of some kind of neural network firing, but connected to other neural networks that make it not schizophrenia, but a dissociative experience. Someone who has schizophrenia can also have dissociation and dissociative experience, because there's actually a very high incidence of childhood mistreatment in adults with schizophrenia.

MH: Maybe people could also talk about how they see working with people with DID. You know, how does the work go? How long does it take? What are the fundamentals of it? Does it feel different to you than work you do with other people?

RC: Well, I'm smiling because my work with my patients with dissociative disorders has changed the way I work with other people.

MH: Exactly. That's exactly the right answer.

RC: It's not the other way. Once I became aware of the affect regulation issues, and the state changes and so on, I see that because it's there.

MH: That's the point Karen was making.

RC: What Karen was saying is like what I say about fishing and dissociative waters. Once you learn how to see a fish you never forget, but until someone points to the little shadow that moves, you don't know what you're looking at.

MH: Right.

KH: Right. That's great.

RC: So it's the model of mind thing, Marg.

MH: Yes, exactly.

RC: You know, I've never been the same since I became aware of DID. Since you asked about the beginning, I'm recalling my first two patients on a hospital psychiatric service, both of whom had a dissociative disorder. It was the first day of my residency in psychiatry and I didn't show up for the appointments. I got so frightened by their kind of cloud of experience that not only did I not show up, but I forgot that I didn't show up. I had no idea that I didn't show up. I came in after the Fourth of July and my service chief caught me in the hall and said, "Dr. Chefetz, I'd like to talk to you." Then, in her Prussian accent, "Did you know you didn't come to see your patients? Do you really want to be here, Dr. Chefetz?" and apparently I didn't, but I went and made new appointments.

So it was frightening. It's also true that I have a tremendous debt of gratitude to my patients who saw me struggling. They knew that I really intended to understand but couldn't get a grip, and one of them said it to me. Two of my inpatients talked to each other, and one of them said to me, "We saw how you looked the morning after your on-call . . . " (Because I was 40 when I retrained in psychiatry after family practice, and I was a mess. I was sleepless.) ". . . and you didn't cancel your appointments with us, like the other doctors would do. And we felt bad for you, and we decided we would stop dumping on you, so let me tell you about how to understand what's going on in my mind." Then one said, "Do you remember *The Pinky Lee Show*?" Anybody my age remembers Pinky Lee talking to the kids in the bleachers. "All of me is sitting in the bleachers, and there's only one of us in the spotlight. If you talk to the one in the spotlight and you forget about the ones in the bleachers, you're lost."

KH: You know, an interesting thing about that is that when you do that now with people who don't have DID, they relate to it.

MH: Yes.

RC: There's a part of me *this*, and there's a part of me *that*.

SI: Absolutely, yes.

EH: Yes.

KH: It's no problem to talk to someone who's far outside of that spectrum to say, "Is there a part of you . . ." or "I want a part of you to hear this." It's not like, "What are you talking about?"

EH: I don't want this to get lost, and I know that it's a parenthetical thing, but since we're going in the direction of talking about how it changes practice generally, one thing I find is I'm more often putting out fires with DID patients. It's more often, "Well, I didn't show up at work yesterday." Well, who was it? Then finding out who it was that didn't show up at work, and what was going on, and what the triggers were, etc.

One thing that I think just needs to be said is that there have been some research studies, with respect to the denial of DID that are important, that do document the reality of DID. There are two studies, with Reinders as the first author (Reinders, Nijenhuis, Paans et al., 2003; Reinders, Nijenhuis, Quak et al., 2006), in which they had 11 DID patients who could switch from an emotionally charged, traumatized kind of personality state to a depersonalized, more apparently normal personality state. They had trauma scripts of the patient's trauma, something that had happened in their own lives, that they would read. There were four conditions: (1) a neutral script and the depersonalized, apparently normal state of mind; (2) a trauma script paired with the depersonalized, apparently normal state of mind; (3) a neutral script with a traumatized, hyperactivated state of mind; (4) the trauma script and the traumatized state of mind (aka the emotional part of the personality).

And only in the last condition of the traumatized state and the trauma script did they find highly significant autonomic changes—increased blood pressure, increased heart rate, as well as an activation of the amygdala—and in the depersonalized states, they found an activation of the parts of the brain that would suppress emotionality. So that's one, and more recently in *Psychological Bulletin*, there's been a huge meta-analysis in 2012.

MH: Is this Bethany Brand's research?

EH: Bethany Brand (Brand, Armstrong, & Loewenstein, 2006; Brand, Classen, Lanius, et al., 2009; Brand, Classen, McNary, et al., 2009; Brand & Loewenstein,

2010; Brand, Loewenstein, & Spiegel, 2014; Brand et al., 2013, Lanius et al., 2010) has been doing a good deal of important research for many years. One of the most important pieces is her studies of the progress of DID and Dissociative Disorder Not Otherwise Specified [DDNOS] patients who are in therapy with therapists who are trained to treat DID (see Brand et al., 2013). If the hypothesis of those who say that DID is fabricated and iatrogenic was correct, then these patients should have increased DID symptoms, and their numbers of alters should increase over the course of therapy. But Brand's research shows just the opposite: After time in therapy, the patients' symptoms decrease, the numbers of alters decrease, and their overall well-being increases.

Constance Dalenberg (Dalenberg et al., 2012; Dalenberg et al., 2014) is the lead author of the recent, groundbreaking *Psych Bulletin* article "Reality Versus Fantasy: Reply to Lynn et al." [Dalenberg et al., 2014]. They had eight hypotheses about testing the fantasy model versus the trauma model. The trauma model holds that trauma is linked to dissociation, which is where we began today. As the research shows and the trauma model holds, in general, after a traumatic event people tend to show symptoms and gradually they decline. With treatment they decline faster. The fantasy model would say that that's not the case, that fantasy is what's producing the belief in the dissociation, and is what's generating the false memories that something bad happened. Basically, according to the fantasy model, you would expect that as a result of therapy, people would have more troubling memories, and that these memories and their associated symptoms would increase in therapy. These would be symptoms that fantasy is generating through treatment, but what this research clearly shows is that through treatment, as treatment progresses, all of this diminishes. Troubling flashbacks and other symptoms of unintegrated trauma decrease with therapy. The researchers found in all of these eight different hypotheses that the trauma model was the one that was substantiated. Especially when they used objective trauma, they found that people who recovered memories, that these memories had the same degree of accuracy as people who had remembered something all along.

And so, there is resounding support for the trauma model. Then there was another recent study about simulation of memories, and again Reinders (Reinderes, Willemsen, Vos, den Boer, & Nijenhuis, 2012) is the first author. People can simulate a subjective state of being in a different identity, but they're not going to have the same psycho-physiological brain changes.

KH: There have also been quantitative EEG studies (see Hopper et al., 2002; Teicher et al., 1997) that show that.

MH: Van der Kolk said that years ago with his MRI pictures of different states.

KH: Well, van der Kolk was really looking at PTSD and flashbacks (see Rauch et al., 1996). Whereas these articles, and some of these physiological studies and

the quantitative EEG studies are very fascinating, because they're actually looking at electrical pattern shifts with state changes. Those state changes have to do with something called rhythmic coherence. This can be looked at on a brain level, it can be looked at on a whole-body metabolism level, and it can be looked at as interpersonal rhythmic coherence, and then on a community and then global level.

MH: And I love that you make the connection that there are in biology and in neuroscience different words for what we call attunement, but that they refer to similar things. This rhythmic coherence is a reflection of that, whether you are talking about mirror neurons or you're talking about entrainment, or interpersonal attunement.

SI: I want to make a left turn here and go back to personal experience, just for a second. I think that working with DID patients has allowed me to experience two feeling states that I don't think I was as aware of or sensitive to in my work previously. One is tenderness, and the other is terror and fear. I've learned about those experiences from working with those feelings in a different way when working with DID patients. The other thing, that I brought up earlier and I didn't get a chance to . . .

MH: Excuse me, Shelly. Do you think that's because it's so vivid?

SI: The vividness is in the experience of being with someone who is either experiencing a flashback and is in the *past*, but feeling and thinking as if it's happening in the *present moment*, or is in a dissociated state that is markedly different from the person that presented her- or himself for the session. There's a revivification in the room, being with someone who is experiencing herself, I don't know how to put this. . . .

KH: That's what I call *dissociative attunement*.

SI: Yeah.

KH: Dissociative attunement (see Hopenwasser, 2008). Which . . .

SI: In a way, there's no doubt in your mind that this person who is in massive pain in front of you is telling you about something that happened to her.

KH: Right.

MH: And often, in a way, and in a state, and in a voice, and in a body language . . .

SI: Absolutely.

MH: . . . that is of a younger person.

SI: Right. When that kind of switch happens, that's the kind of stuff that gets the hair on the back of my neck to stand up, and makes me feel like there's ice water in my veins. I'm just totally frozen. When I'm working with supervisees and they come in with what sounds like a DID patient, nothing excites me more than that, to have the opportunity to teach what it is, or what it is like, and what to expect, and that you're going to be terrified, that this is very frightening, but that you're going to be okay.

KH: I have a different reaction. When supervisees come in with DID patients, instead of getting excited, I go, "Oh no," because almost everyone who I've supervised treating a DID patient has needed to talk to me in between the supervision sessions with lots of e-mailing, and that maybe speaks to how do we work differently with DID patients. And yet I've often commented that some of the very long-term patients I've worked with who have DID are some of the ones who have contacted me the least between sessions, so there are different presentations. It depends on the individual.

MH: It depends on the individual or the stage of therapy—which one are you speaking of?

KH: Both. But there's no question that over the course of working with dissociative patients, I have reevaluated some of the rules of how I work. Actually, they're not rules anymore, and there's much more spontaneous evaluation of what's right in the moment. But certainly I have done things as a clinician that, as a younger clinician, I would never have told anyone. Now I write about it, so I tell everybody.

MH: Like?

KH: I think we don't have time for that today. [*Laughter*]

MH: We actually do, because we have fifteen minutes left.

KH: But I wanted to say something else.

MH: All right, say something else, Karen.

KH: If I think about what has changed the most for me, since I came into it already so interested in the science, it's that it has deepened my personal experience of spirituality. Perhaps I would have gone that way anyway; life experiences might have led me there, but I really see it as connected to my patients. Because so many moments are in a place where you cannot reassure someone that it's going to be okay, you cannot tell someone to be hopeful. You just have to be there in the moment, in that state, and stay focused on being there, which to me became a spiritual process—a private, spiritual process. People talk about it sometimes,

but it's not necessarily something you talk about. The other thing is if I looked at all the people I have worked with, what would be some of the things that allowed someone to do better in treatment? There's no question in my mind that people who had some kind of spiritual practice or felt some kind of spiritual connection, I think, did evidence more resiliency.

MH: Well, I also think that there's something really powerful about being a witness to people's horror, but also people's change and their courage—their courage at the time of horrors being visited upon them, and their courage to face it later. Because there is that double jeopardy thing we were talking about earlier, which is that the dissociation works in some way, but it limits you in so many other ways, and then you have to go through it again in order to recover. There is something that is very moving, and I would say spiritual, about being engaged in that process and bearing witness to it.

SI: In terms of spirituality, it reminds me of Fairbairn's (1952) moral defense, which is what allows the child to maintain hope, and when I hear you talk about spirituality, I think that is what allows a person to maintain hope.

KH: Yes, I would agree with that.

RC: I responded from a professional perspective earlier about change. I want to respond from a personal one that interfaces with the clinical work. That is, unfortunately and sadly, that this work has opened me up to a whole world of shame experience that was below my radar, and I think it would be reasonable to say predicted my interest in working with people with dissociative experience, because shame is so toxic. It turned out that I was much more familiar with it on a personal level than I ever imagined when I first started doing this work. So that's been a real watershed for me; it's been painful, but really valuable. I have a thing about patients speaking to this rather than clinicians, and I wanted to quote you something from a patient who sent me an e-mail earlier today.

She said, "I just posted the image I sent you onto my blog, and I'm happy because even though it's very painful, it's less painful than the pretending, and I'm happy because for so long I've been so unclear. I've had to be unclear inside of myself so I could not really see anything in me or outside me, clearly at all then, either. But now it's starting to be more clear on the inside of me, and I also see I'm starting to be able to be far more clear on the outside of me, too. What I wrote on my blog feels like one of the most clear things that I've ever been able to say or write about my art and how it functions for me, and also why the blog is important to me."

So the pretending is an element. It's part of what I think of under the heading of self-deception. I think the work of healing is so fraught with difficulty because there's so much sadness and so much shame about what's been lost, and the inability to see one's way through the fog, and to know what's real or not.

To heal, you really have to own impossible amounts of loss and sadness and regret and shame, and I don't know how my patients do it.

MH: Right.

RC: I mean, I know, but I don't know. I don't know if I could do it.

MH: Right. Well, in fact, there's a way that we do some of it, by holding what we are hearing, being willing to listen to such horror, and sit with so much sadness and shame. There are lots of questions that come up in this, questions about how people regain trust after such terrible violations of trust.

RC: Yeah, yeah.

MH: How do they believe that what somebody's telling them is actually true? Even after working with somebody for ten years, and we have a great alliance, there are moments when that question still arises. How do I know for sure you won't abandon me or betray me? Then there are lots of questions about reconciliation, and about what working through means.

KH: You know, that makes me realize a couple of things that we should mention because we are talking about basic concepts in the clinical work. When these things come up, I think that that is one of the differences between working with individuals who are unable to tell the difference between the past and the present. When the issue of trust comes up, it is an opportunity in clinical work to talk about the difference between the past and the present, and not in the form of saying, "You can trust me." I would never say that to someone. I would talk about the possibility of whether or not you can figure out now if you should trust me, as opposed to what happened in the past, and to see that difference as a very big part of work with dissociative patients—seeing the difference between the past and the present and the future. Because there's a confusion about the future as well as the past.

RC: There's a future? [*Laughter*]

KH: Well, it's as if what happened in the past will happen in the future, too, for those who feel there is a future. So at the same time, one has to learn that this happened in the past and it's not happening now, one also has to learn it's not happening now and let's not assume it will happen in the future. So it's also about teaching, and I talk about it as teaching the brain to tell time.

MH: I just want to interrupt, because you might have wanted to say something, Elizabeth? Did you? I also want to invite the two of you, Deborah and Maggie, if you have a comment, a question, a reaction? We only have five minutes left.

EH: With some trepidation I will share that sometimes with my patients—now I really feel something like Rich's title "Feeling Real" (see Chefetz, in press). With some of my DID patients I feel more real, even though it's very painful. There's something very clear about it, and in that way it helps to expand me, too.

RC: Feeling alive.

EH: It's a validation that goes both ways. It has a lot to do with resonance.

MH: Yes, absolutely, it's very true.

RC: Yeah, I agree.

MH: Deborah or Maggie?

Deborah Pines (coeditor in chief, *Psychoanalytic Perspectives*): I just wanted to say that I once had a patient—I never worked with an officially DID patient—but I had a woman who I'd been seeing for 12 years, who came in one day and she was very, very angry like she'd never been angry before, and she was talking in another voice. It was so interesting to me, because I thought at the time that this is another personality. But I'd never seen it before, and I've never seen it again. She was furious, and that day and the entire session, she was talking in this other voice. It was really fascinating.

Also, when you were talking about rapid cycling, I've never heard of that being DID before, but it makes so much sense. I don't ever think the rapid, rapid cycling is bipolar. And I've always wondered what could it be? It's very interesting to think of it as DID.

RC: Yeah, I mean it might not be DID, but it sure isn't by definition bipolar disorder.

DP: Exactly.

MH: Well, does anyone else want to make some last statement?

RC: Yes. I want to say thank you to all of you. To Elizabeth, I was online with you in Orlando—in what, 1995?—to give a presentation at ISSTD when we met, and John O'Neil and Su Baker were in the line also, and Steve Marmer was moderating. We've known each other for a while now, and so I want to say thank you to you. I also want to say thank you to Karen, Shelly, and Marg. But it goes far beyond the collegiality [*voice becoming emotional*] at the table. It's in the place where it's impossible to do this work alone. It's so painful, and I know the four of you get it and understand what I don't have words for in my tears, and that's really special. So thank you for tolerating what's so painful that doesn't have words, and for being friends. I really appreciate it. You can't do this work alone. I'm kind of

glad [*group chuckle—a knowing laughter*], because it pushes me outside my usual pathways, because I can't stand to not connect because it just hurts too much. Then it feels really good to make the connection, and that's the best part of it.

SI: I just want to put a plug in for ISSTD (International Society for the Study of Trauma and Dissociation; http://www.isst-d.org), because I think I know how you feel, Rich. When I'm at an ISSTD conference, I have the clear sense that we share a similar experience. I feel understood, people get it, and I don't feel like I have to defend myself, or justify myself. Clinicians who have not had this experience sometimes look at me kind of oddly, like, "You're dealing with really crazy people."

EH: And maybe you're crazy, right?

SI: I probably am crazy, too, but . . . [*Laughter*]

RC: If you're going to plug ISSTD, may I plug my listserv?

KH: I was just going to plug it for you. Let me plug it, because Rich, I sometimes wonder, "How do you do this?" What is it called when you're the webmaster?

RC: The list owner.

KH: The list owner. The Dissociative Disorders Internet Forum[1] which is an amazing online experience in which internationally, people can communicate with each other about dissociative disorders' issues—clinical issues, practice issues. Rich also introduces people to each other, or you let them introduce themselves, and it's a tremendous resource.

EH: What are the numbers of people on it?

RC: We have over 1,179 members now, and we're growing.

MH: One of the things that I also appreciate is that it's international, which I think makes a huge difference. It does create a real sense of community.

RC: Two other resources for people. One, if people can tolerate the notion of mental status examination, there's an article by Richard J. Loewenstein, son of Richard M., but Richard J., in the 1991 *Psychiatric Clinics of North America,* on a mental status exam for chronic complex dissociative disorders. I think it's the best collection of clinical wisdom on diagnosis that exists. The other is, in addition to Elizabeth's (see Howell, 2005, 2011) really excellent books (*The Dissociative Mind* and *Understanding and Treating Dissociative Identity Disorder*) is the Boon, Steele,

[1]Instructions for those interested in joining are at www.dissoc.icors.org.

and van der Hart (2011) book *Coping with Trauma-Related Dissociation*. The authors are Suzette Boon and Onno van der Hart from the Netherlands and Kathy Steele from Atlanta. It's mostly Suzette's work over 30 years, but it's added to by Onno, who is one of the older and wiser clinicians in the field, and Kathy, who is incredible. It really is great for people new to the treatment, whether clinician or patient. Sometimes the clinician and patient can work through the book together. It's a great resource, as are Elizabeth's books.

MH: And also the website, the ISSTD website has several things that I think are very useful for clinicians that are new to working with dissociation and DID—the frequently asked questions section, the bibliography, and the "Treatment Guidelines for Adults and Children."

RC: And I was webmaster for that. [*Laughter*]

EH: Something that Rich was also a founding person for are the courses that are taught by ISSTD. There are over 15 sites now, around the world: There's a trauma course, and there's a standard course, with Levels 1 and 2, and an advanced course and a master's course. They're working on certification for this, too, so that you can sign up for these courses in certain key cities, or there are online versions of all of these levels of courses.

MH: And you also have taught them for many years here in New York!

EH: Yes, I have.

MH: Yes. Well, thank you very much one and all.

RC: Thank you.

MH: On behalf of all of us here today I would like to thank the editors Deborah Pines and Steven Kuchuck, the entire board of *Psychoanalytic Perspectives,* and the leadership of the National Institute for the Psychotherapies for sponsoring this event, "Exploring Dissociation and Dissociative Identity Disorder: A Roundtable Discussion."

Epilogue: Talking About Dissociation

We gathered together to do something that felt natural, something we've been doing for years now, to talk about Dissociative Identity Disorder. We each have decades of experience, practiced in the deep exploration of working with trauma and dissociation. So why in the end did we uniformly experience the *feeling* that somehow we had not said enough of what needed to be said?

If one looks at the history of psychoanalytic work with individuals who are severely traumatized, we can appreciate the following paradox: There is a desperate need for expertise in this clinical work, yet at the same time, what defines an expert? For many clinicians, dissociation is like a smoke and mirrors magic show. Now you see it, now you don't. Did I miss something here? No, there are ways to understand this. We have theories. We have ideas about the mind. We have psychopathology. Psychopathology. Is dissociation psychopathological? Or is dissociation the antithesis of psychopathology? Is dissociation a symptom of traumatic injury? Or a manifestation of resilience? Or better yet, is it simply a process of the mind at a particular moment in time? Dissociation can be described in all these ways, none mutually exclusive. Is expertise in Dissociative Identity Disorder simply the capacity to listen, without judgment, to human experience that does not fit into our theories, to listen without urgency to explain? It takes so much practice to learn to listen this way, in which we use ourselves as agents of healing, to listen, hold, contain, and process.

In this discussion we each brought to the table our unique, individual paths that began in traditional training but veered off into far less chartered territory. We struggled to speak coherently about multiple pathways of knowing and experience that intersect, converge, and diverge. Understanding the processes of dissociation brings a vibrant, kinetic energy into the consulting room, makes the clinical work feel like a field of mutual creativity. In some ways, Dissociative Identity Disorder is the perfect vehicle for understanding the complex influence of social, political, cultural, and biological forces upon mental health. The only known etiology for Dissociative Identity Disorder is severe, pervasive abuse during childhood. Yet biological vulnerabilities influence both symptoms and resilience. Cultural and religious customs influence group trance as well as individual experiences of dissociation. There have always been pockets of psychoanalysts attentive to these social and cultural influences, and in the late 20th century, there was a burst of interest in the neuroscience of psychoanalysis. No other "disorder" reveals as much about the world in which we live as does Dissociative Identity Disorder in that no other disorder so clearly illuminates the impact of violence on the lives of children.

Dissociation is a window into understanding consciousness, a keen example of how difficult it is to use our awareness to talk about awareness. Perhaps that is what *felt* difficult for us in this discussion. Toward the end of the day, under fluorescent lights in a room without windows, we found ourselves in a place of feeling deeply connected with each other. Trance induced by violence is fragmenting, whereas trance induced by collaborative teamwork is transcendent. Every day we sit alone in our offices with individual patients. Yet one thing our experience has taught us most is that treating dissociative patients is not work we can do alone. We hope this roundtable discussion reads as an invitation to readers to join us in this growing community.

—Karen Hopenwasser, MD

Our Panelists

Sheldon (Shelly) Itzkowitz, PhD, has been the moving force behind conceiving, planning, and organizing this event. We can thank him for bringing us together today. Dr. Itzkowitz, a psychologist and psychoanalyst, is an Associate Professor of Psychology and Clinical Consultant in the NYU Postdoctoral Program in Psychotherapy and Psychoanalysis; Guest Faculty, EDCAS Program of the William Alanson White Institute; as well as on the teaching and supervisory faculty of NIP. He's been treating adults with dissociative disorders for two decades and has presented his work with patients who suffer with DID at numerous conferences. He is in private practice in Manhattan.

Richard Chefetz, MD, is a psychiatrist in private practice in Washington, DC. He's a faculty member at the Washington School of Psychiatry, the Institute of Contemporary Psychotherapy and Psychoanalysis, and the Washington Center for Psychoanalysis. He is the past president of the International Society for the Study of Trauma and Dissociation, 2002–2003; a founder and Chair of their dissociative disorders psychotherapy training program; as well as a distinguished visiting lecturer at the William Alanson White Institute of Psychiatry, Psychoanalysis, and Psychology. He is also a certified consultant at the American Society of Clinical Hypnosis and is trained in Level 1 and 2 EMDR. In addition to numerous journal articles, he has a book in press under a contract with Norton, *Intensive Psychotherapy for Persistent Dissociative Processes: The Fear of Feeling Real,* due out in March 2015.

Margaret Hainer, LCSW, is a psychoanalytic psychotherapist specializing in trauma and dissociation. She is currently a supervisor in the trauma program at the Institute of Contemporary Psychotherapy and has taught and written about DID and other clinical understandings of dissociation for many years. She is trained in Level 1 and 2 EMDR and has completed a 1-year training program in sensorimotor psychotherapy. Ms. Hainer is a facilitator with the North American Branch of the Institute for the Healing of Memories located in Cape Town, South Africa, and in private practice in New York City.

Karen Hopenwasser, MD, is an integrative psychiatrist in private practice in New York City and Clinical Associate Professor of Psychiatry at the Weill Cornell College of Medicine. She has been evaluating and treating adults with dissociative disorders for more than two decades, with a special focus on understanding the neurobiology of body memory in clinical work. She is currently exploring the relationship between rhythm entrainment and attunement in therapeutic healing.

Elizabeth Howell, PhD, a psychoanalyst and traumatologist, is the author of two definitive books on dissociation: *The Dissociative Mind* (2005) and, particularly germane toward our discussion today, *Understanding and Treating Dissociative Identity Disorder, a Relational Approach* (2011). She's an associate editor of the *Journal of Trauma and Dissociation* and the co-director of the Dissociative Disorders Psychotherapy Training Program of the International Society of the Study of Trauma and Dissociation. Dr. Howell is an associate professor of Psychology at the NYU Postdoctoral Program in Psychotherapy and Psychoanalysis, faculty member of the Trauma Center of the Manhattan Institute for Psychoanalysis, and at NIP's trauma program. She writes and lectures widely on trauma and dissociation and is in private practice in New York City.

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