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How do patients diagnosed with dissociative identity disorder experience conflict? A qualitative study

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Abstract

The role and nature of conflict in the development and manifestation of dissociative identity disorder (DID) remains underexplored beyond theoretical deduction. In this qualitative instrumental case study, we explored the subjective experience and nature of conflict in a group of adult psychiatric patients diagnosed with DID. We purposively selected typed transcriptions of 28 previously recorded in-depth individual interviews with 15 patients, their audio recordings and associated field notes. The data were thematically analysed and constant comparison was applied. Two main themes emerged from the transcriptions, namely, participants' experiences of having one or more incompatible and conflicting worldviews about their DID, and the type and nature of conflict that arises between dissociative identities, i.e., conflict of information in awareness, conflicting actions or behaviours, conflicting emotions, conflicting goals, conflicting values, and a battle of wills. Patients with DID have contextually and culturally variable comprehension of the origin of their DID. Conflict between dissociative identities was pervasive, multifaceted, and exacerbated by a lack of awareness between identities. The study provides insight into the complexities of conflict between dissociative identities, as well as highlights the role of inter-identity awareness in conflict.

Keywords: dissociative identity disorder; psychiatry; psychopathology; qualitative methods; adults; clinical samples; dissociation; inpatient; multicultural beliefs; sociocultural differences.

Although our understanding of dissociative identity disorder (DID) has improved (Brand et al., 2016; Dorahy et al., 2014; Şar, Dorahy, & Krüger, 2017), the role of conflict in the development and manifestation of DID is largely unexplored in empirical studies. Although conflict has been partially addressed in several aetiological theories of DID such as the Betrayal Trauma Theory (Freyd & Birrell, 2013); Attachment Theory (Blizard, 2003; Liotti, 1999; Sachs, 2013); Discrete Behavioural States Model (Putnam, 2016); and Structural Dissociation of the Personality (Steele, Van der Hart, &

Nijenhuis, 2005; Van der Hart, Nijenhuis, & Steele, 2006), few studies have specifically addressed the role and nature of conflict in the development and manifestation of DID.

A full overview of how conflict in DID is conceptualised by different schools of thought is beyond the scope of this article, however we briefly refer to a few theories to provide context.

Betrayal Trauma Theory highlights betrayal of trust as a driver for the formation of dissociative identities (Freyd & Birrell, 2013). Conflicting experiences with 'caregiver' and 'abuser' cannot be held in consciousness simultaneously. These conflicting experiences cause the child to choose one experience over the other, thereby dissociating the other from consciousness (Freyd & Birrell, 2013).

According to Attachment Theory, severe childhood relational trauma may cause children to cope by developing multiple internal working models or dissociative identities (Blizard, 2003; Liotti, 1999; Sachs, 2013). Sachs (2015) argues that non-dissociative individuals who have conflicting experiences, such as feelings of fear and safety, may resolve these conflicts through great internal struggle. In contrast, someone with DID may experience internal conflict as external and explicit conflict between their dissociative identities. When a person with DID is unaware of their other identities, external conflict may be battled blindly as they may not know who is opposing their actions (Sachs, 2015).

Putnam's Discrete Behavioural States (DBS) Model asserts that in one person, dissociative identities may have limited awareness of each other and may act in conflicting, opposing and self-defeating ways (Putnam, 2016). Dissociative identities may have their own sense of self, and may have conflicting emotions, past experiences, goals, memories, and behaviours. Identity states may also embody different

developmental phases related to past traumatic experiences that led to the development of the dissociative identities (Putnam, 2016).

The theory of Structural Dissociation of the Personality maintains that patients with severe structural dissociation, may struggle to reconcile conflicting goals, thoughts, feelings, and life roles (Steele et al., 2005; Van der Hart et al., 2006). Such an individual may also struggle to acknowledge these conflicts, further dissociating from any conflicting information (Steele et al., 2005; Van der Hart et al., 2006). It is possible for dissociative identities to have their own first-person perspectives of their view of self, their world and how they relate to their world (Nijenhuis & Van der Hart, 2011).

Underlying these aetiological theories of DID is the concept of 'trance logic', coined by Orne (1959) in the context of the hypnosis literature, which refers to the ability of a person in a trance state to "mix freely his perceptions derived from reality with those that stem from his imagination and are perceived as hallucinations. These perceptions are fused in a manner that ignores everyday logic" (Orne, 1959, p. 295). This concept has been applied widely to the psychotherapeutic treatment of severely dissociative patients (see for example, Chefetz, 2015; Van der Hart et al., 2006).

Trance logic in a patient with DID manifests as the juxtaposition of logically incompatible elements of their experience without anxiety (Chefetz, 2015). The patient is unaware of the conflict, or pre-conflictual. The aim of psychotherapy includes an exploration of the dissociated mental contents, to develop awareness and tolerance of the conflict (Chefetz, 2015).

According to Chefetz (2015), theoretical deductions need to be developed in two ways. Firstly, he argues that the dissociative process should be investigated to explore conflicts in terms of specific interests, qualities, attitudes, and views between dissociative identities to resolve tension and eventually integrate states. Secondly, he

argues that qualitative inquiry is important to understand the subjective experiences of dissociation and DID (Chefetz, 2015, p2).

Studying the subjective experience of conflict in participants who by the nature of their disorder might be unaware of their conflicting experiences, would present a challenge in the sense that conflict might be more the problem of the observer than of the patient. Such subjective qualitative inquiries would, however, lay the groundwork for exploring empirically the role of mutually exclusive and conflicting dissociative identities in developing and maintaining DID. Rich descriptions of other patients' experiences may also help clinicians better to understand and treat their patients.

This study explored the subjective experiences of conflict and the nature of conflict in a group of adult psychiatric patients diagnosed with DID which will contribute to further theoretical deduction.

Methods

Qualitative research approach

In this study, a qualitative research approach facilitated an in-depth understanding of the underexplored, subjective experiences of conflict of patients diagnosed with DID (Creswell, 2013). We adopted the paradigm of interpretivism according to which realities are socially constructed, hence subject to change, and may be multiple (Creswell, 2013). In-depth descriptions were analysed in line with interpretivism.

Research design

This study was designed as an instrumental case study focusing on conflict in DID (Creswell, 2013). The bounded system or case of the study was a set of previously transcribed in-depth interviews with 15 adult patients diagnosed with DID or other

specified dissociative disorder (OSDD).

Sampling, participants and data collection

We purposively sampled the typed transcriptions of previously recorded in-depth individual interviews of 15 adult patients with DID/OSDD, who were anticipated to have subjective knowledge of the phenomenon of interest.

The in-depth interviews were conducted between 2013 and 2016 as part of a broader mixed methods study (Krüger & Fletcher, 2017). Preliminary qualitative analyses of interviews with 14 patients with DID/OSDD were described in Krüger (2016). Following Krüger (2016), another patient with DID was recruited to the study, bringing the number of patients with DID/OSDD to 15.

The patients with DID/OSDD were identified from 116 psychiatric in-patients, 58 patients each from a specialised, academic state psychiatric hospital and a regional hospital rendering primary psychiatric care. Fifteen patients met the DSM-5 criteria for DID or OSDD (American Psychiatric Association, 2013). Patients were diagnosed using a combination of instruments: the Dissociative Experiences Scale (DES) (Carlson & Putnam, 1993), Multidimensional Inventory of Dissociation (MID) (Dell, 2006), Structured Clinical Interview for DSM-IV Dissociative Disorders – Revised (SCID-D-R) (Steinberg, 1994), and clinical psychiatric interviews. The latter also confirmed that no other psychiatric disorders, including psychotic disorders, were present.

A clinical summary of the 15 research participants is presented in Table 1, and gender and employment are described in Table 2. Three patients diagnosed with OSDD had clear dissociative identities but did not meet DSM-5 criteria for DID.

Table 1. Clinical summary of research participants

Patient No.	**Docu-ment No.**	**No. of inter-views**	**Age**	**Gender**	**Language of inter-view**	**Diagnosis**
Pt1	D1	1	26	F	E	DID
Pt2	D2	1	35	F	A	DID
Pt3	D3-4	2	33	F	E	DID (with possession)
Pt4	D5	2	23	F	A	DID
Pt5	D7-10	4	41	F	A & E	DID, and conversion disorder (with seizures)
Pt6	D11	1	30	F	A	DID (with possession) , and conversion disorder (with seizures)
Pt7	D12-13	2	54	F	E	DID
Pt8	D14	1	41	F	A	DID, and conversion disorder (with seizures)
Pt9	D15-16	2	45	F	A	OSDD
Pt10	D17	1	19	F	E	OSDD, and conversion disorder (with seizures)
Pt11	D18-19	2	39	M	A & E	DID
Pt12	D20	1	33	M	E	OSDD
Pt13	D21-22	2	42	M	A & E	DID
Pt14	D23	1	21	F	E	DID (with possession)
Pt15	D24-28	5	27	F	E	DID (with possession)

Abbreviations: Pt=Participant; D=Document number; F=Female; M=Male; A=Afrikaans; E=English
Table 1 is authors' own creation.

Table 2. Distribution of participants in terms of gender and occupation

Occupation	Female	Male
Unemployed	8	2
Personal assistant	1	0
Security guard	1	0
Land surveyor	0	1
Administrator	1	0
Student	1	0

Table 2 is authors' own creation.

In this study, we analysed data from 28 in-depth interviews conducted with 15 patients, including audio recordings, transcriptions, and associated field notes. The

original semi-structured interview guide explored the events leading to hospitalization, current life circumstances and problems, specific dissociative and other psychiatric symptoms, possession and trance symptoms, experiences relating to identity, roles and role conflict, spiritual experiences, and experiences around information processing. The interview guide was iteratively adapted in subsequent interviews, depending on the themes that emerged in previous interviews.

Data analysis

The data were thematically analysed, allowing for flexibility and freedom from any pre-existing theoretical framework (Braun & Clarke, 2006). We analysed the first-person, subjective experiences of patients outside of the different aetiological theories of DID. We uploaded the data to Atlas.ti to facilitate data management and analysis. The entire data set was coded. We read each interview transcript carefully, which was followed by inductive, open coding. Codes were grouped into categories and sub-categories through axial coding, based on similarities and differences within a single interview and between interviews. Themes were developed by describing and re-analysing latent patterns formed by combining categories across participants' transcripts. The themes described how patients with DID experienced conflict.

Trustworthiness of the research

We used six of Creswell's suggested validation strategies for qualitative researchers to ensure trustworthiness, rigour, and credibility (Creswell, 2013). All cases were analysed, even negative cases. Triangulation was ensured by reviewing audio recordings and field notes for information not captured in the transcriptions. Peer debriefing was achieved through regular meetings, where researchers discussed the research process. Rich thick descriptions and verbatim quotes were used as far as word

count limits allowed. A clear audit trail was captured in Atlas.ti of all decisions regarding coding, merging codes and consolidating themes. Personal researcher reflections were written but not included due to space constraints.

Ethical considerations

This research was approved by the Faculty of Humanities Research Ethics Committee and Faculty of Health Sciences Research Ethics Committee. All participants signed written informed consent before participating in the study after the study had been explained to them. Participants' data were collected anonymously to protect their identity. All research data were stored securely according to the university's policies. All precautions were taken to safeguard the participants from unjustifiable risk or harm.

Findings

Two themes emerged from the data, namely, that participants experienced having one or more incompatible and conflicting worldviews about their DID, and that there was conflict between their dissociative identities. Participants were assigned numbers or pseudonyms to protect their anonymity. Space constraints limited the number of examples that could be accommodated.

Theme 1: Conflicting worldviews used by participants to understand their DID

In this theme, worldviews referred to participants' specific beliefs about the origin of their DID, or how they made sense of their dissociative experiences. Participants did not have static worldviews, which were better described as being varied, multiple and conflicting at times.

Participant three (33-year-old woman) described having recurrent possession experiences in church or healing contexts. Her possession experiences were

characterised by fainting spells, seizures, and aggressive behaviour. The participant made sense of her possession experiences in three ways.

The participant's first worldview was informed by her church affiliation, where her experiences were described as demonic possession.

> It's hard for me just because when I'm at church they will tell me that I have the demons and they will pray for me. But after, the same thing is always happening and I wonder, why in different churches they are always praying for me and even the prophets are always praying for me but when I go again the same problem is still there, why this problem doesn't end. (Pt3:D4:Par201)

Her second worldview was framed by her African traditional background. She had been told by a traditional healer that her ill health was due to her ancestral calling to become a sangoma (diviner) or prophet.

> And when I go to the sangomas they will tell me about, it is a calling and even the chest pain I have and the headache, they will tell me that it's from the calling. (Pt3:D4:Par201)

The participant's third worldview was framed by the belief that she had been bewitched by a traditional healer because someone had wished bad fortune upon her. The participant described this bewitchment as the tokolosh, a dwarf-like mischievous spirit with baboon-like features (Du Plessis & Visser, 2012).

> Int: And this, um, do you feel like you are possessed by something or somebody?
> Pt: Yes.
> Int: Who do you think it is?
> Pt: I'm not sure. Like they, they say in black people, the other people like they are witching and they can put something like a tokolosh, they call it tokolosh, so I… my mind always thinks like it's true just because each and every day, each and

> every dream I have I'm always having a baby boy. I'm always having a baby boy with me on my back. Each and every time. (Pt3:D3:Par396-403)
> Pt: Because tokolosh is a thing, a small person, a small person like this, but a big person but small like this. And then they sometimes say people they put you that thing and you will have bad lucks wherever you go… and whenever you are dreaming a baby, a baby boy, they say there is a tokolosh. (Pt3:D3:Par423)

Bewitchment and the tokolosh are common South African culture-bound idioms of distress that are not necessarily an indication of any mental disorder. This participant was also not psychotic on clinical psychiatric evaluation.

This participant experienced difficulty in navigating her conflicting worldviews because none of these worldviews seemed to bring any real relief from her pain or problems (see the quotations above: Pt3:D4:Par201).

This theme showed how participants diagnosed with DID experienced having one or more incompatible and conflicting worldviews about the origin of their DID. Their worldviews depended largely on their unique social, cultural and ethnic backgrounds. Each worldview explained their DID in unique ways. Some patients did not seem to recognise the conflict that existed between their different worldviews. For some patients, being aware of their conflicting worldviews brought anxiety, yet for other patients the prospect of alternative worldviews brought relief.

For these patients, worldviews differed according to their socio-cultural background and were shaped according to their unique experiences. While participants' unique worldviews apparently interacted in unique and complex ways, participants uniformly experienced some confusion and difficulty in reconciling all the possible explanations for their DID.

Theme 2: Conflict between dissociative identities

Invariably, conflict between dissociative identities arose when identities had

incompatible thoughts, feelings and/or actions. Some participants described explicit conflict between their dissociative identities, yet other participants were seemingly unaware of the conflicts and inconsistencies in their thoughts, feelings, and actions. This theme had six sub-themes, including conflict of information in awareness, conflicting actions or behaviours, conflicting emotions, conflicting goals, conflicting values, and conflict of control.

Conflict of information in awareness

Conflict of information in awareness arose when one identity withheld information from another, potentially impeding everyday functioning and decision-making.

For example, Participant 15 (27-year-old woman) described an explicit conflict between herself and her childlike identity who withheld important information about her past. She believed that this information was the missing link in her life and that this information was needed for her to form a more unified self.

> But there's so many different conflicts that daily, daily things that I'm trying to, um, that I, that I argue with in my mind. Right now what's happening is that I have a, another part of me that's like a little child and I call that child Difficult Child. And so I always feel like Difficult Child hides things from me so I'm trying to remember things now, but I'm struggling and I feel like Difficult Child is standing in between me and my real self… (Pt15:D25:Par61)

Participants experienced different conflicts of information in awareness, with different identities withholding different types of information. Information conflicts may be sustained by a lack of communication between identities and the need for self-preservation, where one identity may withhold traumatic information from the other identities.

Conflicting actions or behaviours

Participants described having dissociative identities that behaved in conflicting ways. One identity may behave in a manner that other identities perceive as foreign or problematic. Participants described several behavioural conflicts, including stealing, damage to property, sexual behaviour, and aggression towards self and others.

In a case of stealing, Participant seven (54-year-old woman) described an occasion where her child identity took control and walked out of a store without paying for items. She explained that her child identity did not know how to do anything, often got lost and was confused about how things worked in the world. The participant did not want this to happen to her, but in situations where she felt overwhelmed her child part often took control.

> Pt.: Like one part of me is a small child and that's really scary because that small child just can't do anything. It doesn't know how to buy in shops or anything like that. So sometimes it takes over, I don't know why.
> Int.: Mmm.
> Pt.: Like, I don't know why they threw pots at me. Like I, I just want to be a normal person but like this other small child takes over and it just walks out with things. And then nobody would understand. It doesn't know it's got to pay, or anything. It just sometimes in the shop, like the colours are so bright and everything and all that, then I just follow this little child in that shop. Because it's so overwhelming and then suddenly I am a small child and I just cry. (Pt7:D13:Par161-166)

The other participants described similar experiences, with one identity behaving problematically with the other identities not condoning the behaviour. Often a host identity did not accept that the behaviour might belong to itself, and therefore ascribed it to someone or something else.

Conflicting emotions

Participants reported sometimes having different or conflicting emotions. For example, Participant 10 (19-year-old woman) described having two parts of herself with very different ways of feeling. She was usually an anxious and quiet person who struggled to interact socially, while her other identity was a happy, playful child. Her child part quickly vanished into her quiet and anxious part:

> Int.: So this child, the happy part, doesn't come out a lot?
> Pt.: No. It does not a lot. And even if it does it doesn't last as long as the quietness lasts… Just for a little bit and then, let's say like if something bad happens or if I get, um, maybe someone speaks bad to me or hurts my feelings mostly, then that happy child just, you know, vanishes away and like it's not known in me. I mean that's when like the quietness just fills my whole emotions. (Pt10:D17:Par754-761)

Several participants described having identities that displayed different and conflicting emotional patterns. Although participants described being aware of their different emotions, their unique identities would experience unique emotional patterns.

Conflicting goals

Conflicting goals arose when one identity had goals that were incompatible with the goals of their counterpart/s.

Participant 15 (27-year-old woman) described three different dissociative identities with conflicting goals. Nandi (pseudonym), the identity that felt most like herself, had the goal of staying admitted in hospital to receive treatment for her illness. However, the participant's second and third identities, Hannah and Kelly (pseudonyms), felt differently about being admitted to hospital and what this might mean for their future. Hannah wanted to go home as soon as possible and carry on with her life and

work towards a future. Alternatively, Kelly wanted to rekindle her relationship with her much older and financially well-off ex-boyfriend to get out of hospital.

> Um, for instance when I was admitted in hospital, me as Nandi, I will have decided, I would have wanted to stay admitted in hospital to finish my time and my treatment in hospital, but the battle was that, the, the part of myself that I call Hannah, just wanted to take control of the situation, wanted to go home, wanted to start a new life like immediately. And the part of myself that's Kelly want.., was sure that she can mend the relationship with her ex, to make sure that I just, just to make sure I get out of hospital. And so I have conflicts, conflicts like, like, like, like that with myself… (Pt15:D25:Par53)

In patients with DID, the respective identities may have mutually exclusive goals that cannot be reconciled to benefit the whole self. For one identity to achieve their goals, for example, the goal of getting out of hospital or working towards a future, the other identities must sacrifice their goals, which could even harm the whole self.

Conflicting values between dissociative identities

Different identities may have conflicting values if one identity has a belief that conflicts ideologically with the beliefs of other identities. Conflicting values were particularly evident when one identity tried to force their values or beliefs onto one or more of the other identities.

Participant one (26-year-old woman) described having several identities, each with their own unique belief or value system. This participant experienced conflicting beliefs that could not all be considered true at the same time. These opposing beliefs could not exist simultaneously and resulted in an internal struggle, or a struggle between good and evil:

> At one stage I used to believe, very strongly that I was the devil's wife. When I was very small I used to say I was the devil's child and slowly as I grew, it became

> wife and it… I feel like that's some things that need to push that part of me, like, I need to fight it because I don't want to feel like that. And the part that is… who I believe is me, is… wants to be close to God and not the devil… and I used to… I don't know it was just… it's like… they're parts of me, I can't deny it, it's parts of me that probably I am fighting, that I don't want to see, that I don't want to have in me because I don't want to be that. (Pt1:D1:Par183)

Several participants described having different identities with conflicting beliefs and ideologies. Participants' identities struggled to accept these opposing beliefs, for example about the good and bad within.

The battle of wills: Conflict of control

Conflict of control occurred when one or more identities had to relinquish control to allow another identity to assume control. Some dissociative identities resisted giving up their autonomy, which led to conflict between identities. A lack of control and autonomy may contribute towards dissociative identities thinking, feeling, and behaving in conflicting ways and even explicit fighting.

Participant one (26-year-old woman) described having several internal voices. However, she felt that if she named them all, they would have control over her:

> Those parts, they have no control because they… it's like, I don't know, I feel like if I was to name the others they would come out more. I feel that it would be me giving them power. It's like because I'm acknowledging them and okay, well you know we are here now so move aside, you know. (Pt1:D1:Par503)

Identities often resisted giving over control to other identities, resulting in a battle of wills. Explicit conflicts occurred when the whole self was aware of contradictions in their thoughts, feelings, and actions. At other times, participants were not aware of their battling identities.

Discussion

In this study, we qualitatively explored how patients with DID experienced conflict. In this study, patients with DID experienced conflict as pervasive and complex. Patients experienced conflict when trying to understand their DID, their experience of self, and when trying to integrate their different dissociative identities. This conflict also impacted patients' general mental functioning and interactions.

Culture and conflicting worldviews

An individual's worldview reflects how they think about reality and make sense of their world, experiences and more specifically here, their DID (Koltko-Rivera, 2004). People's worldviews are socially constructed or are formed while interacting with others, and within their broader social and cultural context (Creswell, 2013). Similarly, culture and its associated contextual factors may influence the development and expression of DID (Şar et al., 2017). South Africa is known for its diverse traditions, cultures, and languages. In this context, dissociation may help individuals or communities survive in a world of conflicting ideologies, where conflict is often embedded in relational, cultural and/or societal structures (Krüger et al., 2007; Şar et al., 2017). As worldviews are diverse and multiple in nature, a person with DID may have various socially and culturally situated worldviews that inform how they understand and interpret their DID (Creswell, 2013).

Martinez-Taboas (1991) argues that dissociation is informed by cultural norms that help shape the patient's knowledge, judgement, experience, how they express their experiences, and how they cope with stressors in their life. This way of thinking about dissociation highlights that dissociative experiences may be expressed in different ways across the world.

Conflict between dissociative identities

In this study, participants diagnosed with DID experienced six main types of conflict between their dissociative identities: conflict of information in awareness, conflicting actions or behaviours, conflicting ways of feeling, conflicting goals, conflicting values, and conflict of control. Conflict between dissociative identities was particularly evident when identities differed greatly in terms of their awareness, behaviours, emotional patterns, goals, values, and control. When participants were aware of these differences, conflict was more likely to be experienced as an explicit battle or struggle between identities. In contrast, patients who were not aware of these conflicts were more likely to be unaware of any battles they were fighting against their other identities.

Although various theoretical constructs describe dissociative identities in different ways, they all agree that conflict occurs between dissociative identities. These theories also agree on two other aspects, namely that dissociative identities *may not be equally aware* of each other, which could lead to conflict between identities. In this study, participants who had identities with varying levels of awareness experienced prominent conflict.

Secondly, most of these theories, Betrayal Trauma Theory excluded, maintain that dissociative identities may have *their own sense of self* and may experience conflict in terms of behaviours, feelings, goals, values, and will. Our findings show that conflict between dissociative identities was particularly evident when identities differed greatly in terms of their thoughts, feelings and/or actions. The conflict itself often presents in the building blocks that contribute to a sense of self in a person, or in their dissociative identities, namely, actions, feelings, goals, values and will.

Conflict is exacerbated when there are different and incompatible senses of self, combined with different levels of awareness between dissociative identities. Patients in

this category have the greatest potential for the disruption of and/or discontinuity in the integration of mental contents that is considered characteristic of patients diagnosed with DID (APA, 2013).

Our findings provide preliminary support for the hypothesis that DID patients experience irresolvable conflict which is aggravated by different levels of awareness between identities. This irresolvable conflict may prevent them from integrating their dissociative identities into a coherent self. If this hypothesis is supported, then these patients may benefit from identifying the areas of conflict between dissociative identities, the nature of the conflict and working towards increased awareness between identities (Chefetz, 2015).

Limitations of the study

We retrospectively analysed previously collected data, which led to several limitations. We could not focus our enquiry on conflict, but had to extract themes related to conflict from interviews that explored the rich experiences of patients with DID. Despite these limitations, our findings contribute to how patients with DID experience conflict, which is not a widely explored phenomenon.

Although this study explored culturally informed worldviews, the concepts of culture and ethnicity were explored in limited scope, and race not at all. Giving the participants the opportunity to self-identify may have provided a different depth of insight into the topics explored in this study.

The study was also limited by eight of the interviews being conducted in Afrikaans, necessitating translation of quotations into English. It is possible that some meaning may have been lost in translation. Also, two participants could not conduct

interviews in their home language, which may have changed how they expressed themselves.

Strengths of the study

Our findings are based on in-depth first-person accounts and provide verbatim quotations, which add to the trustworthiness and validity of our findings. The anticipated challenge in studying the subjective experience of conflict in participants who by the nature of their disorder might be unaware of their conflicting experiences, was not borne out, as the rich data yielded several themes related to conflict.

This study adds to the conceptualisation and contextualisation of DID in a South African context. Our findings revealed different expressions and experiences of DID, not only compared to Western perspectives but also between different people from South Africa.

Our findings contribute to the conceptualisation of conflict, and patients' experiences of conflict in DID. These studies are rare. To the best of our knowledge, conflict in DID has not been explored in this qualitative manner. This study lays the groundwork for further qualitative investigations in this underexplored field.

Recommendations

Further qualitative research within other patients with DID will provide a more context appropriate and situated understanding of DID. Future studies should also explore conflict in DID using primary data. A better understanding of the role of conflict in DID may help clinicians. By recognising that conflict is irresolvable and linked to awareness, clinicians might focus on inter-identity conflict, and facilitating inter-identity co-consciousness to help resolve conflict and ultimately promote integration of these states.

Clinicians treating patients diagnosed with DID might fruitfully consider a contextually appropriate diagnostic and therapeutic approach when working with these patients.

Conclusions

This study explored the subjective experiences and nature of conflict in a group of adult psychiatric patients diagnosed with DID. We retrospectively explored first-hand accounts of a group of 15 adult psychiatric patients diagnosed with DID, where they described their subjective experience of conflict, as well as the nature of their conflict.

Our findings revealed that participants had a contextually and culturally variable understanding of the origin of their DID. Within the whole self, different identities had different explanations for their DID, which had the potential to cause conflict.

Participants' identities experienced pervasive and multifaceted conflict. Dissociative identities conflicted with each other in terms of accessibility of information in awareness, behaviours, emotional patterns, goals, values and control. Conflict was often related to fundamental factors that contributed to a sense of self in a person as a whole or in their dissociative identities. Both the data and theory indicate that differing levels of awareness between dissociative identities might exacerbate the experience of conflict as well as the degree of dissociation.

This study provides insight into the complexities of conflict between dissociative identities, as well as highlights the role of inter-identity awareness in conflict.

Data Availability Statement

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington DC, USA: American Psychiatry Association.

Blizard, R.A. (2003). Disorganized attachment, development of dissociated self-states, and a relational approach to treatment. *Journal of Trauma & Dissociation, 4*(3), 27–50.

Brand, B.L., Şar, V., Stavropoulos, P., Krüger, C., Korzekwa, M., Martínez-Taboas, A., & Middleton, W. (2016). Separating Fact from Fiction. *Harvard Review of Psychiatry, 24*(4), 257–270.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

Carlson, E.B., & Putnam, F.W. (1993). An update on the Dissociative Experiences Scale. *Dissociation: Progress in the Dissociative Disorders, 6*(1), 16–27.

Chefetz, R.A. (2015). *Intensive psychotherapy for persistent dissociative processes: The fear of feeling real*. New York, NY: W. W. Norton & Co.

Creswell, J.W. (2013). *Qualitative research design: Choosing among five approaches* (3rd ed.). Los Angeles, CA: SAGE Publications.

Dell, P.F. (2006). The Multidimensional Inventory of Dissociation (MID): A comprehensive measure of pathological dissociation. *Journal of Trauma & Dissociation, 7*(2), 77–106.

Dorahy, M.J., Brand, B.L., Şar, V., Krüger, C., Stavropoulos, P., Martínez-Taboas, A., Lewis-Fernández, R., Middleton, W. (2014). Dissociative identity disorder: An empirical overview. *Australian & New Zealand Journal of Psychiatry, 48*(5), 402–417.

Du Plessis, L., & Visser, C. (2012). Disorders with dissociative and somatic symptoms. In A. Burke (Ed.), *Abnormal Psychology: A South African Perspective* (2nd ed., pp. 264-347). Cape Town, South Africa: Oxford University Press.

Freyd, J.J., & Birrell, P. (2013). *Blind to betrayal: Why we fool ourselves we aren't being fooled*. Hoboken, NJ: Wiley & Sons Inc.

Koltko-Rivera, M. (2004). The psychology of worldviews. *Review of General Psychology, 8*(1), 3–58.

Krüger, C. (2016). Variations in identity alteration – A qualitative study of experiences of psychiatric patients with dissociative identity disorder. In A.P. Van Der Merwe & V. Sinason (Eds.), *Shattered but unbroken: Voices of triumph and testimony* (pp. 133–161). London, England: Karnac Books.

Krüger, C., Sokudela, B., Mataboge, L., & Dikobe, A. (2007). Dissociation – A preliminary contextual model. *South African Journal of Psychiatry, 13*(1), 7–7.

Krüger, C., & Fletcher, L. (2017). Predicting a dissociative disorder from type of childhood maltreatment and abuser–abused relational tie. *Journal of Trauma & Dissociation, 18*(3), 356–372.

Liotti, G. (1999). Understanding the dissociative processes: The contribution of attachment theory. *Psychoanalytic Inquiry*, *19*(5), 757–783.

Martínez-Taboas, A. (1991). Multiple personality disorder as seen from a social constructionist viewpoint. *Dissociation: Progress in the Dissociative Disorders*, *4*(3), 129–133.

Nijenhuis, E.R.S., & Van der Hart, O. (2011). Dissociation in trauma: A new definition and comparison with previous formulations. *Journal of Trauma & Dissociation*, *12*(4), 416–445.

Orne, M.T. (1959). The nature of hypnosis: Artifact and essence. Journal of Abnormal and Social Psychology, 58, 277-299.

Putnam, F.W. (2016). *The way we are. How states of mind influence our identities, personality and potential for change*. Los Gatos, CA: International Psychoanalytic Books.

Sachs, A. (2013). Still being hurt: The vicious cycle of dissociative disorders, attachment, and ongoing abuse. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis Journal, 7*(1), 90–100.

Sachs, A. (2015). Who done it, actually? Dissociative Identity Disorder for the criminologist. *International Journal for Crime, Justice and Social Democracy, 4*(2), 65–76.

Şar, V., Dorahy, M.J., & Krüger, C. (2017). Revisiting the etiological aspects of dissociative identity disorder: A biopsychosocial perspective. *Psychology Research and Behavior Management*, *10,* 137–146.

Steele, K., Van der Hart, O., & Nijenhuis, E.R.S. (2005). Phase-oriented treatment of structural dissociation in complex traumatization: Overcoming trauma-related phobias. *Journal of Trauma & Dissociation*, *6*(3), 11–53.

Steinberg, M. (1994). *Structured Clinical Interview for DSM-IV Dissociative Disorders – Revised (SCID-D-R)*. Washington, DC: American Psychiatric Press.

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