Type	Dissociative
General	**Identical with the diagnosis of Dissociative Identity Disorder** Dissociative problems range from mild depersonalization to polyfragmented multiple personality disorder. Constitutional capacity for self-hypnosis; early, severe, and repeated physical and/or sexual trauma
Affect, Drive, Temperament	Constitutional capacity for self-hypnosis. Overwhelming affect that could not be processed: primordial terror and horror. *The more numerous and conflicting the emotional states activated the harder is to assimilate an experience without dissociation*.
Defenses	**Dissociation** is often an invisible defense. When al alter/system of alters is running things smoothly, no one outside the patient can see the dissociative process. **BASK model** (behavior, affect, sensation, knowledge) of dissociation subsumes under the phenomenon of dissociation a number of related processes. One can dissociate **behavior** (e.g. a paralysis or trance-driven self-mutilation), **affect** (as in *la belle-indifference* or the memory of trauma without feeling), **sensations** as in conversion anesthesias and body memories of abuse, or **knowledge** as in fugue states and amnesia.
Object relations/ interpersonal	Outstanding feature abuse, usually including but not limited to sexual abuse; parents of people with multiple personality disorder are frequently themselves dissociative. Because they often have amnesia for what they do they both traumatize their children and fail to help them understanding what has happened to them. Object-seeking, hungry for relationship, and appreciative of care.
Self	**Fractured** into numerous split-off partial selves, each of which perform certain functions that include host personality (usually the seeker of treatment who tends to be anxious, dysthymic, and overwhelmed) infant and child components, internal persecutors, victims, protectors and helpers, and special-purpose alters. The self is not only fragmented but also permeated by paralyzing fears and self-blaming cognitions. **Everyone is the patient.**
Transference/ Countertransf.	**Transference** Very intense because of the intensity of the abuse. Especially when child alter personalities are in ascendance, the present can feel so much like the past that hallucinatory convictions (e.g., the therapist is about to rape me etc.) are not uncommon. **Countertransference** Dissociative patients induce intense responses of love, care, and wishes to rescue. Their suffering is so profound and undeserved, their responsiveness to simple consideration so touching, that one yearns to put them on one s lap and take them home (especially the child alters). However, they are also petrified by any violation of normal boundaries between therapists and clients.
Therapeutic implications	**Treatment feels a lot like doing family therapy with one person, and as in well-conducted family work, the system, not a particular favored member is the client.** Slow pace is important especially when dealing with trauma. Hypnosis may put these patients at ease when exploring traumatic emotions. Because transference inundates dissociative patients it is valuable for the therapist to be somewhat more real than he or she customarily behaves. Transferences usually become analyzable because the client discovers a tendency to make attributions in the absence of the evidence, and he or she discovers that the sources of such assumptions are historical. In contrast, dissociative people tend to assume that current reality is only a distraction from a more ominous reality: exploitation, abandonment, torment. To

	explore a dissociative person s transference, the therapist must first establish that he or she is someone different from the expected abuser someone respectful, devoted, modest, and scrupulously professional.
Differential diagnosis	**Most people with dissociative psychologies do not come to the therapist stating that their problem dissociation.** Data that should raise the suspicion: known hx/o trauma, family background of severe alcoholism/drug abuse; personal hx/o unexplained serious accidents; amnesia for the elementary school-years; pattern of self-destructive behavior w/o rationale; complaints of lost time , blank spells; referral to self in the third person or the first person plural; voices or noises in the head. **Dissociative conditions vs. Psychoses** Dissociative switching might be construed as schizoaffective and bipolar condition due to the lability of mood. Premorbid personalities and object relatedness make the difference. Dissociatives are very attaching while genuinely schizophrenic are flat and do not draw the therapist into intense attachment. However, dissociative symptoms can coexist with schizophrenia and with affective psychoses. To assess if dissociation is part of a psychotic picture when voices are reported, one should ask to speak with the part of you that are saying these things . **Dissociative vs. Borderline conditions** Are not mutually exclusive. Dissociation resembles splitting and switches to alter personalities can be easily mistaken for changes in ego-states. Amnesia makes a difference. **Dissociative vs. Hysterical conditions** Considerable overlap. Conversion symptoms are common in people with multiple personality disorder; hysterical people dissociate in many ways. In anyone with pronounced hysterical symptoms one should ask about dissociation. Hx/o trauma might be absent in hysterical people while it always severe in the dissociative ones. **Dissociative vs. Psychopathic conditions** Many antisocial people have dissociative defenses. Hard to make the difference between a sociopathic person with a dissociative streak and a dissociative person with a psychopathic alter. Clinicians can resolve dissociation easier than they can alter antisocial patterns. Since dissociative people have a good prognosis, there would be significant crime preventive value in giving intensive therapy to perpetrators discovered to have DP.