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Research Paper

# Historical and contemporary conceptions of trauma-related dissociation: A neo-Janetian critique of models of divided personality

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ABSTRACT

Both Pierre Janet and the neo-Janetian contemporary theory of structural dissociation of the personality (SDP) view dissociation as inherently pathological – trauma-related dissociation. However, since the late 19th century, other theories have viewed dissociative subsystems of the personality developing after traumatic experiences as continuous with proposed divisions of normal personality. Taking Pierre Janet's hierarchy of degrees of reality as a guide, along with the basic premises of the theory of structural dissociation of the personality, this paper examines this assumption in constructs from the late 19th through 20th centuries, including ego states, self-states, schema modes and complexes. It is concluded that the SDP concept of dissociative parts of the personality is most consistent with the historical and empirical literature, and that dissociation is best thought of as discontinuous with normal personality.


## 1. Introduction

Since the time of Pierre Janet, it has been recognized that the human personality may become dissociated in response to extreme events – particularly those that are typically referred to as traumatizing. Various conceptions of trauma-related dissociation have been proposed over the past century and a quarter, with the most recent and influential version being the theory of structural dissociation of the personality (Van der Hart, Nijenhuis, & Steele, 2006). At the same time, other theorists have developed conceptions of trauma-related dissociation as part of broader theories of divided normal personality, conceptualized as containing independent or semi-independent components (variously referred to as ego states, self-states, complexes, modes, etc.). Importantly, several of these approaches argue (explicitly or implicitly) for a continuum from the compartmentalization of normal personality to the dissociative parts of the personality developing in response to traumatizing events. But is such a continuum conception consistent with what we know about trauma-related dissociation? In other words, do clinical and theoretical approaches to personality development or functioning that posit normal divisions or compartmentalization adequately explain the phenomena associated with trauma-related dissociation, including the characteristic features of dissociative parts of the personality? Or, to put it differently, can the effects of traumatizing experiences on the personality be understood simply as an exaggeration of normal personality structure? It is this question, which has important theoretical and clinical implications, that we seek to address in this paper.

We begin with the seminal ideas of Pierre Janet, writing in the late 19th and early 20th century, highlighting some of his key, including the notion of a 'hierarchy of reality', as important to an understanding of dissociation of the personality. The contemporary theory of structural dissociation of the personality, which builds on and expands Janet's ideas (and can thus be seen as *neo-Janetian*) will then be presented. This section will include a discussion of the meaning of trauma, and presentation of the concept of 'trauma-related dissociation'. The second section will be an overview of a range of approaches from the early 20th century to today, primarily clinical in nature, that view normal personality as consisting of clusters or groups of personality states ('ego states', 'self-states', etc.). We will use the generic term 'subsystems of the personality' in characterizing these theories or models. After presenting a few of these approaches, focusing on the manner with which they deal with the consequences of traumatization, we will consider how adequately they can explain the phenomena associated with trauma-related dissociation.

In the third section, we will compare and contrast the various constructs, including the notion of dissociative parts of the personality as presented in the theory of structural dissociation of the personality (SDP; Van der Hart et al., 2006). We will consider

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here the extent to which SDP theory can adequately explain the clinical and experimental phenomena associated with trauma-related dissociation, in comparison to the approaches presented earlier. In the final section, we will summarize the findings of this review, highlight remaining outstanding questions to be considered, and address the clinical and research implications.

Subsystems of the personality have been labeled in different ways, each with its advantages and disadvantages. Some variations are 'states of consciousness', 'parts of the personality', 'complexes' and 'personalities'. In considering each of these constructs, one of the criteria used will be Janet's model of the hierarchy of degrees of reality (described below), as a means to assess whether the concept proposed adequately characterizes the nature of trauma-related dissociation. Advantages and disadvantages of utilizing various terms will be considered, as well as whether 'consciousness' or 'personality' is the more appropriate domain for the division/separation. Finally, we will consider whether the models or concepts proposed allow for a division of the personality into one dissociative part immersed in the trauma and another part trying to function in daily life – a core feature of all trauma-related dissociation.

In short, with trauma-related dissociation as the point of departure, the questions we wish to discuss are:

- what important terms did various authors apply to subsystems of the personality;
- which of these concepts do justice to trauma-related dissociation?

## 2. The beginning: Pierre Janet

Janet's pioneering studies, rooted in his study of the historical literature on somnambulism as well as in his experimental work with patients, were rediscovered by Henri Ellenberger in his milestone publication, *The Discovery of the Unconscious* (Ellenberger, 1970). Following his magnum opus, *L'Automatisme Psychologique*, a careful study of dissociation in patients suffering from hysteria (Janet, 1889), Janet continued this work in the studies published in *The Mental State of Hystericals* (Janet, 1894a, 1894b, 1901, 1911). In these studies, he recognized that hysteria was characterized by a mental state or condition, which he called psychological misery (Janet, 1889) or mental depression (Janet, 1907), by which he meant a lowering of the individual's integrative capacity ('malady of personal synthesis'; Janet, 1907, p. 332). Hysteria was the old diagnostic category for a wide range of dissociative disorders, ranging from posttraumatic stress disorder (PTSD), somatoform disorders and borderline personality disorder, to dissociative identity disorder (DID; Van der Hart et al., 2006). In hysteria, Janet argued that this integrative failure manifested in:

- a retraction or narrowing of the field of personal consciousness;
- a tendency to the dissociation and emancipation of the systems of ideas and functions that constitute personality (Janet, 1907, 1909a).

Note that Janet carefully separates these two aspects of hysteria – unlike many contemporary thinkers who refer to changes in levels or breadth of consciousness as 'dissociation'. Janet referred to these (sub)systems of the personality using different labels, such as psychological existences, states, and personalities (Janet, 1887, 1889, 1898, 1907). In his view, psychological existences all have their own sense of self (*idée du Moi*; Janet, 1889); that is, they include their own first-person perspective. These subsystems involve perceptions, thoughts, memories, sensations, fantasies, decision-making, and behavioral actions. Janet's definition implies that each of these psychological existences is characterized by a smaller field of consciousness than a well-integrated personality (Janet, 1889, 1907). Such dissociative subsystems may include, for example, awareness of some type of sensory experiences but not others (such as in the case of dissociative anesthesia).

Janet argued that humans ascribe a level of reality to internal or external events that could be conceptualized in terms of a hierarchy of degrees of reality. He included on this hierarchy various concepts, including behavior, thoughts, imagination, and various perceptions of the past, present, and future (Janet, 1928). The immediate future and recent past are usually accorded high levels of reality, and thoughts and ideas, low levels. Janet argued that the perception of the degree of reality of a phenomenon was directly related to the 'tendency to act in response' to it (Janet, 1932, p. 141); that is to say, the higher an experience is placed on the hierarchy, the greater the pressure it places on a person to act. The highest level of the reality function (*la fonction du réel*) involved what Janet called *presentification* (Janet, 1928), the capacity to act in a fully-focused and meaningful way in the present, integrating one's past experiences and future plans (discussed at length in Van der Hart et al., 2006). Mental health requires the present to be (usually) accorded the highest level of reality, so we can act in the present and effectively adapt with required action (manifesting *personification*, which is the recognition and appreciation that one's actions derive from one's self – a sense of 'ownership' of one's actions; Janet, 1929). In contrast, thoughts or fantasies would, under normal conditions, not lead to the expression of actions in the current spatiotemporal context. Janet argued that much of psychopathology could be conceptualized as a failure to accurately organize reality in time and space, as a 'mixing up' of levels of reality. Examples of this would be the inability to distinguish between thoughts and actions in obsessive compulsive disorder (which leads to excessive 'checking' behavior), and experiencing the distant past as happening in the present, which occurs in PTSD and dissociative disorders.

Thus, trauma survivors may place their traumatic memories too high in the hierarchy when they feel as though the traumatizing event were occurring in the present; their actions in response to flashbacks are inappropriate to the present context but appropriate to the past. An important question is whether clinicians' approach or model may place dissociative subsystems of the personality too high or too low in this hierarchy, causing them to overlook relevant aspects of the subsystems. Another question is whether or not the proposed language allows for a differentiation between prototypes of these trauma-generated subsystems.

## 3. The theory of structural dissociation of the personality

The theory of Structural Dissociation of the Personality (SDP), as proposed by Van der Hart, Nijenhuis and Steele in their 2006 book *The Haunted Self*, and in other publications, builds on and expands the seminal ideas of Janet. This *neo-Janetian* theory proposes that trauma-related dissociation among dissociative parts of the personality occurs along the lines of evolutionary-prepared action systems (also known as motivational or behavioral systems) of daily life and of defense. Thus, there are two main categories of dissociative parts: one type tends to primarily function in daily life while avoiding reminders of the trauma, while the other is primarily fixed in various trauma-related defenses (fight, flight, freeze, collapse/immobility), mostly stuck in 'trauma time', and, when reactivated, relives traumatic experiences (e.g, DSM-IV's dissociative flashback episodes, also recognized in DSM-5 [American Psychiatric Association, 2013]) as a positive dissociative symptom of PTSD).

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One prototypical type is called the apparently normal part of the personality (ANP), and the other, the emotional part of the personality (EP), each with its first-person perspective and sense of self (Van der Hart et al., 2006). These terms were adapted from Myers (1940), whose ideas are discussed below. A case could be made that dissociative EPs remain in a kind of malignant trance state; one in which, when reactivated, the experience of being in trauma time has for them the highest degree of reality (cf., Janet, 1928).

The theory recognizes the basic division of the personality in response to trauma into a single ANP and a single EP; notably, the core Posttraumatic Stress Disorder (PTSD) symptom clusters of avoidance and re-experiencing reflect this division (though separate first-person perspectives are not proposed as part of the PTSD criteria). As Janet (1909b) and Ferenczi (1933) already noted, dissociation is typically more complex and chronic when the individual experiences more intense trauma, starting at an earlier age, with more repetition and longer duration. This involves the development of two or more EPs, along with two or more ANPs. Crucially, like Janet, SDP theory does not include the notion that structural dissociation of the personality is a feature of normal personality development or functioning.

## 4. Trauma-related dissociation

The benchmark against which all of the following theories and concepts will be assessed is that of trauma-related dissociation, as initially conceptualized by Janet and informed by contemporary research. Accordingly, in this section, we will discuss the core characteristics of trauma-related dissociation, after consideration of what is meant by the term trauma itself.

### 4.1. Trauma

The term 'trauma' comes from the Greek word for 'wound' and has been used for centuries to describe medical wounds. It was first used in a psychological sense in the late 19th century (Van der Hart & Brown, 1990). The original psychological conception of 'trauma' focused primarily on an individual's reaction to a stressful event, and later, with the development of the PTSD diagnosis, on extreme emotional reactions to life-threatening events (Moskowitz, Heinimaa, & Van der Hart, 2019). However, the definition of trauma contained in the diagnosis of PTSD in the DSM-5 (American Psychiatric Association, 2013) dispenses with the individual's reaction entirely, defining trauma solely as certain life-threatening events or sexual assaults, occurring to a person or someone close to them, or (in certain cases) witnessed.

There are two core problems with defining trauma in this manner:

- the same event will lead to a traumatic reaction in some individuals but not in others (or even in the same individual at one time but not another time; Kilpatrick et al., 1989);
- events that are not directly physically threatening (but may trigger the attachment system), such as losing one's home or the breakup of an important relationship, can lead to all of the symptoms required for a PTSD diagnosis (Carlson, Smith, & Dalenberg, 2013).

For this reason, Van der Hart et al. (2006) have argued that events should not be considered traumatic as such, but traumatizing or, in general, potentially traumatizing. Accordingly, we have proposed a conception of 'trauma' as an ongoing 'inability to integrate the implications of an event into the existing conceptions of one's self and the world' (Moskowitz et al., 2019). Such events are common in life but not ubiquitous; definitions of trauma that view it as occurring in everyone's lives are, in our opinion, too broad. In addition, our concept of trauma is closely tied to the concept of dissociation as a 'failure of integration', which leads us to the concept of trauma-related dissociation.

### 4.2. Characteristics of trauma-related dissociation

The concept of trauma-related dissociation refers primarily to a division of the personality occurring in response to traumatizing events. Nijenhuis and Van der Hart (2011) have proposed the following definition of trauma-related dissociation (it is recognized that *transient* dissociation may occur without trauma, as in the case of certain hypnotic states in susceptible individuals, for example). Trauma-related dissociation involves:

> a division of an individual's personality, that is, of the dynamic, biopsychosocial system as a whole that determines his or her characteristic mental and behavioural actions. This division of personality constitutes a core feature of trauma... (and) evolves when the individual lacks the capacity to integrate adverse experiences in part or in full... The division involves two or more insufficiently integrated dynamic but excessively stable subsystems... Each dissociative subsystem, that is, dissociative part of the personality, minimally includes its own, at least rudimentary, first-person perspective. As each dissociative part, the individual can interact with other dissociative parts and other individuals, at least in principle. (p. 418)

The fundamental ideas of Janet reviewed above, including his hierarchy of reality, and the neo-Janetian theory of structural dissociation of the personality, along with definitions of trauma and trauma-related dissociation, provide the basis for the following analysis of historical and contemporary conceptions of personality subsystems.

## 5. Historical and contemporary conceptions of subsystems of the personality

Subsystems of the personality, in the 19th and 20th centuries, have been conceptualized as various states (including modes), complexes and personalities. They have also been conceptualized as part of the personality in the SDP theory, which will be considered at the end.

### 5.1. Subsystems of the personality as states

The word 'states' carries a number of connotations, for example, 'a person's condition at a particular time', and 'a particular process or mode of consciousness' (OED, 2018). These are clearly very broad definitions applying to persons even when asleep and dreaming (but not when completely unconscious). At the same time, 'state' refers to a particular mode of consciousness (used explicitly in the concept of 'schema modes') and, as such, can change rapidly and frequently in one individual throughout the day. After reviewing a number of these conceptions, we will comment on their characteristics and limitations.

#### 5.1.1. États seconds *(secondary states)*

The French psychiatrist Laurent (1892) used the already well-known expression *états seconds* (secondary states) – in contrast to *primary* or *normal states* under which he subsumed a wide variety of concepts related to a division of the personality. The first concept he discussed was natural somnambulism, a phenomenon which,

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according to Janet (1889), is only meaningfully considered in relation to other moments in the life of the patient – that is, the normal state of waking consciousness. This state of somnambulism may develop into a secondary personality, alternating or being co-present with the primary personality, and is often characterized by the 'development of a larger memory, a faster speed of the association of ideas and a particular state of hyperexcitability of the senses' (Laurent, 1892, p. 163). Laurent also regarded hysterical attacks, often involving reliving traumatizing events, as secondary states.

The label of *états seconds* was re-introduced by World War I physicians, including Maurice Dide (1918) and Germain Peretti, as indicated by the title of his medical thesis, *Réflections sur les états seconds après les batailles* (1920). In their focus on traumatized soldiers, these authors emphasized that the secondary states were usually the condition in which these patients re-experienced their traumas.

#### 5.1.2. Hypnoid states

Sigmund Freud had been aware for many years of the remarkable case of Anna O., treated by his esteemed elder colleague, Josef Breuer. In the early 1890s, Freud convinced Breuer to join him in a 'preliminary communication' on 'the psychical mechanism of hysterical phenomena'; in that manuscript Breuer and Freud (1893/1955) laid out their concept of 'hypnoid states' (the word was chosen deliberately to relate to the recognized phenomenon of *double conscience* (e.g., Azam, 1876, 1887; Binet, 1890), and to indicate a close connection with somnambulism or 'hypnosis'). The *Preliminary Communication* was incorporated into *Studies on Hysteria* (1895), which also included Breuer's Anna O. case, illustrating the clinical reality of hypnoid states, and a theoretical chapter by Breuer on the phenomenon (where the term 'auto-hypnosis' was frequently used). But by that time, Freud, in his chapters in *Studies in Hysteria*, had already begun to distance himself from Breuer's ideas.

Breuer and Freud (1893/1955) and Breuer and Freud (1895/1955) not only coined the term hypnoid states (replacing the more general term secondary states), but also described them as abnormal states of consciousness or abnormal psychical states. Importantly, not only were hypnoid states only pathological (i.e., not present in 'healthy' individuals), they were present only some of the time in hysterical patients and (as in the concept of secondary states) contrasted with patients' so-called normal consciousness or normal psychical states.

The concept of hypnoid states was inspired by the French concept of somnambulism. In the Preliminary Communication, hypnoid states and their relation to hysterical attacks are described as follows:

> Hysterical attacks... appear in a specially interesting light if we bear in mind... that in hysteria groups of ideas originating in hypnoid states are present and that these are cut off from associative connection with the other ideas, but can be associated among themselves, and thus form the more or less highly organized rudiments of a second consciousness, a *condition seconde*. (pp. 66–67)

In his portions of *Studies on Hysteria*, Freud began to argue that hypnoid states were not necessary for the formation of hysteria, but Breuer continued to emphasize the importance of this special state of consciousness. Freud subsequently completely rejected the notion of hypnoid states and of the theory of a trauma-related dissociation of consciousness, placing instead great emphasis on the etiological role of instinctual drives and intrapsychic conflict in the development of hysteria and other neurotic forms.

#### 5.1.3. Ego states

John Watkins and Helen Watkins (1977) developed Ego State Therapy under the inspiration of Federn (1952). Federn argued, in contrast to Freud, that there were two forms of psychological energy (or libido) – those which are invested in object representations – which leads to *introjections* – and those which are invested in self representations – which leads to *identifications*. In other words, it is the form of energy, which determines whether an internal representation is part of the personality or not. As described by Watkins and Watkins (1977):

> An introject is like a stone in the stomach, within the self but not part of it, ingested but not digested. For the individual to act and talk spontaneously like the other, the object cathexis must be withdrawn and the image ego cathected. (p. 16)

Watkins and Watkins (1977) defined an ego state as: 'an organized system of behavior and experience whose elements are bound together by some common principle and which is separated from other such states by a boundary that is more or less permeable' (p. 25). This 'common principle' is not defined and varies considerably in the examples given. The Watkins' present a 'differentation-dissociation' continuum of ego states, which ranges from 'normal, well-adjusted ego states' (adaptive differentiation) to those, which are characteristic of multiple personality (pathological); in their view not only traumatized individuals but all individuals have ego states.[1]

Importantly, Watkins and Watkins (1977) clearly did not believe that the ego states in 'multiple personality' differed in essence from those in 'normal' personality, only by degree; in both cases, these states could have opposing aims.

> Ego states that are cognitively dissonant from one another or have contradictory goals frequently develop conflicts with one another. When they are highly energized and have rigid, impermeable boundaries, multiple personalities may result. (p. 30)

In a later publication, Watkins and Watkins (1988) reiterated that the difference between 'normal' personality and 'true multiples', in their view, was simply the 'degree of separation as measured by the relative rigidity or permeability of the separating boundaries' (p. 68).

#### 5.1.4. Self-states

Modern relational psychoanalysis emphasizes the concepts of self and self-states rather than ego and ego states (e.g., Bromberg, 1998, 2006; Chefetz, 2015; Howell, 2005, 2011). This change can be attributed to the rise of 'self-psychology' (and the decline of 'ego' psychology) with the publications of Kohut (1971, 1977) and others. The position of these authors is similar to that of the Watkins', in that they argue that the human self is not a unity but consists of multiple self-states that emerge and change depending upon the context and its demands (Howell, 2011). Philip Bromberg (1998), a major representative of this school, defines self-states as 'constellations of affects, memories, values, and cognitive capacities' (p. 182). Richard Chefetz (2015), another important figure in this area, argues that self-states are 'ubiquitous and normal'. He continues:

> When they are linked to each other and knowledge, behavior, emotion, and sensation flow freely from state to state, then we

[1] Notably, 'individual' means 'one in substance or essence' or 'indivisible' (OED Online, http://www.oed.com/view/Entry/94633; in other words, 'not capable of being divided').

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> are in relative harmony with our sense of self and the world. We all benefit by being able to seamlessly trot out one or another authentic versions of ourselves to function in various situations. (p. 81)

The development of dissociative disorders (which Chefetz calls dissociative 'process') is associated with getting 'stuck in a self-state [in order] to maintain the isolation, exclusion, or deflection of psychological content that is unconsciously or consciously feared or has simply previously led to physiologic destabilization' (p. 81). And Bromberg (2006) contrasts the healthy personality with dissociative disorders in the following passage:

> What was formerly a flexible multiplicity of relatively harmonious self-states – a normal mind whose shifting configuration enabled the person to 'feel like one self while being many' – becomes a rigid multiplicity of adversarial self-states. Each self-state is hypnotically sequestered from the others and operates within its specific pattern of interpersonal engagement that gives it self-meaning, the most extreme form of this dissociative structure being dissociative identity disorder. The hypnoid isolation among self-states gives personal identity a subjective sense of consistency and coherence within each self-state regardless of which has access to consciousness and cognition at a given moment because the individual states are unlinked from one another so as to function independently. The security of the personality has now become totally linked to a trauma-based view of reality. Always, some dissociated part of the self is vigilantly "on call" because the person cannot afford to feel safe. (pp. 191–192)

#### 5.1.5. Schema modes

A popular form of psychotherapy developed some decades ago by Jeffrey Young is called schema therapy. The therapy proposes that all individuals' actions are driven by schemas, which are dominant in an individual, and in particular by the schema mode which is active at a particular time. In their 2003 book, *Schema Therapy: A Practitioner's Guide*, Young, Klosko and Weishaar defined schema as 'a broad, pervasive theme or pattern comprised of memories, emotions, cognitions, and bodily sensations regarding oneself and one's relationships with others developed during childhood or adolescence (and) elaborated throughout one's lifetime' (p. 7). About the concept of schema modes, they note the following:

> At any given point in time, some of our schemas or schema operations... are inactive, or dormant, while others have become activated by life events and predominate in our current moods and behavior. The predominant state that we are in at a given point in time is called our 'schema mode.' We use the term 'flip' to refer to the switching of modes. (Young et al., 2003, p. 37)

Practitioners of schema therapy have identified ten schema modes, grouped broadly into four categories – child modes, dysfunctional coping modes, dysfunctional parent modes, and the healthy adult [this has echoes of Eric Berne's (1964) *Transactional Analysis*]. The goal of therapy is to help a person change their behavior through identifying and modifying their dominant schema modes and dysfunctional schemas.

Young et al. (2003) have also written about the relation between schema theory, dissociation and dissociative disorders. For example, they note that schema modes can be characterized by the extent to which they have become 'dissociated, or cut off, from an individual's other modes' or as 'a part of the self that is cut off to some degree from other aspects of the self' (p. 40). Note that many terms are used to refer to the same thing – modes or parts, aspects or – elsewhere – facets 'of the self'.

According to Young et al. (2003), individuals with a low 'level of dissociation' are 'simultaneously able to experience or blend more than one mode' at the same time (p. 42). This is not true for persons with high levels of dissociation who 'in one mode may not even know that another mode exists'; they further add that patients with DID 'may even have different names for each mode' (p. 40). Persons with DID are argued to 'have more modes' than persons with borderline personality disorder, because they frequently have more than one mode of each type (e.g., three Vulnerable Child modes, each a different age; p. 42).

Finally, modes are more rigid and less flexible in highly dissociative individuals and the mode they refer to as the 'healthy adult' is weaker, and thus less able to moderate or inhibit the more 'dysfunctional' modes.

#### 5.1.6. Comments

In this section, five historical and contemporary conceptions of subsystems of the personality as states have been considered. While some of them occasionally use other alternative terms, and one of them primarily uses the term 'modes' instead of states, all of them meet the definition of states as a person's 'condition' or 'mode of consciousness' at a 'particular time' (OED, 2018).[2]

The 19th century proposals – Laurent's *secondary* states (1892) and the hypnoid states of Breuer and Freud (1893/1955) – share some similarities. Both see these states as essentially pathological and contrast them with the person's primary or normal personality – which they consider to be not fundamentally different from the (undivided) 'normal' personality in individuals who do not experience hypnoid or secondary states. However, Laurent, and particularly Peretti (1920) viewed secondary states as arising from traumatizing experiences, while Breuer and Freud (1893/1955) felt that hypnoid states could occur without trauma, in individuals who were predisposed to experience intense daydreams, for example.

Both of these concepts have a number of weaknesses, when considered in light of Janet's hierarchy of reality and the theory of structural dissociation of the personality. First of all, they do not refer to the person's entire personality, but only to the special state in which individuals sometimes find themselves; the rest of the time, the person is assumed to be functioning normally. This is not consistent with clinical and research knowledge of dissociative subsystems produced by traumatic experiences; after traumatization, part of the person is functioning normally. Even when appearing apparently normal, the person's actions and emotions are constricted as they try to avoid all reminders of the traumatic experience. As such, these theorists placed the part of the person outside of the secondary or hypnoid states too high on Janet's hierarchy of reality – as they are not functioning like a whole person who has not been traumatized.

The three 20th century conceptions that posit subsystems of the personality as states – the Watkins' ego states, the self-states of Bromberg, Chefetz and others and Jeffrey Young's schema modes – all differ from the 19th century versions in one fundamental and essential way: states are considered to be ubiquitous, existing in all

[2] While Young, Klosko, and Weishaar (2003) use the term 'state' interchangeably with 'mode', they propose that healthy individuals can experience more than one 'mode' at the same time – which would not be consistent with the usual understanding of the term 'state'. However, they also assert that persons with DID, unlike healthy persons, cannot experience multiple 'modes' (i.e., parts of the personality) at the same time. But clinical documentation of 'co-consciousness' (Chu, 2011; Dell, 2009; Janet, 1889), and the conceptualization of voice hearing as dissociative (Moskowitz & Corstens, 2007), clearly argues against this.

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individuals whether or not they have been traumatized. While such positions may have merit in themselves (which is not evaluated here) – particularly when states are defined so broadly as to simply encompass normal moods, or common everyday experiences such as attending sporting events – none of these formulations adequately addresses the fundamental changes seen in subsystems of the personality after traumatization. For example, all of the authors above proposed that the development of rigid, impermeable 'boundaries between states', or rigid, inflexible modes, were characteristic of complex dissociative disorders, but they did not propose any convincing process by which such a transformation from normal personality to dissociative disorders could take place. Furthermore, Young and colleagues propose that the 'healthy adult' mode in DID is weaker and less able to inhibit more 'dysfunctional' modes than in 'normal' personality, but there seems little evidence to suggest that any part of the personality developing after trauma could be considered to be a 'healthy adult'; such parts are conceptualized in the theory of SDP as 'apparently normal' for a reason – the appearance of normality is superficial.

Relatedly, none of conceptions above proposes or allows for the most fundamental tenet of the theory of structural dissociation of the personality – the essential, trauma-related, division between the emotional (or primarily trauma-immersed) part or parts of the personality, and the apparently normal (primarily daily life functioning) part or parts of the personality. However, some of the conceptions, particularly the Watkins' ego states and Bromberg's self-states, have a more sophisticated conception of dissociative disorders. For example, when Bromberg notes that, in traumatized individuals, there is always some dissociated part of the personality which is vigilantly 'on call' because the person cannot afford to feel safe, he seems to be referring to subsystems of the personality which are stuck in trauma and related defense (like the concept of EPs in SDP theory). And the Watkins recognize the existence of certain states (they also used the word 'alter') in 'multiple personality disorder' (DID) whose purpose is to dissociate the 'pain' from the primary alter or to make it easier for the 'major personality' to deal with the perpetrator 'without inviting retaliation' (Watkins & Watkins, 1977, p. 28; note the use of 'states', 'alters' and 'personalities' interchangeably). Thus, while both Bromberg and the Watkins identify trauma-immersed states (i.e., the state that holds the pain), and the Watkins daily life functioning parts (i.e., the part that related to the perpetrator – often the parent – in non-abusive situations in a calm manner), neither of these conceptions differentiate fundamentally between these two sets of subsystems.

Finally, the contemporary state-based conceptualizations, like the 19th century ones before them, locate these subsystems of the personality too high on Janet's hierarchy of reality – as each dissociative part of the personality developing after traumatization may contain many states, not just one. In other words, one ANP of an individual with DID may express several of Young's modes at different times.

### 5.2. Subsystems of the personality as complexes

Several authors refer to subsystems of the personality as 'parts of the personality' (e.g., Ferenczi, 1930, 1932, and McDougall, 1926, at times). One of these was Carl Jung, who early his career, developed the notion of a 'complex'. Jung, particularly in his early work (for example, Jung, 1902/1970, 1907/1960), referred repeatedly to Janet. Jung's view that the human mind comprised a number of subpersonalities, which he called 'complexes', was inspired by Janet's concept of 'simultaneous psychological existences' (Janet, 1889). However, for Janet these 'existences' were dissociative in nature because they were not integrated with the rest of the personality and thus, by definition, pathological, while Jung felt that everyone's personality contained subpersonalities. Based on his research with word association tests, Jung developed the concept of a complex, which he had borrowed from the German psychiatrist Ziehen (Jung, 1906/1909). As Myers (1940) did with regard to 'personalities', Jung distinguished between two main types of complexes. The first type referred to the ego as a complex of ideas, which constituted the center of the field of consciousness and appeared to possess a high degree of continuity and identity, hence the label ego-complex. The second type pertained to 'emotionally charged complexes' or 'feeling-toned complexes of ideas,' which were understood as core networks of emotions, memories, perceptions, and wishes generated around a common theme, which Jung equated with Janet's subconscious *idées fixes* (Ellenberger, 1970, p. 406).

In his 1907 book *The Psychology of Dementia Praecox*, Jung clearly saw a 'complex' as an independent psychological entity, describing it as a 'being, living its own life and hindering and disturbing the development of the ego-complex' (p. 47). The connection between complexes and dissociative disorders is made even clearer in a later publication:

> (T)here is no difference in principle between a fragmentary personality and a complex... Today, we can take it as moderately certain that complexes are in fact 'splinter psyches'. The aetiology of their origin is frequently a so-called trauma, an emotional shock or some such thing, that splits off a bit of the psyche. (Jung, 1934/1960, pp. 97–98)

In his book on war neuroses and psychological trauma, Ernst Simmel adopted Jung's terminology, and presented his understanding, observations and treatment of traumatized combat soldiers (Simmel, 1918). He discussed a trauma-generated 'splitting of the personality' (*Spaltung der Persönlichkeit*) into two 'groups of experience' (Empfindungsgruppen) in conflict with each other, that is, a 'personality complex' (*Persönlichkeitskomplex*) or 'Ego complex' (*Ichkomplex*) versus a 'feeling-toned complex of ideas' (*gefühlsbetonte Komplex*), cut off from the former. Simmel thus implied the dissociative nature of these complexes, with the emotions of the latter 'complex' being in the service of psychological self-defense. In treating war trauma, he used hypnotic induction of hypermnesia in order to have the patient – as both complexes – re-experience the trauma, including the emotions involved. He believed that adequate affective expression led to healing. Then he encouraged the patient to experience the safety of the present, allowing for a sense of liberation. In some cases, he observed that an older trauma-generated 'splitting' (dissociation) of the personality, for instance related to childhood sexual abuse, existed.

#### 5.2.1. Comments

Jung and Simmel's complexes seem to encompass, in principle, more than one mental state, and suggest that each complex has its own first-person perspective. As such, Jung's complexes do not seem to be placed too low on the hierarchy of reality. However, like the Watkins' ego states (and the more contemporary notion of self-states), he saw complexes as present in everyone, and did not suggest that they were by nature different when due to trauma-related dissociation. In addition, there is no suggestion that traumatic experiences produce different kinds of complexes – some fixed in the trauma and some trying to function in daily life. Simmel, in contrast, wrote about complexes only with regard to traumatized soldiers, but the other criticisms of Jung's concept of complexes also apply to his.

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### 5.3. Subsystems of the personality as personalities

In line with Janet (1907, 1909a), a number of authors consider dissociation to be a division or dissociation of the personality (e.g., McDougall, 1926; Mitchell, 1922; Prince, 1906). As the use of the terms 'double personality' (Ribot, 1885) and 'multiple personalities' (Azam, 1887; Binet, 1896; Bourru & Burot, 1888; Prince, 1906) indicates, some authors (including Janet, at times) referred to these dissociative systems as 'personalities' (cf. Van der Hart & Dorahy, 2009). Mitchell (1922), for instance, argues that 'secondary personalities' can develop out of 'dissociated material', provided that it has a 'certain amount of unity of structure' and is 'accompanied by an affect of a certain intensity' (pp. 114–115). McDougall (1926) likewise considers the possibility of two or more personalities manifesting 'in and through the one bodily organism' (p. 545). In his view, dissociative 'activity' can be adequately described as 'the self-conscious purposive thinking of a personality; and, when we study the minor cases in the light of the major cases, we see that the same is true of them' (p. 544).

#### 5.3.1. Apparently normal and emotional personalities

The English physician and psychologist Charles Myers, who observed and treated many acutely traumatized WWI soldiers, distinguished between two prototypes of dissociative subsystems of the personality, which he labeled the 'apparently normal' personality and the 'emotional' personality (Myers, 1940). He noted that the attention of these traumatized soldiers would often at first

> appear to be concentrated on some narrow field, doubtless generally on the scene which produced his condition. ... The recent emotional experiences of the individual have the upper hand and determine his conduct: the normal has been replaced by what we may call the 'emotional' personality. (pp. 66–67)

While this occurred, they would appear to be in 'a state of light stupor' or in states of excitement, depression and automatism.

> Gradually or suddenly an 'apparently normal' personality usually returns – normal save for the lack of all memory of events directly connected with the shock, normal save for the manifestation of other ('somatic') hysteric disorders indicative of mental dissociation. Now and again there occur alternations of the 'emotional' and the 'apparently normal' personalities, the return of the former being often heralded by severe headache, dizziness or by a hysterical convulsion. On its return, the 'apparently normal' personality may recall, as in a dream, the distressing experiences revived during the temporary intrusion of the 'emotional' personality. The 'emotional' personality may also return during sleep, the 'functional' disorders of mutism, paralysis, contracture, etc., being then usually in abeyance. On waking, however, the 'apparently normal' personality may have no recollection of the dream state and will at once resume his mutism, paralysis, etc. (p. 67)

#### 5.3.2. Comments

The authors whose views are discussed above used the term 'personalities' to refer to the trauma-related subsystems of the personality; in McDougall's terms, each with its 'self-conscious purposive thinking', that is, first-person perspective. They adhered to the notion – which held sway for much of the 20th century – that persons were capable of having more than one personality, and that the most severe form of trauma-related dissociation was multiple personality disorder. The DSM-III and III-R (American Psychiatric Association, 1980, 1987) used this diagnostic label, and referred to 'personalities' or 'personality states'. However, the diagnosis was changed to dissociative identity disorder in the DSM-IV (American Psychiatric Association, 1994), in rejection of the notion that one individual can have more than one personality. This position makes sense if one considers personality as 'the dynamic organization within the individual of those psychophysical systems that determine his characteristic behavior or thought' (Allport, 1961, p. 28) or as 'a person... considered as the possessor of individual characteristics' (OED Online, 2018). We believe that the OED definition applies even to the divided personality of traumatized individuals. As a consequence, when the dissociative subsystems of the personality are called 'personalities', this places these dissociative systems too high in the hierarchy of degrees of realities. The clinical consequences of this – relating to parts of the personality as though they were 'personalities' – is that these dissociative subsystems are reinforced in viewing themselves as separate 'people'; such a position would clearly make the ultimate goal of integration more difficult. On the other hand, referring to these subsystems as 'personality states,' as in DSM-IV and DSM-5, places the subsystems too low.

In contrast to Mitchell and McDougall, Myers distinguished between two prototypical subsystems of the personality, the apparently normal personality and the emotional personality, which is a major step forward in our understanding. The addition of 'apparently' constituted an improvement over normal state of consciousness, as used by Breuer and Freud (1893/1955); and the adjective emotional personality seems more to the point than *états seconds*, as used by Laurent and others.

## 6. Discussion: how best to understand trauma-related dissociation

All of the above historical conceptions of subsystems of the personality, as states of consciousness, personalities, or complexes, have limitations when applied to trauma-related dissociation. The concept of 'state', as usually defined, is clearly too narrow, as each dissociative subsystem of the personality may involve any number of states. Likewise, 'consciousness' is also too limited, as that term usually refers exclusively to the mental realm and does not reference physical actions; it also would not denote unconscious or non-conscious mental activities. The division of personality associated with trauma-related dissociation involves far more than consciousness.

Some of these conceptions – particularly ego states and Jung's complexes – are argued to be present in all persons; while these models consider traumatization or multiple personality, they appear to assume that the subsystems are essentially the same as those present in everyone – only that the separations between them are more pronounced. Of those concepts which consider subsystems of the personality to occur only in cases of psychopathology, several – including hypnoid and secondary states – view only the alternate state as abnormal; in both of these models, the person is considered to be functioning normally when in their primary or normal state of consciousness. As such, these conceptions would appear to lie both too low (in that, for example, secondary states are not seen as having their own unique first-person perspective) and too high (because the primary state of consciousness is viewed as a whole person) on Janet's hierarchy of reality. Likewise, the operation of ego states, self-states, and Jung's complexes in *normal* personality appear to imply distinct first-person perspectives and, as such, would lie too high on Janet's hierarchy.

In addition, conceptualizing subsystems of the personality as personalities also clearly places them too high on Janet's hierarchy of reality. Treating these different parts as different persons would

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likely provide an obstacle to the clinical goal of integration. Myers' (1940) conception at least has the advantage of recognizing that a traumatized individual is not 'normal' in any state of consciousness as no part of the personality is fully integrated – hence the term 'apparently normal personality'; but viewing an ANP as a personality places it too high on Janet's hierarchy, with all the consequences noted above.

By more specifically referring to dissociative parts of the personality, the contemporary theory of structural dissociation of the personality (Nijenhuis, 2015; Nijenhuis, Van der Hart, & Steele, 2002; Van der Hart et al., 2006) addresses these problems with the historical conceptions of trauma-related dissociation. One of the concerns of this theory is that the dynamic biopsychosocial dissociative subsystems – as they are called in SDP theory – in trauma-generated dissociation should not be placed too high or too low in the hierarchy of degrees of reality, for reasons discussed above. The theory assumes that each individual has but one personality, however divided it may be; it also assumes that dissociative subsystems include a constellation of mental and behavioral states rather than a singular state (Nijenhuis, 2015; Nijenhuis & Van der Hart, 2011; Van der Hart et al., 2006). Some of these subsystems encompass far more states than others; for instance, they may include combinations of action or motivational (sub)systems that mediate their typical goal-directed actions.

As Janet (1889, 1898, 1911) already carefully documented, this division of the personality phenomenologically manifests in dissociative symptoms that can be categorized as negative (functional losses such as amnesia and paralysis) or positive (intrusions such as flashbacks or voices), and psychoform (cognitive-emotional symptoms such as amnesia, hearing voices) or somatoform (sensorimotor symptoms such as anesthesia or tics or somatic sensations related to trauma). What is experienced in one dissociative part of the personality is either not experienced by other parts or experienced as an 'intrusion' not belonging to the prevailing sense of self (Nijenhuis, 2015; Van der Hart, Nijenhuis, Steele, & Brown, 2004; Van der Hart et al., 2006). Unfortunately, in much of contemporary literature (and in the DSM-5 dissociative subtype of PTSD) attention seems to be directed exclusively at negative symptoms, in particular depersonalization and derealization (e.g., Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012).

Of particular clinical importance, SDP theory states that dissociative disorders involve the erecting and maintaining of boundaries between dissociative parts of the personality. This trauma-related dissociation initially occurs because the traumatized individual does not have sufficient integrative capacity but is maintained because the individual develops a series of intense phobias or fears, which keep them apart. As already observed by Janet (1904, 1911), the basic phobia is of the traumatic memories themselves, but intense phobias also develop between EP(s) and ANP(s), and (in more severe dissociative disorders) between different EPs (Van der Hart et al., 2006).

### 6.1. Relevant research findings

In recent years, a series of research studies have been conducted that are relevant to one of the questions considered here – whether the dissociative subsystems of the personality developing after trauma in dissociative disorders can be considered to be on a continuum with normal personality 'facets', 'aspects' or 'states'. These studies were designed to address two competing theories of dissociative identity disorder, generally known as the 'trauma' model and 'sociocognitive' or 'fantasy' model. The latter model proposes that DID can be 'created' in highly suggestible or highly fantasy-prone individuals by certain therapeutic practices (such as hypnosis).

A series of studies (e.g., Reinders, Willemsen, Vos, Den Boer, & Nijenhuis, 2012; Schlumpf et al., 2013; Schlumpf et al., 2014; Vissia et al., 2016) was designed to assess the assumptions of these models. They involved assessments of a wide range of psychological (anxiety, depression dissociation, trauma history, suggestibility, fantasy proneness, etc.) and physiological variables, along with brain scans, under a variety of conditions. Individuals with DID were compared with individuals assessed as highly suggestible and/or trained actors; the non-DID (control) groups were carefully trained to try to 'fake' the symptoms of DID, in particular different dissociative parts of the personality.

While the 'trained' controls (suggestible individuals and actors), under a variety of test conditions, experienced subjective changes in response to instructions to 'switch' between EP (called 'trauma identity states' in these studies) and ANP ('neutral identity states'), the changes in their physiological indices (blood pressure, heart rate variability), self-ratings, and brain functioning were dramatically and significantly different from those seen in the 'genuine' DID patients. Such findings led the authors to conclude that 'identity states in DID were not convincingly enacted by DID simulating controls' (Reinders et al., 2012, p. 1).

Thus, this series of research studies argues against the notion that trauma-related dissociation, as manifested in the dissociative parts of the personality seen in DID and other dissociative disorders, is simply an extension or exaggeration of normal divisions of the personality, such as ego states, self-states, schema modes, etc. If this were the case, then certainly trained actors, whose profession requires them to convince audiences that they are different people at different times, would be able to adequately mimic the different parts of the personality seen in DID. But the research strongly suggests that they cannot.

### 6.2. Clinical implications

There are a number of potential problems that would arise if some of the models of subsystems of the personality described above were applied to the treatment of dissociative disorders. Such problems are overcome by valid treatments for dissociative disorders (e.g., Brand et al., 2013; Kluft, 2016; cf. Brand, Loewenstein, & Spiegel, 2014, for an overview), including those proposed by SDP theory.

Several of the models (schema modes, secondary states) propose dissociative subsystems of the personality following trauma that lie too low on Janet's hierarchy of reality. Such models do not explicitly recognize that each dissociative part of the personality has its own first-person perspective. Treatment approaches arising from such a perspective might refuse to engage with each part, exploring and respecting the viewpoints and attitudes expressed. Correspondingly, the specific fears and phobias between the parts, an important target of the first phase of DID therapy (Nijenhuis, 2017; Fisher, 2017; Ogden & Fisher, 2015; Steele, Boon, & Van der Hart, 2017; Van der Hart et al., 2006), would be unlikely to be addressed by therapeutic approaches which do not recognize the unique first-person perspective of the parts. Since some 'protective' EPs will always be cautious and suspicious of therapy, if their concerns or fears are not dealt with, they could well engage in actions to 'sabotage' therapy. In addition, the potential for self-harm or harm to others could be increased by therapy which does not recognize the capacity of these parts to directly engage in action, not merely encourage the person to harm him or herself (Kluft, 2016).

On the other hand, models which consider dissociative parts of the personality as separate personalities place these parts too high on Janet's hierarchy of reality. Treating these parts as though they were separate personalities or persons could lead to a treatment strategy, such as that espoused by ego state therapy, which does

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not see unification as a treatment goal. Instead, improved cooperation or relations between the parts is viewed as the appropriate goal of therapy (Watkins & Watkins, 1977, 2003). However, as Richard Kluft (2016) and others have noted, there are clear risks to this strategy: 'When alters' autonomous identities and senses of self are retained, under stress the threshold for a return to dysfunctional dividedness is lowered' (Kluft, 2016, p. 245).

Further, none of the models described above (except perhaps for Simmel, 1918) recognize the core aspect of trauma-related dissociation – the fundamental distinction between parts immersed in the trauma (EP) and parts attempting to function in the present (ANP). This distinction, and the phobias between (and within) these broad categories of dissociative parts of the personality, is central to an effective approach to the treatment of dissociative disorders.

A theory and therapeutic approach which places the dissociative subsystems of the personality at the appropriate level in Janet's hierarchy – higher than 'states' or 'modes' and with their own first-person perspectives, but at a lower level of 'reality' than a full person or personality – most accurate captures the reality of dissociative disorders and most effectively informs their treatment. An approach like this, such as that embedded in the theory of SDP, would guide clinicians to carefully address phobias early in treatment, including those between parts and of the traumatic memories, and work slowly but steadily toward unification (that is, the integration of all dissociative parts into a cohesive whole with one overarching sense of self). Improving attitudes and relationships between the dissociative parts of the personality is an essential step in therapy, and is adaptive as such, but where possible treatment should aim toward complete unification of the personality.

## 7. Conclusion

The point of departure of this article was that traumatic experiences involve a dissociation or division of the personality into two or more dissociative subsystems. A number of historical and contemporary models of subsystems of the personality were reviewed – some of which posited divisions in normal personality – with regard to their utility in describing trauma-related dissociation in comparison to the contemporary theory of structural dissociation of the personality. These concepts were assessed with regard to Janet's *hierarchy of reality*, whether the subsystems of the personality involved different first-person perspectives, and whether a distinction between trauma-fixated and daily life functioning parts was incorporated. All of the concepts or models reviewed were found to have limitations with regard to trauma-related dissociation and were argued to be inconsistent with research on genuine and factitious DID. The theory of structural dissociation of the personality, with its notions of dissociative parts of the personality and phobias between parts (and of the traumatic memories), seems to do most justice to the clinical and research findings presented. This is not to say that SDP is the only approach that is effective for the treatment of complex dissociative disorders; this is clearly not the case. As the longitudinal, naturalistic study by Brand et al. (2013) shows, treatment for DID by therapists from a wide range of backgrounds (adhering to the ISSTD treatment guidelines; International Society for the Study of Dissociation, 2011) appears to be successful. The theoretical foundations on which those approaches are based are, by and large, not inconsistent with those espoused by SDP theory.

We have not, in this paper, taken a stance on the validity of those theories reviewed above which posit some sort of division inherent to normal personality. Rather, we have argued that these theories do not well account for dissociative subsystems of the personality occurring after trauma. Possibly such a theory could be developed, but none of the ones we have here reviewed are convincing in this regard. And as noted, those historical models reviewed above which were focused on trauma-related dissociation could not adequately explain the core posttraumatic phenomena, as explicated in clinical and research studies.

As we seek to increase our understanding of the impact of trauma-related dissociation on the human personality, additional research studies will be crucial. Clearly, further research on dissociative subsystems of the personality following trauma is needed. In addition, studies should be mounted to address the validity of models positing 'normal' divisions of personality and, if such validity is established, with the delineation of factors that determine the intensity and severity of such divisions. These studies may be important in helping us to understand the development of the personality in the context of severe traumatizing experiences, possible preventative approaches to limiting the negative effects of trauma-related dissociation, and more effective treatments in helping persons diagnosed with complex dissociative disorders.

## Disclosure of interest

The authors declare that they have no competing interest.

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