An exploration of the experience of conflict in psychiatric patients diagnosed with Dissociative Identity Disorder: A collective case study

by

Lizanda Marais

Submitted in partial fulfilment of the degree Masters of Research Psychology

in the Department of Psychology

at the University of Pretoria

Faculty of Humanities

Supervisor: Professor Christa Krüger

Co-supervisor: Miss Monique Bezuidenhout

October 2019

Declaration

- I, Lizanda Marais, declare that this mini-dissertation is my own work. It is submitted to the University of Pretoria for the degree MA Research Psychology. Where other people's work has been used, this has been referenced in accordance with departmental requirements.
- This work has not been submitted previously for any degree at the University of Pretoria or any other university.
- I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.

_____

Signature

_____

Date

Dedication

It gives me great honour to dedicate this research to my friends, family and all the people who supported and encouraged me through this long and testing journey. I am eternally grateful for having such remarkable people in my life.

Acknowledgements

I would like to express sincere gratitude to the following people:

- The successful completion of this dissertation owes much to the efforts of Prof. Christa Krüger for her guidance, support, patience and continuous motivation and assistance as a supervisor. Her contribution was invaluable. Her interest and passion in the field of trauma and dissociative disorders made a major impact on me and this body of work.
- I wish to extend my sincere appreciation to Ms Monique Bezuidenhout for her loyal support, encouragement and continuous guidance throughout and in the finalising of this dissertation. Her contribution was invaluable to this body of work.
- I am grateful for my family and friends for their love and support throughout this project.

Abstract

Background: The role and nature of conflict in DID is underexplored beyond theoretical deduction. The present study sought to explore the subjective experience of conflict and the nature of conflict in psychiatric patients diagnosed with DID.

Methodology: Qualitative methods were used for this study. First-hand accounts in the form of secondary data were explored – i.e. typed transcriptions of previously recorded in-depth interviews. A collective case study design was used, and the data analysed using thematic analysis alongside the constant comparison analysis method as formulated by Boeije (2002)

Findings: Three main themes emerged from the data, viz.: 1) participants' levels of separateness and unity of the self, 2) participants' experience of having one or more incompatible and conflicting worldviews about their DID, and 3) the type and nature of conflict that arises between dissociative identities, i.e., conflict of information in awareness, conflicting actions or behaviours, conflicting ways of feelings, conflicting goals, conflicting values, and battle of wills.

Conclusion: DID patients experienced distinct and separate parts or identities and these identities were experienced as separate to a lesser or greater extent. The participants' understanding of the origin of their DID is contextually situated and variable. The conflict between one's various belief systems may contribute to further dissociation. The study also revealed the nature of the different types of conflict that may be present between participants' dissociative identities. Conflict between dissociative identities was found to be pervasive and multifaceted. The study provides insight into the complexities of conflict between dissociative identities as well as the role of awareness in DID.

Key terms: Dissociative identity disorder, participant experiences, the nature of conflict, psychiatric patients, awareness, case study, thematic analysis.

Table of contents

List of figures

List of tables

Chapter 1: Introduction

1.1. Introduction and background

Dissociative identity disorder (DID), formerly known as multiple personality disorder, has a longstanding history in the field of psychology. An increasing research literature is now uncovering the underlying aetiology involved in DID. In typical child development, different behavioural and affective states are integrated into a unitary self (Putnam, 1997). Chronic, early relational trauma, such as sexual and physical maltreatment (Cohen, 2004; Dorahy et al., 2014; Du Plessis & Visser, 2012), and a disorganised attachment (DA) (Main & Solomon, 1986; Main, 1996; Sachs, 2013) relationship to the caregiver have been implicated in the development of DID (Blizard, 2001; Dorahy et al., 2014; Liotti, 2004; Sachs, 2013). In other words, severe trauma during childhood may cause behavioural and affective states to not integrate properly and become separate (Dorahy et al., 2014; Putnam, 1997). Separate or unintegrated states may become more defined over time and develop into dissociative identities (Putnam, 1997).

Dissociative identities provide the child with a way in which to split off severe and conflicting feelings of betrayal, fear, love and guilt towards a caregiver (Dorahy et al., 2014; Putnam, 2006). This pattern may continue into adulthood where dissociative identities provide a solution to both the presence of unbearable trauma and irreconcilable conflict in the mental, physical, social and cultural life of an individual with DID. To put it differently, the person wants to avoid these unbearable and/or conflicting thoughts, feelings, beliefs and/or memories and, in doing so, these unbearable and conflicting thoughts, feelings, beliefs or memories become the domain of dissociative identities. Putnam (1988, 1997, 2016) asserts that dissociative identities

or identity states may have limited awareness of each other and as such may act in conflicting, opposing and self-defeating ways (Putnam, 1988, 1997, 2016). For the purpose of this study, conflicting dissociative identities can be conceptualised as dissociative identities that cannot be kept in awareness at the same time, as would be required to ensure a unified sense of self.

1.2. Research problem

Notwithstanding the progress that has been made in the field of DID (Brand et al., 2016; Dorahy et al., 2014), the role of conflict in the development and maintenance of DID is largely unexplored in the literature. Several aetiological theories of DID discussed conflict in DID in some capacity and these theories will be discussed in the literature section (Chapter 2). These theories include: Betrayal Trauma Theory (Freyd & Birrell, 2013); Psychoanalytic Theory (Freud, 1961); Object Relations Theory (Kernberg, 2018); Attachment Theory (Blizard, 2003; Liotti, 1999; Sachs, 2013); Cognitive model of dissociation (Kennedy, 2013; Kennedy et al., 2004); Discrete Behavioural State Model (Putnam, 1988, 1997, 2016); and Structural Dissociation of the Personality (Steele et al., 2005; Van der Hart et al., 2006). Upon review of these theories, it became evident that the role and nature of conflict in the development and manifestation of DID is underexplored beyond theoretical deductions, thereby leaving a gap in present-day research.

In Richard Chefetz's (2015) book *Intensive Psychotherapy for Persistent Dissociative Processes*, he makes two significant observations. Firstly, Chefetz (2015) argues that in the investigation of the dissociative process it is important to explore and identify conflicts in terms of specific interests, qualities, attitudes and views that may be present between states in order to

resolve the tension between them and eventually integrate the states. Secondly, Chefetz argues the case for a qualitative inquiry into the subjective experience of dissociation and DID.

> *Understanding what really happens in dissociation – or in clinical entities like dissociative identity disorder – will not be achieved by a technical effort to decide once and for all what the neural or psychological basis of dissociation is all about. That will help, but it must be joined by an effort to spell out in clear and straightforward language what the subjective experience of dissociation is like.* (Chefetz, 2015, p2)

Much is still unknown about the role of mutually exclusive and conflicting dissociative identities or self-states in the development and maintenance of DID. What is needed is a qualitative inquiry to lay the groundwork for further exploration into this phenomenon. This dissertation focuses on gaining a better understanding of the subjective experience of conflict of adult psychiatric patients diagnosed with DID. A study of this nature will contribute to a better understanding of the subjective experience of conflict in patients diagnosed with DID and assist clinicians to better understand and treat these patients.

1.3. Problem statement

What is the subjective experience of conflict and the nature of conflict as described by a group of 15 adult psychiatric patients diagnosed with dissociative identity disorder (DID)?

1.4. Justification, aim and objective of the study

DID is considered the most severe and chronic form of DD and its prognosis is typically guarded (APA, 2013; Du Plessis & Visser, 2012; Şar, 2017). DID may be accompanied by several other psychiatric disorders making it increasingly complex to formulate a diagnosis (Şar & Ross, 2006).

Research findings regarding the prevalence of DID differ among psychiatric inpatients, outpatients, and community samples. In Turkey, the prevalence rate of DID is 5.4% among general psychiatric inpatients using the Dissociative Disorders Interview Schedule (DDIS) (Tutkun et al., 1998). In Israel, the prevalence of DID is 0.8% among inpatients using the Structured Clinical Interview for Dissociative Disorders (SCID-D) (Ginzburg et al., 2010). Studies report higher prevalence of DID in outpatient units, 14% (Şar et al., 2007) and 6% (Foote et al., 2006) respectively. DID has been found among nearly 1.1-1.5% of general population samples (Brand et al., 2016).

Cultural aspects may influence how DID is formed, presented and expressed (Dorahy, 2001; Şar, Dorahy, & Krüger, 2017). Dorahy et al. (2014) argue that cultural differences in the clinical manifestation of DID remains a gap in current research endeavours. Notwithstanding the recent changes to the DSM-5 classification category of dissociative disorders, South Africa with its historically diverse set of cultures and languages proves to be a difficult setting to capture the full extent of DID using historically westernised models (Krüger et al., 2007). Therefore, the full extent of DID in South Africa is largely unknown.

The sample for the present study consisted of previously transcribed in-depth interviews (secondary data) with 15 adult patients (3 men and 12 women) diagnosed with DID or Other

Specified Dissociative Disorder (OSDD) who were studied between 2013 and 2016. This sample used for this dissertation is unique for several reasons, which are as follows: the sample consists of participants who were recruited within two South African psychiatric hospitals, viz., Weskoppies Psychiatric Hospital and Tshwane District Hospital; the sample consists of both men (n=3) and women (n=12); and the demographics of this sample are diverse (three black, three coloured, and nine white participants). Research of this nature with a sample of this nature is few and far between globally and even more so within the context of South Africa, as such the unique study settings provides further justification for this study.

The role of conflict in DID is underexplored beyond theoretical deductions leaving a gap in present-day research. It would therefore prove necessary to explore the first-hand accounts of the role of conflict as it is subjectively experienced by adult psychiatric patients diagnosed with DID. This study employs qualitative methods to gain such a subjective understanding of conflict in DID. A qualitative approach is also considered a suitable approach when the topic of inquiry is relatively underexplored as it allows for an inductive and flexible way of conducting research (Terre Blanche, Durrheim, & Painter, 2006). A qualitative research approach therefore suited this study as it facilitated an in-depth understanding of the experience of conflict by patients diagnosed with DID.

It is evident that further research and a greater understanding of DID are necessary to improve the level of care and treatment being provided to DID patients globally and more specifically in the South African context. This study may provide a better understanding of DID in a South African context.

The present study sought to explore the subjective experience of conflict, as well as the nature of conflict of a group of adult psychiatric patients diagnosed with DID. The aim of this

study was achieved by retrospectively exploring first-hand accounts of a group of adult psychiatric patients diagnosed with DID, where they describe their subjective experience of conflict and also the nature of their conflict.

1.5. Dissertation structure

This dissertation consists of five chapters:

Chapter 1 provided a short introductory overview of the background to the study and contextualised conflict in DID. The background to the study was followed by a statement of the research problem.

Chapter 2 constitutes the literature review section of this dissertation. The literature consists of various definitions of dissociation, the clinical understanding of DID, and the aetiological theories that inform our understanding of DID. Finally, this chapter will outline how conflict in DID is conceptualised by the different schools of thought.

Chapter 3 provides information about the methodological processes of this dissertation. This chapter outlines a discussion on the retrospective analysis of previously collected data (i.e. secondary data); the researcher's paradigmatic point of departure; research design; sampling method and participants; data collection methods and procedures followed; data analysis; trustworthiness of the research; and ethical considerations.

Chapter 4 introduces the findings of this dissertation. The goal of this chapter is to describe and discuss the themes and subsequent sub-themes that emerged from the data. The findings section consists of three themes. Theme one describes patients' different levels of separateness of the self. The second theme discusses how patients diagnosed with DID

experience having one or more incompatible and conflicting belief system or worldview about their DID. Theme three is an in-depth account of the different types of conflict that exist between dissociative identities.

Chapter 5 will be a consolidation of the work of this research endeavour and will provide the reader with a summary of the main findings of the study. Subsequently, the findings will be discussed within the context of relevant literature. This will be followed by a discussion on the possible limitations and strengths of this study as well as recommendations for future research. The chapter will end with the researcher's reflections and a concluding summary of the research project.

Chapter 2: Review of the literature / theoretical framework

2.1. Introduction

Dissociative identity disorder (DID), formerly known as multiple personality disorder (MPD), is a fascinating albeit controversial phenomenon in the field of psychology. A growing research endeavour is now uncovering the underlying aetiology involved in the development of DID. However, much is still unknown about the role of mutually exclusive and conflicting dissociative identities or self-states in the development and maintenance of this disorder. Before exploring this phenomenon of conflict in the literature of DID, it is useful to discuss what is known about DID itself.

This chapter will focus on the various definitions of dissociation, the clinical understanding of DID, the aetiological theories that inform our understanding of DID and how these theories have evolved over time. Finally, this chapter will outline how conflict in DID is conceptualised by the different schools of thought.

2.2. What is dissociation?

Many definitions and theories have been proposed to conceptualise the construct of dissociation. However, there is a lack of conceptual clarity with regard to the nature of dissociation (Van der Hart, Nijenhuis, Steele, & Brown, 2004). Some theorists and authors use the term dissociation to refer to the processes that produce and maintain integrative failure, yet others use it to refer to the outcome of these processes and/or symptoms of dissociation

(Nijenhuis, & Van der Hart, 2011; Van der Hart et al., 2004). The definitions of dissociation vary according to the school of thought that underlies these definitions. Several definitions will be provided in order to orientate the reader with the various perspectives that exist (please see Table 1 for an overview of the definitions of dissociation).

The Discrete Behavioural States Model (DBS), developed by Frank Putnam, defines dissociation as a switch or transition between states and/or as a distinct state disconnected from other mental and behavioural states (Putnam, 1997, 2016). The DBS Model argues that dissociation is a complex psychophysiological process that occurs along a continuum of severity, and produces a series of clinical and behavioural events relating to alterations in memory and identity (Putnam 1988, 2016). For example, dissociation can range from normal dissociative states, such as daydreaming, to maladaptive dissociative states, such as detachment, numbing or "out-of-body experiences", to the most severe or extreme state of DID (Bernstein & Putnam, 1986; Putnam 2016).

Various authors describe dissociation from the perspective of traumatisation. Pierre Janet (1889) first implicated the role of trauma in the development of dissociative symptoms. Janet (1907) believed dissociation to be a structural or organised division of the personality. This division involves the inadequate integration of various systems of ideas that make up the personality (Janet, 1907). Similarly, Nijenhuis and Van der Hart (2011), in their theory of Structural Dissociation of the Personality, suggest that trauma can produce a division or split of an individual's personality into dissociative parts. Division of the personality occurs when the individual lacks the capacity to integrate elements of the past trauma with everyday life (Nijenhuis, & Van der Hart, 2011; Van der Hart et al., 2004).

From a psychodynamic perspective, dissociation can be understood as an intrapsychic and primitive survival strategy (Fonagy, 1991). The traumatised individual attempts to protect against the overwhelming anxiety or emotions of the trauma event by continuously denying that the trauma occurred and by splitting between a coping self and a traumatised self (Blizard, 1997; Fonagy, 1991; Kernberg, 1976, 1985).

From a cognitive perspective, dissociation occurs because of the decoupling or separation of mental processes, which may occur at various stages of information processing (Kennedy, 2013; Kennedy, et al., 2004). Dissociation involves a number of psychological processes, including amnesia, inaccessibility of information, and alternations in consciousness (Kennedy, 2013). These processes serve to reduce awareness of unbearable information.

Dissociation from a clinical perspective can be described as an involuntary disruption of normal integration of psychological aspects (Spiegel et al., 2011). Dissociation may manifest as a disconnect in thoughts, traumatic and non-traumatic memories, emotions, identity, perception of others, as well as behaviour (American Psychiatric Association [APA], 2013, p. 291; Spiegel et al., 2011).

Despite the differences that underlie these definitions of dissociation there is a common thread among them, which is the separation of information. Whether dissociation is considered a switch between states, a separate state or as a functional separation, the common thread between these definitions is that dissociation allows memories, behaviour, affect and knowledge to be sectioned off and stored in a way that is not easily accessible to the individual.

Table 1: Definitions of Dissociation

Theory or model	Definition
Clinical definition	Dissociation from a clinical perspective can be described as an involuntary disruption of normal integration of psychological aspects (APA, 2013; Spiegel et al., 2011). Dissociation may manifest as a disconnect in thoughts, traumatic and non-traumatic memories, emotions surrounding the memory, identity and perception of others, as well as behaviour (APA, 2013, p. 291; Spiegel et al., 2011).
Discrete Behavioural States model	Dissociation can be defined as a switch or transition between states, and/or as a distinct state disconnected from other mental and behavioural states (Putnam, 1997, 2016).
Structural Dissociation of the Personality	Trauma produces a division or split of an individual's personality into dissociative parts. Division of the personality occurs when the individual lacks the capacity to *integrate* elements of the past trauma with daily life (Nijenhuis, & Van der Hart, 2011; Van der Hart et al., 2004).
Psychodynamic perspective	Dissociation can be understood as an intrapsychic survival strategy utilised by the traumatised individual in an attempt to protect against the overwhelming anxiety of the trauma by denying that the event occurred and by splitting between a coping self and a traumatised self (Blizard, 1997; Fonagy, 1991; Kernberg, 1976, 1985).
Cognitive perspective	Dissociation occurs because of 'decoupling' of mental processes, which may occur at various stages of information processing (Kennedy, 2013; Kennedy, et al., 2004).

2.3. Clinical description of dissociative disorders, including DID

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) describes Dissociative Disorders (DD) as an involuntary disruption of normal integration of psychological aspects (APA, 2013; Spiegel et al., 2011). Dissociative symptoms include intrusions of consciousness and behaviour, with disruptions in subjective experience and/or the inability to access information or to control mental functions that normally are readily available.

The DSM-5 lists five dissociative disorders (APA, 2013) (see Table 2 below for an overview of the dissociative disorders).

Table 2: Description of DSM-5 Dissociative Disorders

Dissociative disorders	Description of disorder
Dissociative identity disorder	Patients describe experiencing pervasive amnesia and identity fragmentation that result in either two or more distinct personality states or possession experiences (APA, 2013).
Dissociative amnesia	Patients experience abnormally severe gaps in their memory of events, with or without travelling of which they are unaware (fugue) (APA, 2013).
Depersonalisation/derealisation disorder	Patients experience severe feelings of detachment from themselves or their surroundings (APA, 2013).
Other Specified Dissociative Disorder (OSDD)	Patients experience lesser versions of DID, trance states, or dissociative reactions to stressful events or brainwashing (APA, 2013).
Unspecified dissociative disorder	Where patients' severe dissociative symptoms do not (yet) fit into any of the other categories (APA, 2013).

DID is considered the most severe and chronic of the dissociative disorders (APA, 2013; Braun, 1988; Du Plessis & Visser, 2012; Ogawa et al., 1997; Seligman & Kirmayer, 2008). The disruption in identity, which characterises DID, involves severe disturbances in the sense of self and agency (APA, 2013). The DSM-5 indicates that these disturbances occur alongside variations of, "*in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning*" (APA, 2013, p. 292).

2.3.1. Course, presentation, and prevalence of DID

Over the last decade the body of research on DID has grown considerably (Brand et al., 2016; Dorahy et al., 2014). DID is considered the most severe and chronic form of DD and its prognosis is typically guarded (APA, 2013; Du Plessis & Visser, 2012; Şar, 2017). DID may be accompanied by several other psychiatric disorders making it increasingly more complex to formulate a diagnosis (Şar & Ross, 2006). Common comorbid disorders include borderline personality disorder, post-traumatic stress disorder, attention deficit hyperactivity disorder, obsessive compulsive disorder, epilepsy, non-epileptic seizures, migraines, factitious disorder and malingering (APA, 2013; Du Plessis & Visser, 2012; Şar 2017). DID holds an enduring cost not only to the life of the individual but also to the larger health care system (Dorahy et al., 2014; Şar, 2017). People, on average, spend between six to twelve years in the mental health care system before being correctly diagnosed with DID (Brand et al., 2016). In addition, Sachs (2008, 2013) suggests that individuals with a DD, especially DID, often enter into a pattern of maltreatment that continues into adulthood. DID has also been found to be more prevalent in women than men (Du Plessis & Visser, 2012).

Research links DID to severe childhood maltreatment by a close caregiver (Dorahy et al., 2014; Du Plessis & Visser, 2012; Krüger & Fletcher, 2017; Putnam, 2016). Putnam (1995) describes the usual age of trauma leading to DID as around three to ten years old. Vonderlin, Kleindienst, Alpers, Bohus, Lyssenko and Schmahl (2018) conducted a meta-analysis that systematically investigated the relationship between childhood interpersonal maltreatment and dissociation using the Dissociative Experience Scale (DES). Dissociation was found to be higher for abuse than non-abuse samples. The highest dissociation scores were found to be for sexual

and physical maltreatment. The study revealed that higher dissociation scores were significantly predicted by several aspects, namely: abuse that started at a young age, abuse that endured over a longer period of time, and abuse by a parent (Vonderlin et al., 2018).

Research findings regarding the prevalence of DID differ among psychiatric inpatients, outpatients, and community samples. With regards to inpatient prevalence, two cross-sectional studies from North America that used DDIS as a diagnostic instrument found that 4.0–5.4% of psychiatric inpatients met DSM-IV criteria for DID (Ross et al., 1991; Saxe et al., 1993). In Turkey, the prevalence rate of DID is 5.4% among general psychiatric inpatients using the DDIS (Tutkun et al., 1998). In Israel, the prevalence of DID is 0.8% among inpatients using the SCID-D (Ginzburg et al., 2010). Studies report higher prevalence of DID in outpatient units. In a university emergency department in Istanbul cross-sectional rates of DID were 14% (Şar et al., 2007). In yet another study by Foote et al. (2006) conducted in an outpatient psychiatric unit in New York City the prevalence of DID was found to be 6%. Şar, Önder, Kilincaslan, Zoroglu and Alyanak (2014) conducted a study with the purpose of determining the prevalence of DID and other dissociative disorders among a sample of adolescent psychiatric outpatients. The sample consisted of 116 outpatients ranging between the age of 11 and 17. The results revealed that 45.2% of the participants were diagnosed with a dissociative disorder, 16.4% were diagnosed with DID and 28.8% had OSDD.

DID has been found among nearly 1.1-1.5% of general population samples (Brand et al., 2016). Variations in prevalence across studies might be due to methodological differences (studies that use Dissociative Disorders Interview Schedule (DDIS) or Structured Clinical Interview for Dissociative Disorders (SCID-D)), study site or cultural variation (Brand et al., 2016; Dorahy et al., 2014; Şar et al., 2013). The DSM-5 introduced pathological possession into

the DID criteria (APA, 2013). A recent general population study of 628 women from a town in central Eastern Turkey revealed that 2.1% of the sample recounted an experience of possession (Şar et al., 2014). When the women were assessed with the DDIS, the authors found that 2 of the 13 women who reported an experience of possession also had DID.

Cultural aspects may influence how DID is formed, presented and expressed (Dorahy, 2001; Şar, Dorahy, & Krüger, 2017). Dorahy et al. (2014) maintain that cultural difference in the clinical manifestation of DID remains a gap in current research endeavours. Notwithstanding the recent changes to the DSM-5 classification category of dissociative disorders, South Africa with its historically diverse set of cultures and languages proves to be a difficult setting to capture the full extent of DID using historically westernised models (Krüger et al., 2007). Therefore, the full extent of DID in South Africa remains largely unknown.

2.3.2. Dissociative identities in DID

Dissociative identities observed in dissociative disorders such as DID are often described in the literature using various terms, depending on the particular theoretical underpinning. These terms include alternate identities, distinct identities, alters, personality states, personalities, dissociative parts, self-states, parts of the mind, parts of the self, or dissociative parts of the personality (APA, 2013; Maiese, 2016; Putnam, 1997; Van der Hart, Nijenhuis, & Steele, 2006). In some cultures, dissociative identities may also be described as external spirits, powers or deities (APA, 2013). The DSM-5 describes dissociative identities as relatively enduring entities with fairly consistent ways of perceiving, relating to and thinking about the environment and self (APA, 2013). Yet another influential definition of alters (a synonym for dissociative identities),

which not only accounts for the traumatic developmental pathways of forming alters, but also allows for alters to be scientifically measured, was proposed by Frank Putnam. In his Discrete Behavioural States Model, Putnam describes alters as *"...complex, enduring, identity-based, discrete dissociative states that evolve during childhood and adolescence [and] arise in the context of severe trauma occurring early in childhood... Over time, they become increasingly differentiated..."* (Putnam, 1997, p.175).

Several other theorists have proposed similar definitions, which focus on shifting states of consciousness such as Kennedy's (2004) Levels of Dissociation Theory. The various theorists' definitions of dissociative identities will be discussed below in their respective sections.

Dissociative identities could be thought of as having their own identities, collections of memories, feelings, thoughts, preferences, ambitions, habits and patterns of behaviour (APA, 2013; Maiese, 2016). Identities may differ in their personal characteristics, such as name, age, race, gender, sexual orientation, areas of expertise, predominant affect, vocabulary and apparent intelligence. It is also possible that different dissociative identities may be in control of the person and their body at different times and may have discrete affective abilities uniquely suited to deal with certain circumstances (Farley, 2003; Maiese, 2016).

The question of "what is a dissociative identity" is linked to the question of whether dissociative identities truly exist. Empirical neurophysiological research speaks to the validity of distinct dissociative identities present in a single individual. Several empirical studies that measure neurological function, viz.: functional Magnetic Resonance Imaging (fMRI); Positron Emission Tomography (PET) and/ or Single-Photon Emission Computerized Tomography (SPECT), provide evidence that different patterns of activation of brain regions exist for different dissociative identities in DID patients (Nijenhuis & Den Boer, 2009; Reinders et al., 2012; Şar,

Unal, Kiziltan, Kundakci, & Ozturk, 2001). From these studies, it is evident that the variability between dissociative identities in a single person is more significant than the variability between non-dissociative people simulating this phenomenon. In other words, these studies provide evidence of neurological differences between patients with DID compared to a control group who simulate the presence of dissociative identities.

2.4. Aetiology of DID / How does DID develop?

2.4.1. Schools of thought that inform the aetiological theories of DID

2.4.1.1. Traumatology

DID is understood as a complex post-traumatic developmental disorder (Dalenberg et al., 2012). Research shows that dissociative disorders (DD), including DID, are statistically significantly predicted by severe psychological trauma, such as early childhood physical, sexual or emotional maltreatment committed by a close caregiver (Dalenberg et al., 2012; Krüger & Fletcher, 2017; Lewis-Fernandez, Martinez-Taboas, Şar, Patel, & Boatin, 2007; Ogawa, Sroufe, Weinfield, Carlson, & Egeland, 1997; Putnam, 2016; Ross et al., 2008; Şar, 2011).

As presented above, the relationship between trauma and DID is widely accepted among present-day dissociation thinkers. Pioneer theorist in the field of dissociation, Pierre Janet (1889, 1907), a nineteenth-century psychiatrist, believed dissociation to be the mind's way of disconnecting adverse events from memory and awareness. This assumption still underlies modern-day understanding of the role of trauma in dissociation. Dissociation is conceptualised as

a means of coping with overwhelming trauma experience. This means of coping may, however, jeopardise a person's ability to integrate adverse experiences into conscious awareness. The traumatised person defends against the pain by not acknowledging their trauma-related memories and affect. This coping strategy may be adaptive at the moment of traumatisation, but might possibly be related to an increased probability of dissociative and trauma-related pathology in later life (Lewis-Fernandez et al., 2007). Spiegel (1991) explains the role of dissociation in the face of traumatisation as follows, *"Dissociative defences, which allow individuals to compartmentalize perceptions and memories seem to perform a dual function. They help victims separate themselves from the full impact of physical trauma while it is occurring, and, by the same token, they may delay the necessary working through and putting into perspective of these traumatic experiences after they have occurred"* (p.261).

While trauma appears to be related to dissociation and the development of dissociative disorders such as DID, not all trauma survivors develop a dissociative disorder, while some individuals who have not experienced an apparent trauma sometimes develop a dissociative disorder. This suggests that there may be more to the aetiology and development of DID than trauma alone (Lyons-Ruth, Dutra, Schuder & Bianchi, 2006).

2.4.1.2. Betrayal Trauma Theory

Many distressing events, including maltreatment and violence, can have traumatic effects; however, not all traumatic events result in dissociative disorders or more specifically DID (Birrell & Freyd, 2006). Freyd and Birrell (2013) propose betrayal trauma as a unique type of trauma that motivates the individual to forget the abuse or information related to the abuse

(Freyd & Birrell, 2013). Examples of such betrayals would be childhood physical, emotional or sexual maltreatment by a close and trusted caregiver. Betrayal Trauma Theory (BTT) postulates that traumatisation that occurs in the context of interpersonal relationships, committed by a trusted and needed caregiver, can be particularly damaging, as this betrayal involves the violation of basic assumptions of a close and protective caregiver–child relationship (Birrell & Freyd, 2006). As a result, the traumatised child will be more motivated to forget about the abuse.

The betrayal lies in the fact that the one person who is supposed to care for and protect the child, and the one person the child looks up to for this care and protection, turns out to be the one who actually harms the child. Such a caregiver has betrayed the trust of the child, who then has no-one to turn to for care and protection. The knowledge that the carer is also the abuser is too unbearable for the child to keep in awareness (Birrell & Freyd, 2006; Freyd & Birrell, 2013).

BTT highlights the importance of betrayal of trust as a precursor in the development of dissociative symptoms. Understood from a clinical perspective, dissociation may be used as a means of coping with overwhelming trauma experience. This means of coping may impair a person's ability to integrate adverse trauma experiences into conscious awareness. It can be said that the traumatised person defends against the pain by not acknowledging their trauma-related memories and affect. BTT similarly explains how dissociating information from awareness is mediated by the threat that the information may pose to important relationships with caregivers (Freyd & Birrell, 2013; Freyd, 1994, 2003). It is within these instances of betrayal that the potential for conflict between the need to continue the relationship with the caregiver (for survival purposes) and the awareness of betrayal (information that may threaten the child's well-being) is at its highest and memory will be most impaired (Freyd & Birrell, 2013). How could a child continue to have a trusting relationship with an abusive caregiver, if the child were aware

that the caregiver is also their abuser? Thus, the child may remain unmindful or forget caregiver-perpetrated maltreatment as this safeguards the child's relationship with the caregiver.

BTT predicts that unawareness and forgetting of abuse will be higher when the relationship between the perpetrator and victim involves closeness, trust and/or caregiving. Research supports this prediction. Using the Betrayal Trauma Inventory measure, Freyd, DePrince and Zurbriggen (2001) examined the relationship between amnesia or memory impairment and betrayal by a close caregiver. The results showed that physical and sexual maltreatment, committed by a caregiver, was related more to self-reported memory impairment for the adverse event/s compared to abuse not committed by a close caregiver (Freyd, DePrince, & Zurbriggen, 2001). Research also provides evidence that exposure to betrayal trauma is linked more to dissociation compared to abuse not related to betrayal of trust. Platt and Freyd (2015) conducted a study to assess the role of betrayal trauma history on aspects of shame, dissociation and fear in response to threat. The researchers found that a history of high betrayal trauma, but not low betrayal trauma, predicted increases in shame and dissociation following exposure to an interpersonal threat environment (threatening images in a computer screen).

2.4.1.3. Psychoanalytic theory

This section discusses the foundation of the concept of dissociation more broadly in the field of psychology and specifically in psychoanalytic theories. This is not an exhaustive overview of the psychoanalytic approach, but rather a presentation of the pioneers in the field.

The role of early psychoanalytic theory in the aetiology of DID: Nineteenth-century hysteria

Pierre Janet (1889) first implicated the role of trauma in the development of dissociative symptoms evident in trauma-related disorders. At the time, dissociation was referred to as hysteria. Janet described dissociation as a structural division or split of the personality (McAllister, 2000; Putnam, 2016; Van der Hart, & Friedman, 1989; Van der Hart, Nijenhuis, & Steele, 2006). Janet believed that traumatic events and frightening experiences created subconscious fixed ideas that were expressed through hysterical or dissociative symptoms (Putnam, 2016). Janet theorised that the fixed ideas created divisions within the person's consciousness, which became semi-autonomous entities capable of independent behaviour. However, Janet's theory was neglected at the time in favour of Sigmund Freud's body of work on hysteria (McAllister, 2000; Van der Hart, & Friedman, 1989).

In summary, Freud conceptualised the structure of the personality as consisting of three parts: the id, the ego and the superego (Freud, 1964a; Moore, Meyer, & Viljoen, 2008). These three parts function on three different levels, namely: the conscious, preconscious and unconscious (Freud, 1964a; Moore et al., 2008). The conscious level holds information of which the individual is aware of. The preconscious, the level below consciousness, holds information that can be easily recalled. However, the unconscious is the domain of drives that are deemed forbidden or unacceptable. The id holds primitive or rudimentary desires and wishes (Freud, 1961). The id is unconcerned by external constraints or consequences but is rather concerned with gratification of biological drives. The id is mediated by the ego, whose main concern is repressing these biological drives and impulses of the id (Freud, 1964a). The superego is an extension of the ego and places moral restrictions on the individual (Freud, 1964b). The superego

is mediated by the fear of punishment for deviating from social codes and values (Freud, 1964b; Moore et al., 2008).

Freud's earlier work with Josef Breuer (1893) shares similarities with the work of Janet. Freud and Breuer originally conceptualised hysteria in terms of dissociation, which they referred to as a splitting of consciousness (Breuer, & Freud, 1893). Breuer and Freud (1893) theorised that trauma events that occur in childhood result in hypnoid states. Hypnoid states are what Breuer and Freud (1893) referred to as "*abnormal states of consciousness*", which form the basis of hysteria and resemble a state of hypnosis (Breuer, & Freud, 1893, p.12). Hypnoid states are accompanied by amnesia and can bring about the splitting of the mind or consciousness (Bliss, 1988). In their joint work, *On the Physical Mechanism of Hysterical Phenomena: Preliminary communication*, Breuer and Freud stated:

"*We have become convinced that the splitting of consciousness which is so striking in the well-known classical cases under the form of double consciousness is present to a rudimentary degree in every hysteria, and that a tendency to such dissociation, and with it the emergence of abnormal states of consciousness (which we shall bring together under the term 'hypnoid') is the basic phenomenon of this neurosis*" (Breuer, & Freud, 1893, p.12).

In his book, *The Aetiology of Hysteria* (1962), Freud proposes his Seduction Theory, which argues that the root of hysteria lies in the sexual seduction of a child by an adult. That is to say, childhood sexual abuse is the cause of hysterical symptoms. However, around 1905 Freud abandoned this view because he could not come to terms with the thought that so many fathers could have sexually abused their children without anyone noticing (Putnam, 2016). Freud instead formulated his well-known intrapsychic theory of defences and fantasies, which emphasised the belief that what people with hysteria repress from their consciousness was in fact not sexual

trauma but sexual wishes (or fantasies). That is to say, rather than having actually experienced sexual abuse by their fathers, these girls fantasised about seducing their fathers (Putnam, 2016). Freud's replacement for dissociation was repression, which he described as a defence against unacceptable biological drives involving the relocation of conflicts to the unconscious mind (Spermon, Darlington, & Gibney, 2010). According to Freud (1961), repression is an unconscious process where distressing information is buried below or split from (by the ego drive) the level of consciousness in the unconscious mind (the domain of the id drive). This horizontal division into conscious and unconscious differs from dissociative dividedness or dissociative split (Spermon, Darlington, & Gibney, 2010). Conversely, dissociation represents a vertical splitting where states and trauma-related memories are inaccessible to one another.

The role of later psychodynamic theories in the aetiology of DID: Object relations theory

In the 1950s, psychoanalysts took a turn away from traditional thinking and biological drives theories. Fairburn (1952) held that the key motivator in humans was perhaps not biological drives, as proposed by Freud, but rather a child's need for an attachment relationship to a caregiver. Fairbairn's focus on object relations has reoriented psychoanalysis by placing the child's need for relationship at the centre of development and functioning (Blizard, 1997; Fairburn, 1952).

Object relations theory comprises a series of psychodynamic philosophies of human motivation in which the internalisation of early interaction with important others is considered the foundation of psychological growth and functioning (Caligor & Clarkin, 2010). In object relations theory the object refers to a person with whom the subject has a relationship, i.e. the attachment figure (Blizard, 1997; Caligor & Clarkin, 2010). Object relations refers to the quality of the relationship that the subject has with the object (Caligor & Clarkin, 2010). Internal object

denotes the representation of another within the mind of the subject (Caligor & Clarkin, 2010). Representation signifies the way in which the child retains or possesses an object (St. Clair, 1986), whereas the concept of self-representation refers to the mental manifestation of the self as it is experienced in relation to the object.

The main premise of object relations theory is that the infant forms stable internalised representations of the self, the object and their related affect connecting these internalised representations (Kernberg, 1976, 1985). Internalised representations originate from the infant's early relational experience to the main caregiver (Blizard, 1997; Kernberg, 1976, 1985). In some instances, the internalised representation may involve a self that is represented as self-assured and capable, the object as available and caring, and the affect connecting the internal representations as happy and calm (Blizard, 1997). In yet another instance, the self may be represented as fragile and insecure, the object as somewhat inaccessible but helpful, and the affect connecting these representations as anxious (Blizard, 1997). Alternatively, the internalised representation may include a self that is proficient but unlovable, an object that is rejecting and avoidant and the affect connecting the two as detached.

The internalisation of object relations determines basic psychological structures and gives rise to the drive systems (Christopher, Bickhard, & Lambeth., 2001; Kernberg 1966). Kernberg (1966, 1976) maintained that the internalisation of object relations consists of three stages: introjection, identification and ego identity.

Kernberg (1966) viewed ego states (or self states) as compartmentalised psychic manifestations and considered introjection to be one of the earliest levels in the organisation of the internalisation of object relations. According to Kernberg (1966), introjection is the replication and preoccupation with an interaction through a collection of memory traces.

Kernberg (1966) considered introjection essential for both psychic maturation and ego defence. Kernberg (1966) considered affective or emotional colouring of the introjection as vital to the process of forming bad and good self-objects. Introjections with good and bad representations that were alike could develop into self-images, which later result in the differentiation of self and ego boundaries (Kernberg, 1966).

Kernberg (1966) considered identification to be a more complex level of introjection. At this level, the child can identify that the object takes on a specific role in interpersonal interaction with the self. Compared to introjection, at the level of identification the self can be more clearly seen as separate from the object and affective colouring is more organised and not as intense (Christopher et al., 2001; Kernberg, 1966). Kernberg considered ego identity to be the highest level in the organisation of internalisation of object relations (Christopher et al., 2001; Kernberg, 1966). Ego identity characterises the integration of ego structures and the formation of a sense of continuity of the self.

Otto Kernberg (1976) argued that under conditions of adversity and trauma, in order to avoid intrapsychic conflict and emotional distress and in order to preserve the self, the object and the attachment, the child makes use of several primitive defences, viz.: idealising, devaluing, projective identification, splitting and dissociation (Blizard, 1997; Caligor & Clarkin, 2010; Kernberg; 1976).

When a caregiver is abusive, the child may idealise the object. In so doing, the object is maintained as good, and the child can safely continue their attachment to the caregiver (Blizard, 1997; Kernberg, 1975). Alternatively, when the self is idealised, the self is maintained by splitting off any feelings of humiliation or fragility associated with memories of the trauma event. On the other hand, by devaluing the self the child preserves the object by shifting any

feelings of guilt or humiliation about the adverse experience onto the self, and in this way the object can continue to be idealised (Blizard, 1997; Kernberg, 1975).

Melanie Klein, a pioneer in the field of object relations, was the first to coin the concept of projective identification (Klein 1946). Kernberg (1967) believed that projective identification only occurs in the most severe psychiatric cases where the individual has an overwhelming need to project the bad objects (object representation or image) and self-representations.

Kernberg (1966) described splitting as a primitive defence that only appears once introjections have formed. According to Kernberg (1966), splitting occurs at the age of three to four months and then decreases again at around the age of one year. Splitting is a normal developmental process in which introjections are kept separate (or split) for the purpose of ego defences. Splitting can be thought of as a defence where the child divides self-representation or self-image into a good and bad me, and splits the object image into a good and bad caregiver (Kernberg, 1975). In so doing, the child idealises the good image of both the self and the caregiver and devalues the bad.

In the field of psychoanalysis, splitting generally denotes the dissociation of the awareness of good and bad representations of self and object, whereas the term in the field of trauma, dissociation is used to explain the separation of adverse experiences from everyday consciousness (Blizard, 1997). Blizard (1997) argues that the process of splitting off images of self and object is closely related to the dissociation of memories of abuse by the object. Blizard (1997) points out that both splitting and dissociation are used in the literature to emphasise the splitting or separation of the contents of conscious awareness. Accordingly then, when the child is faced with unbearable adversity, the child may dissociate memory of such an experience. In doing so, memories of trauma are kept separate from non-traumatic memories of everyday life

(Blizard, 1997). In some instances, memories of adverse experiences may become associated with a personality or self-state that is dissociated or separated from the personality that holds the memories of everyday mundane experiences.

2.4.1.4. Theoretical models of Disorganised Attachment (DA) and dissociative self-states

Attachment theory grew out of the object relations theory (Blizard, 1997). John Bowlby (1973) was one of the earliest scholars to suggest a connection between child caregiver attachment relationship and dissociation. More specifically, unsatisfactory care-seeking interactions between a child and caregiver may cause the infant to form various unintegrated internal representations (Internal Working Models) of self and the attachment figure. Mary Ainsworth (1983) later expanded on Bowlby's attachment theory by suggesting that infants need to develop a secure dependence on caregivers from which the child can then explore and discover the world.

The term attachment is used in this report specifically as coined by Bowlby (1958) to signify a survival instinct. The young of every species instinctively hold on, follow and act in ways that engage the adult's attention to maintain their close contact by using methods such as crying, anger and sweetness (Bowlby, 1958; Sachs, 2013). The survival of the young depends on their ability to engage with and draw the closest attentiveness from the caregiver (Sachs, 2013). These methods of engaging become enduring patterns of relating to others throughout life (Sachs, 2013).

Several different types of attachment behaviour have been conceptualised in the context of attachment theory, viz.: secure attachment, insecure attachment and disorganised attachment (Sachs, 2008, 2015, 2017; Liotti, 1992). Given that attachment behaviour exists for the purpose of survival, the abovementioned types of attachment behaviour exist on a continuum of most to least effective in achieving the purpose of survival. These attachments are elaborated below.

Secure attachment: Secure attachment describes a relationship between a child and a caregiver that is stable, consistent and organised (Sachs, 2008, 2015, 2017). The caregiver responds to the child in a predictable, consistent and loving manner. The child is free to explore their surroundings and play independently. Secure child–caregiver relationships and interactions promote secure future relationships that in turn ensure long-term survival and the development of a coherent sense of self. (Sachs, 2008, 2015, 2017; Liotti, 1992). Secure attachment is also the most effective with regard to survival (Sachs, 2013).

Insecure attachment: Contrary to secure attachment, insecure attachment denotes a relationship that is incoherent, ambivalent and dissociative in nature (Sachs, 2008, 2017; Liotti, 1992). The child continuously has to modify their behaviour in order to draw the attention and affection of the caregiver. The behaviour that the baby displays may not reflect their true self or emotions, the result being that the baby's concept of self, confidence and ability to communicate openly may be inhibited (Sachs, 2017). The attachment relationship is still functional as their early ability to engage their attachment figure had never been compromised. However, the child may have difficulty forming future intimate relationships (Sachs, 2008, 2015, 2017). Insecure attachment is less effective for survival purposes than secure attachment (Sachs, 2013).

Disorganised attachment: According to Sachs (2008, 2017), disorganised attachment occurs in the sphere of trauma. The attachment figure does not respond to the infant's attachment

requests in a predictable or reliable way. Rather, the same behaviour may elicit a different response from the caregiver, i.e., a hug or a beating, or perhaps a neglectful or avoidant response (Sachs, 2008, 2015, 2017). It can be thought of as if the child is left in a continuous and chaotic search for effective ways to engage the caregiver. This type of attachment relationship with a caregiver is confusing because the very relationship that the child is dependent on for self-preservation is also a source of great threat to the child (Sachs, 2008, 2015, 2017). In such times of such internal conflict and chaos, it may be difficult for the child to form a stable sense of self, and a consequence of this may be that the child's sense of self remains fragmented (Blizard, 2003; Putnam, 2006; Sachs, 2013).

Sachs (2008, 2015, 2017) maintains that DA is not truly disorganised, as the caregiver's reactions are not truly random. Instead, they follow the caregiver's mental states and preoccupations, and the child eventually learns to find the pattern of these reactions (Sachs, 2008, 2015, 2017). The particular pattern of reacting that each child learns becomes their blueprint for relating to others in the future (Sachs, 2013).

Sachs (2013) proposed that further sub-groups exist within disorganised attachment patterns, namely: cannot classify (Hesse; 1996); erotising, agonistic, care-giving patterns (Liotti, 1999); infanticidal attachment (Kahr, 2007); which further subdivides into symbolic and concrete infanticidal attachment (Sachs, 2008). See Table 3 below for a description of the different disorganised attachment patterns.

Table 3: Sub-groups of Disorganised Attachment

Sub-groups of Disorganised Attachment
Hesse (1996) noted that a distinct group of people exist who do not fit the category of DA. Hesse proposed a new category, which was named "cannot classify".
Liotti (1999) outlined three patters of disorganised attachment, viz.: erotising pattern, which describes a relationship where the erotic relationship is drawn on as an alternative for close attachment; an agonistic pattern, which denotes a relationship where aggression is used as a way to stay close; and a care-giving pattern, which describes a relationships where caring is used for maintaining proximity to others.
Kahr (2007) described infanticidal attachment as a pattern that aims to engage an attachment figure who has preoccupations or wishes of death for the child. The child engages the caregiver with behaviours that put the child in danger, for example, self-harm, risky or self-destructive behaviour, addiction, personality disorders or even attempts at suicide.

Similar to Kahr's (2007) description of infanticidal attachment, Sachs (2008) described this particular pattern of attachment as symbolic infanticidal attachment. According to Sachs (2008, 2013), this is because in a symbolic infanticidal attachment relationship the death wishes are not acted upon or caused by the caregiver. Harm occurs by the hand of the child who attempts to engage the caregiver by means of acting out their preoccupations or wishes. In instances of concrete infanticidal relationships, the harm is not symbolic, but is instead acted upon in a real way (Sachs, 2008, 2013). Concrete infanticidal relationships include direct acts of maltreatment or death threats. The most meaningful engagement between the child and caregiver takes place during times of maltreatment.

Note. *Adapted from* "Still being hurt: The vicious cycle of dissociative disorders, attachment, and ongoing abuse," by Sachs, A. 2013.

When the attachment relationship between the child and caregiver is disorganised (in all its various forms), the child is constantly focused on and preoccupied with the attachment figure (Sachs, 2017). This may hinder the child's ability to explore their environment or develop a coherent sense of self (Sachs, 2008). These developmental impairments carry into adulthood and are evident in many forms of mental disorders, including DID (Sachs, 2008, 2017). Some with DID are unable to escape the vicious cycle of abuse and are unable to remain safe. Every new painful experience may cause new dissociation and their DID can become even further embedded (Sachs, 2013, 2017). Sachs (2013) positions dissociation as an important function for surviving the physical pain and emotional unbearableness of severe abuse. It can, however, also be a dangerous tool (Sachs, 2013, 2017). It undermines the person's ability to learn from his or her experience, as these experiences are not available. As a result, the capacity to recognise danger and to act for safety is diminished (Sachs, 2013).

Empirical evidence that supports the link between DA and dissociation

Research findings point to DA as a potential predictor of psychological problems associated with maltreatment in childhood. A meta-analytic study conducted by Cyr, Euser, Bakermans-Kranenburg and Van Ijzendoor (2010) found a significant association between childhood abuse and disorganised attachment relationships. Other studies have related DA to dissociation. In a longitudinal study by Ogawa, Sroufe, Weinfield, Carlson and Egeland (1997), the authors found that in addition to later abuse, both infant disorganised attachment behaviour and maternal emotional unavailability in the first two years of life predicted dissociation at age nineteen. Yet another study conducted by Dutra, Bureau, Holmes, Lyubchik and Lyons-Ruth (2009) found that parental emotional unavailability at eighteen months was the most reliable determinant of dissociation at the age of nineteen.

2.4.1.5. Cognitive model of dissociation

The present model of dissociation, proposed by Kennedy et al. (2004) and Kennedy (2013), is adopted from Beck's (1996) cognitive theory of personality and psychopathology. According to the model proposed by Kennedy et al. (2004, p.28), personality constitutes a series of "*modes*". Modes are considered a specialised collection of "*schemas*" or conscious control systems that unify the self. Modes are internal representations that assist in processing (or encoding) cognitive, emotional, behavioural and bodily information, as well as generating a fitting response in different situations (Kennedy, 2013; Kennedy et al., 2004). Schemas act as a gatekeeper for incoming information. "*Orienting schemas"* encode internal and environmental information and initiate modes appropriate to the context (Kennedy et al., 2004, p.28). For

example, the personality contains a mode (which consists of a set of schemas) with information about how a person feels (afraid), thinks (I need to escape), reacts physically (perspires), and behavioural responses (freezes) when in a particular situation (fear eliciting). This particular mode is only activated when the orienting schemas process relevant input, otherwise they remain dormant. This early process is assumed to take place automatically, without any mental effort (Kennedy, 2013; Kennedy et al., 2004).

The conscious control system is tasked with bringing together different modes into an integrated sense of self, i.e. a sense of "me", "self", and "I", which has multiple ways of being via different modes (Kennedy et al., 2004; Kennedy, 2013; Şar, Dorahy, & Krüger, 2017). Under normal circumstances, there would be an exchange of information between connected modes throughout the conscious control system, both within and across schemas (Kennedy, 2013; Kennedy et al., 2004). Moving between different modes (of personality) is seamless and appropriate to the situation.

Dissociation occurs as a result of "decoupling" of the abovementioned mental processes. Decoupling can occur at three levels of information processing, namely: automatic (threat) processing, within-mode processing, and between-mode processing (Kennedy, 2013; Kennedy et al., 2004).

Level 1: Automatic threat perception and response schemas

Automatic dissociation is believed to be implicated in the decoupling of associations or cognitive connections between orienting schemas (Kennedy, 2013; Kennedy et al., 2004). Early associative processes allow incoming information to be identified as threat cues or signals. Automatic dissociation results in compartmentalisation (that is, the failure to access information

when it is required) of information both during trauma and long after the trauma event has occurred (Kennedy, 2013; Kennedy et al., 2004).

The task of the orienting schema is to associatively process incoming, physiological and environmental information (Kennedy et al., 2004). When a stimulus is recognised as threatening, the orienting schema stops processing new incoming information. This recognition is based on sensory input such as colour, smell and sound (Kennedy, 2013; Kennedy et al., 2004). Once incoming input has been matched with existing information in the orienting schemas, and identified as threatening, information is relayed directly to the part of the brain (the Amygdala) where the flight, flight or freeze response is triggered. Chemicals are released (such as cortisol and adrenalin) and as a result may stop further encoding of incoming information and may produce dissociative symptoms such as detachment, depersonalisation and derealisation (Kennedy, 2013; Kennedy et al., 2004).

What this means is that at the time of the trauma event, dissociation at this early stage will stop associative encoding. This process may result in the abnormal encoding of information, and memories of the trauma event may be fragmented (Kennedy et al., 2004). That is to say, the dissociation of that which would be associated under normal circumstances inhibits the integration of the traumatic material and its elaboration into significant memories. Constraints on integration may result in trauma-related material (such as a memory of the traumatic event) being triggered at a conscious level, without any understanding of the context of the information. Automatic processing may therefore produce “isolated” dissociative symptoms, such as the experience of trauma flashbacks (Kennedy et al., 2004).

Level 2: Within-mode dissociation

Within-mode dissociation involves a decoupling of connections between schemas within a mode (Kennedy, 2013; Kennedy et al., 2004). In other words, there is a failure to integrate relevant information from different schemas (cognitive, affective, behavioural or physiological) within the same mode. This holds consequences for the storage and retrieval of information, including accessing information when it is not suitable (thought intrusions) or the failure to access information when it is required (compartmentalisation) (Kennedy, 2013; Kennedy et al., 2004). Within-mode dissociation is considered strategic processing rather than an automatic process (Kennedy et al., 2004). For example, reduced emotional response following trauma may be understood as the decoupling of an affective schema from other schemas within a mode.

Level 3: Between-mode dissociation

Between-mode dissociation involves a partial or complete decoupling of various modes (Kennedy, 2013; Kennedy et al., 2004). Dissociation at this level may produce and maintain more than one unintegrated conscious control system. It is possible for each conscious control system to have its own sense of identity, values and desires guiding behaviour that may conflict with the identity, values and desires of another control system (Kennedy, 2013; Kennedy et al., 2004). Therefore, from a cognitive perspective, DID is the result of the persistent decoupling or dissociation of the links between modes and the development of different and separate conscious control systems.

When the information processing system is overwhelmed by an adverse event, the characteristic associative style of encoding may switch to a dissociative or inhibitory pattern (Kennedy, 2013; Kennedy et al., 2004). This is likely to occur under conditions of severe childhood maltreatment. The maladaptive encoding of information may inhibit the formation of a

coherent self and could lead to changes in personality structure, typically seen in cases of DID. This damaging pattern may be maintained because it offers an adaptive consequence to the child in the face of adversity (Kennedy, 2013; Kennedy et al., 2004). Multiple control systems help the child to cope with unbearable and irresolvable conflicts between the need for attachment to and the need for safety from an abusive caregiver.

At this level of dissociation, integration of modes may occur between some modes, but not others (Kennedy, 2013; Kennedy et al., 2004). Post-trauma symptoms developed during early adversity may be restricted to a limited number of modes within the personality structure. A separate sense of self, belief and value system may develop around these isolated set of modes.

When such a separate sense of self, belief and value system becomes very pronounced, Kennedy (2013) refers to it as a dissociative self-state or identity. Kennedy (2013) describes a dissociative self-state or identity as a compartmentalised or isolated set of modes each with its own conscious control system. In DID, isolated clusters of modes may be so dissociated from each other that the individual could experience them as not part of the self. Often there is a lack of awareness regarding the existence or nature of another dissociative self-state/s. This lack of awareness may be conceptualised as an amnesic gap when a switch between identities takes place and another identity takes control (Kennedy et al., 2004). The extent of this control may vary (Kennedy, 2013; Kennedy et al., 2004). For example, the dissociative part may be described as a co-host, as an alien entity, or as an outside force taking over.

2.4.2. Integrated aetiological theories of dissociation and DID

Above and beyond the previously mentioned aetiological theories of DID, there are authors who have integrated several schools of thought into their conceptualisation of the aetiology of DID. The following section will explore such integrated theories; more specifically, the Discrete Behavioural States (DBS) model (Putnam, 2016) and the Theory of Structural Dissociation of the Personality (Van der Hart, Nijenhuis, & Steele, 2006).

2.4.2.1. Discrete Behavioural States Model

The Discrete Behavioural States Model (DBS), developed by Frank Putnam (1997, 2016), conceptualises a way of understanding dissociative states, including the pathological dissociation found in DID (Putnam, 2016). The DBS defines dissociation as a switch or transition between states and/or as a distinct state disconnected from other mental and behavioural states (Putnam, 1997, 2016). According to Putnam (1993, 1988), dissociation occurs along a continuum of severity. For example, dissociation can range from normal dissociative states, such as daydreaming, to maladaptive or pathological dissociation, such as detachment, numbing or "out-of-body experiences", to the most severe or extreme states found in DID (Bernstein & Putnam, 1986; Putnam & Trickett, 1993). The DBS defines pathological dissociation "*as a discrete state of consciousness, recurrently activated by stress, trauma, or by stimuli reminiscent of trauma*" (Putnam & Trickett, 1993, p. 41). Putnam and Trickett (1993) continues by stating that this discrete state of consciousness processes (or encodes) information

in a way that not only disrupts the retrieval information, but also the integration of information into everyday consciousness.

The development of states:

Healthy children are born with a limited number of mental and behavioural states, such as asleep, waking, hungry, and in pain, that the child transitions or switches between. The number of states, the number of pathways that exist between states and the ease with which a child moves from one state to another (switch) improves with development (Bob, 2013; Putnam 1988, 1997, 2016). States differ in how they manifest (e.g. the need to escape or the need for nurture) as well as in their psychophysiological underpinning, such as arousal level, heart rate, memory, sense of self, affect, cognition, appraisal and brain region activation. These states exist in a "*multidimensional state-space*" (Putnam, 2016, p.36). The state-space is made up of a collection or system of states that cycle recurrently (Bob, 2013; Putnam, 1988, 1997, 2016). The cycling or habitual pattern of states constitutes a person's personality (Putnam, 2016). In early childhood, sense of self is highly dissociative in nature (Putnam, 1997, 2016). A child's ability to integrate states into a coherent whole, and to sustain and practice control over states advances with the maturation of brain structures and the availability of a secure attachment relationship in the child's life (Putnam, 1997).

Two predominant types of states of consciousness exit within the state-space, namely, everyday states and extreme states (or discrete behavioural states). Putnam (2016) describes everyday states as a set of states that encompass a person's everyday activities and roles. Everyday states are easily accessible to the individual and an established pathway exists between them. These pathways ensure the seamless transition or switch between states. Conversely, extreme states are those states that reside on the outskirts of the state-space that are quite separate

and far removed from everyday consciousness. Putnam argues that trauma exposure, specifically repeated adverse childhood experiences (ACE), may lead to the development of such extreme states (Putnam, 2016).

Early adverse childhood experiences and the development of alter personality states:

Alter personality states (a synonym for dissociative identities), commonly found in DDs such as DID, are described as *"...complex, enduring, identity-based, discrete dissociative states that evolve during childhood and adolescence [and] arise in the context of severe trauma occurring early in childhood... Over time, they become increasingly differentiated...*" (Putnam, 1997, p. 175). Putnam (1988) proposes two ways in which early trauma may increase the distinctiveness and discreteness of "*alter personality states*" (p. 26).

Firstly, early adverse childhood experiences may disrupt the normal developmental pathways that are meant to link or integrate fragmented states (discrete behavioural states) into a more cohesive personality (Putnam, 1988, 1997, 2016). Because trauma interferes with the normal linking process, the connections among states may be limited and transition between them may be abrupt. As a result, post-trauma memories of the event may not be connected to everyday state memory that is easily accessible to the individual (Putnam, 1988, 1997). For example, extreme states elicited by a negative feeling towards an abusive attachment figure may be dissociated from other easily accessible states in an attempt to safeguard the relationship to the attachment figure. Children who have been faced with extreme adversity try to stay away from overwhelming emotional pain by avoiding the mental jumps needed to integrate fragments of identity into a more cohesive identity (Putnam, 2016). Integrating trauma states and everyday states would require confronting information that is too unbearable for the child (Putnam, 2016).

Secondly, early adverse trauma experience may result in trauma-specific extreme states of consciousness. In the face of repeated severe threat, the child may form and depend on restrictive extreme states of being (for example, debilitating terror, excruciating pain and devastating grief) that alter their sense of reality, and are adaptive in the face of threat (Putnam, 1988, 1997, 2016). Recurrent use of these trauma-related alter personality states (or dissociative identities) embeds alter personalities with a detailed sense of self who personify particular feelings, emotions, behaviours and developmental phases. Over time, trauma-related personality states may become very distinct from and conflict with other personality states (Putnam, 1988, 1997).

2.4.2.2. The Theory of Structural Dissociation of the Personality

The Theory of Structural Dissociation of the Personality (TSDP) proposed by Van der Hart, Nijenhuis and Steele (2006) is an integrated theory of dissociation that aims to explain dissociation in the context of trauma (Nijenhuis & Van der Hart, 2011). The TSDP makes inferences about the kind of differences that exist among dissociative parts of the personality in trauma-related disorders (Van der Hart, Nijenhuis, Steele, & Brown, 2004). The TSDP is based on the work of Pierre Janet, a nineteenth-century psychiatrist, and Charles Samuel Myers, a British WW1 psychologist and psychiatrist (Nijenhuis & Van der Hart, 2011; Van der Hart et al., 2006).

According to the TSDP, trauma produces a division or split of an individual's personality into dissociative parts (Nijenhuis, & Van der Hart., 2011). The division of the personality occurs when the individual lacks the capacity to integrate elements of the past trauma with everyday life

(Nijenhuis, & Van der Hart, 2011; Van der Hart et al., 2004). The lack of unity of the personality may present as alteration between and coexistence of the re-experiencing of trauma and avoidance of reminders of the traumatic experience (Van der Hart et al., 2006). The aim is to function and manage in everyday life. This pattern of intrusion and avoidance is characteristic of trauma-related disorders, including DID (Van der Hart et al., 2006).

Action systems

Nijenhuis, Van der Hart and Steele (2010) relate detachment from and re-experiencing of trauma to evolutionary-derived psychobiological systems referred to as action systems or emotional operating systems (Van der Hart et al., 2006; Nijenhuis & Van der Hart, 2011). Action systems are the fundamental components that help to organise and regulate major functions of the personality with respect to attention, feeling, physiology and behaviour (Van der Hart et al., 2006). Action systems develop over the courses of development and maturation and require sufficient life-experiences to maximise functioning (Steele, Van der Hart, Nijenhuis, 2005; Van der Hart et al., 2006). Organisational function of action systems may be disrupted by early adverse experiences, resulting in maladaptive organisation of various action systems, leaving the individual susceptible to dissociation (Van der Hart et al., 2006). This pattern of maladaptive organisation may persist even after the threat has dissipated.

Various action systems exist, each geared towards different tasks and goals. Van der Hart et al. (2006) distinguish between the daily life action systems and defence action systems. Daily life action systems regulate mental and behavioural action tendencies primarily aimed at securing everyday necessities while avoiding reminders of the trauma (Van der Hart et al., 2006). These action tendencies include exploration, play, energy management, attachment, sociability, procreation and caring for others, whereas other action systems focus largely on defensive

actions in response to threat, interpersonal rejection and attachment loss (Van der Hart et al., 2006). Defence systems include various subsystems, such as freezing, escape, fight and submission. The defence action systems are primarily stuck in experiencing various defences, as they were at the time of the adverse event (Van der Hart & Matar, 2012). Daily life action systems and defence action systems can have overlapping action tendencies (such as speaking and walking), and can have action tendencies and goals unique to the particular action system (for example, eating, drinking, and attachment). The purpose of action systems is to distinguish between helpful and harmful experiences, and to generate the best adaptive response to current life circumstances (Steele et al., 2005; Van der Hart et al., 2006).

Human beings are capable of engaging in both tasks of daily life and surviving under conditions of threat independently, but engaging in both simultaneously proves to be a much more difficult task (Van der Hart et al., 2006). When both are necessary, particularly for long periods of time, some individuals develop a rather rigid division of their personality to deal with these very conflicting tasks (Van der Hart et al., 2006).

Two major types of dissociative parts

The TSDP describes two types of dissociative parts of the personality: the *apparently normal part of the personality* (ANP), and the *emotional part of the personality* (EP) (Steele et al., 2005; Nijenhuis, & Van der Hart, 2011; Van der Hart et al., 2006). The ANP is predominantly mediated by action systems for functioning in daily life. ANP action systems include energy management, working, attachment and caretaking (Nijenhuis & Van der Hart, 2011). The action system for energy management, for example, will be geared towards looking for food and eating (Nijenhuis & Van der Hart, 2011). The ANP is fearfully avoidant of traumatic memories. This

avoidance may manifest in various degrees of detachment, numbing, depersonalisation, and partial or complete amnesia (Nijenhuis & Van der Hart, 2011; Steele et al., 2005).

The EP is primarily mediated by the defence action system regarding threats to the integrity of the body (Nijenhuis & Van der Hart, 2011; Van der Hart et al., 2006). The core values of the physical defence action systems are avoiding or escaping from aversive stimuli (Nijenhuis & Van der Hart, 2011; Van der Hart et al., 2006). EPs contain traumatic memory, often being stuck in or reliving and experiencing various defences, as they were at the time of the traumatic event, i.e. fight, flight or freeze (Steele et al., 2005; Van der Hart & Matar, 2012). The aim of the EP is to detect and survive threats, for example, by freezing, fighting, fleeing, submitting, or crying for the attention of the attachment figure (Steele et al., 2005; Nijenhuis, Van der Hart, & Steele, 2011; Van der Hart et al., 2006).

Levels of dissociation

The TSDP describes three levels of structural dissociation of the personality ranging from least to most complex. These levels include primary structural dissociation, secondary structural dissociation and tertiary structural dissociation (Van der Hart et al., 2006).

Primary structural dissociation denotes the most basic form of trauma-related division of the personality between a single ANP and a single EP (Steele et al., 2005; Van der Hart et al., 2006). In the case of primary structural dissociation, the ANP remains the predominant part of the personality and the individual can still function relatively normally in everyday life. However, action tendencies of the EP present at the time of the adverse experience may intrude on daily life (Van der Hart et al., 2006). In primary dissociation of the personality the EP is not clearly defined or elaborate, does not necessarily manifest independently in everyday life, and does not necessarily have a separate sense of self (Van der Hart et al., 2006). Primary structural

dissociation characterises simple trauma-related disorders such as Post-Traumatic Stress Disorder (PTSD) (Steele et al., 2005).

Secondary structural dissociation is a more complex division of the individual's personality into multiple EPs and a single ANP (Steele et al., 2005; Van der Hart et al., 2006). Secondary dissociation occurs when trauma is increasingly overwhelming or continues over an extended time (Steele et al., 2005; Van der Hart et al., 2006). More complex and prolonged dissociative division is particularly evident when the adverse experience took place during childhood. This may be due to naturally limited integrative ability in childhood (Van der Hart & Matar, 2012). In secondary division of the personality, the single ANP functions quite normally in everyday life. Similarly, to the EP in primary structural dissociation, the EPs in secondary structural dissociation are not very elaborated or autonomous (Steele et al., 2005; Van der Hart et al., 2006). Van der Hart and Matar (2012) suggest that the creation of multiple EPs may be based on the failed integration among relatively unconnected defences and their trauma-related memories, for example fight, flight, freeze and collapse, and unbearable emotional experiences associated with the adversity such as shame or loneliness. Secondary structural dissociation characterise disorders including complex PTSD, trauma-related borderline personality disorder, and dissociative disorders not otherwise specified (DDNOS) (which is the previous DSM-IV term for what is now DSM-5's OSDD).

Tertiary structural dissociation is the most extreme form of structural dissociation of the personality into more than one EP and more than one ANP (Nijenhuis, Van der Hart, & Steele, 2010; Steele et al., 2005; Van der Hart et al., 2004; Van der Hart, Nijenhuis, & Steele, 2006). Tertiary structural dissociation involves the formation of dissociative identities, characteristic of disorders such as DID (Nijenhuis et al., 2010; Steele et al., 2005; Van der Hart et al., 2004; Van

der Hart, Nijenhuis, & Steele, 2006). According to the TSDP, tertiary divisions occur when certain inescapable aspects of daily life become associated with trauma (Steele et al., 2005; Van der Hart et al., 2006; Van der Hart & Matar, 2012). In this way, everyday aspects of life can become a trigger for traumatic memories. Ongoing reactivation of EPs and their traumatic memories may impede functioning of the ANP to the extent that everyday life itself is too overwhelming, and new ANPs develop in an attempt to avoid trauma-related memories (Van der Hart & Matar, 2012; Van der Hart et al., 2006). The action systems of daily life, such as exploring, attachment, caretaking and sexuality, which are normally found in a single ANP in primary and most secondary structural dissociation, are now divided among several ANPs (Van der Hart et al., 2006). As we have seen in secondary dissociation, the multiplication of EPs are activated by trauma-related memories. The development of multiple ANPs, as is evident in tertiary division, are evoked by specific goals and functions involved in the person's life. For example, some parts may be evoked for the purpose of work, another part may be activated for parenting and yet another for sexual activity (Van der Hart et al., 2006). ANPs are restricted to the tasks and goals of the action system by which the part is mediated. Division of the ANP occurs when normal life becomes too unbearable for the individual, at which time the individual may then use dissociative parts of the personality to cope with and function effectively in everyday life (Van der Hart et al., 2006).

In severe cases of secondary and in all cases of tertiary dissociation, more than a single EP will be defined and elaborated on in terms of name, age, gender and preference (Steele et al., 2005; Van der Hart et al., 2006). EPs may also be able to function and act independently, without influence or control from other parts of the personality (Steele et al., 2005; Van der Hart et al., 2006). On occasion, some EPs may even feature in daily life and take on elements of daily life

action systems in addition to the defence systems it is dedicated towards (Van der Hart et al., 2006).

The aetiology of tertiary structural dissociation of the personality

According to the TSDP, when adverse experiences occur at an early age (prior to the age of eight), is significantly severe, continues over an extended time, and forms a substantial part of everyday life, tertiary structural dissociation of the personality is likely to occur (Van der Hart & Matar, 2012; Van der Hart et al., 2006). Early and chronic traumatisation inhibits the development of a cohesive personality (Nijenhuis et al., 2010; Van der Hart et al., 2004). The traumatisation may interfere with the normal developmental pathway dedicated towards integration of daily life action systems, promoting the emergence of more than one ANP. In addition, recurrent childhood traumatisation promotes the division of the EP (Nijenhuis et al., 2010; Van der Hart et al., 2004).

The TSDP holds the view that children who have been physically or emotionally hurt by caretakers in early childhood, with maltreatment comprising an unavoidable part of everyday life, will have trouble forming a unified and cohesive daily life system (Van der Hart et al., 2006). The EPs may take on the action systems that would normally be a part of everyday life, but conversely, have become an element of the trauma. For instance, the sexuality action system normally belongs to the ANP as a component of everyday life. Under conditions of trauma, however, the sexuality action system may become associated with an EP tasked with coping with sexual maltreatment.

The role of attachment in tertiary structural dissociation of the personality

Van der Hart, Nijenhuis and Steele (2006) implicate extreme disturbance in attachment relationship between the child and caretaker in the development of complex division of the

personality. The action system directed towards attachment is an essential component that promotes the formation and organisation of other action systems (Van der Hart et al., 2006). More specifically, the attachment action system mediates threat response that would disrupt the development and integration of daily life action systems.

When a child engages with an attachment figure who is negligent, violent or terrifying, a response to threat follows (Van der Hart et al., 2006). This threat response sets in motion defensive subsystems of flight, freeze or fight. When the caregiver's response to the child is unpredictable, the child may be unable to develop a coherent and organised pattern of relating to and engaging with the attachment figure (Blizard, 2003; Sachs, 2013). The TSDP maintains that DA may in fact not be entirely disorganised (Van der Hart et al., 2006). The irresolvable conflict that the child faces, between approach and avoidance, encourages a structural division between the different action tendencies that are activated by insecure attachment and the defensive action system (Van der Hart et al., 2006). The attachment and defence action systems are organised within individual parts of the personality, but are not organised in a cohesive manner across parts (Van der Hart et al., 2006). Alterations between or intrusions of conflicted parts are not voluntary, and thus behaviour appears to be frantic. Van der Hart, Nijenhuis and Steele (2006) suggest that patients diagnosed with DID may continue to develop new ANPs to cope with events that they cannot integrate.

2.5. Conflict as covered by the above schools of thought and integrated theories

The respective aetiological theories of DID previously discussed differ in their conceptualisation of the origin of DID as well as in their terminology used to describe the nature and formation of dissociative identities. As will be discussed below, notwithstanding these differences, conflict in DID is discussed in some capacity.

Although aetiological theories (which were discussed at length in the literature section) discuss conflict in DID in some capacity, they are however limited in their scope as to the role and the nature of such conflict in the life of a DID patient.

Psychoanalytic theory

The psychoanalytic theory developed by Sigmund Freud (see also above, Chapter 2, section 2.4.1.3.) describes conflict in hysteria as a conflict that exists between unconscious primitive biological drives (fantasies and wishes) and an internalised rejection of these drives. Freud describes repression (or dissociation) as a defence against biological drives involving the relocation of conflicts to the unconscious mind (Spermon, Darlington, & Gibney, 2010). According to Freud (1961), repression is an unconscious process where distressing information is buried below or split from (by the ego drive) the level of consciousness in the unconscious mind (the domain of the id drive). Freud believed that hypnoid states form the basis of hysteria and that these hypnotic-like states can bring about the splitting of the mind or consciousness (Bliss, 1988).

Object relations theory

Object relations theory can be thought of as an extension of the classical psychoanalytic theory (see also above, Chapter 2, section 2.4.1.3.) (Kernberg, 2018). From this perspective, the conflict between impulse and defence becomes a conflict between contradictory, conflictual internalised object relations (Kernberg, 2018). Kernberg (1976) believed that especially under conditions of adversity and trauma, in order to avoid intrapsychic conflict and emotional distress and in order to preserve the self, the object, and the attachment, the child makes use of splitting. Splitting is a primitive defence mechanism and can be thought of as a process that allows two conflicting experiences of good and bad self and object representation to exist in consciousness, but not simultaneously or in relation to the same object relation (Caligor & Clarkin, 2010; Kernberg 1976). Kernberg (1976) believed splitting to be a normal developmental mechanism. However, maladaptive splitting can threaten the integrity of the ego and the future developmental capacity of the ego as a whole. Kernberg (1976) saw maladaptive splitting as interfering with the integration of affects, with the development of a representational world, and the overall integration of the self. Maladaptive splitting can be seen as the origin of dissociative states found in DID.

Betrayal Trauma Theory (BTT)

BTT highlights the importance of betrayal of trust as a precursor in the development of dissociative symptoms (see also above, Chapter 2, section 2.4.1.2.) (Freyd & Birrell, 2013). Central to BTT is the conflict that exists between ‘caregiver’ and ‘abuser’ (Freyd & Birrell,

2013; Freyd, 1994, 2003). In other words, the one in whom the child should put her/his 'trust' is also the one who is 'not to be trusted'. It leaves the child with an irresolvable dilemma or paradox (Freyd & Birrell, 2013). For survival, the child has to trust an adult for care. However, in cases of betrayal trauma, the adult on whom the child is dependent for care, is not trustworthy. The child then has to 'let go' or 'dissociate' one of the facts because the child cannot keep two mutually exclusive, contradictory facts (i.e., 'I trust my caregiver' vs. 'I should not trust my caregiver') in consciousness at the same time (Freyd & Birrell, 2013; Freyd, 1994, 2003). Often then it would be the fact that the adult is not trustworthy that is dissociated (or'forgotten'), because the child has no choice but to trust that adult for survival (Freyd & Birrell, 2013). In this way, the child then remains 'unaware' that the caregiver is also an abuser. The pattern of dissociating information from awareness may continue into adulthood and pave the way towards more distinct dissociative identities seen in cases of DID (Freyd & Birrell, 2013).

Attachment Theory

Attachment theory proposes that when a caretaker's behaviour towards the child is dissociative, confusing or even frightening, it is difficult for a child to integrate the conflicting experiences of fear/avoidance and safety/approach (see also above, Chapter 2, section 2.4.1.4.) (Liotti, 1992; Blizard, 2003). This type of frightening relationship with a caregiver is confusing for the child because the very relationship that the child is dependent on for self-preservation is also a source of threat to the child (Sachs, 2008, 2015, 2017). In such inner chaos and conflict, the child is likely to cope by developing multiple, incoherent and conflicting working models (or dissociative identities) (Blizard, 2003; Liotti, 1999; Sachs, 2013). Sachs (2015) argues that, non-

dissociative people can resolve discrepant thoughts (such as feelings of fear and safety towards a caregiver) through great internal struggle and conflict sometimes, and decide on which action should follow. However, for someone with DID, discrepancies could lead to conflict in their behaviour and action. Someone with DID may experience internal conflicts as an external and explicit conflict among their different identities. It is also possible that when the person with DID is unaware of other identities, in such instances this external conflict or struggle is often battled blindly as they may not even be cognisant of who is opposing their actions (Sachs, 2015).

Cognitive model of dissociation

The Cognitive model of dissociation describes level three dissociation as one that can produce and maintain more than one conscious control system simultaneously (Kennedy et al., 2004). Multiple conscious control systems often have an adaptive purpose. In the face of abuse, the child is bound by an irresolvable conflict (Kennedy et al., 2004). The person that the child depends on for safety and survival is also a source of danger and threat. The child may persistently dissociate from the pain and fear that the cargiver/s are abusive and separate conscious control systems (dissociative identities) may develop to help the child to cope with these conflicting needs.(see also above, Chapter 2, section 2.4.1.5). Once developed, conscious control systems may form their own sense of identity, values, needs and desires guiding their behaviour (Kennedy et al., 2004). Differing control systems may conflict with other control systems in terms of sense of self, beliefs, values, needs and desires (Kennedy et al., 2004; Kennedy, 2013).

Discrete Behavioural States (DBS) Model

In his DBS Model, Putnam describes alters or dissociative identities, found in disorders such as DID, as discrete behavioural or personality states that form during childhood in the context of severe trauma (see also above, Chapter 2, section 2.4.2.1.) (Putnam, 1997, 2016). Children who are faced with extreme adversity try to stay away from overwhelming emotional pain by avoiding the mental jumps needed to integrate these extremely disconnected discrete behavioural identities into a more cohesive identity (Putnam, 2016). Putnam (1988, 1997, 2016) conceptualises conflict in DID in two ways. Firstly, as an internal event or struggle. Among the various paradoxes in the individual's identity and behaviour they may experience tremendous difficulty in making sense of and coming to terms with who they are (Putnam, 2016). Secondly, he describes conflict that may arise among disconnected discrete identity states. These states may have limited awareness of each other and as such may act in conflicting, opposing and self-defeating ways (Putnam, 1988, 1997, 2016). These different identity states may have their own sense of self, and may have different sets of feelings, emotions, past experiences, goals, memories and behaviours and/or embody a different developmental phase, based on the specific trauma-related experiences that led to the development of the personality state (Putnam, 1997, 2016).

The Theory of Structural Dissociation of the Personality (TSDP)

TSDP maintains that most people experience parts of themselves as less cohesive (see also above, Chapter 2, section 2.4.2.2.). This may be experienced as conflicts between goals, thinking, feeling and different roles in life (Steele et al., 2005; Van der Hart et al., 2006). However, the ability to reconcile these conflicts, prioritise what is important and then decide what is the best point of action is a function of integration. When someone who has survived an extreme trauma develops a degree of structural dissociation, these inner conflicts are by effect relatively unavailable for reconciliation (Van der Hart et al., 2006). Such an individual may find it difficult or impossible to acknowledge other parts or goals that may be quite discrepant (Steele et al., 2005; Van der Hart et al., 2006). Dissociative parts may have divergent ideas of which values and goals are most important in the life of the person as a whole (Van der Hart et al., 2006). Dissociative parts may also have their own first-person perspective, i.e. their own point of view as to who they are, what the world is like, and how they relate to that world (Nijenhuis & Van der Hart, 2011).

For the purpose of this dissertation, the assumption is that dissociative identities provide a solution to the presence of unbearable trauma and irreconcilable conflict in the life of the DID individual. The person wants to avoid these unbearable thoughts, feelings, beliefs and/or memories. As a result, these unbearable thoughts, feelings, beliefs or memories become the domain of dissociative identities, which sometimes leak into the person's life and result in a tremendous amount of internal conflict and pain. Conflicting dissociative identities can be conceptualised as dissociative identities that cannot be kept in awareness at the same time, as would be required to ensure a unified sense of self. These unbearable thoughts, feelings, beliefs

and memories differ from and conflict with the thoughts, feelings, beliefs and memories of other dissociative identities.

2.6. Conclusion

This chapter introduced the various aetiological theories of DID. The discussion included the various definitions of dissociation, the clinical understanding of DID, the aetiological theories that inform our understanding of DID and how these theories have evolved over time. The last section of this chapter provided an overview of how conflict in DID is conceptualised by the different schools of thought.

Chapter 3: Design and methods

3.1. Introduction

The present study sought to explore the subjective experience of conflict and the nature of conflict of a group of adult psychiatric patients diagnosed with DID. The aim of the proposed study was achieved by exploring first-hand accounts of a group of adult psychiatric patients diagnosed with DID, where they describe their subjective experience of conflict as well as the nature of their conflict. The first-hand accounts are in the form of secondary data – i.e. typed transcriptions of previously collected data in the form of previously recorded in-depth interviews.

The goal of this chapter is to describe the methodological process of this study. This chapter outlines a discussion on the retrospective analysis of previously collected data (i.e. secondary data); the researcher's paradigmatic point of departure; research design; sampling method and participants; data collection methods and procedures followed; data analysis; trustworthiness of the research; and ethical considerations.

3.2. Retrospective analysis of previously collected data

In the present study, qualitative analyses were performed retrospectively on typed transcriptions of previously recorded in-depth individual interviews. The in-depth interviews were conducted between 2013 and 2016 by Prof. Christa Krüger, Department of Psychiatry, UP, as part of a broader mixed methods research project. The methodology of that mixed methods study in 116 psychiatric in-patients is described in Krüger and Fletcher (2017), and the findings of preliminary qualitative analyses of interviews with 14 of those patients who had been diagnosed with DID or other specified dissociative disorder (OSDD) are reported in Krüger (2016). Subsequent to the latter reporting of the preliminary findings on the 14 patients with DID or OSDD, another patient with DID was recruited to that study, bringing the total number of patients with DID or OSDD to 15.

3.3. Qualitative research approach

As mentioned in the introductory chapter of this dissertation, the role of conflict in DID is underexplored beyond theoretical deductions leaving a gap in present-day research. Likewise, the subjective experiences of conflict of people diagnosed with DID have largely been excluded from research. It would therefore prove necessary to explore the first-hand accounts of the role of conflict as it is subjectively experienced by adult psychiatric patients diagnosed with DID. This study employed qualitative methods to gain such a subjective understanding of conflict in DID.

According to Schmid (1981), qualitative research can be characterised as an inquiry of the empirical world from the perspective of the person under investigation. Schmid (1981)

identified two basic assumptions that underlie qualitative research. Firstly, human behaviour is influenced by the physical, social and mental world. Secondly, human behaviour exists beyond what can be observed by the researcher. The subjective meanings and perceptions of the participants are critical in qualitative research, and it is the role of the researcher to gain insight into these meanings and perceptions (Krefting, 1991).

Qualitative research is exploratory in nature (Gagliardi & Dobrow, 2011). That is to say, qualitative inquiry aims to describe, understand and explain social constructs. A qualitative approach is also considered a suitable approach when the topic of inquiry is relatively underexplored as it allows for an inductive and flexible way of conducting research (Terre Blanche et al., 2006). A qualitative research approach therefore suited this study as it facilitated an in-depth understanding of the experience of conflict of patients diagnosed with DID.

3.4. Paradigmatic point of departure

A paradigm encompasses the researcher's assumptions or beliefs about ontology (nature of reality), epistemology (how we know the world), axiology (the role of values in research) and methodology (the process of research) (Creswell, 2007; Guba, 1990; Wahyuni, 2012). As the aim of this study is to explore and understand the subjective experience of conflict and the nature of conflict of patients diagnosed with DID, the paradigmatic point of departure for this study is interpretivism. Interpretivism is also referred to as social constructivism in the literature (Creswell, 2013; Denzin & Lincoln, 2011). Interpretivism can be traced back to the body of work by Max Weber (1864–1920) who argued that the purpose of social research is to understand ('*Verstehen'*) (Crotty, 1998).

Interpretivists believe that people continuously try to make sense of the world they live in. This they do by ascribing subjective meanings to their experiences (Crotty, 1998; Creswell, 2007). The central tenet of the interpretivist paradigm is that realities are socially constructed (DeLamater & Hyde, 1998; Du Preez & Eskell-Blokland, 2012; Wahyuni, 2012). People do not exist in a void, but form these subjective meanings in the course of interacting with others and within their broader social context (Creswell, 2007; Crotty, 1998; DeLamater & Hyde, 1998; Du Preez & Eskell-Blokland, 2012). Because meaning making is a subjective process, it is subject to change and can be multiple (Creswell, 2013; Wahyuni, 2012).

Interpretivist research attempts to gain an understanding of the social world by examining the experiences and subjective meanings people might have (Terre Blanche et al., 2006; Wahyuni, 2012). Wahyuni (2012) describes good social knowledge, from within this paradigm, as a study that uncovers insider perspective or real meaning of a phenomenon. In this study, patients' own words will be analysed to explore the subjective experience of conflict of adult psychiatric patients diagnosed with DID. Interpretivist research makes use of qualitative research methods that provide in-depth descriptions of social constructs (Henning, Van Rensburg, & Smit, 2004; Wahyuni, 2012). In this study, in-depth descriptions were used and the researcher aligned this with interpretivism.

3.5. Research design

The present qualitative study was designed as a collective case study, as described by Robert Stake (2005) (Creswell, 2007, 2013; Stake, 2005). Stake (2005) argues that a case study is not a methodology but rather a choice of what is to be studied. That is to say, the researcher

defines a bounded system or parameters which will form a case study inquiry. A case can be bounded in terms of time, place, activity, context or setting (Baxter & Jack, 2008; Creswell, 2013; Stake 2005). The case being studied could be a programme, process, event, the individual or individuals (Baxter & Jack, 2008; Leedy & Ormrod, 2010). In addition, a case study involves extensive, in-depth data collection from various sources of information, including observations, interviews, documents, retrospective records and audio-visual materials (Creswell, 2007, 2013; Leedy & Ormrod, 2010). Case study research allows for in-depth and comprehensive understanding of the case (Creswell, 2013; Henning et al., 2004).

Robert Stake describes three types of case study designs (Creswell, 2007, 2013; Stake 2005). *Intrinsic case study* design is used when the intent of the study is to gain a better understanding of a unique case or phenomena. *Instrumental case study* is used when the intent of a study is to understand a particular issue or problem. In this instance the case itself is not the main focus, rather, the case facilitates understanding of the selected issue or problem. The specifics of the case are still looked at in depth, examined and detailed in order to inform external interest. *Collective case study* describes an instrumental case study extended to multiple cases that illustrate the issue or concern. Cases are selected to enable exploration of differences and similarities within and across cases.

The current study is designed as a collective case study. The focus of this study was to examine and describe the bounded system in depth. The bounded system or case of the study is the set of previously transcribed in-depth interviews of 15 adult patients diagnosed with DID or OSDD who were studied between 2013 and 2016. Access to the data transcriptions of the 15 patients was provided by Prof. Christa Krüger, the principal investigator of the broader mixed methods research project and senior supervisor for this research project.

A collective case study design is the appropriate method when the intent of the study is to better understand a particular issue or problem (Creswell, 2007; Creswell, 2013; Stake, 2005). Cases are selected to enable exploration of differences and similarities within and across cases. In the present design, multiple cases of psychiatric patients diagnosed with DID were selected to facilitate a better understanding of the experience of conflict of patients diagnosed with DID.

3.6. Sampling method

Creswell (2014) suggests that the premise behind qualitative inquiry is for the inquirer to purposefully select participants (or in this case documents) that may assist the inquirer in better understanding the research question. The present study made use of the purposive sampling method. This method is used when sampling is done with a particular purpose in mind (Henning et al., 2004). That is to say, the research participants fit specific criteria or illustrate some feature of interest for the study (De Vos, Strydom, Fouché, & Delport, 2011). The aim of the study was to gain a better understanding of the subjective experience and the nature of conflict of adult psychiatric patients diagnosed with DID. The previously transcribed in-depth interviews of 15 adult patients diagnosed with DID or OSDD who were studied between 2013 and 2016 constituted the sample for the present study.

The sampling methods followed to identify the patients with DID or OSDD are described in Krüger and Fletcher (2017) and Krüger (2016). In summary, the patients with DID or OSDD had been identified from 116 psychiatric in-patients, i.e. 58 patients from each of two hospitals: Weskoppies Hospital (WKH) (a specialised state psychiatric hospital in Pretoria, and one of the academic training hospitals for the University of Pretoria) and Tshwane District Hospital (TDH)

(a regional hospital that also renders primary level psychiatric care). Of the 116 psychiatric in-patients who participated in the broader study, 15 met the criteria for DID or OSDD. The patients with DID or OSDD were diagnosed using a combination of Dissociative Experiences Scale (DES) scores (Bernstein & Putnam, 1986; Carlson & Putnam, 1993), Multidimensional Inventory of Dissociation (MID) scores (Dell, 2006) and in nine instances the principal investigator's conducting clinical psychiatric interviews and administering the Structured Clinical Interview for DSM-IV Dissociative Disorders – Revised (SCID-D-R) (Steinberg, 1994).

3.7. The research participants

3.7.1. A clinical summary of the research participants

The clinical summary of the 15 research participants (Table 4) as well as the demographic characteristics related to gender and employment (Table 5) are presented in table format below.

Table 4: A clinical summary of research participants

Pt No.	Doc No.	No. of interviews	Age	Gender	Language of interview	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

Pt No.	Doc No.	No. of interviews	Age	Gender	Language of interview	Diagnosis
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=Participants; D=Document number; F=Female; M=Male; A=Afrikaans; E=English.

Table 5: The distribution of patients 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

3.8. Data collection

The data for the present study were collected from the original mixed methods research project. For the qualitative component of the original mixed methods research project, a total of 28 in-depth interviews were conducted with 15 patients (Krüger, 2016). The in-depth interviews were conducted between May 2013 and October 2016 by the principal investigator, Prof. Christa Krüger. The investigator made use of a semi-structured interview guide that covered the events leading up to this hospital admission, current life circumstances and problems, specific psychiatric symptoms, dissociative symptoms, symptoms relating to possession and trance, experiences relating to identity, roles and conflict, spiritual experiences, and experiences around information processing. Field notes were also made by the principal investigator. All interviews were audiotaped and transcribed professionally. The interview guide was adapted in subsequent interviews, depending on what themes emerged in the previous interviews, resulting in an iterative, reflexive process.

The abovementioned 28 transcribed interviews and accompanying field notes constituted the data for the present study. The researcher for the present study was given access to electronic versions of the original dataset (transcriptions and audio recordings). The data were stored securely on the researcher's password protected laptop. The researcher also had access to the field notes made in the course of data collection. In addition, the researcher obtained ethical clearance from the Faculty of Health Sciences Research Ethics Committee (protocol 411/2017) to re-use the data for this research project (please see Appendix B for a copy of the research ethics approval).

3.9. Data analysis

The professional transcriptions of the 28 interviews of the 15 patients and accompanying field notes made by the principal investigator were analysed by means of thematic analysis. The focus of thematic analyses is to identify and describe implicit and explicit concepts within qualitative data, i.e. themes or patterns (Guest, MacQueen, & Namey, 2012). Codes that represent the themes are derived in order to assist in analysing and interpreting of the data. This study followed an inductive approach to research. Durrheim (2006) describes an inductive approach as a process of engaging with the details and particulars of the data to uncover relevant categories, components and connections (Cited in Terre Blanche et al., 2006).

The researcher sought to explain what the experience of conflict is like for patients diagnosed with DID. Because the topic of inquiry for this study is relatively underexplored in present-day research, and a thematic approach allows the researcher to derive an explanation for this particular phenomenon under investigation, the researcher deemed a thematic analytic approach an appropriate tool for this research project. Thematic analysis is a flexible method and as such is particularly useful when the work diverse in nature, as was the case with the present study (Braun & Clarke 2006).

The data were further analysed using the constant comparison analysis method formulated by Boeije (2002). The constant comparison method allowed the researcher to derive an explanation rooted in the data.

Boeije (2002, p. 395) outlines five steps that can be used when working with the constant comparison method, which are as follows: 1) comparison within a single interview, 2) comparison between interviews within the same group with the same experiences, 3) comparison

of interviews from groups with different experiences, 4) comparison in pairs of interviews with two partners belonging to a couple, and 5) comparing interviews with several couples. However, due to the nature of the data comprising only one group, only steps one and two were used for the purpose of this study. Each of the previously mentioned steps will be discussed in relation to the analysis for the present study in the section that follows.

Because the principal researcher was not part of the original data collection, it was deemed necessary for the researcher to become familiar with the data. This was achieved by means of reading the data transcriptions, listening to the audio recordings and reading the field notes taken at the time of data collection. The data was uploaded on the computer software program Atlas.ti, which assisted in organising and analysing the data. In doing so, the transcriptions were also reviewed for accuracy, and for correcting any errors made in the transcription process.

Step one: Comparison within a single interview

The first step of the constant comparison method involved the comparison within a single interview (step 1 is summarised in Figure 1). The data was coded inductively, using the open coding method suggested by Boeije (2002). Each paragraph of the interview transcript was read carefully to try to understand what the participant is saying. Each paragraph or phrase was then coded accordingly, thus creating different fragments within the interview. This step was done independently for each participant. The codes were refined in several ways. Each participant interview and its emerging codes were reviewed and deliberated in weekly or bi-weekly meetings scheduled with the supervisors for the project. These regular meetings were used to

discuss the research process as well as problems stemming from the research. Revisions to the codes were made according to deliberations with the supervisor, including renaming codes, merging similar codes together and adding new codes to the data. In addition, codes that belonged to the same category were grouped together. For example, there were several codes and quotations related to religious conflicts that patients described. Quotations were reviewed and based on the content of the quotation, the codes were grouped together, for example, by adding religious conflict in the title, codes appeared together in the code list on Atlas.ti. Consider "Religious conflict: Demonic possession" as an example.

Next, using the output function on Atlas.ti, outputs with code names and their associated quotations were generated and exported to Microsoft Word documents. This was done individually for each participant. This process enabled the researcher to look for similarities and differences among fragments or codes within the same interview. Thus, the researcher was able to develop a description of the characteristics of each into meaningful categories. These findings were discussed with the supervisor. Revisions to the codes were made accordingly. Figure 1 below provides a graphical representations of step one in the data analysis process.

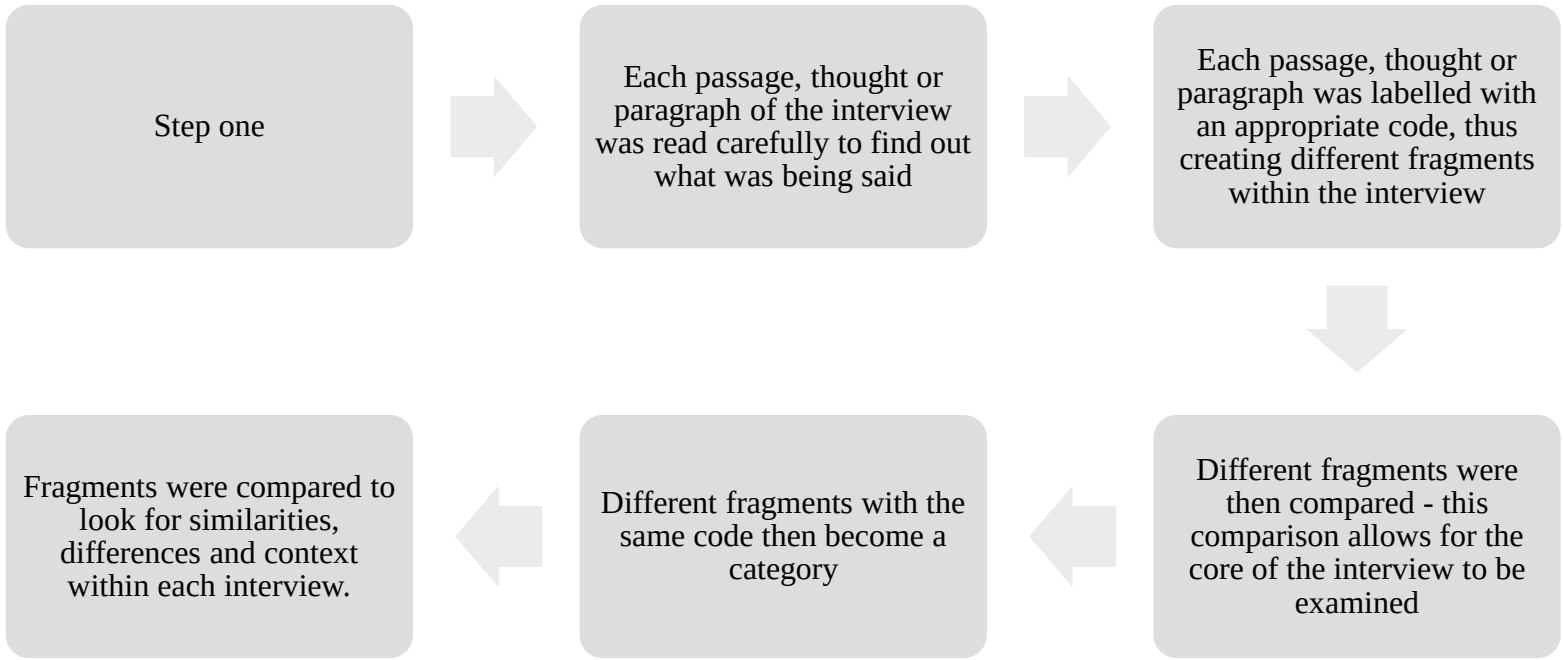

Figure 1: Step one: Comparison within a single interview

Step two: Comparison between interviews within the same group (people who share the same experience)

As proposed by Boeije (2002), step two involved comparing interviews among the different participants with the aim of conceptualising the codes into more overreaching categories and sub-categories (step 2 is summarised in Figure 2). The axial coding method was used for this step, as suggested by Boeije (2002). Categories derived in step one, and their associated codes and quotations were then compared across participant interviews. Similar categories or themes across participants were grouped together by creating families in Atlas.ti. The process of grouping codes into families was discussed in-depth with the supervisor of the study after which revisions were made. This process involved the merging of existing codes and revision of code names. The process of comparison between participants was also facilitated by generating an Atlas.ti output which included all the codes that belonged to a particular family and their associated quotations for the 15 participants in one Microsoft Word document. This document was generated in addition to the per participant output in step one to ensure that no context was lost in the consolidation process.

The output document was then assessed for similarities and differences within each category. Combinations of codes or categories were looked for within the text. These combinations of codes formed a pattern that describes what a particular experience is like for different participants, for instance, what the experience of conflict between dissociative identities is like for patients with DID. Step two of the data analysis process allowed the researcher to derive descriptions and characteristics of each identified category. Emerging categories and sub-categories were reviewed and discussed with both the supervisor and co-supervisor of this

research project. This process entailed revising codes into more overreaching categories and sub-categories.

It became evident that some interviews did not fit the established pattern. The analysis revealed that certain interviewees experienced, for example, religious conflicts in very different ways. The basis on which participant experiences differed could be obtained from the comparison among participants.

The final phase of the analysis comprised of writing the findings section of this report. The findings were produced by presenting each category or theme and their associated sub-categories by providing clear descriptions of each category as well as providing evidence supporting each category description, viz., direct quotations.

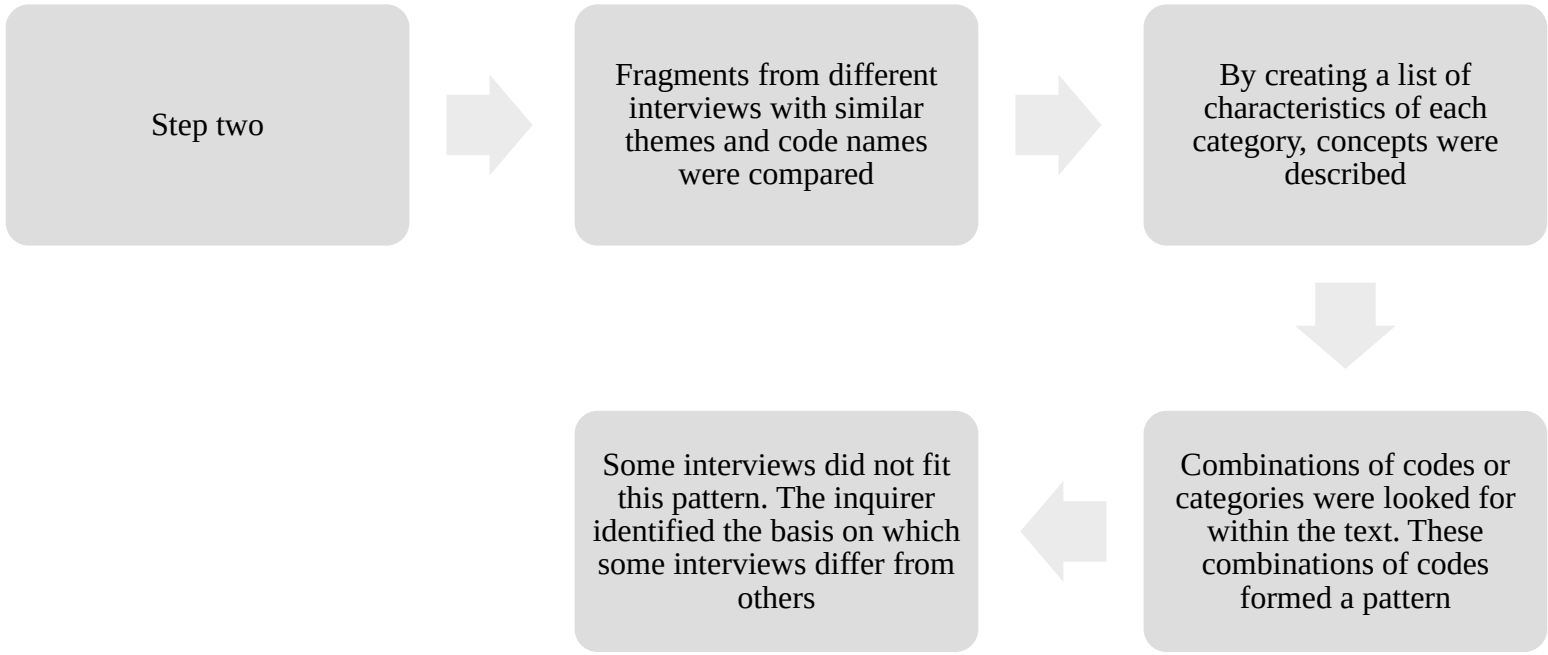

Figure 2: Step two: Comparison between interviews within the same group

3.10. Trustworthiness of the research

Qualitative and quantitative researchers are both required to demonstrate the credibility of their research (Golafshani, 2003). Quantitative researchers employ concepts such as reliability and validity to achieve such credibility in their work (Shenton, 2004). Qualitative approaches are often assessed against standards suitable to quantitative research and are found lacking in this regard (Krefting, 1991). Krefting (1991) maintains that because the nature and goal of qualitative research are different to those of quantitative research it is wrong to apply the same conditions of truthfulness to both approaches. Shenton (2004) states that, despite the reluctance of some to accept the trustworthiness of qualitative inquiry, a framework for ensuring rigour in qualitative inquiry does exist.

Creswell (2007, 2013) suggests several validation strategies to be used by qualitative researchers to ensure the accuracy of their findings. These strategies are: prolonged engagement between participant and researcher, triangulation of multiple sources of information, peer debriefing, negative case analysis, reflexivity of the researcher, member checking, writing rich thick descriptions, and audit trails. Creswell (2013) suggests that qualitative inquirers engage in at least two of these strategies. The following six strategies were used in the present study:

Negative case analysis: This strategy encourages the researcher to not only look for information that confirms but also information that does not fit the initial research question. The method of analysis used for this project ensured that all accounts of the phenomena under investigation were included. The constant comparison analysis method places emphasis on looking for both confirming cases and those cases that do not fit patterns identified by the

researcher (Boeije, 2002). The researcher is also required to identify the basis on which these accounts differ.

Triangulation: Data triangulation refers to the process of collecting data in several ways from as many sources as possible (Creswell, 2007; Terre Blanche et al., 2006). In the present study, data were analysed that had been collected in several different ways, including data transcriptions, audio recordings and field notes taken at the time of data collection. The data transcriptions constituted the main data that were analysed for this project. Prior to coding and further analysis, the transcriptions were read thoroughly to allow the researcher to become familiar with the data. Recordings of the interviews were listened to in order to get a better understanding of the intent with which statements were made. Field notes were reviewed for information (such as physical gestures) that were not captured by the audio recordings.

Peer debriefing: Lincoln and Gube (1985) suggest making use of peer debriefing as a means to add to the credibility of the research. Peer debriefing involves exposing the inquirer to an individual well versed in the subject of inquiry (Creswell, 2007). Regular meetings were held with both Prof. Christa Krüger (Supervisor), a consultant psychiatrist at Weskoppies Psychiatric Hospital, and also the Head of Research, Department of Psychiatry, University of Pretoria, and Ms Monique Bezuidenhout (Co-supervisor) (Lecturer: Department of Psychology, and Clinical Psychologist: UP) to deliberate and discuss the research process, the findings, the interpretations of these findings, as well as how to proceed. The principal researcher for this project moved to Cape Town in March 2018. Regular communication and feedback were maintained with both supervisors via email. To further ensure the accuracy of the findings, the analysis process was inspected by Prof. Krüger and Ms Bezuidenhout.

Researcher's reflexivity: My personal reflections are noted in Chapter 5, section 5.7.

Rich thick descriptions: Creswell (2007) suggests that rich descriptions involve describing the study setting, participants and themes in as much detail as possible. Rich thick descriptions speak to the credibility of the research (Creswell, & Miller, 2000). This report provides a description of the demographic and clinical characteristics of the participants. Furthermore, a full description of the methodological processes used in the research project is outlined. This report comprises a rigorous and in-depth description of the phenomena under investigation. The authentic voices of the participants were used to inform the interpretations and findings of this study. Extensive verbatim quotes of the participant's interviews were used to further substantiate the researcher's findings. The verbatim quotes were kept inclusive of contextualising sentences, and not truncated unnecessarily.

Audit trail: According to Creswell and Miller (2000), by establishing an audit trail the researcher provides clear documentation of all research decisions and related activities, by means of keeping a diary to record all research activities and noting data analysis procedures extensively. This process speaks to the credibility of the research. The data were uploaded, coded and analysed using the data analysis software tool Atlas.ti. By using Atlas.ti the researcher was able to leave a clear audit trail. Within the main Atlas.ti file, the researcher's decisions regarding coding, consolidation of themes and methodological decisions in terms of merging codes and derived families can be accessed. In addition, the researcher made process notes during the data analysis stage in a diary, outlining discussions with supervisors, thoughts, insights, questions and queries that emerged during the research process. All Microsoft Word documents including coding lists and family output documents generated from the software program Atlas.ti were stored securely on the principal researcher's computer.

3.11. Ethical considerations

The original research protocol received ethics approval from the Research Ethics Committee of the Faculty of Health Sciences, University of Pretoria (Protocol 121/2012) and minor amendments were approved by the same committee in April 2013, August 2013 and January 2014. An extension of ethics approval for a further four years was granted on 1 July 2016 (please refer to Appendix A). All participants signed written informed consent before participating in the study after the study procedures were explained to them. Written informed consent was obtained for both the broader project as well as for the qualitative study that included audio recordings. Participants' data were collected anonymously so as to protect their identity. All research data are stored securely according to the Policy for the Preservation and Retention of Research Data of the University of Pretoria.

Institutional ethics approval to commence with the present study was obtained from the University of Pretoria (UP), Faculty of Humanities Research Ethics Committee, on 22 November 2017 (please refer to Appendix C) and the Faculty of Health Sciences Research Ethics Committee, on 29 September 2017 (protocol 411/2017) (please refer to Appendix B). All precautions were taken to safeguard the participants from unjustifiable risk or harm. Specifically, no identifiable information was used in this study in order to ensure the anonymity of the study participants. Verbatim quotes of the participants' interviews were used in this report to ensure the authenticity of the findings.

3.12. Conclusion

This chapter provided an outline relating to the methodological approach that was employed to answer the research question. This study employed qualitative methods to gain a subjective understanding of conflict in DID and the researcher aligned this with interpretivism. A collective case study design was followed and a thematic analysis guided by Boeije's (2002) constant comparison method, was performed retrospectively on typed transcriptions of previously collected data in the form of previously recorded in-depth individual interviews. The chapter was concluded with the steps that were taken to ensure the trustworthiness of the research and findings and a description on the ethical considerations that were pertinent to this study.

Chapter 4: Findings

4.1. Introduction

The goal of this chapter is to describe and discuss the themes and subsequent sub-themes that emerged from the data (please see Figure 3 below for a visual representation of the themes). The findings section consists of three themes. Theme one describes patients' different levels of separateness of the self. Theme two describes how patients diagnosed with DID experience having one or more incompatible and conflicting belief system or worldview about their DID. Theme three is an in-depth account of the different types of conflict that exist between dissociative identities. Participants were assigned specific participant numbers or pseudonyms to protect their anonymity.

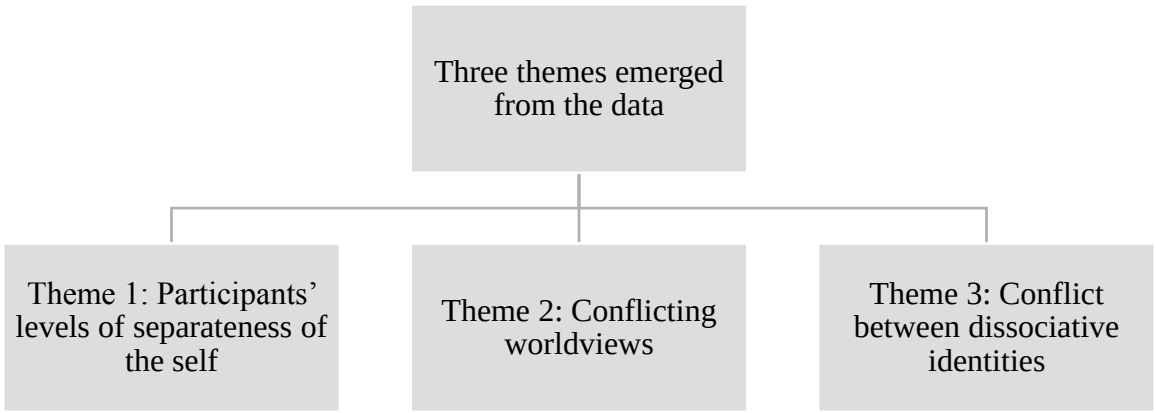

Figure 3: Themes that emerged from the data

4.2. Theme 1: Participants' levels of separateness of the self

Participants varied in their levels of separateness (dissociation) and unity of the self. Participants' level of separateness and unity of the self refer to how singular a person feels they are. A well-integrated person might experience who they are as different from time to time but still regard themselves as one person with one overreaching identity. Someone with DID, however may experience themselves as multiple. In other words, they feel that they have different and separate parts inside of them and these parts are integrated to a lesser or greater degree.

Three different levels of this nature appeared from the data. At level one, participants experienced a single self made up of different parts, which are not completely separate from the person. At level two, participants described several different dissociative parts or identities that appear to be quite separate from the self. At level three, participants described a separate external force possessing the person. Figure 4 provides a visual representation of the different levels.

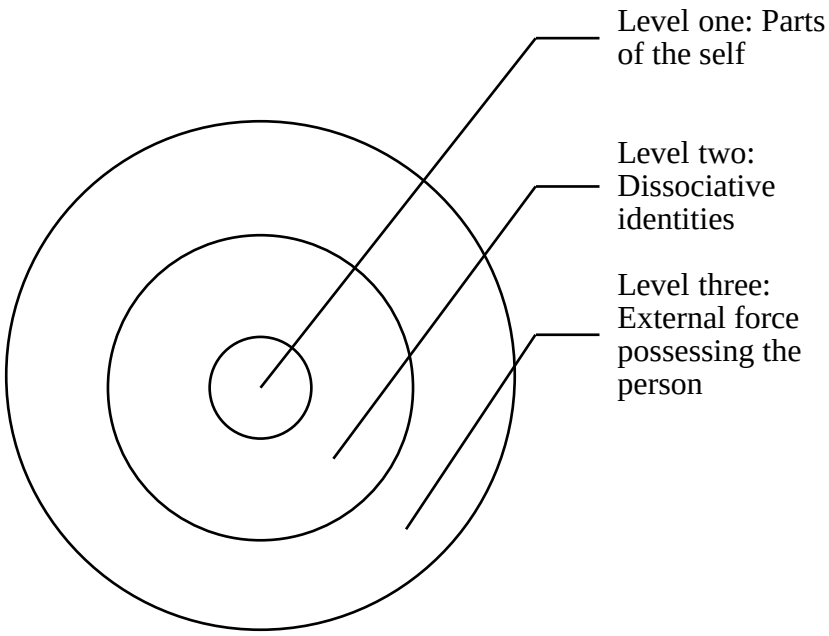

Figure 4: Levels of self-states

4.2.1. Level one: Parts of the self

At level one, participants describe the self as consisting of different parts, all belonging to a single identity. Although this level can be characterised by some degree of separateness among the parts, they form part of one person. In addition, the data show that there is a degree of co-awareness among the different parts.

Participant one is a 26-year-old woman with a diagnosis of DID. The participant described having two distinct parts that she experienced as belonging to her unitary self.

> *Not that I don't recognise myself. It's like… it's like looking and seeing someone else, like, I can see it's me but it's not me, like, when I was young I used to… I used to hear voices and I gave them names and at times I'd see someone in the mirror and be like, okay who*

are you and it's like… it's like almost as if they… it's like being in other parts of… it's like different parts of me. **(**Pt[1]1: D[2]1: Par[3]46**)**

In the transcript below the participant explained that although she experienced these parts as part of her identity they do feel separate from her. She described it as a tug of war between two parts of herself pulling her in either direction and she is in the middle trying to negotiate who she is. Thus, it can be said that feeling separated or dissociated from the other parts of the self and feeling unified is not a static experience for this participant. Rather, the participant described moving between these different levels of awareness.

Pt.: It's like, yes… it's like… it's like almost as if… it's like if there was a tug of war rope and the flag was in the middle. It's not like I become fully that person, like, I can… at times maybe I do but it's like… it's like being pulled and then it becomes… it's like just less of that part and more of that part. And then the other part tries to come back and it can't and then…
Int.: So it's more of a fluid shifting.
Pt.: Yes. It's like… it's… but that's what I'm saying, it's like it is me but it's… like, they are me but they're not me, it's like I can see them clearly as separate but they… but they still are me. **(**Pt1: D1: Par310-311**)**

4.2.2. Level two: Dissociative identities

At level two, patients described having several different selves, parts or identities. For the purpose of this dissertation, these different selves will be referred to as dissociative identities. Dissociative identities can be characterised by a measure of separateness among them.

---

[1] Abbreviation Pt: Participant number
[2] Abbreviation D: Document number
[3] Abbreviation Par: Paragraph number

Participants appear to be less aware and in control of the thoughts, actions and feelings of the other parts or dissociative identities.

Participant two, a 35 year old Afrikaans-speaking woman, was asked by the interviewer if she regarded herself as one person. The participant described herself as having one body, but having more than one identity inside of her that take over her body at different times.

> *Well, I am one person in front of you, but meanwhile I am not one person sitting here. If I can put it like that. I do not know if you understand what I'm saying… Yes, I'm more than one, but as you look at me you see one person. That's what I'm getting to, but inside of me there are parts that are there. And that's what people do not understand. So well, yes.* (Pt2: D2: Par488) (Translated from Afrikaans).

Patient two described the difficulty of her experience of her dissociative identities before she was diagnosed with DID. When the other dissociative identities took over the participant was unaware of and unable to control what was happing to her. She explained that the separateness between herself and her dissociative parts resulted in a great deal of confusion and loneliness.

> *After a while I didn't know what I was doing anymore, I didn't know why I was dressing the way I was dressing. Each identity had their own set of clothes. They had their own aftershave, things like that. I was very alone in the beginning. And many people thought I was lesbian because of it, because of every DID that came out [and] had his own set of clothes, with his own aftershave and his own everything.* (Pt2: D2: Par448) (Translated from Afrikaans)

Participant eleven is a 39-year-old man diagnosed with DID. During his interview, the participant conveyed having three different dissociative identities. His knowledge of his dissociative identities was informed by the accounts of others. He is completely unaware of what happens when his dissociative identities take over.

> Pt.: *No. The thing is, like people have told me, I've got three different personalities speaking, call it like that. But I apparently, they call themselves my names, it's David*[4]*, William and Sean.*

[4] Pseudonyms were used throughout this dissertation to protect the participants' identities.

Int.: *David, William and Sean.*
Pt.: *And apparently David is like a no s**t person, pardon my language. He doesn't take that c**p from nobody.*
Int.: *Yes.*
Pt.: *William is the personality I am the majority of the time. And then Sean is like this, he's like the weakling. He can't stand his ground, he's … People have called him a m****e, like.*
Int.: *As in gay?*
Pt.: *No, no like in …. Just cries, and like … It's hard for me to explain. That's what they told me.* (Pt11: D18: Par371-384)

In the following quotation the participant emphasises how separate he considers himself to be from his aggressive dissociative identity.

Int.: *Does it feel as if David is not part of yourself?*
Pt.: *Ja, it's not the person that I am.*
Int.: *Right. Not even part of you?*
Pt.: *He is totally opposite of what I am, or what William is.* (Pt11: D18: Par813-820)

4.2.3. Level three: External force that possesses the person

There were also participants who experienced their dissociative identities as an external force that possesses and takes control of them. In these instances the origin of the possession is attributed to either a demonic or ancestral force, depending on the cultural, religious or ethnic background of the participant. In the subsequent theme, participants describe having multiple beliefs or worldviews regarding the origin of the possession force. For the purpose of this theme, the data revealed that participants' awareness of what is happening to them during the time of the possession was dependent on secondary accounts of others present at the time of the event.

Participant six, a 30-year-old Afrikaans-speaking woman, described her possession experience as feeling as though something from the outside comes in and then takes control of her body.

> *I feel like it is something that takes me, because my body feels fine the one minute and then the next minute I have to, if I feel it coming on, I have to concentrate in one place. I can feel something takes over me.* (Pt6: D11: Par104) (Translated from Afrikaans)

This participant believed it was a demonic force that took control of her. However, her belief was founded on the opinions and beliefs of others. That is to say, the participant's beliefs were informed by what others had told her about the origin of her possession.

> *They say that there are demons, it can happen that demons attack people, they attack you and they take control of you. It may be that something went wrong in your life or something, and then doors opened, you took the wrong path or something, Satan gets a place in your life and then he attacks you and once he has that hold over you, it must be cast out.* (Pt6: D11: Par144) (Translated from Afrikaans)

Participant fifteen, a 27-year-old Zulu-speaking woman, describes her possession experience as an outside ancestral spirit or being that takes control of a piece of her mind. According to the participant, this occurred as a result of *Amafufunyana*, a culture-bound possession phenomenon.

> *OK. So what would happen is that my body would start burning, particularly my hands and my legs. And to me it felt like somebody else now has entered my body and is taking control of my body at that point in time. It literally, literally, literally felt like somebody was inside my body. Because then I would start burning like that. Sometimes it would only be half of my, of my body. Either the right hand side or the left hand side and it would be complete, someone else like possessing, taking possession of my body, my mind, my thoughts and my actions. That's how it used to feel for me when I used to feel like that.* (Pt 15b: D25: Par220)

Participant fifteen continued by expressing how separate she experienced this external force to be from herself. The participant described it as feeling as though she had completely disappeared without a sense of control or autonomy. In addition, the participant could not

provide a first person account of her possession experience. Her description of the event was informed by a recording that her father had made of her during the event. Even after having seen this video, the participant identified a clear distinction between herself and the force that had taken control over her.

> *It's literally like I disappear and in those states I am not even the one observing. I'm not even, I completely, completely disappear. I am powerless and it's a completely new person, a new thing. My father recorded me the one time when I was in these moments of being in a trance and completely possessed and it doesn't sound like me, it is not me, the things that are coming out of my mouth are not me, my voice is much deeper.* (Pt15b: D25: Par248).

This sample of DID patients experienced varying levels of separateness and unity of the self. The participants ranged from experiencing a single self with differing parts to having identities that are completely separate, to the most extreme cases of an external force possessing the person. Because one can think of dissociative identities as separate parts that may differ in significant ways, it may also be possible for conflict to manifest between these separate parts.

4.3. Theme 2: Conflicting worldviews used by participants to understand their DID

Worldviews or belief systems refer to the specific beliefs that the participants had about the origin of their DID. Alternatively, one can think of it as the way that participants made sense of or understood their dissociative experiences. Participants' worldviews were not static, but instead were described as varied, multiple and as conflicting at times. The present theme demonstrates how participants diagnosed with DID experience having one or more incompatible and conflicting belief system or worldview about their DID.

Participant two, a 35-year-old Afrikaans-speaking woman, describes two such conflicting worldviews (please see Figure 2).

Figure 5: Participant two's conflicting worldviews

In the two extracts below it becomes evident that the participant's first worldview is shaped by her history of trauma as well as her experience with psychiatric health care. In this worldview, the participant describes early trauma experiences as the cause of her DID. This trauma caused her to split into different personalities. The participant accepts this diagnosis and believes that therapy is beneficial to understanding the different parts of herself.

> *In the beginning, I realized that there was something wrong with me because I started to hide things from myself, for example things I have to work with every day and such. And then I went to talk to someone about this, she told me you had to come in for counselling so that we can have a look. And then they got her out for me. And that's when I did intensive counselling, and after a year, they diagnosed me as, okay that time it was MPD* [Multiple Personality Disorder]*, so then they diagnosed me there and when I had to come to WKH again they told me you're DID and that was the year 2000, but I wanted to know that I was DID.* (Pt2: D2: Par755) (Translated from Afrikaans)

> *It is trauma and abuse that you go through as a child, like I did. I went through a lot of trauma and abuse and that's why I split. When I went for counselling they told me that it would be intense counselling, you have to go once a week to see your counsellor for them to analyse you. After a year she told me that I was DID. And my dad didn't want to accept it. Then they taught me who is who in my house. Someone will come out without me knowing it, months and days will pass and without me realising that I attended counselling sessions and things like that, but now I am aware of every identity in me. I know why he's there, I know whose pain he is carrying and all those kinds of things. And I know what they do for me.* (Pt2: D2: Par763) (Translated from Afrikaans)

Her second worldview is framed by her own and significant others' religious beliefs. The participant's friends, church and work colleagues believe that she is possessed by demons. Her

work colleagues convinced her to stop taking her medication and instead engage in prayer to get rid of the demons possessing her. This series of events caused the participant to become ill.

> *In the past they told me that I should leave my medication and I don't know what else, and then when I did that I became ill, so yeah also because of a church that started to influence me, fix me with prayer. Then I told her but the doctors gave it to us. And those are the kinds of things that they do not understand.* (Pt2: D2: Par919) (Translated from Afrikaans)

Participant three is a 33-year-old Shona-speaking woman who described having recurrent possession experiences in either church or a healing context. During these episodes of possession, the participant was unaware of what was happening. Her possession experiences were characterised by fainting spells, seizures and aggressive behaviour. The participant described three ways of making sense of and understanding her possession experience.

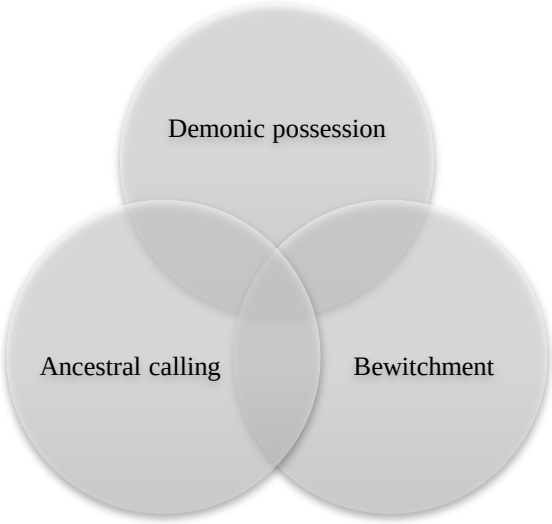

Figure 6: Participant three's conflicting worldviews

The participant's first worldview is informed by her affiliation with the church. Within this context, her experience is described as demonic possession. The church believes that prayer will bring the patient some relief from her possession experiences.

> *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. 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 second worldview is framed by the participant's traditional background. A traditional healer informed the participant that her ill health was as a result of her ancestral calling to become either a sangoma or a prophet. The participant believes that the calling requires her to decide between two ancestors who want her to take their jobs. The first ancestor is a man, which she characterises as her grandfather. This male ancestor wants her to become a sangoma who uses traditional herbs to heal people. The second ancestor is a woman of the church who uses prayer to heal people.

> *I was worried, I was worried and I started confirming to the elder of the family, and they were telling me that yes, they know that I am supposed to take that job for my grandfather which he, he was doing and they told me that there, there, there are two people who want me to take their job. The other one is a man, the other one is a woman and the woman is using, mm, church, like it's praying for people and that is what I am supposed to do and the other one is using herbs, making traditional herbs and that one is a man. And they* [sangoma] *always tell me that that is why I don't have a, a boyfriend. It's because of, eh, I didn't do, oo, all those things which they were telling me to do* [accept the ancestral calling]. *Just because they are the ones who are going to open my waist so that I can get married or what.* (Pt3: D3: Par287)

The participant is of the belief that her path is blocked by her male ancestor because of the calling and she is required to do a series of preparations which will 'open her way' and bring relief to her illness.

> *Yes, the calling, so I didn't* [accept the calling] *so that is why all the things are blocked. It is like I have to do all the things and then after all my things are going to be open. They said the one who is a man, the ancestor, is the one who is blocking my ways.* (Pt3: D3 Par 290)

Before her admission into hospital, the participant performed some of these preparations but felt that her way was still blocked as she was still experiencing poor health.

The participant's third worldview is captured by the belief that she had been bewitched by a traditional healer because someone wished bad fortune upon her. The participant described this bewitchment as the tokolosh. In Zulu mythology, a tokolosh refers to 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.* (Pt 3: D3: Par396-403)

The participant described the tokolosh as something that brings about bad luck in her life. She describes seeing the tokolosh in all of her dreams, in this way haunting her at night.

> *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. You, they won't see you as a normal person. Always some people undermine you and they just take you cheap always, just because of that thing and whenever you are dreaming a baby, a baby boy, they say there is a tokolosh*. (Pt 3: D3: Par423)

Participant three described her experience of trying to negotiate through her conflicting worldviews as difficult because none of them seem to bring her any real relief from her pain or problems.

> *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. 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)

Participant four is a 23-year-old Afrikaans-speaking woman diagnosed with DID. Some of the participant's symptoms included recurrent possession experiences, gaps in time and unexplained bruising. She described two ways of understanding her dissociative experiences: firstly, that her dissociative experiences may be a demonic possession experience, or secondly, that she may have split personalities or DID (please see Figure 7).

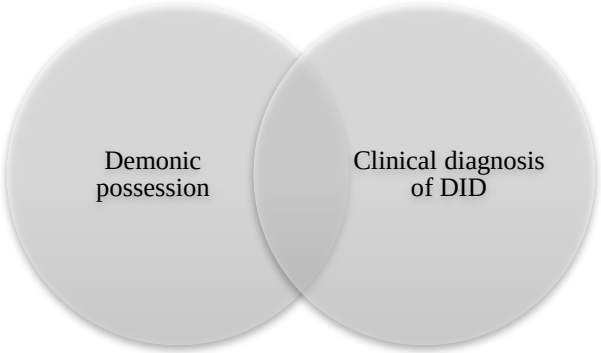

Figure 7: Participant four's conflicting worldviews

The participant's first worldview is shaped by her own religious beliefs and the opinions and beliefs of others. The first significant event that the participant describes was a possession experience when she attended a church service.

> *There have been people who have told me I had a demon inside of me, because when I go into a church, okay, I cannot walk into a church and the day I eventually decided I was going to go to church because I wanted to give it a try – when the minister preached to me my skin started to burn. It felt like it was on fire and I couldn't look the minister in the eyes and when I eventually looked him in the eyes I felt so much hate in me that it was I couldn't help myself, I just had to sit down, because when the minister starts talking to you, then you fall down as the holy spirit comes over you. But it did not happen to me, and when I sat down, my hands and fingers made funny movements, as if it wasn't my own ... as if it wasn't me that controlled the funny movements. It was very scary that time*. (Pt4: D5: Par12) (Translated from Afrikaans)

Yet another noteworthy event that informed her understanding of what was happening to her was when a Christian minister told the participant that she was possessed by a demonic force as a result of her online searches and interests in “dark arts” and “cults”. According to the minister, this opened her up to demonic possession.

> Pt.: *That reverend told me, when he asked me a few questions about looking for the dark arts on the internet and if I search for it. Then I told him yes, then I wrote yes because I have been looking at it. Because I'm not a Christian, I want to turn around completely. I went to the devil's side. So I have been looking for a lot of that stuff on the internet and I wanted to hear how it is and how it feels to belong to a cult and all that stuff. The minister told me if you open those things, it's an opening for a demon to come in, or someone can come inside you that can completely overthrow you and all those things.*
> Int.: *So does it means you believe what he said about the demon? Do you think these things are caused by a demon?*
> Pt.: *Yes, how can I say now. At one point I believed it because I think I was looking for a lot of things on the internet and now a complete stranger comes here and tells me there is a demon inside me and that's when I started to believe it. But I recently did not believe it anymore, only that I have two personalities within me, but not a demon, But I still do not know where the blue bruises come from. It may be that is why I doubt whether there is a demon inside me or not.* (Pt4: D6: Par19-24) (Translated from Afrikaans)

The second worldview from which the participant makes sense of her dissociative experiences is described by the participant as having two personalities inside of her. These two personalities have been around for as long as she can remember and they have different thoughts.

> *It always seemed to me as though there were two people inside of me, because one has these thoughts and then the other one has these thoughts and it overlaps so fast it is like a split second when it overlaps.* (Pt4: D5: Par56 (Translated from Afrikaans)

> *Yes, those two, and I have never told anyone about it* [about her personalities]. *My mom once told me I had a split personality, but I just laughed it off because I mean to admit it, it's scary*. (Pt4: D5: Par62 (Translated from Afrikaans)

The participant has hidden her dissociative personalities from others because she is afraid of how they may respond. In the quotation below the participant describes her anxiety surrounding telling her mother. The participant is fearful that her mother may become afraid of her and ultimately reject her. Similarly, the participant has not told her health professional team

at the hospital because she is afraid of being sent to a closed ward if she discloses her personalities. However, the description of DID makes sense to the participant.

> *Well some people think split personalities, if you can call it that, they say it's scary [and] you belong in a serious mental hospital if you have it. So I'm scared if people find out, they are going to … then someday they will stay away from me even more than they already do. And my mom and them may become scared of me. They will never know what I can do if I suddenly have that split. So that's why I have never told anyone about it, but I mean if I can get the help for it, if I do have it, then I will share with people and then I will give permission that others can know about it. The correct people may know about it. Not patients or anything like that. So if there is help for me if I have it, if there is help then I will take it because it's scary to me, I don't understand it ... and some of the people also say if you have a split personality and those things, like schizophrenia, they then send them to those closed wards and I don't want that, because they talk so much about these closed wards and so that it is not nice and all that stuff and I don't want that. That's why I haven't told anyone. I haven't told anybody about it, except now, when he asked me the questions then it all came down to it, now the guy asks exactly how I feel, you know, and it's like, and I didn't know who it was in the beginning, when he started asking the questions then I was, jislaaikit, that I don't know, it is very bad …* (Par4: D6: Par80) (Translated from Afrikaans)

Nandi (Participant fifteen) is a 27-year-old Zulu-speaking woman. In her interview Nandi described several differing and conflicting worldviews that each provide a comprehensible explanation for her dissociative experiences. The participant's respective worldviews are informed by her traditional African heritage, her Christian religious beliefs, and westernised beliefs with regard to social media and psychiatric illness (please see Figure 8).

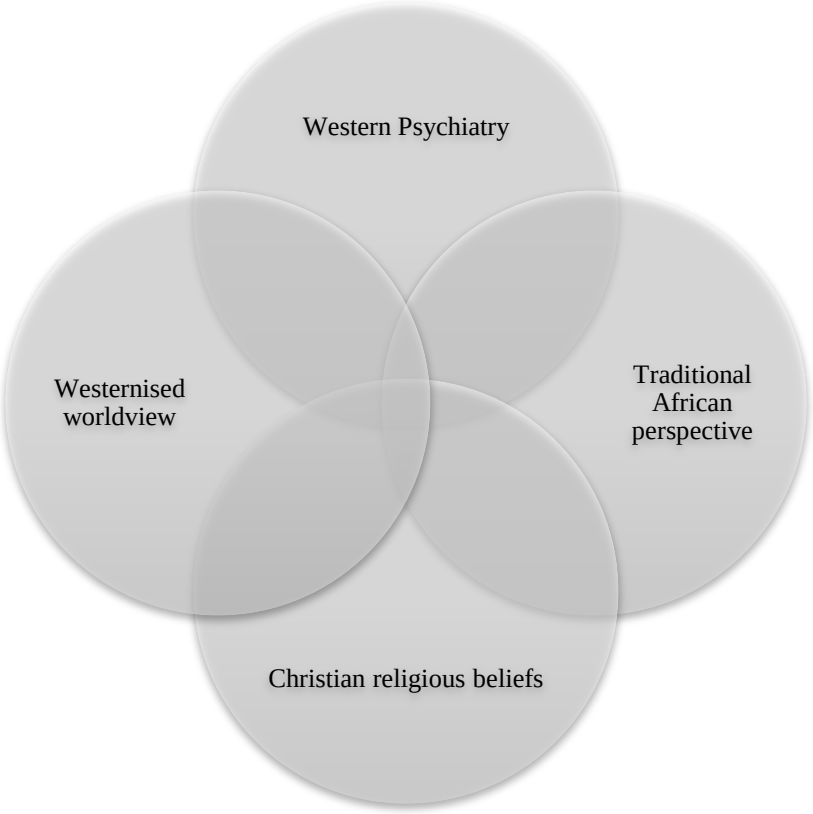

Figure 8: Participant fifteen's conflicting worldviews

From a traditional African perspective, the participant's journey of becoming a traditional healer began at the age of 20. At this time, the participant was fed a piece of cake by her aunt who is a sangoma (also referred to here as a traditional healer). This also marks the beginning of her amafufunyana.

> *That's the first thing. And that thing that you have* [been] *fed makes you ill [she was fed a piece of cake by her aunt] with amafufanyana. And so, it gives birth to all of these spirits inside you. Which these spirits are meant to lead you*. (Pt15: D27: Par32)

In this context the term amafufunyana is used to denote a culture-bound possession experience. Nandi stated that amafufunyana gave birth to spirits (the participant uses spirits synonymously with ancestors) inside of her. These spirits possess her in order to guide her on her

journey of becoming a traditional healer. The participant describes this as the point in her life where she became mentally ill.

> *When this happened* [being fed the cake] *I knew it… and I found out that mental state or illness is called amafufunyana… and once it reaches a certain point then the illness starts to come back to the surface, then… it's like then… that's just the time, but that the calling is… I can't describe it to you, but it's just like… your whole world goes black, everything is dark… it was just…* (Pt15: D26: Par260)

To her it felt as if an outside force possessed her and took over a piece of her mind, dividing her into different parts.

> *Like it's a moment where I would feel like my mind was divided into different pieces and I would feel like, oh my gosh, this thing that has just come into mind has possessed a certain part or portion of my mind. Because I would have a headache in the front sometimes, a headache at the back other times, and on the left sometimes and on the right. And so I would feel like this person has possessed that part of my being. Ja.* (Pt15: D25: Par248)

For a two-year period after eating the cake the participant described herself as being psychotic. The participant was told by a family member that her life was not working out because she has not yet gone through 'ukuthwasa'. The term 'ukuthwasa' refers to the process of accepting the ancestral calling to become a traditional healer (Du Plessis & Visser, 2012). After having accepted the calling, the person would then have to go through Initiation or thwasa training. Initiation follows on a misfortune befalling the person and this misfortune is understood as a calling from ancestral spirits (Du Plessis & Visser, 2012).

> *My family was telling me that I have to go and do ukuthwasa, we call it ukuthwasa. They were telling me I have to go and do an ukuthwasa, that's why things are not working out in my life and that the ancestors are going to be angry at me if I don't. That was supposed to be at the time … and so I couldn't go and just make such a drastic decision and if I, if I had, I would have been a completely different person to, to myself and dissociated even, even more and I may not have ever had the opportunity to try to even find who I really am. I would have ended up being a completely different person on a different path.* (Pt15: D25: Par308)

The participant's Christian religious beliefs conflicted with her traditional African beliefs. The church that she belonged to at the time, the ZCC church, believed that sangomas were evil and the path of becoming a sangoma should be avoided. From this point of view, the participant tried to reject her becoming a traditional healer. For a time the participant became so deeply entrenched in her Christian religious beliefs that she isolated herself from everyone and believed that everyone around her was evil.

> *This church, this ZCC church, they are absolutely against it… so that's another thing… because what I did was I got into the church so, so deeply that it became like a part of me… it became like… not even a part of me… it was like an obsession… it felt like I had nowhere else to go… I mean I was in the only place… in the church... where I can be… where I need to be… it was like… It literally came inside me… I was cornered, I was stuck, I was… I had nowhere to go… that's the thing, I find a way to do that to myself all the time... all the time… I always put myself in a corner… I know that I am doing it myself… and I don't know how I do it mentally... that is where it literally feels like if I step one step out of this box I would die… it's like… I was so into this church… that I started to believe that every sangoma is evil, that everyone I see is evil, that everyone is out to get me, everyone is poisoning my food…* (Pt15: D26: Par212)

From the participant's westernised worldview, she tried to make sense of her internal division by looking to media icons or famous people in the media and how they described having alter egos. The participant decided to also refer to her different parts as alter egos, give them different names, and define the roles that they play in her life. This process helped her to become aware of and better understand all the different parts of herself. The participant came to this understanding without any help from a mental health professional.

> *Ja, there was no one that actually assisted me, um, but I did watch [TV] a lot. And I saw it actually from the media that they call it alter egos. So I thought, OK, well these are all of my alter egos and I can give them names, my alter egos, and I can also describe the role that they play in my life. So my biggest, the biggest person who I saw this from was Beyoncé actually. And she also has many names for her, for her alter egos as they call it. So I thought, well, that's exactly how I'm going to also help myself to understand my illness. I'm just going to have different names and um, ja, there's those different characters [who] are going to have roles, different roles that they play. But there was no medical assistance or anything.* (Par15: D25: Par69)

From a Western psychiatric point of departure, the participant believes that she has a psychiatric disorder. She believes that pieces of her soul were trapped in moments of her life where she experienced a lot of trauma and pain. These pieces of her soul were trapped in the different characters that she formed throughout her life. After the participant's admission to a psychiatric hospital she learned what DID was and the diagnosis made sense to her. The participant was relieved about this diagnosis as it gave her an alternative way of understanding her experiences that was different to her traditional African understanding. This relief was not due to her wanting to reject her traditional way of understanding, but rather that she was afraid of following the path of becoming a sangoma.

> *Going to hospital… being hospitalised… and learning about what DID was, it [she clicks her fingers] just clicked… it just made a lot of sense… it just sort of… it was like, this is exactly what I was hoping for… what I was looking for… and umm… yeah… I accept the diagnosis.* (Pt15: D26: Par375)

Although Nandi's worldviews seem to interact and connect in very complex ways, she did experience some conflict negotiating between them. Different significant people in the participant's life supported the respective worldviews that the participant believed in. Her sangoma aunts wanted her to accept her calling and become a sangoma, her mother supported her Christian religious orientation and her father wanted her to get Western psychiatric help.

> *Different people are pulling me this way. Go and be ukuthwasa, become a sangoma. And then my mom is, is with church and my dad funnily enough is with like going to a psychologist like medically, my dad is on that side. Ja.* (Pt15: D25: Par388)

This theme showed how participants diagnosed with DID experience having one or more incompatible and conflicting belief system or worldview about the origin of their DID. Each worldview provides a comprehensible explanation for the same phenomenon, i.e. their DID. In some instances participants were seemingly unaware of the conflict that existed between their respective worldviews. The analysis showed that participants' worldviews differ not only

according to their religious and cultural background but also due to their own unique experiences. Although it appears that participants' respective worldviews interact in very unique and complex ways, they do experience some confusion and difficulty in negotiating their way towards some kind of understanding of their dissociative experiences.

4.4. Theme 3: Conflict between the dissociative identities

Conflict between dissociative identities arises when the thoughts, feelings and/or actions of one or more identity are seemingly incompatible with that of another identity. Some participants described explicit conflict between their dissociative identities, yet other participants were seemingly unaware of the apparent conflicts and inconsistencies in their thoughts, feelings and/or actions. Six sub-themes of this nature emerged from the data, viz.: conflicting goals, conflicting actions or behaviours, conflicting ways of feeling, conflict of information in awareness, conflicting values, and conflict of control.

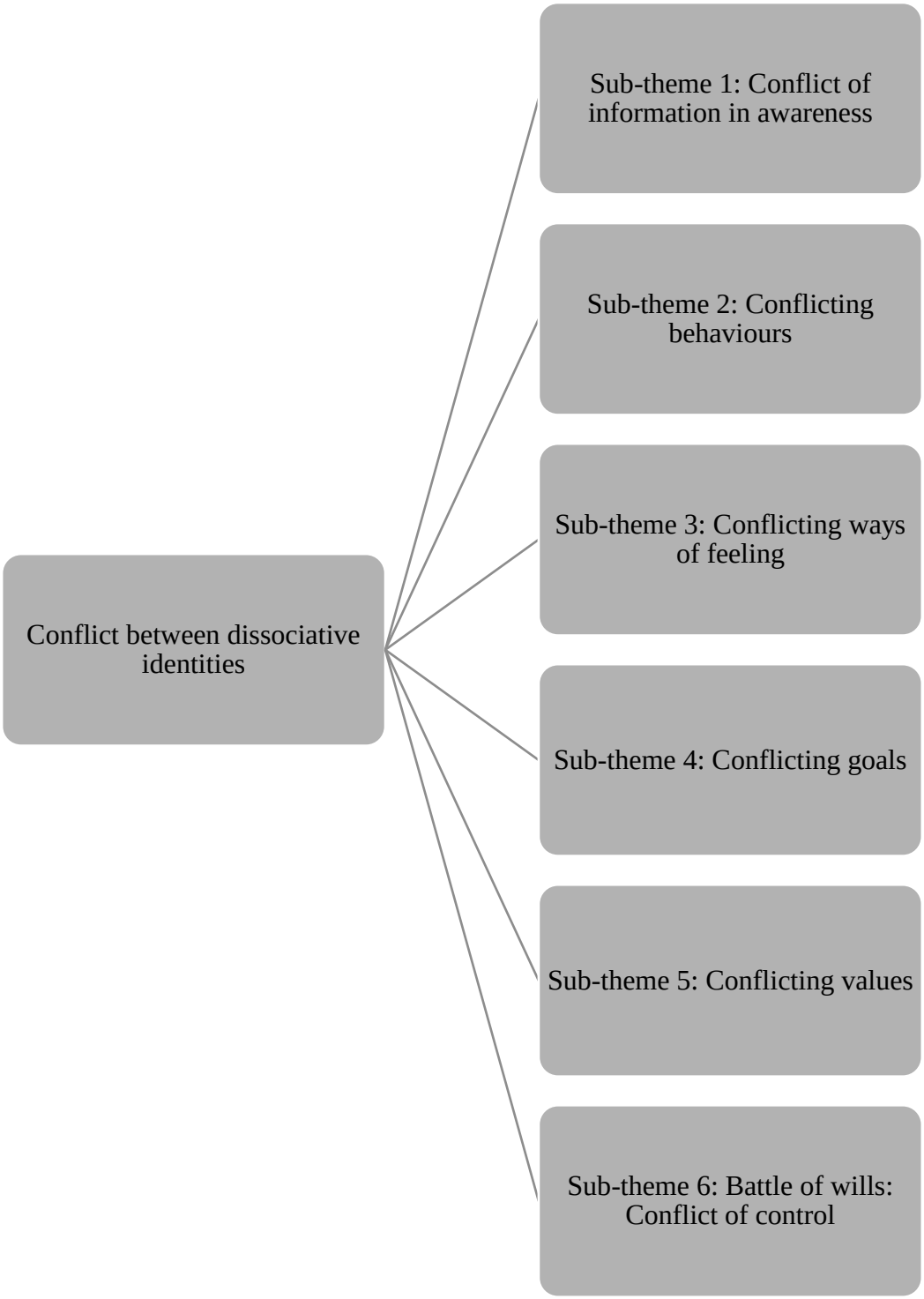

Figure 9: Six "Conflict between dissociative identities" sub-themes emerged from the data

4.4.1. Conflict of information in awareness

Conflict of information arises when important information is withheld from one identity by another. In some cases, this may impede everyday functioning and decision-making. Participant two describes simple withholding of information where her other identities hide stationary, work equipment or money from her.

> *They* [participant two's dissociative identities] *wear me out sometimes, like we will be doing something, and I know, I know I am like this at home, I do not know who does what. Hiding small things like my pens and things that I need and they know that there is a bedside table to put it in, but when you look you can't find it, now I first have to go search for that identity to ask him where it is, where did you put it and then I find it again. So yes.* (Pt2: D2: Par373) (Translated from Afrikaans)

Nandi (Participant fifteen), a 27-year-old Zulu-speaking woman, described a more explicit conflict between herself and her childlike identity. This childlike identity is withholding important information about her past. Nandi believes that this information is the missing link in her life and that this information is needed for her to form a more unified self in the future. However, she has yet to come to terms with this childlike identity.

> *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. So I can't always remember things because of this character that I call Difficult Child. Because I call them all my different characters.* (Pt15: D25: Par61)

This sample of participants diagnosed with DID experience conflict of information between dissociative identities. This type of conflict occurs between identities when a certain identity withholds information from one or more of the other identities. The type of information withheld by the identities varies across participants. Information conflicts may be sustained by lack of communication among the identities and the need for self-preservation. The content

information that is being withheld by the one identity might be traumatic in nature and, in an attempt to preserve the self, other identities are safeguarded against its traumatic content.

4.4.2. Conflicting behaviours

Participants described having dissociative identities that behave in conflicting and contradictory ways. Put differently, identity A might behave in one way and identity B in a way that may seem inconsistent. Behaviours committed by certain dissociative identities feel foreign and may be considered problematic behaviours by the rest of the identities. In other words, the host or the rest of the identities may not agree with the behaviour committed by a certain identity. Several behavioural conflicts were described by the participants, viz.: running away, smoking, stealing, damage to property, sexual behaviour, and aggression towards self and others.

In the first case, running away was highlighted by Lene (participant four) as a problematic behaviour committed by another dissociative identity. The behaviour of running away feels foreign to Lene. The self that she believes she is would never run away from home, clearly conflicting with the behaviour of her other dissociative identity. Lene described herself as being too much of a fearful person to run away from home. When the participant regains consciousness she feels frazzled and confused not knowing how she got where she is.

> *Yes, like when I run away. I am not the type of child that will run away. I will not make it, I am afraid, I am really afraid of the outside world so I am not the type of child that will run away. And sometimes when I run away, I have run away three times. Twice at my mom's house and once at my aunt's house. Twice at my mom's house in Kleinmond. It is as if I just decide, the one minute I am sitting, I am just sitting watching TV and then the next minute I get up, pack my bags and I start walking. That is not me. I would not do that. I would not just do that, even if I think about it for hours I will not do it. So it is scary.* (Pt4: D6: Par88) (Translated from Afrikaans)

When asked if she was aware of what was happening while in the process of running away, the participant responded as follows:

> *As I was walking I was aware and I wanted to turn around. I wanted to turn around so much but I was too far away and it was getting dark. I was closer to Strand than I was to Kleinmond. And my grandfather found me along the way. My mother must have let him know that Lene is missing and then my grandfather drove to look for me and everything. Then he found me next to the road on the N2* (Pt4: D6: Par100) (Translated from Afrikaans)

The conflicting behaviour of the other part of her scares her because she does not know what situation she will find herself in next.

> *Of course I was glad I was very scared. I was a scared person back then. I am still scared. When these things happen I do not know, I do not know what I will do the next time. Am I going to run away from home again or what. So… that is why I am scared.* (Pt4: D6: Par104) (Translated from Afrikaans)

In another case, a 33-year-old woman (participant three) asked if she could smoke cannabis (ganja) while having a possession experience. The participant herself does not smoke cannabis and this behaviour feels out of character for her.

> *My mother sometimes is there and my father when he was still alive he was also there many times when we go and this thing will start and then sometime they say I smoke cigarettes but me, I don't remember smoking cigarette but I, I sometimes dream smoking cigarette but I didn't see myself smoking. But when I wake up they will tell me that the grandfather said he wants to smoke ganja, you know ganja, it's what do they call, something which the people sometimes they take it. I don't know what can I call it.* (Pt3: D3: Par198)

In another instance, one of participant eleven's identities showed the problematic behaviour of stealing. Participant eleven, a 39-year-old man, has three identities: one which he feels is most like himself, another which he describes as hostile and angry, and another who he refers to as the emotional weakling. The participant is unaware of his dissociative identities. He experiences a lapse in time when the other identities take over. He described instances where he found items in his possession not knowing how he acquired these items, for example, a different

brand of cigarettes and a food steamer. In the quotation below he describes stealing women's shoes as a young child. The participant was unaware of stealing the shoes and later found them in his possession.

> Pt.: *Well, I've been in trouble before for stealing, but I can't really remember much about it. And that happened in my childhood years. But the stuff that I stole was like stuff you can't use. It's simple stuff.*
> Int.: *For example?*
> Pt.: *It was almost like trinkets or something. It's like something …*
> Int.: *Trinkets?*
> Pt.: *Ja, it's like … it was almost like a trophy or something. I don't know. But it's … like for example I stole women's boots or girl's boots. That's something I can't use, but still I stole it. I don't know why.*
> Int.: *Yes.*
> Pt.: *I didn't remember how it happened or anything.* (Pt11: D18: Par583-596)

In another case of stealing, participant seven, Amber, described an instance where her child identity took control and walked out of a store without paying for items. Amber explained that this child part does not know how to do anything and often gets lost and confused about how things work in the world. Amber does not want this to happen to her, but in situations where she feels overwhelmed the child part often takes 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)

Another problematic behaviour committed by a dissociative identity was described by Nandi, participant fifteen. Nandi's dissociative identity, Kelly, set her family's belongings and home on fire.

> *The most drastic thing that I did, a month ago, before I was admitted into hospital, I was having these fits of rage towards my family and then I… they were gone the one day and I took things, appliances, I took clothes, everyone's clothes, I took all my belongings and I took them outside and I lit a fire on the clothes, the appliances, anything I could find. I was so out of control that I told myself that the next thing I'm going to burn the house, lock myself inside the house and I'm going to make sure that this fire just reaches… that the house just burns down. But I really was not in my normal state of mind when I was thinking that.* (Pt15: D25: Par55)

In the moment, Nandi felt like she had no control over the situation and was instead just an outside observer, watching as Kelly set fire to her family's home and belongings. She could not stop Kelly from behaving in this way.

> *That's when I started to observe something about myself that I feel like I'm just the one watching and right now I don't have control of what this person is doing and that person, I called her Kelly, that's what I called her, that I have no control right now, I'm just helpless and that's when I started to really see that there's this gap between me and this person and I can't even reach for them to stop myself from doing what I was doing at the time. Then I was admitted into hospital and that's when I became aware.* (Pt15: D24: Par56)

Two participants, participant one and fifteen, described dissociative identities that showed problematic sexual behaviour that was considered inconsistent and conflicts with the behaviour of the person as a whole. That is to say, the sexual behaviours are not supported by the whole person but rather by one identity that partakes in these acts. Participant one recalled a scenario where her alter Gen took over and started touching herself while she was among a group of her peers.

> Int: *And Gen is the sexual one.*
> Pt: *Yes, and it's like at one stage I had now… I … it's like Gen's more in control. It's like she… I don't know, she comes out at the weirdest of times, like, the one day at youth, she… I was… can I say I? It sounds bad saying she… I don't want to, yes it's like I… I…*
> Int: *Is she here now?*
> Pt: *Yes, because she's not a fool. It's like… like… it's like I'd say… it's like I'm… all I could think about was sex and I was at youth and I was sitting there (inaudible 0:08:07) and I was pretending to be cold because I couldn't stop feeling myself, like, just rubbing myself and people were asking me if I'm cold, I'm, like, yes I'm cold. And eventually someone gave me their jacket and the jacket had this, like a felt material, like a… you know, that, yes, like that soft. And that became the fixation. (Inaudible 0:08:47) and it*

> *was like it… all the while still looking around me and, it's like… it's like… it's like these things happen and it's like, no one sees, it's like…*
> *… It feels like I have no control, it feels like I'm put in the bottle, like I…*
> *… Yes, it's like I'm watching from the inside, like I can see, like… and everything but at the same as I'm seeing this other part of me that I'm going okay, there's just this, you know, like…* (Pt1: D1: Par416-423)

Participant fifteen described her dissociative personality Kelly as someone who does not mind sleeping around or having sex with older and married men. However, Nandi herself feels that she would not participate in such behaviour.

> *The character that is Kelly she, um, she, she doesn't mind dating older men. She doesn't mind sleeping around. She doesn't mind dating married men. But, the real me knows better than that and so there's a lot of conflict now between what, what is the, between the decisions that I make for my life.* (Pt15: D25: Par109)

Conflicting behaviour was also expressed in terms of aggressive behaviour committed by one or more of the identities. These aggressive acts are not condoned by the whole person or all of the parts but rather the behaviour of one dissociative identity.

Participant fourteen, Emma, recounted two instances of her behaving in an aggressive manner during her possession experience. In both instances she spoke in a foreign language and violently tried to stab the people around her. Emma was unaware of her behaviour during the possession episode and holds that she would not behave in such a way in her normal state of mind. In Emma's account of her first possession experience, she not only tried to harm others, but also herself.

First possession experience:

> Pt: *Um. He* [Emma's ex-partner] *said that I tried to slit my wrists. And I tried to s… cut, it was him and his female housemate and her boyfriend. I tried to stab them. But it's blank.*
> Int: *You don't remember…?*
> Pt: *And I spoke fluent Russian apparently.*
> Int: *Fluent Russian?*
> Pt: *Ja. Well she says she thinks it was Russian.*
> Int: *Did you ever learn Russian?*
> Pt: *No.*

Int: *No. Do you have no background in Russian?*
Pt: *No.*
Int: *But they say you were speaking Russian?*
Pt: *Ja, so …* (Pt14: D23: Par383-404)

Second possession experience:

Int: *So you think you were possessed?*
Pt: *Well, I'm not sure. The previous time a very similar scenario happened.*
Int: *Ja, please tell me about that.*
Pt: *Except the person said I, it was with an ex. That I picked him up, and he's a very big guy. It seemed like they're too afraid to tell me everything.*
Int: *Is it?*
Pt: *I don't remember, anything ever. Still. And he said I spoke in Hebrew. So, I could say it's a meltdown or whatever, but I don't explain the languages.*
Int: *Yes.*
Pt: *That's the part that I just don't understand.*
Int: *That's what makes you think you are, were possessed at the time?*
Pt: *Mm, yeah.*
Int: *And when you say possessed, you mean by an outside force, of sorts?*
Pt: *Or something?*
Int: *Something. Something not you? So do you think it wasn't you doing that? It wasn't you speaking the Russian?*
Pt: *Mm. I don't think, I don't understand how it would be possible. And also I don't think I would in a conscious logical state try to stab everyone in the house.*
Int: *Ja. It's not your intention. So, you have no desire to stab anybody. Is that right?*
Pt: *Uh, not in my conscious mind, no*. (Pt14: D23: Par405-436)

Participant thirteen, David, described a dissociative identity Bobby as aggressive and often getting into physical altercations with others. David is unaware of Bobby, and has no recollection of any event when this identity has taken control. His knowledge of the events is solely based on what others have told David about Bobby. David remarked that he himself would never act in such an aggressive manner and he would rather walk away from a fight.

Pt.: *Apparently it is aggression. I stand up for myself. Something that the David here in front of you will not do. You know, I am the type of person that will walk away from a fight, but it is not because I am a coward, it is purely because I am not in the mood for it. You know, I fought my whole life and I will rather just walk away. But in that walking away others will tell me… I wake up the next morning then the stories will start.*
Int.: *Stories about what you did?*
Pt.: *About what I did. I have no knowledge of what happened. I mean, in my relationship with Lesley, whom I have now broken it off with, I have dragged her brother around in a*

> *house because he kept on and on and on with me. Then I walk out of the house to get into my vehicle, then I wake up the next morning in the house and then everyone's mouths are thick for me.*
> Int.: *What did you do then?*
> Pt.: *Grab him and drag him around in the house. And I don't know about it.* (Pt13: D21: Par171-180) (Translated from Afrikaans)

The present sub-theme showed that participants diagnosed with DID may have certain dissociative identities that behave in conflicting and contradictory ways, and which seem incompatible to the rest of the identities or host identity. In many of these cases it is only one identity that behaves in this problematic way, while the other identity/identities do not condone the behaviour. It may be possible that the host identity cannot even consider that these behaviours may belong to itself, and therefore ascribe it to someone or something else.

4.4.3. Conflicting ways of feeling

Participants reported at times having different and conflicting ways of feeling or emotional patterns. In other words, participants experienced different parts within themselves that have very different emotional patterns.

Participant ten, a 19-year-old woman, described two different parts of herself that have very different ways of feeling. The first part of herself, the part of her that she feels like most of the time is an anxious and quiet person. This part has difficulty interacting with others in a social context.

> Pt: *I can't recall if there was ever a time where I was happy. Because I'm not, I don't see myself as a happy person because of what I'm going through. I don't, I'm not depressed but I just, you know, can't get hold of who I am.*
> Int: *Yes.*
> Pt: *Because of the anxieties, and the social phobias that I, that I'm facing.* (Pt10: D17: Par420-424)

The participant described the second part of herself as the happy child. She described the child as happy and playful. However, this child part quickly vanishes into the part of herself that feels quiet and anxious all of the time.

> 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.*
> Int.: *Mmm.*
> Pt.: *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)

In another case, participant twelve, a 33-year-old man, described two conflicting emotional or feeling patterns. When participant twelve is his normal self, he described it as feeling relaxed. Conversely, when he enters a state of anger he described it as feeling as though he has extra powers. In his angry state he described feeling violent and aggressive.

> *Ah, it's like if I got annoyed. When I get angry I, it's like, I run out of words, I can't speak and then it's like maybe I'm speaking fast, fast and then I will suddenly stop. There won't be any words to say and then. That time and when I get angry it's like I'm being energised to, to do violence, like I'm getting powers to fight. Because whenever, if ever I was involved in a fight I've never lost a single fight because of that. Because I'm, if I'm relaxed, I'm just like a normal person but once I get angry it's like I'm getting those extra powers that wants me to fight and when I fight I, I become very violent because I fought a lot, even with cops I've fought with a lot of cops. One time there was an incident at Sunnyside at the flat. I fought, er, seven policemen. They tried to handcuff me and put me in the back of the van but I struggled with them, I fought with them and then four of them they were on the ground. And I'm, they called for a backup. That's when they were able to handcuff me and put me in the back of the van but still I was fighting…* (Pt12: D20: Par165)

The present theme showed that participants diagnosed with DID may have certain parts that display very different and conflicting emotional patterns. Although participants described being aware of their different emotional patterns, it would appear that the different emotional patterns are experienced exclusively by the respective parts within themselves. In other words, the either feel happy or sad, or normal and relaxed, or angry and aggressive.

4.4.4. Conflicting goals

Conflict among goals arises when the goals of one identity are incompatible with the goals of their counterpart/s. The respective goals of the identities cannot be reconciled in a manner that is mutually beneficial to all. In other words, in order for one identity to achieve their goals the goals of their counterpart/s need to be forfeited.

Participant seven, Ashley, described conflict that resulted from incompatible goals between her identities.

Ashley is a 54-year-old woman. In her interview she told the story of her transfer from TDH to WKH. During her transfer Ashley was involved in a physical altercation with hospital staff. Ashley's memory of the event is limited, not knowing exactly what had taken place. During Ashley's interview it was revealed by Liz, Ashley's other identity, that she is so desperate not to get admitted into hospital and thinks so differently about the value of receiving treatment that she is willing to physically attack hospital staff and sign herself out of hospital.

> *...I don't care. I'll just go f*** the woman up right now* [she is referring to an altercation with hospital staff]. *Do you know what I mean. Because I'm so sick of your beating up Ashley the whole f*****g time. So if she tried that, you know I'll just go in there and confront her. And if she kills me fine. Then she kills Ashley as well. And Ashley's gonna lose suffering any more. I'm not letting Ashley suffer any more. That's why she still thinks she* [Ashley] *can get help at Weskoppies. I'm not going to let her. I just RHT* [Refuse Hospital Treatment] *every time. She can try for three days and then leave them here and after that I'd fight my way and taking over and I just RHT her out of here.* (Pt7: D13: Par126)

Ashley herself may be open to treatment, but because she knows that Liz is determined to not make it work and she is not going to respond positively to receiving therapy she cannot even consider treatment as a goal.

> *It's unbelievable. Then like, I get into trouble. Then I have to take her, like I have to get into trouble for what she's* [Liz] *done. And I can't tell anybody. No. And I just get*

> *confused. So if she* [Liz] *says she doesn't need therapy here, um, I don't think it sounds good. I don't think it's going to work. I don't know. I really don't know, OK.* (Par7: D13: Par154)

In addition to participant fifteen's possession experience, Nandi described three different dissociative identities with conflicting goals. Nandi, the identity that feels most like herself, wants to stay admitted in the hospital with the goal of receiving treatment for her illness. However, the participant's second and third identities, Hannah and Kelly, feel very differently about their admission to hospital and what this may mean for their future. Hannah would like to go home as soon as possible and carry on with her life and work towards a future. Alternatively, Kelly is prepared to rekindle her relationship with her much older and financially well-off ex-boyfriend who is able to take care of her in order 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. I've had conflicts of, um, oh my word, like when you're trying to reach, when you're trying to like reach for yourself there's a conflict between I know who I am, it's like part of me says but I know who I am, I can be this person. And another part of me says but there's still a lot more that I need to learn about myself and that part of myself is mainly lying in the Nandi that I'm trying to reach for.* (Pt15: D25: Par53)

From the two cases of conflicting goals discussed above, it is evident that the respective identities may have mutually exclusive goals that cannot be reconciled in a way that benefits all involved. In other words, in order for one identity to achieve their goals, for example the goal of getting out of hospital or working towards a future, the goal/s of their counterpart/s gets sacrificed. Some of the goals, if achieved, can affect the life of the individual negatively, as can be seen in the case of Ashely where she cannot even consider receiving treatment because her other identity Liz will not allow it.

4.4.5. Conflicting values between dissociative identities

Conflicting values refers to the conflicting values and beliefs that may exist among the different dissociative identities. In other words, one identity may have a certain belief that ideologically conflicts with the belief of another identity. Value conflict occur when identities attempt to force one set of values or beliefs onto one or more of the other identities. Theme two (conflicting worldviews) is qualitatively different from the present theme as it speaks to the different beliefs that participants have around the origin of their disorder that may conflict with each other. However, the present theme describes the conflicting values and beliefs that exist among the different dissociative identities.

Participant one, a 26-year-old woman, described having several identities each with their own opposing belief or value systems. These beliefs conflict with each other and cannot be thought of as true at the same time. In order words, these opposite beliefs cannot exist simultaneously. Opposing beliefs result in a struggle within her and among her identities.

> *… it's like I'm fighting myself. It's like I'm fighting… it's like believing two different things, like believing opposite things and how can you believe opposite things because you can't believe opposite things, you can't believe… you can't believe something is black and white. You can't believe something… do you know what I mean?* (Pt1: D1: Par191)

She believes that there is an evil dissociative identity (the one belief) inside of her that she describes as the devil's wife. Conversely, the identity that she feels is mostly herself wants to be close to God (the second belief). This good part of herself fights against the evil part.

> *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)

She believes that she can change the devil's wife identity into not being so evil any more.

> Pt.: *She [evil part] writes spells and…*
> Int.: *What spells?*
> Pt.: *She writes spells, she's… believes she had control over things that she couldn't have control of that doesn't… that just doesn't seem possible, it just… it's like the part of me believes I could change the evil part into not being so evil.* (Pt1: D1: Par562-567)

In the quotation below, Nandi (Participant fifteen) described having conflict between her own values and the values of her dissociative identity Kelly. Kelly is happy to date older men or married men and to have sexual relations with several different partners.

> *There's a lot of conflict with my morals, um, in terms of, in terms of this illness because the character that is Kelly she, um, she, she doesn't mind dating older men. She doesn't mind sleeping around. She doesn't mind dating married men.* (Pt15: D25: Par109)

Nandi herself however believes that this is wrong and knows that it is wrong to participate in such acts.

> *But, the real me knows better than that and so there's a lot of conflict now between what, what is the, between the decisions that I make for my life.* (Pt15: D25: Par109)

From the accounts provided above, it is evident that the respective identities may have mutually exclusive beliefs that cannot be thought of as true at the same time. In other words, one identity may have a certain belief that ideologically conflicts with the belief of another identity. Participants experience difficulty accepting these varying beliefs that they may have, i.e. that they cannot be both good and bad at the same time.

4.4.6. The battle of wills: Conflict of control

Conflict of control occurs when one or more identity has to give up their control so that another identity can take over. Some dissociative identities are more resistant to giving up their control and this can lead to conflict between the different dissociative identities. The lack of control could contribute towards dissociative identities thinking, feeling and behaving in ways that conflict with each other.

Participant one described having several voices within her. However, she feels that if she gives them names it will give them control over her.

> *They, it is… it's like I feel like the parts that are not… 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)

In some cases conflict between identities for control and autonomy leads to explicit fighting among the parts. In the quotation below, participant one, a 26-year-old woman, describes fighting against her dissociative identities in order to prevent them from taking control or becoming her.

> *…it's like I, like parts of me that I don't want almost … it's almost… if I could say that like… that… there will be… that I just don't want that I'm fighting not to be them.* (Pt1: D1: Par95)

In the quotation that follows, she recounted her experience of trying to regain control over her counterparts. The participant gave the analogy of being stuck in a jar, unable to come out again. She is stuck in the jar observing what is happening around her.

> *It's like… it's like…. It's like, when I'm in the jar it's like I lose 90% and I'm 10% and I know and can see and I feel but, yes, I'm just… but then… but I'm not there, it's like I'm… like I'm… it felt like I just couldn't get back to me again, it's like I couldn't come out of the jar and I was trying so hard to get out of the jar and I was stuck and I*

> *couldn't… it's like because I was trying to control my breathing and trying to come back, it was like… it was just awful.* (Pt1: D1: Par263)

In Nandi's (participant fifteen) account of burning her family's belongings, she described feeling like a mere observer in her own body. She described having no control over what her dissociative identity was doing at the time. The lack of control left her feeling helpless.

> *That's when I started to observe something about myself that I feel like I'm just the one watching and right now I don't have control of what this person is doing and that person, I called her Kelly, that's what I called her, that I have no control right now, I'm just helpless and that's when I started to really see that there's this gap between me and this person and I can't even reach for them to stop myself from doing what I was doing at the time. Then I was admitted into hospital and that's when I became aware.* (Pt15: D24: Par55)

In another case, participant three, a 33-year-old African woman, explained that when she gets angry she loses all sense of what is important to her and is unable to control her actions. After behaving in an aggressive way she regrets what she has done and cannot believe it was her who behaved in this way.

> *I don't just understand, sometimes I just get angry and when I get angry I can do anything, no one can control me and then after I will start to regret and I can't believe it was me doing like that but just… it's like each and every time when I get angry, I don't care even for the things I want to protect, I don't care when by that time I'm angry, yes.* (Pt3: D4: Par37)

Conflict of control occurs when one identity takes over control at the expense of the autonomy of another identity. Taking over control is often met with resistance by another identity, at times expressed as an explicit battle between identities. The lack of control over body, mind or will could contribute towards certain dissociative identities thinking, feeling and behaving in ways that may feel inconsistent to another identity.

Theme three conceptualised conflict that may arise between the respective dissociative identities when identities differ greatly in terms of thoughts, feelings and/or actions. Several sub-themes were discussed, viz.: conflicting goals, conflicting actions or behaviours, conflicting

ways of feeling, conflict of information in awareness, conflicting values, and conflict of control. At times conflict between identities was experienced as an explicit battle or struggle between the parts. Explicit conflicts occurred when the person was aware of the contradictions in their thoughts, feelings and actions and disagreed with the dissociative identities on the basis of this. At other times, the participants were not aware of the battle that they were fighting against their other identities or parts.

4.5. Conclusion

The aim of the findings chapter was to describe and discuss the conflict-related themes and sub-themes that were derived from the retrospective in-depth interviews with 15 patients diagnosed with DID. The findings section consisted of three themes. Theme one described patients' different levels of separateness of the self. This sample of DID patients experienced varying levels of separateness and unity of the self. The participants ranged from experiencing a single self with differing parts to having identities that are completely separate, to the most extreme cases of an external force possessing the person. Although this theme may not be directly related to conflict in DID it provided a foundation for thinking about conflict between dissociative identities. Theme one also provided a better understanding of how patients with DID experience their own DID. In other words, what their disorder is like for them and how it is expressed.

Theme two conceptualised how participants diagnosed with DID experience having one or more incompatible and conflicting worldviews about the cause or aetiology of their DID. Each worldview provides a comprehensive albeit different explanation for their DID. In some

instances participants appeared to be oblivious to the conflict that existed between their respective worldviews, in some it brought about anxiety and yet in other instances the prospect of another alternative brought relief. Responses differed according to the cultural, religious and ethnic background of the participants. However, what was uniform in their responses was that they experienced difficulty coming to terms with some if not all of the possible explanations for their DID.

Theme three speaks to the type and the nature of the characteristics of conflict between dissociative identities. Conflict between identities appeared to be particularly evident when identities differed greatly in terms of their thoughts, feelings and/or actions. Several sub-themes related to conflict between identities were discussed, viz.: conflicting goals, conflicting actions or behaviours, conflicting ways of feeling, conflict of information in awareness, conflicting values, and conflict of control. Participants varied with regard to their level of awareness of the contradictions and struggles between the identities.

Conflict in DID was found to be pervasive and complex. Conflict in DID may affect not only the experience of self and contribute to participants' difficulty in integrating their different identities, but may also impact on patients' mental functioning and indirectly affect their lives and their interactions with others. The Discussion section will provide more insight into these findings.

Chapter 5: Discussion

5.1. Introduction

The aim of this chapter is to consolidate the work of this research endeavour in line with the research aims and objectives that were outlined in Chapter One. The aim of this study was to explore the subjective experience and nature of conflict within a group of adult psychiatric patients diagnosed with DID.

In this chapter, this discussion will firstly provide a summary of the main findings of the study. Subsequently, the findings will be discussed within the context of relevant literature. This will be followed by a discussion on the possible limitations and strengths of this study as well as recommendations for future research. This chapter will end with a concluding summary of the research project.

5.2. Main findings

The conflict-related themes and sub-themes that were derived from the retrospective in-depth interviews with 15 patients diagnosed with DID were described in Chapter 4. Theme one described patients' different levels of separateness of the self. Although theme one was not directly related to the experience of conflict, this theme contributed towards an understanding of the spheres between which conflict can occur. As such it provides a better insight and understanding into how patients with DID experience their own DID. Themes two and three addressed the type and the nature of conflict found in this particular groups of DID patients. That

is, conflict between participants' different worldviews and conflict between dissociative identities respectively. The findings of this study will be discussed and interpreted in the next section.

5.3. Discussion of findings within the context of DID literature

5.3.1. Levels of separateness and unity of the self

The analysis revealed (see also above, Chapter 4, theme 1) that participants varied in their levels of separateness (dissociation) and unity of the self. Participants' levels of separateness and unity of the self refers to how singular a person feels they are. Participant responses revealed they felt that they have different and separate parts within them and these parts are integrated to a lesser or a greater degree. Three different levels of dissociation and unity of the self presented in the data.

- At level one, participants experienced a single self made up of different parts; these parts are not completely separate from the person.
- At level two, participants described several different dissociative parts or identities that appeared to be quite separate from the self and/or each other.
- At level three, participants described a separate external force possessing the person.

These findings contribute to the broader literature of DID in two ways. Firstly, that DID patients describe having distinct and separate parts or identities inside of them; and secondly, that their identities or parts are experienced as separate to a lesser or greater extent. The variable

degree of separateness also emerged from the analysis in the original research study (Krüger, 2016). However, there the focus was on identity rather than conflict. Nevertheless, the fact that a second researcher's coding of the data revealed a similar theme can be taken as a form of triangulation, which adds to the trustworthiness of the present analysis (see also Chapter 3, section 3.10).

In line with these subjective experiences, cognitive and neurophysiological studies have also revealed that dissociative identities found in disorders such as DID display some characteristics of separate entities, however they are not wholly distinct from each other (Putnam, 1997; Reinders et al., 2012). Putnam (1997) argued that dissociative identities are discrete states of consciousness that are prominently dissociated from each other in terms of their neurological and physiological features. Reinders, Willemsen, Vos, Den Boer and Nijenhuis (2012) reported distinct patterns of neural activation and cerebral blood flow between dissociative identities.

Dissociation has been conceptualised as a dimensional phenomenon, present to a lesser or greater degree in all individuals (Putnam, 2016). Dimensional models, such as the Discrete Behavioural States Model proposed by Frank Putnam (1988, 2016) argue that dissociation is a complex psychophysiological process that occurs along a continuum of severity and produces a series of clinical and behavioural events relating to alterations in memory and identity. For example, dissociation can range from normal or adaptive dissociative states, such as daydreaming, to maladaptive dissociative states characterised by profound disturbances in the organisation and integration of self, cognition and behaviour commonly found in DID (Bernstein & Putnam, 1986).

The dissociative continuum model has been critiqued for being too vague in its conceptualisation (Holmes et al. 2005). The findings from this study revealed that even within the diagnosis of DID (the most extreme end of the continuum) there are differing levels of separateness or dissociation and unity of the self that should be considered. Dissociation and 'unity of the self' are not categorical 'on-off' phenomena.

5.3.2. The conflicting worldviews

Worldview or belief system refers to ways that an individual thinks about reality and makes sense of their world, experiences and more specifically their DID (Koltko-Rivera, 2004). People's worldviews or beliefs about reality and their world are socially constructed. What this means is that worldviews (for example, about the origin of their DID) are formed in the course of interacting with others and within their broader social and cultural context (Creswell, 2007; Crotty, 1998; DeLamater & Hyde, 1998; Du Preez & Eskell-Blokland, 2012). Culture and its associated contextual factors can influence the development and expression of DID (Du Plessis, & Visser, 2012; Krüger et al., 2007; Şar, Dorahy & Krüger, 2017). South Africa is known for its historically diverse set of traditions, cultures and languages and, in this context, dissociation may help individuals (or communities) to survive in a world of conflicting ideologies, where conflict is often embedded in relational, cultural and/or societal structures (Krüger et al., 2007; Şar, Dorahy & Krüger, 2017).

Worldviews are also diverse and multiple in nature (Creswell, 2013; Wahyuni, 2012). In other words, one person can have more than one worldview that informs their understanding and interpretation of their experiences. What this literature contributes to the discussion is twofold:

culture informs how people experience and express their DID, and people can have several different socially and culturally situated worldviews that inform their understanding of their DID.

The analysis revealed (see also above, Chapter 4: Theme 2) that participants diagnosed with DID experience have one or more incompatible and conflicting worldviews about their DID. Participants' understanding regarding the origin of their DID is largely dependent on their specific religious and cultural background. The four descriptions below provide an example of how each worldview that the participant may have about their DID could provide a comprehensive explanation for their DID. The examples below are not an exhaustive list of instances where worldview conflict occurred in the data, but rather, the most prominent examples were selected for reporting purposes.

- Participant two, a 35-year-old Afrikaans-speaking woman, described two conflicting worldviews regarding the origin of her DID in the interview, namely: early trauma and demonic possession.
- Participant three, a 33-year-old Shona-speaking woman, described three conflicting worldviews about her DID, namely: demonic possession, ancestral calling and bewitchment.
- Participant four, a 23-year-old Afrikaans-speaking woman, described two conflicting belief systems regarding her DID, viz.: demonic possession and clinical diagnosis of DID.
- Participant fifteen, a 27-year-old Zulu-speaking woman, described several differing and conflicting worldviews, viz.: her traditional African heritage, her Christian religious beliefs, and her westernised beliefs about social media and psychiatric illness.

Although all four participants had one or more conflicting worldviews that were apparent in their interviews, it was clear that the basis of these worldviews differed according to the cultural, ethnic and social background of the participant. In line with this finding, 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 the potential for different expressions of dissociative experiences across the world (Schumaker, 1995).

5.3.3. Conflict between dissociative identities

The analysis revealed (see also above, Chapter 4: Theme 3) that participants diagnosed with DID experienced conflict between their dissociative identities. These findings provide insight into the different types of conflict that exist between identities and the nature of these conflicts.

Six conflict types emerged in the data, which are as follows: conflict of information in awareness, conflicting goals, conflicting actions or behaviours, conflicting ways of feeling, conflicting values, and conflict of control. The nature of each of the six different types of conflict are described in Table 6 below.

Table 6: The type and nature of conflict between dissociative identities

Type of conflict	Nature of conflict
Conflict of information in awareness	Information conflicts occur when a certain identity withholds information from one or more of the other identities. Information conflicts may be sustained by lack of communication among or awareness of identities and the need for self-preservation.
Conflicting actions or behaviours	Behavioural conflicts occur when dissociative identities behave in conflicting and contradictory ways. Behaviours committed by certain dissociative identities feel foreign and may be considered problematic behaviours by the host identity.
Conflicting ways of feeling	Conflict of this nature occurs when one dissociative part displays very different and conflicting emotional patterns to the host identity. The conflicting emotional patterns are experienced exclusively by the respective parts.
Conflicting goals	Conflict among goals arises when the goals of one identity are incompatible with the goals of their counterpart/s and their respective goals cannot be reconciled in a manner that is mutually beneficial to all.
Conflicting values	Conflicting values arise when one identity has certain beliefs that ideologically conflict with the beliefs of another identity. Value conflicts are particularly evident when identities attempt to force one set of values or beliefs onto one or more of the other identities.
The battle of wills: Conflict of control	Conflict of control occurs when one or more identity has to give up their control so that another identity can take over. Some dissociative identities are more resistant to giving up their control and this can lead to fighting among the different dissociative identities.

Notwithstanding the progress that has been made in the field of DID (Brand et al., 2016; Dorahy et al., 2014), the role and nature of conflict in DID is largely unexplored beyond theoretical deduction. As mentioned in the literature section of this dissertation, several aetiological theories of DID consider conflict in DID in some capacity (see above, Chapter 2, section 2.5.). These theories include: Betrayal Trauma Theory (Freyd & Birrell, 2013); Psychoanalytic Theory (Freud, 1961); Object Relations Theory (Kernberg, 2018); Attachment Theory (Blizard, 2003; Liotti, 1999; Sachs, 2013); Cognitive Model of Dissociation (Kennedy et al., 2004; Kennedy, 2013); Discrete Behavioural States Model (Putnam, 1988, 1997, 2016); and Structural Dissociation of the Personality (Steele et al., 2005; Van der Hart et al., 2006).

However, two of these seven theories, Psychoanalytic Theory and Object Relations Theory, conceptualise conflict as mainly an intrapsychic phenomenon, and will be excluded from further discussion. The other five theoretical or aetiological approaches all conceptualise conflict as arising among what may broadly be considered as dissociative identities (see also Chapter 2, section 5):

The Cognitive Model of Dissociation maintains that, in DID, it is possible for each conscious control system to form their own sense of identity, values, needs and desires that guides their behaviour (Kennedy et al., 2004). Different conscious control systems may conflict in terms of sense of self, beliefs, values, needs and desires (Kennedy et al., 2004; Kennedy, 2013).

Betrayal Trauma Theory highlights the importance of betrayal of trust as a necessary factor in the development of dissociative symptoms and the formation of dissociative identities (Freyd & Birrell, 2013). Conflicting sets of information and experiences (with 'caregiver' and 'abuser') cannot be held in consciousness at the same time and the conflicting facts cause the child to have to choose the one set of information and experiences over the other, thereby dissociating the other from consciousness or awareness (Freyd & Birrell, 2013; Freyd, 1994, 2003).

According to Attachment theory, under conditions of severe childhood relational trauma, the child may cope by developing multiple internal working models (or dissociative identities) (see also above Chapter 2, section 2.4.1.4.) (Blizard, 2003; Liotti, 1999; Sachs, 2013). Sachs (2015) argues that, when discrepancies in thoughts occur a non-dissociative individual may be able to resolve discrepant and conflicting thoughts (such as feelings of fear and safety) through great internal struggle. However, someone with DID may experience internal conflicts as

external and explicit conflict among their different dissociative identities. It is also possible that when the person with DID is unaware of other identities, in such instances this external conflict or struggle is often battled blindly as they may not even be cognisant of who is opposing their actions (Sachs, 2015).

Putnam's Discrete Behavioural States (DBS) Model asserts that dissociative identity states may have limited awareness of each other and as such may act in conflicting, opposing and self-defeating ways (Putnam, 1988, 1997, 2016). Dissociative identity states may have their own sense of self, and may have different and contradictory sets of feelings, emotions, past experiences, goals, memories and behaviours and/or embody a different developmental phase, based on the specific trauma-related experiences that led to the development of the personality state (Putnam, 1988, 1997, 2016).

The Theory of Structural Dissociation of the Personality (TSDP) maintains that someone with a severe level of structural dissociation, may find it difficult to reconcile conflicts between goals, thinking, feeling and different roles in life (Steele et al., 2005; Van der Hart et al., 2006). Such an individual may find it difficult to acknowledge other parts or goals that may be discrepant, in effect remaining unaware of any conflicting information (Steele et al., 2005; Van der Hart et al., 2006). It is also possible for dissociative parts to have their own first-person perspective, i.e. their own point of view as to who they are, what the world is like, and how they relate to that world (Nijenhuis & Van der Hart, 2011).

To be clear, each of the five theoretical approaches has their own unique description of the possible equivalents of dissociative identities found in DID (see Table 7):

The cognitive model of dissociation describes dissociative identities, found in DID or level three dissociation, as conscious control systems (Kennedy et al., 2004). Betrayal Trauma

Theory refers to sets of information and experiences (Freyd & Birrell, 2013). Attachment Theory conceptualises dissociative identities as multiple, incoherent and conflicting internal working models that develop in the face of childhood trauma in an attempt to cope with inner chaos and conflict (Blizard, 2003; Liotti, 1999; Sachs, 2013). In Putnam's DBS Model he describes dissociative identities, found in disorders such as DID, as discrete behavioural or personality states that form during childhood in the context of severe trauma (Putnam, 1997, 2016). TSDP considers tertiary structural dissociation to be the most extreme form of structural dissociation and situates DID within this level of dissociation (Nijenhuis, Van der Hart, & Steele, 2010; Steele et al., 2005; Van der Hart et al., 2004; Van der Hart, Nijenhuis, & Steele, 2006). Dissociative identities are then referred to as dissociative parts of the personality and consist of more than one emotional part of the personality (EP) and more than one apparently normal part of the personality (ANP).

Table 7: Theoretical descriptions of the possible equivalents of dissociative identities

Theory	Description of possible equivalents of dissociative identities
Cognitive Model of Dissociation	Separate conscious control systems
Betrayal Trauma Theory	Conflicting experiences about caregiver vs betrayer
Attachment Theory	Internal Working Models
Discrete Behavioural States Model	Disconnected discrete behavioural states
Theory of Structural Dissociation of the Personality	Dissociative parts of the personality

Although the various theories have divergent descriptions of dissociative identities, they concur in the sense that conflict occurs between these dissociative identities.

Two other commonalities exist among these theories. Firstly, these theories assert that there might be a *lack of awareness* among dissociative identities and this could contribute towards conflicting behaviours among dissociative identities. The findings of this study similarly

show that conflict between dissociative identities was particularly evident when identities differed greatly in terms of their thoughts, feelings and/or actions, and that there may be variations in DID patients' level of awareness of the contradictions and struggles between the identities (see also above, Chapter 4: Theme 3). When the participants were aware of the contradictions, conflict between identities were more likely to be experienced as an explicit battle or struggle between the parts. On the other hand, when patients were unaware of these contradictions they may also have been unaware of the battle that they were fighting against their other identities or parts.

Secondly, four of the previously mentioned theories (Betrayal Trauma Theory excluded) maintain that dissociative identities may have *their own sense of self* and may conflict in terms of goals, actions or behaviours, feelings, values, and will.

The findings and analysis indicate that conflict among dissociative identities is pervasive and may appear in complex ways. Oftentimes, the conflict concerns those building blocks that contribute to a sense of self in a person as a whole (or in their dissociative identities), viz., goals, actions or behaviours, feelings, values, and will.

The trouble is exacerbated when there is also a lack of awareness between the dissociative identities – as the data show, and as the theories indicate. When there are different and incompatible 'senses of self' with also a lack of awareness between them, the potential is greatest for the disruption of and/or discontinuity in the normal integration of mental contents that is considered characteristic of patients diagnosed with DID (APA, 2013).

Identifying the bases on which dissociative identities conflict, the nature of their conflict and working towards increased awareness between the identities may help to resolve them and could ultimately promote the integration of these states. Chefetz (2015) similarly argues that an

inquiry into the dissociative process should focus on conflicts between interests, qualities, attitudes and views between states and aim to resolve the tension between them and eventually integrate the states.

5.4. Limitations of the study

Previously collected data were analysed retrospectively in this study. In light of this, several limitations can be noted.

- The principal researcher for this dissertation was not part of the original data collection process. As such, the researcher was restricted in terms of the type of questions that were asked in the interviews.
- Explanations of certain concepts could not be followed up with participants. In addition, certain meanings communicated through body language and facial expressions could have been missed.
- The focus of the original study conducted by Prof. Krüger was not on conflict as such. Despite this limitation, the findings of this study are significant.

Aetiological theories and perspectives on DID are quite extensive, but a complete review of this literature was beyond the scope of this dissertation. Instead, a subgroup of theories that relate to the topic of conflict in DID was selected for the literature review.

Although this study explored culturally informed worldviews - culture, race and ethnicity were explored in limited scope. Research provides support that there exists a unique intersection between culture, race and ethnicity concepts and identity (Hook et al., 2004), which is at the forefront of dissociative identity disorder. In the original study, participants' race was recorded

according to the categories used by Statistics South Africa for national consensus purposes, i.e. four predefined categories namely, White, Black, Coloured, and Indian/ Asian. Affording participants' the opportunity to self-identify may have provided a different depth of insight into the topics explored in this dissertation.

Another limitation of the study was that eight of the interviews were conducted in Afrikaans and their quotations had to be translated. In translating the participants' narratives into English, it is possible that some of the meaning could have been influenced or unknowingly changed. However, the translations were completed by the principal investigator of this dissertation and reviewed by Prof. Krüger, both of whom are Afrikaans speaking. In addition, two participants could not conduct their interviews in their home language. This could have had an impact on how they explained or expressed themselves during their interviews.

5.5. Strengths of the study

Despite the abovementioned limitations, the study makes several research contributions to the field of DID:

- This study contributes towards a much clearer understanding of the experience of conflict in patients diagnosed with DID;
- This study explores the theoretical underpinning of DID in the literature and brings to light an area of research that has been neglected;
- The findings of this study are based on in-depth first person accounts and the study provides lengthy verbatim quotations which add to the trustworthiness and validity of the findings with regard to the experience of conflict in DID;

- This study alleviates some of the confusion among the multitude of aetiological theories and approaches to DID by drawing links between some of the theories;
- This study adds to the conceptualisation and the contextualisation of DID in a South African context; and
- In addition to this, to the best of my knowledge, conflict in DID has never been explored in this qualitative manner. This study adds to the conceptualisation of the experience of conflict in patients diagnosed with DID.

This study lays the groundwork for further investigation into this underexplored field of research. As such this study adds to the empirical body of knowledge on DID in general and more specifically on the qualitative experience of conflict in DID.

5.6. Recommendations

The following recommendations are made for future research:

- Further research of this nature might be conducted with other DID samples in South Africa to gain a more context appropriate and situated understanding of DID;
- It is also recommended that conflict in DID should be further explored using primary data to overcome the limitations set on this study; and
- The data provided preliminary support for a hypothesis that DID patients' experience of conflict as irresolvable (and aggravated by a lack of awareness between identities) may contribute to their particular struggle or difficulty in

integrating dissociative identities into a coherent self. It is recommended that future research endeavours focus on this interesting preliminary finding.

- The findings of this study might be applied in therapy for patients with DID to promote the resolution and integration of conflicting identity states and should be a topic for future research.

The following recommendations might be useful for clinicians treating patients diagnosed with DID:

- It is recommended that professionals consider a more contextually appropriate diagnostic and therapeutic approach when working with patients with DID. The findings of this study revealed that there are different expressions and experiences of DID not only compared to Western perspectives but also among different people within the South African context; and
- Identifying the bases on which dissociative identities conflict, the nature of their conflict and working towards increased awareness between the identities may help to resolve them and could ultimately contribute to promoting the integration of these states.

5.7. Researcher's reflections

While reflecting on the experience of writing this dissertation, I recognise the personal and professional growth that has occurred on this journey. The words of Gibbs (1988, p. 9) resonates with me "*It is not sufficient to have an experience in order to learn. Without reflecting on this experience it may quickly be forgotten, or its learning potential lost.*". The importance of reflection to the research process has been highlighted as adding to the richness and credibility of the work (Creswell, 2007, 2013). Reflection of this nature requires that the researcher outline their personal beliefs, values, and preconceptions that may inform the inquiry (Creswell & Miller, 2000). This process is important as it allows the researcher to bracket or put aside any preconceptions that they may have, and it allows the readers to understand the researchers' positionality. In the narrative below, I discuss several points of reflection.

During the research process, I had to remain conscious of how my own positionality as a young researcher with limited knowledge on DID may have influenced my choice of research topic, and approach to the project. I furthermore had to remain aware of how my positionality may have had an impact on the analyses of the data and how I made sense of what was being said by the participants. In 2016 I was employed as Prof Krüger's research assistant at Weskoppies Psychiatric Hospital (WKH). At the time I had just completed my MA Research Psychology coursework at the University of Pretoria. Prior to my employment at WKH, I had very limited background knowledge of DID. My undergraduate studies formed the basis of my preconceptions about DID, which was that DID is a very rare and uncommon phenomenon, even more so in the South African context. What markedly changed this preconception was when I started working at WKH in February 2016. The research projects that I assisted on at the time

were broadly situated in the field of dissociation, trauma and borderline personality disorder. The contextually situatedness of DID and the role of early trauma in the development of DID became more apparent to me. Throughout the data coding, data analysis, literature searches and write-up my understanding of DID broadened still. The various expressions of the disorder, its multidimensionality and how it could manifest in the South African context, became more apparent. This understanding was coupled with various discussions on the topic with both of my supervisors.

Another point of reflection is the multitude of aetiological theories and approaches on DID. The vast amount of literature resulted in 1) an extensive literature review and 2) added to the complexity of this study. The literature on the topic is diverse and varied and one phenomenon can be viewed from various angles within the different schools of thought. Together with Prof Krüger, the most relevant and fundamental aetiological theories were identified and discussed in the literature section. Despite this narrowing of the field, eight established aetiological theories of DID were included in the literature section. Another complicating factor was the scarcity of literature pertaining to conflict in DID. The exploratory nature of this study allowed for a degree of uncertainty with regards to the concept of conflict in DID but it also meant that I had a limited point of reference when it came to what I was looking for in the data. The lack of literature resulted in a back and forth between the data analysis, literature review and the write-up of the findings chapter. Each layer of this process shaped and guided each other layer. This back and forth process of reflexivity that is so central to qualitative research helped to develop my understanding of DID patients' experience of conflict.

There were several layers of analysis and coding each at a deeper level than the next. In the initial stages of coding the data I noted obvious instances of conflict in participants'

responses and experiences. However, as the analysis and my interpretations evolved, I became aware of the subtle forms of conflict that the participants themselves were not always aware of. At several points in the write-up I found myself having to return to the original coding and transcripts and having to look for deeper meaning and context in the participants' responses.

The research process furthermore required me to reflect on my own background, experience and upbringing and how this may have influenced my understanding of participant's experiences and the themes that I drew from these understandings. The secondary nature of the data contributed to this reflection as I had not interviewed the participants myself and the possibility remained that I may misinterpret what was being said. Throughout the analysis process I noted my initial impressions of each interview transcript, patterns that may emerge in the data and how impressions or orientations may have evolved throughout the analysis process. These notes were made both in Atlas.ti as notes and in a notepad that I was using at the time.

There were two participants that I was initially apprehensive to write about. The two participants' cultural backgrounds and expressions were far removed from my own experiences. However, these were the two participants that myself and Prof Krüger spoke extensively about. After my initial interpretation of the one participant's transcripts Prof Krüger had asked that I rethink and reread her transcript to ensure that my interpretations were in fact what was being said and revisions were made.

Throughout my dissertation journey if found myself in a very fortunate position of having Prof Krüger as my main supervisor and Ms. Monique Bezuidenhout as my co-supervisor. At the time of the analysis and initial write-up I was still working as Prof Krüger's research assistant and we had scheduled weekly or bi-weekly meetings to discuss my progress, my experiences in analysing the data and my struggles in finding literature that pertained to conflict in DID. The

dissertation process helped me to develop a more empathetic grasp for patients suffering from this disorder and more generally of people's experience of trauma.

This chapter started by providing a summary of the main findings of the study. Subsequently, the findings were discussed within the context of relevant literature. This was followed by a discussion on the possible limitations and strengths of this study, recommendations for future research and an explication of the researcher's reflections of the research conducted. The final section of this dissertation will provide concluding statements about the research project.

5.8. Conclusions to the study

The present study sought to explore the subjective experience of conflict and the nature of conflict in a group of adult psychiatric patients diagnosed with DID. The aim was achieved by retrospectively exploring first-hand accounts of a group of 15 adult psychiatric patients diagnosed with DID, where they describe their subjective experience of conflict, as well as the nature of their conflict. The research was conducted from an interpretivist approach.

The data analysis that followed produced the following insights. Firstly, DID patients experience distinct and separate parts or identities. These separate parts were referred to in various ways, viz.: parts, dissociative identities, or as an external possessing force. The identities or parts were experienced as separate to a lesser or greater extent. Secondly, participants' understanding of the origin of their DID is contextually situated. This means that their understanding is largely dependent on their unique social, cultural and ethnic background. There may also be more than one explanation for their DID and these explanations can sometimes

conflict with one another. The conflict between their respective belief systems may contribute to further dissociation. Thirdly, conflict can exist between participants' distinct dissociative identities. The dissociative identities may conflict with each other in terms of accessibility of information, goals, behaviours, emotional patterns, values and control. The study revealed the nature of the different types of conflict that may be present between identities. Conflict among dissociative identities is pervasive and may appear in complex ways. Oftentimes, the conflict concerns those fundamental factors that contribute to a sense of self in a person as a whole or in their dissociative identities (for example, goals, actions or behaviours, feelings, values, and will). Both the data and theory indicate that a lack of awareness between dissociative identities could exacerbate the experience of conflict as well as dissociation. The study provides some insight into the complexities of conflict between dissociative identities as well as the role of awareness in DID.

References

Ainsworth, M. D. S. (1983). Mary D. Salter Ainsworth. In A. N. O'Connell & N. F. Russo (Eds.), *Models of achievement: Reflections of eminent women in psychology* (pp. 200–219). New York, NY: Columbia University Press.

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

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *Qualitative Report, 13*(4), 544–559.

Beck, A. T. (1996). Beyond belief: A theory of modes, personality, and psychopathology. In P. M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 1–25). New York, NY: Guilford Press.

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *The Journal of Nervous and Mental Disease, 174*(12), 727–735.

Birrell, P. J., & Freyd, J. J. (2006). Betrayal trauma: Relational models of harm and healing. *Journal of Trauma Practice*, *5*(1), 49–63. doi: 10.1300/J189v05n01pass:[_]04

Blizard, R. A. (1997a). Therapeutic alliance with abuser alters in DID: The paradox of attachment to the abuser. *Dissociation: Progress in the Dissociative Disorders*, *10*(4), 246–254.

Blizard, R. A. (1997b). The origins of dissociative identity disorder from an object relations and attachment theory perspective. *Dissociation: Progress in the Dissociative Disorders*, *10*(4), 223–229.

Blizard, R. A. (2001). Masochistic and sadistic ego states: Dissociative solutions to the dilemma of attachment to an abusive caretaker. *Journal of Trauma & Dissociation, 2*(4), 37–58. doi: 10.1300/J130v02n04_03

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. doi: 10.1300/J229v04n03_03

Bob, P. (2013). Dissociation, chaos and transcendent function. *Activitas Nervosa Superior*, *55*(4), 151–156. doi:10.1007/BF03379734

Boeije, H. (2002). A purposeful approach to the constant comparative method in the analysis of qualitative interviews. *Quality and Quantity, 36*(4), 391–409. doi: 10.1023/A:1020909529486

Bowlby, J. (1958). The nature of the child's tie to his mother. *The International Journal of Psychoanalysis*, *39*, 350–373.

Bowlby, J. (1973). *Attachment and loss: Separation, anxiety and anger* (Vol. 2) [DX Reader Version]. Retrieved from http://www.abebe.org.br/wp-content/uploads/John-Bowlby-Separation-Anxiety-And-Anger-Attachment-and-Loss-Vol-2-1976.pdf

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. doi: 10.1097/HRP.0000000000000100

Braun, B. G. (1988). The BASK model of dissociation. *Dissociation: Progress in the Dissociative Disorders*, *1*(1), 4–23.

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

Breuer, J. and Freud, S. (1893). On the psychical mechanism of hysterical phenomena: Preliminary communication from studies of hysteria. The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol 2 (1893-1895): Studies on Hysteria, 1–17.

Caligor, E., & Clarkin, J. F. (2010). An object relations model of personality and personality pathology. In J. F. Clarkin, P. Fonagy, & G. O. Gabbard (Eds.), *Psychodynamic psychotherapy for personality disorders: A clinical handbook.* (pp. 3–35). Arlington, VA: American Psychiatric Publishing, Inc.

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.

Christopher, J. C., Bickhard, M. H., & Lambeth, G. S. (2001). Otto Kernberg's Object Relations Theory: A metapsychological critique. *Theory & Psychology*, *11*(5), 687–711. doi: 10.1177/0959354301115006

Cohen, A. (2004). Dissociative Identity Disorder: Perspectives and alternatives. *Ethical Human Psychology and Psychiatry*, *6*(3), 217–230.

Creswell, J. W. (2007). *Qualitative inquiry and research design: choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications.

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

Creswell, J. W. (2014). *Research design: Qualitative, quantitative and mixed methods approaches* (4th ed.). Thousand Oaks, CA: SAGE Publications.

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice*, *39*(3), 124–130. doi: 10.1207/s15430421tip3903pass:[_]2

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. London: Sage Publications.

Cyr, C., Euser, E. M., Bakermans-Kranenburg, M. J., & Van Ijzendoorn, M. H. (2010). Attachment security and disorganization in maltreating and high-risk families: A series of meta-analyses. *Development and Psychopathology*, *22*(1), 87–108. doi: 10.1017/S0954579409990289

Dalenberg, C. J., Brand, B. L., Gleaves, D. H., Dorahy, M. J., Loewenstein, R. J., Cardeña, E., … Spiegel, D. (2012). Evaluation of the evidence for the trauma and fantasy models of dissociation. *Psychological Bulletin, 138*(3), 550–588. doi: 10.1037/a0027447

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The SAGE handbook of qualitative research* (3rd ed.). California, CA: SAGE Publications.

Denzin, N., & Lincoln, Y. (2011). *The SAGE handbook of qualitative research* (4th ed.). Thousand Oaks: SAGE.

De Vos, A. S., Strydom, H., Fouché, C. B., & Delport, C. S. L. (2011). *Research at grass roots: For the social sciences and human services professions* (4th ed.). Pretoria, South Africa: Van Schaik.

DeLamater, J. D., & Hyde, J. S. (1998). Essentialism vs. social constructionism in the study of human sexuality. *Journal of Sex Research, 35*(1), 10–18. doi: 10.1080/00224499809551913

Dell, P. F. (2006). The Multidimensional Inventory of Dissociation (MID): A comprehensive measure of pathological dissociation. *Journal of Trauma & Dissociation, 7*(2), 77–106. doi: 10.1300/J229v07n02_06

Dorahy, M. J., Brand, B. L., Şar, V., Krüger, C., Stavropoulos, P., Martínez-Taboas, A., … Middleton, W. (2014). Dissociative identity disorder: An empirical overview. *Australian & New Zealand Journal of Psychiatry, 48*(5), 402–417. doi: 10.1177/0004867414527523

Dorahy M. J. (2001) Culture, cognition and dissociative identity disorder. In J. F. Schumaker, & T. Ward (Eds.), *Culture, Cognition and Psychopathology* (pp.157–169). Westport, Conn: Praeger.

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.

Du Preez, E., & Eskell-Blokland, L. (2012). Social constructionism. In M. Visser & A. Moleko (Eds.), *Community Psychology in South Africa* (2nd ed., pp. 41-54). Pretoria, South Africa: Van Schiak Publishers.

Dutra, L., Bureau, J. F., Holmes, B., Lyubchik, A., & Lyons-Ruth, K. (2009). Quality of early care and childhood trauma: A prospective study of developmental pathways to dissociation. *Journal of Nervous and Mental Disease, 197*(6), 383–390. doi:10.1097/MD.0b013e3181a653b7

Fairbairn, W. R. D. (1952). *Psychoanalytic Studies of the Personality*. London: Tavistock.

Farley, M. (2003). Prostitution, trafficking, and traumatic stress. Binghamton, NY: Routledge.

Fonagy, P. (1991). Thinking about thinking: Some clinical and theoretical considerations in the treatment of a borderline patient. *International Journal of Psychoanalysis, 72*, 639–656.

Foote, B., Smolin, Y., Kaplan, M., Legatt, M. E., & Lipschitz, D. (2006). Prevalence of dissociative disorders in psychiatric outpatients. *American Journal of Psychiatry, 163*(4), 623-629. doi: 10.1176/ajp.2006.163.4.623

Freud, S. (1961). The Ego and the Id. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 3–68). London: Hogarth Press.

Freud, S. (1964a). An outline of psycho-analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 23, pp. 141–208). London: Hogarth Press. (Original work published 1940).

Freud, S. (1964b). The dissection of the psychical personality. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 22, pp. 57–80). London: Hogarth Press (Original work published 1933).

Freud, S. (1962). The aetiology of hysteria. In J. Strachey (Ed. and Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 3, pp. 187–222). London: Hogarth Press. (Original work published 1896)

Freyd, J. J. (1994). Betrayal Trauma: Traumatic amnesia as an adaptive response to childhood abuse. *Ethics & Behavior*, *4*(4), 307. doi:10.1207/s15327019eb0404pass:[_]1

Freyd, J. J. (2003). Memory for abuse: What can we learn from a prosecution sample? *Journal of Child Sexual Abuse, 12*(2), 97–103. doi: 10.1300/J070v12n02pass:[_]05

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

Freyd, J. J., DePrince, A. P., & Zurbriggen, E. L. (2001). Self-reported memory for abuse depends upon victim-perpetrator relationship. *Journal of Trauma & Dissociation*, *2*(3), 5–16. doi: 10.1300/J229v02n03pass:[_]02

Gagliardi, A. R., & Dobrow, M. J. (2011). Paucity of qualitative research in general medical and health services and policy research journals: analysis of publication rates. *BMC Health Services Research, 11*(Suppl 1), 268–274. doi: 10.1186/1472-6963-11-268

Gibbs, G. (1988). *Learning by doing: A guide to teaching and learning methods*. Oxford, UK: Oxford Brookes University.

Ginzburg, K., Somer, E., Tamarkin, G., & Kramer, L. (2010). Clandestine psychopathology: Unrecognized dissociative disorders in inpatient psychiatry. *The Journal of Nervous and Mental Disease, 198*(5), 378–381. doi:10.1097/NMD.0b013e3181da4d65

Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8*(4), 597–607.

Guba, E. (1990). *The paradigm dialog*. Newbury Park, CA: Sage Publications.

Guest, G., MacQueen, K., & Namey, E. (2012). Applied thematic analysis. Los Angeles: Sage Publications.

Henning, E., Van Rensburg, W., & Smit, B. (2004). *Finding your way in Qualitative Research*. Pretoria, South Africa: Van Schaik Publishers.

Hesse, E. (1996). Discourse, memory, and the Adult Attachment Interview: A note with emphasis on the emerging Cannot Classify category. *Infant Mental Health Journal, 17*, 4–11.

Holmes, E., Brown, R. J., Mansell, W., Fearon, R. P., Hunter, E., Frasquilho, F. & Oakley, D. A. (2005). Are there two qualitatively distinct forms of dissociation? A review and some clinical implications. *Clinical Psychology Review, 25*, 1–23.

Hook, D., Mkhize, N., Kiguwa, P., Collins, A., Burman, E., & Parker, I. (2004). Critical psychology. Cape Town: UCT Press.

Janet, P. (1889). *L 'Automatisme psychologique*. Paris: Félix Alcan.

Janet, P. (1907). *The major symptoms of hysteria*. New York, NY: Macmillan Publishing. doi: 10.1037/10008-000

Kahr, B. (2007). Infanticidal attachment. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis, 1*(2), 117–132.

Kennedy, F. C. (2013). Dissociation, personality and psychopathology: A cognitive approach. In F. Kennedy, H. Kennerley, & D. Pearson (Eds.), *Cognitive behavioural approaches to the understanding and treatment of dissociation* (pp. 17–39). New York, NY: Routledge/Taylor & Francis Group.

Kennedy, F. C., Clarke, S., Stopa, L., Bell, L., Rouse, H., Ainsworth, C., . . . Waller, G. (2004). Towards a cognitive model and measure of dissociation. *Journal of Behavior Therapy and Experimental Psychiatry*, *35*(1), 25–48. doi: 10.1016/j.jbtep.2004.01.002

Kernberg, O. F. (1966). Structural derivatives of object relationships. *The International Journal of Psychoanalysis*, *47*(2–3), 236–253.

Kernberg, O. F. (1967). Borderline personality organization. *Journal of the American Psychoanalytic Association*, *15*(3), 641–685. doi: 10.1177/000306516701500309

Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism*. Northvale NJ: Jason Aronson.

Kernberg, O. F. (1976). *Object-relations theory and clinical psychoanalysis*. New York, NY: Jason Aronson.

Kernberg, O.F. (1985). *Internal world and external reality: Object Relations Theory applied*. Northvale, NJ: Jason Aronson.

Kernberg, O. F. (2018). *Treatment of severe personality disorders: Resolution of aggression and recovery of eroticism*. Washington, DC: American Psychiatric Association Publishing.

Klein, M. (1946). Notes on some schizoid mechanisms. *The International Journal of Psychoanalysis*, *27*, 99–110.

Koltko-Rivera, M. (2004). The psychology of worldviews. *Review of General Psychology, 8*(1), 3–58. doi:10.1037/1089-2680.8.1.3

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy, 45*(3), 214–222.

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. doi:10.4102/sajpsychiatry.v13i1.6

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. doi: 10.1080/15299732.2017.1295420

Leedy, P. D., & Ormrod, J. E. (2010). *Practical Research: Planning and Design* (9th ed.). New Jersey, NJ: Pearson Education Inc.

Lewis-Fernandez, R., Marinez-Taboas, A., Şar, V., Patel, S., & Boatin, A. (2007). The Cross-Cultural Assessment of Dissociation. In J. P. Wilson & C. C. So-Kum Tang (Eds.), *Cross-Cultural Assessment of Trauma and PTSD* (pp. 279–317). New York, NY: Springer Publication.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Liotti, G. (1992). Disorganized/disoriented attachment in the etiology of the dissociative disorders. *Dissociation: Progress in the Dissociative Disorders*, *5*(4), 196–204.

Liotti, G. (1999). Understanding the dissociative processes: The contribution of attachment theory. *Psychoanalytic Inquiry*, *19*(5), 757–783. doi: 10.1080/07351699909534275

Liotti, G. (2004). Trauma, dissociation, and disorganized attachment: Three strands of a single braid. *Psychotherapy: Theory, Research, Practice, Training*, *41*(4), 472–486. doi: 10.1037/0033-3204.41.4.472

Lyons-Ruth, K., Dutra, L., Schuder, M. R., & Bianchi, I. (2006). From infant attachment disorganization to adult dissociation: Relational adaptations or traumatic experiences? *The Psychiatric Clinics of North America*, *29*(1), 63.

Maiese, M. (2016). Dissociative identity disorder and ambivalence. *Philosophical Explorations*, *19*(3), 223–237. doi: 10.1080/13869795.2016.1199728

Main, M. (1996). Introduction to the special section on attachment and psychopathology: 2. Overview of the field of attachment. *Journal of Consulting and Clinical Psychology*, *64*(2), 237–243. doi: 10.1037/0022-006X.64.2.237

Main, M., & Solomon, J. (1986). Discovery of a new, insecure-disorganized/ disoriented attachment pattern. In M. Yogman & T. B. Brazelton (Eds.), *Affective development in infancy* (pp. 95–124). Norwood, NJ: Ablex.

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

McAllister, M. M. (2000). Dissociative identity disorder: A literature review. *Journal of Psychiatric & Mental Health Nursing*, *7*(1), 25.

Moore, C., Meyer, W., & Viljoen, H. (2017). *Personology: From individual to ecosystem* (4th ed.). Cape Town: Pearson.

Nijenhuis, E. R. S., & Den Boer, J. A. (2009). Psychobiology of traumatization and trauma-related structural dissociation of the personality. In P. F. Dell & J. A. O'Neil (Eds.), *Dissociation and the dissociative disorders: DSM-V and beyond.* (pp. 337–365). New York, NY: Routledge

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. doi: 10.1080/15299732.2011.570592

Nijenhuis, E. R. S., Van der Hart, O., & Steele, K. (2010). Trauma-related structural dissociation of the personality. *Activitas Nervosa Superior*, *52*(1), 1–23.

Ogawa, J. R., Sroufe, L. A., Weinfield, N. S., Carlson, E. A., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology*, *9*(4), 855–879. doi: 10.1017/S0954579497001478

Platt, M. G., & Freyd, J. J. (2015). Betray my trust, shame on me: Shame, dissociation, fear, and betrayal trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, *7*(4), 398–404. doi: 10.1037/tra0000022

Putnam, F. W. (1988). The switch process in multiple personality disorder and other state-change disorders. *Dissociation: Progress in the Dissociative Disorders, 1*(1), 24–32.

Putnam, F.W. (1995). Development of dissociative disorders. In D. Cicchetti & J.D. Coatsworth (Eds.), *Developmental psychopathology: Risk, disorder, and adaptation* (Vol. 2, pp. 581–608). New York: Wiley-Interscience.

Putnam, F.W. (1997). *Dissociation in Children and Adolescents: A Developmental Perspective*. New York, NY: Guilford Press.

Putnam, F. W. (2006). Dissociative Disorders. In D. Cicchetti & D. J. Cohen (Eds.). *Developmental Psychopathology* (pp. 657–695). New York, NY: Wiley.

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.

Putnam, F. W., & Trickett, P. K. (1993, March). *Dissociation and the development of psychopathology*. The Development of Maltreated Children. Symposium conducted at the Annual Meeting of the Society for Research in Child Development, New Orleans.

Reinders, A. A. T. S., Willemsen, A. T. M., Vos, H. P. J., den Boer, J. A., & Nijenhuis, E. R. S. (2012). Fact or factitious? A psychobiological study of authentic and simulated dissociative identity states. *Plos One, 7*(6), 1-17, e39279. doi: 10.1371/journal.pone.0039279

Ross, C. A., Anderson, G., Fleisher, W. P., & Norton, G. R. (1991). The frequency of multiple personality disorder among psychiatric inpatients. *American Journal of Psychiatry, 148*, 1717–1720. doi: 10.1176/ajp.148.12.1717

Ross, C. A., Keyes, B. B., Yan, H., Wang, Z., Zou, Z., Xu, Y., . . . Xiao, Z. (2008). A cross-cultural test of the trauma model of dissociation. *Journal of Trauma & Dissociation, 9*(1), 35–49. doi: 10.1080/15299730802073635

Sachs, A. (2008). Infanticidal Attachment: Symbolic and concrete. In A. Sachs & G. Galton (Eds.), *Forensic Aspects of Dissociative Identity Disorder* (pp. 297–304). London, England: Karnac Books Ltd.

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. doi: 10.5204/ijcjsd.v4i2.219

Sachs, A. (2017). Through the lens of attachment relationship: Stable DID, active DID and other trauma-based mental disorders. *Journal of Trauma and Dissociation, 18*(3), 319–339. doi:10.1080/15299732.2017.1295400

Şar, V. (2011). Epidemiology of Dissociative Disorders: An overview. *Epidemiology Research International, 2011*(5), 1–8. doi: 10.1155/2011/404538

Şar, V. (2017). Parallel-distinct structures of internal world and external reality: Disavowing and re-claiming the self-identity in the aftermath of trauma-generated dissociation. *Frontiers in Psychology, 8*, 1–17. doi:10.3389/fpsyg.2017.00216

Şar, V., & Ross, C. (2006). Dissociative disorders as a confounding factor in psychiatric research. *Psychiatric Clinics of North America, 29*(1), 129–144. doi: 10.1016/j.psc.2005.10.008

Şar, V., Akyüz, G., & Doğan, O. (2007). Prevalence of dissociative disorders among women in the general population. *Psychiatry Research, 149*(1), 169–176. doi:10.1016/j.psychres.2006.01.005

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. doi:10.2147/PRBM.S113743

Şar, V., Önder, C., Kilincaslan, A., Zoroglu, S. S., & Alyanak, B. (2014). Dissociative identity disorder among adolescents: Prevalence in a university psychiatric outpatient unit. *Journal of Trauma & Dissociation*, *15*(4), 402–419. doi: 10.1080/15299732.2013.864748

Şar, V., Unal, S. N., Kiziltan, E., Kundakci, T., & Ozturk, E. (2001). HMPAO SPECT study of regional cerebral blood flow in dissociative identity disorder. *Journal of Trauma & Dissociation*, *2*(2), 5–25. doi: 10.1300/J229v02n02pass:[_]02

Saxe, G. N., Van der Kolk, B. A., Berkowitz, R., Chinman, G., Hall, K., Lieberg, G., & Schwartz, J. (1993). Dissociative disorders in psychiatric inpatients. *American Journal of Psychiatry, 150*, 1037–1042.

Schmid, H. (1981). The foundation: qualitative research and occupational therapy. *The American Journal of Occupational Therapy, 35*(2), 105–106.

Schumaker, J. F. (1995). *The corruption of reality: A unified theory of religion, hypnosis, and psychopathology*. Amherst, NY: Prometheus Books.

Seligman, R., & Kirmayer, L. J. (2008). Dissociative Experience and Cultural Neuroscience: Narrative, Metaphor and Mechanism. *Culture, Medicine and Psychiatry: An International Journal of Cross-Cultural Health Research*, *32*(1), 31–64. doi: 10.1007/s11013-007-9077-8

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75. doi: 10.3233/EFI-2004-22201

Spermon, D., Darlington, Y., & Gibney, P. (2010). Psychodynamic psychotherapy for complex trauma: Targets, focus, applications, and outcomes. *Psychology Research and Behavior Management, 3*, 119–127. doi:10.2147/PRBM.S10215

Spiegel, D. (1991). Dissociation and trauma. In A. Tasman & S. M. Goldfinger (Eds.), *American psychiatric press review of psychiatry* (Vol. 10, pp. 261–267). Washington, DC: American Psychiatric Press.

Spiegel, D., Loewenstein, R. J., Lewis-Fernández, R., Şar, V., Simeon, D., Vermetten, E., . . . Dell, P. F. (2011). Dissociative disorders in DSM-5. *Depression & Anxiety*, *28*(12), 17–45. doi: 10.1002/da.20923

St. Clair, M. (1986). *Object relations and self psychology: An introduction*. Monterey, CA: Brooks/Cole.

Stake, R. E. (2005). Qualitative Case Studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (pp. 443–466). Thousand Oaks, CA: Sage Publications Ltd.

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.

Terre Blanche, M., Durrheim, K., & Painter, D. (2006). *Research in practice: Applied methods for the social sciences* (2nd ed.). Cape Town, South Africa: University of Cape Town Press Ltd.

Tutkun, H., Şar, V., Yargiç, L. I., Ozpulat, T., Yanik, M., & Kiziltan, E. (1998). Frequency of dissociative disorders among psychiatric inpatients in a Turkish university clinic. *American Journal of Psychiatry*, *155*(6), 800–805. doi: 10.1176/ajp.155.6.800

Van der Hart, O., & Matar, M. (2012). Amnesia dissociativa e trauma: una prospettiva secondo la teoria della dissociazione strutturale = Dissociative amnesia and trauma: A perspective from the theory of structural dissociation. *Rivista Sperimentale Di Freniatria: La Rivista Della Salute Mentale*, *136*(2), 121–135.

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.

Van der Hart, O., Nijenhuis, E., Steele, K., & Brown, D. (2004). Trauma-related dissociation: Conceptual clarity lost and found. *Australian and New Zealand Journal of Psychiatry, 38*(11–12), 906–914. doi:10.1111/j.1440-1614.2004.01480.x

Van der Hart, O., & Friedman, B. (1989). A reader's guide to Pierre Janet on dissociation: A neglected intellectual heritage. *Dissociation: Progress in the Dissociative Disorders*, *2*(1), 3–16.

Vonderlin, R., Kleindienst, N., Alpers, G. W., Bohus, M., Lyssenko, L., & Schmahl, C. (2018). Dissociation in victims of childhood abuse or neglect: A meta-analytic review. *Psychological Medicine*, *48*(15), 2467–2476. doi: 10.1017/S0033291718000740

Wahyuni, D. (2012). The research design maze: Understanding paradigms, cases, methods and methodologies. *Journal of Applied Management Accounting Research, 10*(1), 69–80. doi: 10.1675/1524-4695(2008)31

Appendices

Appendix A: Health Sciences Research Ethics Approval of the original study

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee
28/07/2016

Prof Christa Kruger

Department of Psychiatry /Weskoppies Hospital
University of Pretoria

Dear Prof Christa Kruger

RE.: 121/2012 ~ Letter dated 1 July 2016

NUMBER	121/2012
TITLE OF THE PROTOCOL	Dissociative disorders in psychiatric patients in the Pretoria/Tshwane region: Proportion, diagnosis, clinical picture, treatment and available services
PRINCIPAL INVESTIGATOR	Prof Christa Kruger Dept: Psychiatry /Weskoppies Hospital; University of Pretoria. Cell: 082 345 6929 E-Mail: christa.kruger@up.ac.za

We approved the following:

- Extension given for 4 years where-after re-approval can be given upon receipt of a 6-monthly progress report

With regards

Dr R Sommers; MBChB; MMed (Int); MPharMed,PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46.

This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

☎ 012 356 3085 fhsethics@up.ac.za http://www.up.ac.za/healthethics ✉ Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4-59**, Gezina, Pretoria**

Appendix B: Health Sciences Research Ethics Approval of the present study

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

28/09/2017

Approval Certificate
New Application

Ethics Reference No: 411/2017

Title: An exploration of the experience of conflict in psychiatric patients diagnosed with Dissociative Identity Disorder: A collective case study.

Dear Ms Lizanda Marais

The **New Application** as supported by documents specified in your cover letter dated 4/09/2017 for your research received on the 4/09/2017, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 27/09/2017.

Please note the following about your ethics approval:
- Ethics Approval is valid for 1 year
- Please remember to use your protocol number (**411/2017**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed,PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

012 356 3084 deepeka.behari@up.ac.za / fhsethics@up.ac.za http://www.up.ac.za/healthethics
Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4, Room 60, Gezina, Pretoria

Appendix C: Faculty of Humanities Research Ethics Approval of the present study

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

22 November 2017

Dear Ms Marais

Project:	**An exploration of the experience of conflict in psychiatric patients diagnosed with Dissociative Identity Disorder: A collective case study**
Researcher:	**L Marais**
Supervisor:	**Ms M Bezuidenhout**
Department:	**Psychology**
Reference number:	**10391322 (GW20171110HS)**

Thank you for the application that was submitted for ethical consideration. It is noted that the Faculty of Health Science's Ethics Committee reviewed and approved the application on 28 July 2017.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 22 November 2017. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

cc: Ms M Bezuidenhout (Supervisor)
Prof C Wagner (HoD)