Therapeutic Hazards of Treating Child Alters as Real Children in Dissociative Identity Disorder

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ABSTRACT. Dissociative identity disorder (DID), with its typical etiology of extreme, repetitive childhood trauma, usually includes manifestations of childlike ego-states, among others. For many patients, these ego-states, originating with the initial traumatic insults to the psyche in childhood, have been called forth again and again as new situations evoke the earlier trauma. When clinicians, family and friends react to them with warmth, nurturing, and empathy, this may exacerbate the illusion that such ego-states are indeed actual children. This can result in a patient becoming increasingly resistant to working through the issues and experiences by which these ego-states have become fixed, with the risk of therapy reaching an impasse. Attitudes, interventions, and approaches to move past such impasses are addressed. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2004 by The Haworth Press, Inc. All rights reserved.]*

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Patients with dissociative identity disorder (DID), arguably the most severe of the dissociative disorders, may be among the most difficult of all psychiatric patients to treat. Clinical manifestations and degree of disability vary widely from person to person. Some patients may be quite functional in their work and relationships, with only isolated areas of disturbance that impact on their quality of life. Others may be so impaired that they cannot remain in one ego-state long enough to make and achieve goals, let alone meet their basic survival needs unassisted. Despite the variability in levels of functioning, one attribute most persons with DID demonstrate in treatment is the presence of childlike ego-states, parts or alters (Putnam, 1989; Fine, 1999; Krakauer, 2001; Shusta, 1999). The inappropriate treatment of these can make a very difficult disorder nearly impossible to advance towards any significant resolution.

THE BACKGROUND

Most experienced clinicians conceptualize the development of DID as stemming as from early childhood trauma including sexual abuse, which is commonly reported (Shusta, 1999; Ross, 1997; Kluft, 1996; Putnam, 1989). The typical scenario is that of a child who is severely and repeatedly traumatized at a vulnerable stage of ego fluidity and rudimentary ego formation, usually beginning before the age of five or six. Patients diagnosed with DID frequently report abuse by a perpetrator on whom the child depended upon for basic survival needs and therefore could not be avoided.

Pathological dissociation may begin as an adaptive response to intolerable experience. For example, the creation of another self-state enables the core of the traumatized child to avoid experiencing the abuse. Dissociation offers an immediate escape through the perception of having another self-state occupy the body, so that the other self-state-often referred to by clinicians as an alter-experiences the pain, suffering and terror of the trauma. This results in the core self-state-usually referred to as the host-subjectively perceiving the trauma as happening to the alter,

and the host may even have amnesia for the event. From an external point of view, the child, in its alter self-state, may appear to observers to be conscious and even cooperative, and may be mistaken for the host, but will tend to be more restricted in emotions and personality traits, with limited access to abilities and memories.

Repeated traumas are likely to elicit repeated emergence of the alter state. The more this happens, the more of the child's autobiographical memory will be stored in the alter state and the greater will be the host's amnesia, leading to an inability to recall significant parts of the past, which is consistent with theories of state-dependent memory.

When trauma is complex and repeated over an extended portion of the child's life, this process may recur repeatedly, resulting in numerous alter states, each containing certain autobiographical memories, skills, procedural and general knowledge, behavioral patterns, physical sensations, and emotions. These are the building blocks of DID. The host, and subsequent alters as a whole–if integrated–constitute a fully cognizant and functioning human being. The various parts taken separately have major deficits in self-awareness and functioning.

Persons with DID often report severe dysphoria and have a sense of feeling chronically victimized. Chu (1998) identifies this experience as part of a syndrome of "chronic disempowerment" and notes how pervasive its debilitating effects can be. What often results is an acute and recurring state of distress that Dell (2002) has labeled "neurotic suffering." Furthermore, DID patients may not experience symptomatic relief from treatment, as many receive incorrect diagnoses for years (Kluft, 1996; Putnam, 1989). Persons suffering from DID may receive inappropriate treatment for disorders they don't have including inappropriate medications, or even electro-convulsive therapy or long-term hospitalization. An astute clinician is required to be able to see past the voices and other pseudo-psychotic symptoms to identify these frightened trauma survivors with fragmented identities. Appropriate treatment can be remarkably successful with lasting results in the hands of a clinician with the experience and attitude needed to address the complex array of problems.

Finding a clinician who understands their internal experiences can feel very nurturing to DID patients. However, a nurturing stance must be tempered by impeccable boundaries, solid psycho-educational instruction, and well-timed and tactful confrontation of the change-resistant aspects of the patient's difficulties. Even though DID patients experience their lives as painful, the prospect of change may be so frightening that embarking on productive treatment may be very rocky

road indeed. It is along that rocky road that a particularly appealing type of self-state may emerge and distract all those involved–clinician, patient and the patient's loved ones alike–from the difficult work ahead.

WHAT CHILD ALTERS ARE AND WHAT THEY ARE NOT

Appealing childlike ego-states-so-called child alters-are often encountered in the personality systems of patients with DID. They can be cute, playful, disarming, frank, open, trusting, and loveable. They may be very emotionally expressive, with weeping, hiding, tantrumming, demanding, blaming and other challenging behaviors. They can be accessible and accepting of the treatment, engaging with the therapist much more than the angry, aloof, depressive, anxious, or numb adult parts. It is easy to like the "children."

These child alters can be identified by any or all of the following: childlike vocal tone and pitch, sing-song or stilted speech cadence, simple or naïve vocabulary, body language and posture including widely open eyes with raised brows, frankness or timidity, brief attention span and rapidly shifting focus, behavior such as playing with office objects, and childish affective tone. Putnam (1989) has observed, "Child personalities may be easily recognized by their nervous fidgeting, movement overflow, and childlike gestures (e.g., rubbing the nose with the back of the hand)" (p. 122). Child alters are so common in cases of DID that that every clinician treating the disorder, however briefly, is likely to have encountered them. Child and infant personality states often outnumber the adult aspects of a patient's system.

It is important to remember that the patient is an adult, despite the childlike ego-states. These parts are not actual children. I am in agreement with Ross (1997) who is of the opinion that "child alters are not packets of *childness* retained in a surrounding sea of adult psyche. They are stylized packets of adult psyche. . . . I hold the child alters responsible for their behavior in the same way as the adult host personality" (p. 147).

COMMUNICATING THE DIAGNOSIS

The treatment of DID is a lengthy process for a variety of complex reasons. Each ego-state has material to work through in therapy, some directly via the host, and some through work with other parts. Bringing

the disparate parts into mutual awareness can be an enormous challenge for the therapist. For example, some ego-states will never emerge in the therapy, and yet they must be part of the treatment process and can benefit by the treatment of the patient as a whole.

For the patient, the work is difficult and painful, often involving the connecting of autobiographical facts of traumatic experiences with split-off affective material and physical distress. Even the process of the patient acknowledging her fragmentation and dissociated experiences can be difficult and painful, and most patients struggle with this acknowledgment in the early phases of the work, and sometimes off and on throughout treatment.

Once a clinician has arrived at the diagnosis of DID, it should be presented to the patient for her to understand and accept. The explanation is often abstract and hard to grasp unless there is some specific mapping of the system. Different clinicians have different approaches. I have used a pie chart with sectors to represent parts or groups of parts and have the patient label these with names, types, and/or traits (Shusta, 1999). Fine (1999) has the various personality fragments write their names on a blank page, organized around a central host part. Fraser (1991), with his Dissociative Table Technique, will have a patient visualize the parts seated around a conference-type table, and then the therapist and patient can diagram the parts. Braun's BASK model (as adapted by and cited in Fine, 1999) may help patients appreciate the complex nature of their minds and the geography of sequestered behaviors, affects, sensations and knowledge (memories).

One way of fostering knowledge of a host's other ego-states is through sharing the results of screening tools, such as the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), the Dissociative Disorders Interview Schedule (DDIS; Ross et al., 1989) or the Multidimensional Inventory of Dissociation (MID; Dell, 2002). When reviewing the MID report with the patient, including its useful charts, graphs and observations, the therapist can introduce the concept of the various types of alters and how these appear to be distributed across this particular patient's system. In my experience, most patients agree with the findings.

Another clinical intervention I have found successful is what I call the "window-blind technique," which, like Fraser's Dissociative Table Technique (Fraser, 1991), involves visualization of one's other ego-states. The patient is asked to visualize a wall with a window, the blinds drawn. She is told that other parts of the system are on the other side.

The patient is asked to twist the wand of the blind slightly and look through and report what she sees, as in the following vignette:

> A patient with persistent adult-specific denial of the existence of other parts continued to take issue with the assessment that she suffered from DID. Review of her high DES score and some of her answers failed to convince her. I would again and again relate to her what I observed in session to support the diagnosis, including childlike behaviors, affective tone, vocabulary and vocal tone and pitch. I also reported to her that she would gather up stuffed toys and interact with them very much as a child would. My reports of these observations seemed to do little to satisfy her that my diagnosis was correct. Eventually we tried the window-blind technique using guided imagery. I started by addressing the issue with her child parts. One of her childlike parts looked through the window and saw adult alters "moping," appearing depressed, with shoulders stooped and heads hanging down, defeated, hopeless and alone. Tears rolled down her face as she said, "It's so sad." Then, one of her adult parts looked through the partially opened blinds and glimpsed a group of little girls playing a colorful children's board game, having fun down on the floor. Seeing them, she suddenly grasped the concept of *not knowing* as being part of the disconnection of dissociation. Following this exercise, she found tears on her cheeks and wondered why. She was told that one of the child parts had seen her and felt compassion for her pain. She was amazed. This was a very difficult but invaluable turning point in this treatment. The technique was used several subsequent times with this patient to help her view her dissociation more objectively. This seems to accomplish in part what videotaping can do, without presenting the dilemmas videotaping can entail.

CHILD ALTERS: HOW THEY ENDEAR

There are many terms for the parts of a dissociative patient's ego system in current use among clinicians and their patients. Some terminology emphasis the differences of the parts (*alter* is Latin for "other"), e.g., alters, others, personalities, alter personalities. Other terms emphasize the states of a single entity, e.g., ego-states, self-states, and still others emphasize the partitioning, e.g., parts, aspects, fragments. Whatever

the terminology, there are many types of parts that are commonly encountered, and a variety of ways of classifying them. Dell (2001, 2002) describes child alters and four others types. Putnam (1989) describes child alters and about 15 other types.

All aspects of the DID patient's personality system can present challenges in treatment. Why, then, single out child alters for attention here? For the very reason that they can be so engaging in treatment–often sweet, vulnerable, guileless, and endearing. Even when mischievous or even malevolent, child alters can be disarmingly intriguing to treat. These very endearing qualities tend to reinforce the activity and appearance of child alters in treatment. For example, a patient with low self-esteem may be self-effacing and reticent about interacting with the therapist. A child in the system may pop out suddenly and exhibit a refreshingly contrasting boldness and curiosity that is captivating to the therapist. In another situation, a diagnostician, conducting an interview in search of historical material and other data with which to better understand a new patient, might be seen as a stern authority figure due to a serious and no-nonsense demeanor. A childlike part may emerge and evoke a response in the clinician as the patient changes from being constricted and despondent to a more physically active, curious, brighter and engaging presentation. The clinician unbends and reacts to the "child" in familiar ways, responding with more warmth and simpler speech. Thus, child self-states elicit and reinforce nurturing and care-taking responses on the part of therapists.

CASE EXAMPLES OF MISTAKING THE PART FOR THE WHOLE

The following are some clinical illustrations that illustrate some of the pressures that face therapists and others, leading to the hazards of treating of child alters as if they were actual children.

> Miss P begins treatment with a new therapist who is known to be experienced in treating DID, and in the first session regresses into a little-girl ego-state and attempts to climb onto her therapist's lap. When this is not permitted by the therapist, the patient breaks into sobs and says that her other therapist did this and she "needs" to be held in order to heal. The bewildered therapist finds herself facing an enraged adult ego-state who fiercely says, "The kids need to be held, and Dr. So-and-so used to do it. If you aren't going to hold

us, we will find someone else who will." Miss P storms out of the office.

Mrs. D is an engaging patient with adult and child parts who are frequently referred to and often witnessed in the treatment hour. She has done a lot of work with other therapists in the past, and she seems insightful about her DID, its etiology, and her need to confront past traumas. She comes in one day, horribly offended by a close friend who knows she has DID, because the friend suggested they go see a new animated children's movie featuring monsters. The patient sobs, "She said, "monsters"! How could she do that to the kids? She knows we can't handle that. The kids were terrified!"

Ms. A discloses that she has gifts for each of her many child alters under the Christmas tree, and speaking indulgently of these parts by name, says that these are "surprises." She admits she has spent hundreds of dollars she cannot afford to provide all these holiday gifts and now has to borrow from an annoyed family member just to pay her rent. Because she has catered to the material wants and once-appropriate age-specific "needs" of her child alters, her apartment looks more like a day-care center or toy store than the residence of a woman in her 30s, and she consequently refuses to invite any of her friends over. If someone succeeds in getting through the front door, Ms. A lies about the array of toys and other accoutrements, saying she watches a neighbor's children. Her lies are usually seen as such quite readily, but the truth is the last thing to occur to anyone else. Most simply see Ms. A as "crazy" or bizarrely deceitful. She lives a life of extreme isolation, her most meaningful relationships being with the "others" within herself.

Miss T has individual and group therapy with a clinician who considers herself an expert in the treatment of DID. The therapist throws a child's holiday party for the group every year, with juvenile favors, lots of candy, children's games, and gifts appropriate for latency-age children. The therapist insists she is providing a reparative emotional experience as a benign parent figure. The adult aspects of these group members find the experience boring and inappropriate, but feel guilty about this reaction, feeling they must "owe it to the kids" to go along. They also feel grateful that their therapist understands their DID and wants them to be happy. Eventually the more adult parts of the system retreat deep into the

> background so as to not interfere with the fun the "kids" are having. As the patients work individually with the therapist and begin to address the reasons for dissociative barriers between and among ego-states, the child-skewed party seems less relevant and less fun. The participants feel let down and "don't want to do this anymore." Several of them begin to confront this in their treatment and the therapist is forced to reevaluate her techniques and attitudes.
>
> Ms. G is dating an older man who is married. She has tried to break it off countless times, but he always wins her over again by playing to her more endearing childish aspects. He takes her out to a fast-food establishment that provides special meals, each including a toy, for children, and he buys her one of these. By catering to her child alters' bottomless need for nurturing, he manipulates Ms. G into spending time with him and usually succeeds in engaging in sexual activity with her, reenacting her childhood traumas of being seduced with favors and gifts into having sex with older men. When they have such an encounter, Ms. G regresses, falls into a deep depression, and entertains ideas of suicide.

CHILD ALTERS: DOTING DURING THERAPY

Patients who have accepted a DID diagnosis and have begun to observe their dissociative switching with greater awareness can become very fond of their child parts, almost as if they were having an adult-child interaction with another person. The same mechanism that thaws the somber professional can penetrate the bleak experiences of an isolative abuse survivor. Why wouldn't anyone welcome such an experience? Ironically, just as a group of adults may each feel differently about children and vary in their levels of comfort in their presence, attitudes towards alters and groups of alters can vary widely within a single patient. In reality, the doting attitudes towards child alters found within a patient's personality system may have evolved only after a great deal of denial and general unwillingness to tolerate or even acknowledge their existence in the system. Doting can be seen as a natural developmental point on the way towards resolution, but it is certainly not a stance that should become permanent, for either the patient or the professional. Before some healthy unbending and doting occurs, it is not uncommon for other aspects of such a system to say in session, "That

bratty kid is here again," "I wish she would just go away!" or "You won't believe what that kid has done!" Besides misbehavior–the sort that is natural for children but so very annoying to some adults–child alters also aggravate adult parts with their extreme neediness. Just as the patient's own parental figures failed to understand and meet age-appropriate childhood needs, the harsh adult parts within recapitulate the failures of the past by denying need in the present. Punishing consequences may be exacted, such as no dinner or terrifying time alone in the closet.

Punishing is usually a cruel reenactment of past harsh treatment at the hands of caretakers, and this type of dysfunctional intrapsychic interaction must be confronted by the therapist and more viable alternatives broached. The work may involve bringing the patient around toward a more family systems approach toward the DID (Chu, 1998), stressing that the safety of the "children" is ultimately in the domain of the patient herself, and not that of her therapist, psychiatrist, parents, partner, employer or friends. The fact that there is only one body despite feelings to the contrary is sometimes a very difficult truth to accept for DID patients.

REAL WORLD SAFETY CONCERNS

When childlike ego-states frequently emerge and no adult part is "minding the store," the patient as a whole is vulnerable. Stressing this vulnerability should be a paramount concern. Putnam (1989) recommends holding the patient responsible for her own safety and overall well-being, despite the frequent emergence of childlike states. Although it is important to reinforce personal responsibility, autonomy and adult capabilities, it is also crucial to confront and deal effectively with child alters in terms of safety and well-being. Before developing an understanding and willingness to exercise sufficient caretaking and nurturing behaviors, adult parts may be in the habit of routinely "abandoning" their child parts by failing to take any responsibility for their safety and comfort. This can be an unpleasant but poignant reenactment of the original poor parenting and even of overt hostility. These kinds of situations can lead to serious consequences, as childlike ego-states may lack access to or at least awareness of adult motor skills and/or procedural memory. For example, a patient who dissociates into a childlike ego-state while driving a car may not have enough command of the body's musculature or reflexes to react safely. The following are additional examples:

> A patient with early multiple sclerosis was in too much pain to drive to an appointment. An adolescent alter got in the car and kept the appointment, fortunately without incident. When questioned, the patient admitted to noticing slower-than-usual reaction times behind the wheel and an increase in pain later on. It was necessary to confer with her and her partner in a collateral session to bring into their awareness the problems with poor judgment and anesthetic ego-states she sometimes experienced.

> A patient began experiencing falls when integrating, due to switching ego-states and to the unfamiliar blending of parts. This was a particular problem while she was in the midst of performing tasks involving climbing, coordination and balance. In therapy, it was necessary to discuss her evident increased vulnerability and plan for it. She agreed to ask another adult to help her if she felt the need to get to an object high off the floor. This was difficult for her, because she wanted so badly to be self-sufficient. One day while home alone, she climbed on a chair to reach something high on a shelf, lost her balance and suffered a bad fall.

Many DID patients report being accident-prone or having a series of inexplicable injuries. Although some of these injuries are may be self-inflicted, many are due to patients experiencing depersonalization or derealization, or being internally preoccupied. Because of the potential for life-threatening or disabling injuries, it is wise to caution severely dissociative patients about the dangers of using ladders or stepstools, standing on chairs, or otherwise engaging in activities where falling could be dangerous. They should recognize the possible need for another competent and supportive adult friend or family member to be present at the time. Caution is also needed for such mundane activities as crossing busy streets or traveling by public transportation (Shusta-Hochberg, 2003). At the very least, adult parts to be in charge of the body and safety needs at such times.

Medication also warrants a word of caution concerning the behavior of child alters. If a patient cannot manage to have adult parts dispense medications reliably, a visiting nurse or medication aide may be indicated. A prudent clinician should remain vigilant for any indications that child alters are putting the patient's physical safety at risk.

REPARENTING

Reparenting is an approach in which a therapist attempts to provide the nurturing and caretaking that was never provided by abusive or neglectful parents, with the belief that such efforts will allow the patient will heal. However, Putnam (1989) has observed,

> . . . the Reparenting process must occur from within the multiple. The adult personalities must come to first acknowledge and then ultimately protect, care for, and raise the child alters. . . . The adult alters learn to let the child alters "out" at appropriate times in appropriate contexts and to provide the child alters with nurturant experiences. They also learn to help the child alters share dissociated traumatic experiences that so many of them hold. (p. 193)

Similarly, Fine (1999) warns, "A therapy primarily geared to satisfying the needs of child personalities in order to give them a corrective emotional experience, in the reparenting sense, is usually misguided" (p. 376).

When receiving a new patient who has worked with one or more previous therapists explicitly on DID symptomatology, the clinician may find that the system is rigid and resistant to movement toward integration or any sort of resolution. Clinicians may sense an attempt to mold their interventions arising out of the difference between past and present therapists, such as, "The kids didn't like it when they heard . . ." or "It scares us that you said such and such a word; did you forget the kids were listening?"

The host may misinterpret integration as death, saying something such as, "We love the kids. We're never going to integrate. It's not fair that they have to die." This "death fear" is a concept that needs to be confronted and reinterpreted in treatment, and the fact stressed that no part of a patient's personality system is going to be, or can be, "killed off." This can be stressed even while ego-states may perceive themselves becoming weaker and feel sad that their individuality is ending.

It helps to explain that each part contains essential aspects of the person's whole self. The separateness among parts will diminish as the differences are resolved, and the need for that separateness will eventually recede to the point that the walls between them come down. The host may not experience herself as switching into dramatically different states anymore, but she will retain access to her childlike joy, to ladylike decorum or to a more "macho" demeanor, as situations warrant.

A VIEW FROM INSIDE A SYSTEM

Perhaps the best illustration of the dilemmas facing patients with prominent child alters is a view from inside a patient's internal system:

> A patient with an arduous treatment history, involving many different clinicians in inpatient and outpatient settings, struggled with many child alters. Excessive doting by clinicians and by the patient herself towards her child parts had presented obstacles to progress. She worked hard to take responsibility for her feelings and behaviors despite long periods of chronic disempowerment and extreme neurotic suffering. After years of hard work and making broad strides toward resolution of her DID, her child parts summarized their predicament as follows: "It's hard for the bigger parts to take us seriously. It's hard to be out in a grownup body, especially in the early days of awareness of the DID. The protectors want to protect us too much *now* from reality, and we can deal with it *now*. They are *over*protective and there's no need to be. We are as much a part of the whole system as the other parts and want to be equal. As the walls come down, we can share our childlike joy with those (older parts) and they won't close us out. We can tolerate their seriousness. And we're able to comfort them, not only them comforting us. They can hold us but we can comfort them, because they need to be loved, comforted, or forgiven. Barriers are coming down. It's mutual."

CONCLUSION

Therapists may engender therapeutic impasses by misinterpreting child alters as real children. One might suspect that this is occurring when the treatment becomes bogged down with excessive caretaking of these alters and fails to address the difficult work of trauma resolution. This is especially significant because child alters are often the holders of vital historical material regarding the etiology of the disorder. Mapping the system, assessing the types of alters in each patient, and which type seems most prevalent, will give the clinician a great deal of valuable information. In patients who have prominent child alters, successful treatment will require particular considerations. Caring and empathic validation must be counterbalanced by psycho-educational efforts. The patient must understand that child alters cannot be allowed to control

the overall personality system, having whatever they want whenever they want it, and that their judgment is often the inadequate judgment of a child-overly trusting or fearful, hedonistic, impulsive, concrete, simplistic and/or naïve. Reparenting treatment that is limited to nurturing and support is doomed to fail, if the treatment goal is achieving independent adult functioning.

Many therapists who become proficient and effective in the treatment of DID have, at some point, unwittingly or misguidedly acted as if child alters were real children, or encountered similar stances in another clinician's work. In either case, the misinterpretation fosters resistance to healing. But, we also learn best by our own mistakes. It seems to be our human lot to learn more from our own stumbling than from that of others. At least we can hope to recognize our stumbling for what it is and make the mid-course corrections necessary to help make the rest of the therapeutic journey ultimately successful for the patient.

REFERENCES

Bernstein, E.M., & Putnam, F.W. (1993). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, *174*, 727-735.

Chu, J.A. (1998). *Rebuilding shattered lives: The responsible treatment of complex post-traumatic and dissociative disorders*. New York: John Wiley & Sons.

Dell, P.F. (2001). Should the dissociative disorders field choose its own diagnostic criteria for dissociative identity disorder? Reply to Cardeña, Coons, Putnam, Spiegel, and Steinberg. *Journal of Trauma and Dissociation*, *2*(1), 65-72.

Dell, P.F. (2002). Dissociative phenomena of dissociative identity disorder. *Journal of Nervous and Mental Disease*, *190*, 10-15.

Fine, C.G. (1999). The tactical-integration model for the treatment of dissociative identity Disorder and allied dissociative disorders. *American Journal of Psychotherapy*, *53*, 361-376.

Fraser, G.A. (1991). The dissociative table technique: a strategy for working with ego states in dissociative disorders and ego-state therapy. *Dissociation: Progress in the Dissociative Disorders*, *4*, 205-213.

Kluft, R.P. (1996). Treating the traumatic memories of patients with dissociative identity disorder. *American Journal of Psychiatry*, *153*(7) Festschrift Supplement, 103-110.

Krakauer, S.Y. (2001). *Treating dissociative identity disorder*. Philadelphia: Brunner-Routledge (Taylor and Francis).

Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford Press.

Ross, C.A. (1997). *Dissociative identity disorder: Diagnosis, clinical features, and treatment of multiple personality*. New York: John Wiley & Sons.

Ross, C.A., Heber, S., Norton, G.R., Anderson, D., Anderson, G., & Barchet, P. (1989). The Dissociative Disorders Interview Schedule: A structured interview. *Dissociation: Progress in the Dissociative Disorders*, *11*, 169-189.

Shusta-Hochberg, S.R. (2003). Affect of the World Trade Center disaster on a Manhattan psychotherapy practice. *Journal of Trauma Practice*, *2*(1), 1-16.

Shusta, S.R. (1999). Successful treatment of refractory obsessive-compulsive disorder. *American Journal of Psychotherapy*, *53*, 377-391.

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