COMMENTARY

BOUNDARIES ON THE CONCEPTS OF DISSOCIATION AND DISSOCIATIVE PARTS OF THE PERSONALITY: REQUIRED AND VIABLE

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It was a privilege to have received several thoughtful and challenging reactions from the esteemed colleagues Ross (2015), and Schimmenti and Caretti (2015) to an article in *Psichiatra e Psicoterapia* (Nijenhuis 2014b) in which I asserted that PTSD, regardless of subtype, essentially is a dissociative disorder. They do not feel that this view goes far enough. Quite to the contrary, Ross (2013, 2014) feels that dissociation of the personality is a feature of far more mental disorders than DSM-5 (APA 2013), ICD-10 (WHO 1992), or the authors of the theory of structural dissociation of the personality (TSDP; Nijenhuis 2015a, b; Van der Hart et al. 2006) regard as dissociative. Schimmenti and Caretti (2015) similarly suggest that dissociation may be a key variable for a comprehensive understanding of psychopathology in general. I am most grateful to the colleague professor Giuseppe Craparo and to the editor-in-chief of *Psichiatra e Psicoterapia* for their invitation to write a rejoinder, and highly appreciated and used Van der Hart's most helpful comments on a previous draft of the present article. Van der Hart concurs with the contents of the final version. I will first respond to Ross' concerns, and later also address the issues that Schimmenti and Caretti have raised.

Arcane Medieval Theology?

I wish to start with some comments on Ross' suspicion that some clinicians may regard the philosophical reflections I offered in the paper as "arcane medieval theology that will not persuade [them] of anything, and may make them believe that structural dissociation is of 'philosophical interest' but not of any clinical interest". This statement is puzzling in several regards. That there are clinicians with little interest in philosophy does not mean that philosophical reflections on clinical theories and practices are not relevant to them. Although not everyone may realize it, any theory, practice, and worldview in fact relies on, and is thus embedded in explicit or implicit philosophical assumptions. These assumptions may, for example, pertain to persuasions such as philosophical dualism (there exist two substances in nature, matter and mind; Descartes' (1639 [2007] original idea); monism (there exists one substance); materialism (that singular substance is matter, so that matter causes mind); idealism (that singular substance is mind, so that mind causes matter); identity theory (there exists a singular substance with many different attributes, two of which are known to man, i.e., mind and matter; Spinoza's (1677 [1996]) original idea; hence, matter and mind do not cause each other, but are rather different expressions of a single substance); realism (there exists a subject-independent, real, 'objective' world, that we can passively perceive and know); cybernetics

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(we are fancy 'information processing machines;' the world involves 'information'); constructivism (what we know are our human mental constructions); epiphenomenalism (the mind is an irrelevant byproduct of matter); or neurophenomenology (brain and mind – i.e., consciousness –are somehow different, but can be studied in intimate relation to each other; Varela's original idea).

These brief philosophical reflections – they are dealt with in much more detail in the forthcoming volumes of *The Trinity of Trauma: Ignorance, Fragility, and Control* (Nijenhuis 2015a, b) – do not exclusively pertain to TSDP. Rather, they are of concern to *any* psychology, psychiatry, other discipline, or worldview. Even a little reflection tells that it makes a major difference for clinicians' understanding, study, and treatment of mental disorders whether they believe, for example, that matter (e.g., the brain, the material environment) determines mind, that the mind determines matter, or that individuals involve intrinsic relationships of the brain, the body, and the environment. It also matters whether they regard trauma as an event, as a particular consequence of an event, or as a particular consequence of some 'objectively existing' event, or of an event understood in terms of subject-object relativity, that is, subject-object co-occurrence, co-dependency, and co-constitution. Psychologists, psychiatrists, and psychotherapists would therefore better know and examine their philosophical suppositions.

When I started to share philosophical deliberations with colleagues in courses on the understanding, assessment, and treatment of trauma and dissociation, like Ross I was concerned that they might not be interested. However, they did became engaged and found it most helpful to understand better how different philosophies have guided and continue to (strongly) influence psychology, psychiatry, and psychotherapy, as well as, more specifically, how these persuasions have affected and affect professional ideas on trauma and dissociation in trauma.

But why would Ross presume that philosophy-ignorant and philosophy-ignoring clinicians would judge my philosophical deliberations to be medieval? It is true that I am inspired by philosophers of former times, such as Aristotle (i.e., his ideas on dynamic causality), Baruch de Espinoza, and Arthur Schopenhauer. But would not any clinician know that Aristotle lived ages before, and Arthur Schopenhauer ages after the Middle Ages (circa 500-circa 1500)? Spinoza's writings, extensively quoted and applied in the above-mentioned books (Nijenhuis 2015a, b), lived in the 17th century. Most other philosophers whose works I cite, value, and use are contemporary (neuro)philosophers: Francisco Varela died in 2001, and Stephen Braude, Michel Bitbol, Timo Järvilehto, Thomas Metzinger, Georg Northoff, and Evan Thompson are alive and well. And why, I wonder next, would these clinicians think that my philosophical statements involve some kind of theology? While Aristotle wrote on the subject of God, his ideas on causality do not require religion. Spinoza was the first to say that God equals Nature[1], and Schopenhauer's metaphysics focused on the will, not on God. Bitbol, Järvilehto, and Northoff's contributions do not concern

[1] Spinoza did not dare to publish most of his ideas during his lifetime, including his Ethics (1677 [1966]), the work that includes the statement that God and Nature are the same thing (he wrote: Deus sive Natura; God or Nature). In fact, the Jewish Church had excommunicated him before he had published a single word on this theme, and the Inquisition did not, to say the least, welcome the Ethics. Commenting on the Ethics, Scruton (2002, p. 32) asserted that "Spinoza wrote the last indisputable Latin masterpiece, and one in which the refined conceptions of medieval philosophy are finally turned against themselves and destroyed entirely". Spinoza did not dare to publish Ethics during his lifetime. Thanks to his friends, the book was brought out shortly after his decease. It did not come as a surprise that the Church of Rome banned it for ages to come. The irony is that that the only remaining manuscript of Ethics was recently found in the Vatican Apostolic Library.

theology either. Arcane? It is true that my brief remarks in Nijenhuis 2014b on philosophical matters that are of concern to any traumatology pertain to complex issues, and they may perhaps sound rather mysterious to some clinicians. If they do, I hope at least some of them will feel invited to study the works of the referenced philosophers--as well as *The Trinity of Trauma*. In this work, I try to show that the historical understanding of trauma and dissociation has swayed between radically different philosophies (and psychologies grounded in these philosophies), and indeed continues to sway between different philosophical persuasions.

For example, in some epochs it was believed that trauma and dissociation in trauma were basically matters of the brain, whereas at other times the reigning idea was that trauma and dissociation were matters of the mind. Different philosophical persuasions have also existed and continue to exist in parallel and in opposition to each other. There is currently the trend in psychiatry and psychology toward philosophical materialism. The neuroscientist LeDoux (2002) even believes that "we *are* our synapses". In this materialistic light, trauma would involve a brain injury and dissociation in trauma a synaptic problem. However, trauma and dissociation exist only among experiencing and knowing individuals, that is, they require and are dependent on consciousness. In fact, consciousness is primary (Bitbol 2008, Varela 1996).

A considerable number of scientists and clinicians feel that cybernetic metaphors can be helpful to explain human experience, thought, and behavior. For example, Shapiro (1995/2001) developed an adaptive information processing theory to explain, or at least guide eye movement desensitization and reprocessing (EMDR). Her idea is that humans include a physiologically based information-processing system. This materialistic and cybernetic model of mind entails serious problems. For example, philosophers have pointed out that 'information' does not provide meaning and a sense of ownership and agency (e.g., Di Paolo et al. 2010, Hutto & Myin 2013). DSM-5 (APA, 2013) describes trauma as events, and traumatic events would only include some types of events. This position reflects philosophical realism, because the idea behind DSM-5 idea seem to be that events exist separately from experiencing and knowing individuals, and that it can be objectively defined which events can and cannot be injurious. However, there are serious reasons to doubt philosophical realism, and good reasons to replace it by the idea that subject and object are intrinsically co-occurrent, co-dependent, and co-constitutive (Nijenhuis 2015a, b; Northoff 2003).

Or, I wonder, did Ross perhaps intend to state that some clinicians regard my philosophical reflections as metaphysics (hence "arcane theology?"), and that, in their view, metaphysics are of no concern to psychology, psychiatry, psychotherapy, and science in general? The first thought applies in some regards. However, *any* view on matter and mind crucially includes metaphysics. For example, not even the cleverest materialist knows the ultimate nature of matter and energy, or how matter would generate mind. Yet, philosophical materialists claim that all that eventually matters is matter. This claim reflects a metaphysical belief, but not a demonstrated fact. The second belief – that metaphysics are irrelevant to clinicians and psychiatry and psychology more generally – is a deep illusion (e.g., Schopenhauer 1819/1844 [1958]).

The audience for the theory of structural dissociation of the personality

Ross' (2015) assumption that the theory of structural dissociation of the personality (TSDP) mainly addresses clinicians is in need of some adjustment. TSDP was also developed for researchers, psychological theoreticians, and philosophers of mind. For example, dissociative parts involving their own person-perspectives should be of major interest to any philosopher of mind. The search for a better understanding of consciousness and self-consciousness has in fact already generated some philosophers' interest in dissociation of the personality (e.g., Braude 1995, Metzinger 2003), and this dissociation will hopefully attract a wider future interest among philosophers of mind. TSDP has further already served as a heuristic and inspiration for research. For example, the theory states that the biopsychosocial reactions of individuals with a dissociative disorder, including those with PTSD and a sensorimotor (somatoform) dissociative disorder depends on dissociative parts of the personality. More specifically, they depend on the kind of dissociative part that is dominant during measurement (e.g., prototypical ANPs, controlling EPs, and various kinds of fragile EPs – e.g., those engaging in active or more passive forms of mammalian defense). Researchers should therefore, at a minimum, check de post facto what (kind of) dissociative part (or parts) was activated and dominant during the scientific experiment. If possible, however, researchers should a priori define and control what kind or kinds of prototypical dissociative parts are participating in the experimental procedure. TSDP has proven its value in this regard (e.g., Reinders et al. 2003, 2006, 2012; Schlumpf et al. 2013, 2014; see Nijenhuis 2014b, this journal). It also offers solid hypotheses to comprehending inconsistent research findings for individuals with a trauma-related disorder (e.g., why sometimes their heart rate increases, decreases, or remains unaltered when exposed to trauma-relates cues), and it pinpoints some crucial flaws of many trauma-research designs. TSDP thus predicted (Nijenhuis et al. 2002) and offers viable hypotheses for the by now documented and accepted fact that some individuals with PTSD do not respond to trauma-related cues with *hyper*arousal (as most trauma researchers originally believed), but with unaltered psychophysiological reactivity, or with *hypo*arousal. This physiological reactivity is not understood in a philosophically materialistic and/or cybernetic frame; rather, it is comprehended as a component of a complex biopsychosocial (re)action of an evolutionary derived organism-environment system whose mind and body constitute two different attributes of a single substance called Nature. This philosophical position is through and through Spinozean.

Considering that consciousness is irreducible to anything else (e.g., to the brain) (Bitbol 2008, Spinoza 1677 [1996]; Schopenhauer, 1818/1840 [1958]; Varela, 1996), elsewhere (Nijenhuis 2015a, b) I have outlined – in part on philosophical grounds – that researchers need to include the first-, quasi-second-, second-, and third-person perspective of the individuals they study far more – and above all – realize that these various person perspectives are intrinsically related to each other. For example, interpreting the results of their studies, many neuroscientists more or less guess what their subjects were feeling, thinking, wishing, hoping, or doing otherwise as their brain activity was measured. However, no one else than the brain's owner can actually experience and say those things. No one--the best neuroscientists included--can or will ever be able to read from the brain what an individual is precisely experiencing and certainly not what

that experience is like. The clinician's acquaintance with the various person perspectives of the different dissociative parts that the patient encompasses can be of additional help to clarifying his or her dissociative part-dependent person perspectives. This results in a trinity of person perspectives that needs to be included in trauma research: (1) the person perspectives of the examined dissociative parts that primarily provides first-person phenomenal experience and phenomenal judgment, (2) the treating clinician's second-person phenomenal judgment of the various person perspectives of the different dissociative parts (for example, the clinician may assist the involved dissociative parts in describing their phenomenal experience and judgment), and (3) the scientists' third-person physical assessment and judgment (e.g., their assessment and interpretation of particular patterns of cerebral blood flow), as intrinsically related to his or her first-, quasi-second-, and second-person perspectives. With regard to the latter, it should not escape attention that 'objective' assessments and judgments are not 'objective.' They involve a subject-object relationship, an 'I – object' relationship, because subject and object exist and function relative to each other. Scientists are subjects, not objective recorders of an independently existing 'reality.'

The need for and the utility of minimal constraints on the concept of dissociative parts

Ross' (2015) next concern is that TSDP does not include minimal constraints on the concept of dissociative parts. In accordance with this very awareness, I wrote a chapter on the issue (Nijenhuis 2012). A partly modified, and, in my view, improved version of this contribution may be found in Nijenhuis 2015b, chapter 12. Ross, however, feels that such constraints are irrelevant. He does not "see the logical, philosophical or theoretical necessity of setting a threshold" (Ross 2014, p. 287). Nor does he "see the clinical utility"(Ross 2014, p. 287). As Ross (2015) wonders, "[w]hy can't some dissociated compartments hold full EPs or ANPs, some partial or near-threshold EPs, and others just a memory without there being a full EP?" (Ross 2014, p. 287). A quick initial answer to that objection is that judging the degree to which some structure qualifies as a full, partial, or rudimentary ANP or EP is only possible when the core features of prototypical ANPs and EPs are identified and defined. Without these characterizations and formulations, judging the degree to which a subsystem of an individual's personality qualifies as a particular prototypical part of the personality is impossible.

Before turning to the minimal constraints on the concept of dissociative parts, let me discuss the general need for constraints on concepts.

Concepts are artificial constructs

To begin with, no concept exists separately from knowing individuals. Any concept out there is necessarily a human and hence artificial, construction. Nature can be parsed in countless ways, any parsing is relevant to a particular human interest, and a particular parsing can be more or less helpful to achieving a set goal (Braude 1995, Spinoza 1677 [1996]; Wittgenstein, 1953).

For example, there are no naturally given distinctions between what is and what is not a 'game' (Wittgenstein 1953), or how one comprehends the word 'man.' As Spinoza observes,

> … notions are not formed by all [men] in the same way, but vary from one to another, in accordance with what the body has more often been affected by, and what the mind imagines or recollects more easily. For example, those who have more often regarded men's stature with wonder will understand by the word *man* an animal of erect stature. But those who have been accustomed to consider something else, will form another common image of men – for example, that man is an animal capable of laughter, or a featherless biped, or a rational animal (p. 56).

Along a dimension of temperature, H2O can be experienced and conceptualized as ice or snow, water, and water vapor, but the boundaries between these different concepts are fuzzy. We have no difficulty experiencing and knowing H2O at a temperature of -10 C as ice (hard matter), and H2O at a temperature of +10 C as water (fluid), but we can have difficulty saying whether there is watery ice or icy water at temperatures around 0 C. Similar problems regarding H2O include the boundaries of the concepts of rain, drizzle, fog, and damp. And there are many different *kinds* of snow and ice. Further, we are able to distinguish between delicate shades of a color as we perceive them, but we may not (be able to) have clear concepts of, say, blue 'shade 1003' and blue 'shade 1004'. That is, we cannot precisely differentiate and think about these shades of blue in absence of their physical appearance.

These examples may suffice to indicate that the difficulty of defining a sharp lower bound of the concept of dissociative parts of the personality is not a weakness in the TSDP. Rather, boundary problems pertain to any concept, to any theoretical construct that aims to capture natural phenomena and positions on a quantitative continuum. Quantitative dimensions tend to include boundary problems between nearby yet different *prototypes* (Rosch 1977). Further, quantitative differences can imply qualitative shifts, including shifts that are of practical, clinical, theoretical, scientific, or other relevance. It is often useful, and sometimes even life saving, to distinguish between these different qualities. Any car driver would prefer to know whether a road is dry, wet, or frozen, or realize how near cold rain can be to glaze.

Unbounded and overgeneral concepts are indistinct, blurry, and vague. For example, a term such as 'thing' can stand for practically any object, the term 'one' covers all individuals, and the term 'they' is sometimes used in a similar way in spoken language (e.g., "give me that *thing*", "*one* should be modest", and in reference to an indistinct group of individuals such as a peoples at large "*they* cannot be trusted"). Such unbounded and overgeneral words are theoretically, clinically, and scientifically useless. Solid theoretical, clinical, and scientific terms and concepts should thus be as clear and distinct as possible, and they should fit their intended use. The concepts of dissociation, dissociative part, and dissociative disorder are no exceptions to these requirements.

Ross (2013, 2015), as well as Schimmenti and Caretti (2014) feel that dissociation is a core feature of many mental disorders--or, in any case, of far more disorders than are seen as dissociative in DSM-IV, ICD-10, or TSDP. Unless they would mean that any mental disorder essentially involves a dissociation of the personality – in which case the term dissociation is

basically a synonym for the term psychopathology – they too will need to set a boundary on the(ir) concepts of dissociation, dissociative part of the personality, and dissociative disorder. *My discussants may prefer more liberal concepts than the ones TSDP proposes, but their versions need boundaries just the same.* Without clear and bounded concepts of dissociation, dissociative parts, and dissociative disorders, we cannot assess what phenomena shall count as instances of these phenomena and constructs. For example, without this clarity, it is impossible to judge with any reasonable precision which individuals have a dissociative disorder, which are false positives, or which have some other (non-dissociative) mental disorder, or what structures count as a dissociative part, what structure includes some but not all core features of a dissociative part, and what structures do not constitute a dissociative part at all.

Integrative limitations

The concept of integrative limitations requires a clear and distinct concept of integration. Merriam-Webster Online defines integration as "the combining and coordinating of separate parts or elements into a unified whole". Perfect integration pertains to Nature as a whole, or, if one prefers, to God. As Spinoza put it, "[a] substance which is absolutely infinite is indivisible" (Ethics, Part I, Propositions 13; see also Proposition 12). Even mentally very healthy human beings fall seriously short of this excellence. Integrative limitations are, in fact, ubiquitous and manifold in mental health and psychopathology. To single out one integrative challenge, like individuals with a mental disorder, mentally healthy individuals experience ambivalences, or rather 'polyvalences.' We all struggle with different interests at times: "Shall I postpone this tedious assignment, or shall I do it right now to get it over with? Shall I enjoy another glass of wine or mind my responsibilities as a driver? Shall I marry someone, postpone my decision or just stay single?" These common integrative problems can often be comprehended in terms of conflicts between different desires or responsibilities, as conflicts between different wills or duties. As applies to any integrative problem, the recognition and fulfillment of one particular will (i.e., one 'element') does not annihilate the existence of one or more different wills (i.e., other 'elements').

Integrative problems such as conflicts between various wills become more intense and elaborate in mental disorders. Often one will has become unduly and chronically dominant. For example, agoraphobia involves a conflict between the defense action system ("it is dangerous to be in the street, I'd better stay at home") and some other action systems such as exploration ("it is interesting to buy fashionable clothes, mine have become outdated and worn"), social engagement ("it is fun to meet friends in a bar") and play ("it would be great to attend a live performance of the Concertgebouw Orchestra" or "I would love to play tennis today"). In agoraphobia the defense system wins at the expense of the interests of other action systems, as it does in several other mental disorders (e.g., obsessive-compulsive disorder, anorexia, avoidant personality disorder et al.).

Conflicts of will also characterize what some call 'ego states' and 'ego-state disorders' (e.g., Phillips 1993, Phillips & Frederick 1995, Watkins & Watkins 1997), as well as what Kellogg and Young (2006) call different 'modi.' An ego-state is defined as "an organized system of behavior and experience whose elements are bound together by some common principle" (H.H. Watkins 1991, p. 233). This formulation is so broad that it is hard to imagine what behavioral and mental

state would not count as an ego-state. For example, one may wonder what distinguishes an outspoken mood from an ego-state. Further, it is not clear if, or in what sense ego-states and modi are different, and what their respective conceptual lower and upper bounds are. Modi, thus, stretch from innate and universal to dissociative parts in DID. Individuals with bipolar mood disorder also display a lack of integration. They shift between different ways of being that involve not just different moods, but also shifts in will that do not become integrated. Being euphoric, they do not or insufficiently integrate their previous existence as a deeply depressed individual, and being depressed, they lose their elated existence.

Whereas common and many pathological conflicts involve integrative problems, regarding any conflict as an instance of dissociation would generate a *huge* as well as *indistinct* category. If the term 'dissociation' were to stand for any lack of integration, it would be most unclear what phenomenon or construct a clinician, scientist, or theoretician has in mind when he or she says that "John dissociates", "Jane is dissociated", "dissociation is a mental defense", etc. Equating any kind of integrative problem/deficit and dissociation would miss important phenomenological, theoretical, clinical, and empirical differences between, on the one hand, common or more pathological conflicts, mood swings, modi, and ego-states, and, on the other hand, dissociation of the personality involving two or more dissociative parts, each with their own phenomenal conceptions of self, world, and self-of-the-world.

Because there are important phenomenal, theoretical, clinical and scientific/empirical differences between dissociative parts of the personality and other human integrative limitations or imperfections, making these distinctions serves phenomenological, theoretical, clinical, and scientific/empirical interests.

Phenomenological interests

Experiencing a conflict between two wills that an individual regards as his or her own is phenomenologically very different from experiencing a conflict between an ANP and a fragile EP or between a fragile EP and a controlling EP – or being flooded by feelings, thoughts, images, or behaviors that stem from one or more dissociative parts than the engulfed dissociative part is now aware of. At best dissociative parts relate to each other in a second-person perspective (e.g., I [ANP] – You [fragile EP]), but they may also, unilaterally or bilaterally, relate to each other in third-person perspective (e.g., I [ANP] – a screaming voice [fragile EP's voice]). They may not relate to each other at all (e.g., an ANP that is not aware of the existence of a fragile EP, whereas this EP may or may not be unaware of ANP). The latter condition involves, so to speak, a zero-person perspective (e.g., ANP-?). For example, an ANP may experience major gaps in time without a clue as to what happened during this episode, and why.

Clinical interests

Clinically, the existence of a dissociation of the personality implies particular symptoms. These symptoms are dissociative symptoms, because they are manifestations of the existence of

this particular organization of the personality. This organization and these dissociative symptoms require clinical interventions that do not fit common ambivalences, mood disorders, mood shifts, modi, ego-states, or would-be dissociative parts in false-positive cases of dissociative disorder. Given the clinical interest of fostering integrative actions, clinicians are ill-advised to regard and treat all kinds of integrative problems or deficits as a dissociation of the personality, as something that implies the existence of dissociative parts. Failure to distinguish between ubiquitous conflicts, mood shifts, modi and the like, and dissociative parts that per our definition include their own phenomenal conceptions of self, world, and self-of-the-world has more than once resulted in ineffective, if not bad therapy. For example, treating an individual with borderline personality disorder as if he or she were a case of dissociative identity disorder tends to obstruct rather than foster integrative actions.

Scientific/empirical interests

The distinction between dissociative parts and conflicts, mood shifts, modi, and ego-states is also of scientific interest. For example, TSDP holds that individuals experiencing common intrapersonal conflicts and individuals encompassing two or more dissociative parts of the personality have different patterns of brain activity. To test this hypothesis, scientists must know which individuals do and do not encompass dissociative parts (i.e., prototypical parts such as an ANP, a hyperaroused fragile EP engaging in flight and freezing, a fragile, hypoaroused EP engaging in tonic immobility). They must also have a clinical and theoretical idea of the biopsychosocial features of each of these prototypical dissociative parts. Further they must know how various dissociative parts and individuals who are or may be involved in common or pathological intrapersonal conflicts but who do not encompass such dissociative parts are different in at least some crucial regards. Equipped with this knowledge, we have been able to study the features of authentic ANPs and fragile, hyperaroused EPs, and we have succeeded in showing that mentally healthy individuals as well as actors and high and low fantasy-prone individuals, have very different supraliminal and subliminal reactions to particular experimental stimuli (e.g., trauma scripts, neutral and angry facial expressions). Another example is that, according to TSDP, dissociative parts and manifestations of dissociative parts (i.e., dissociative symptoms) are bound to have different correlates and causes than phenomena such as absorption, imaginative involvement, a retracted field of consciousness, and low levels of consciousness. If the term "dissociation" captures any integrative problem or deficit, it is practically impossible to say what hypotheses or statements like "dissociation is correlated with adverse events" or "dissociation is caused by adverse events" actually mean.

Empirically, dissociative symptoms – i.e., symptoms of the existence of a dissociation of the personality – are characteristic of individuals with a dissociative disorder, but not of individuals with a mental disorder that does not involve a dissociation of the personality as defined in TSDP (Van der Hart et al. 2006), and as formulated by Nijenhuis and Van der Hart (2011a, 2011b).. For example, bipolar mood disorder is not associated with sensorimotor dissociative symptoms (Nijenhuis et al. 1997, 1999), and demands a different kind of treatment than dissociative disorders. Borderline personality disorder that is not comorbid with a dissociative disorder

(Korzekwa et al., 2009), restrictive anorexia (Waller et al. 2003), major depressive episode (Sar et al. 2000), and anxiety disorders (Nijenhuis et al. 1996, Sar et al. 2000) are not associated with significant somatoform dissociative symptoms either.

These few examples may suffice to demonstrate that there are important phenomenal, theoretical, clinical and scientific/empirical differences between dissociative parts of the personality and other human integrative limitations. This proposition raises the question in what way or ways the concepts of dissociation, dissociative symptoms, dissociative parts, and dissociative disorders can be discriminated from other integrative limitations? According to our definition of dissociation (Nijenhuis & Van der Hart 2011a, 2011b; Nijenhuis 2015a, 2015b) and TSDP (Van der Hart et al. 2006), ambivalences, polyvalences, mood shifts, modi, and ego-states do not qualify as dissociative parts of the individual's personality. Hence, their existence does not justify the classification of individuals with these integrative limitations as bona fide cases of dissociative disorder. Individuals who experience and display these phenomena (e.g., common conflicts or mood shifts), however, still *personify* their different ways of being, that is, still link them with, and embed them in an overarching phenomenal conception of self, world, and self-as-a-part-of-the-world. For example, although different ego-states and modi are conscious and self-conscious structures, and although they can include considerable shifts in the individual's conception of self, world, and this self-as-a-part-of-that-world, the whole organism-environment system that comprises the individual still associates these different conceptions to one overarching conception of self (e.g., I am John). As one of his ego-states, John thus may want to continue smoking, but as a different ego-state he wants to quit this addiction. But John will regard both states as his own. They are both part of his identity, even if he may not welcome his different states and the wishes, feelings, thoughts, wills, and actions these states include.

In contrast to Ross, Schimmenti and Caretti, I thus hold that different kinds and degrees of integrative deficiency constitute quantitatively and qualitatively different phenomena. That said, it is valuable to recognize that conceptual distinctions between prototypical dissociative parts of the personality and other structures such as different moods, modi, and ego-states do not exclude the existence of particular commonalities and similarities between them. This overlap can be an inspiration to apply some of the insights with respect to dissociative parts to these other structures. In this vein, I have described that with respect to chronic childhood abuse, maltreatment, and neglect perpetrators, their partners in crime (e.g., family members who are aware of the ongoing traumatization), psychologists, psychiatrists, and peoples at large can function in alternating ways that can be described as apparently normal, fragile emotional, and controlling emotional (Nijenhuis 2015b, Vol. II, Chapter 20). For example, perpetrators such as child abusers can present themselves and can be seen by other individuals as normal. However, their normality is only apparent, hence, they act in an *ANP-like* way of being and functioning. When abusing a child, they are clearly emotional controlling (*controlling EP-like*), and when accused of abusing the child, they act as if *they* were the victim. Hence, they function in a *fragile EP-like* mode. (Note: If their personality is dissociated, perpetrators or other individuals such as their partners in crime clearly do not function in ANP-like and EP-like ways of being, but include actual ANPs and EPs.) In some regards it may be worthwhile to describe and comprehend Young's modi and ego-states in terms of ANP-like, fragile EP-like, and controlling EP-like ways of being

and functioning. However, it is confusing to address individuals or groups of individuals who do not meet the full criteria of dissociative parts and who do not have a dissociative disorder as ANP, fragile EP, or controlling EP. The point is that there are not just a few commonalities between dissociative part-like ways of being and functioning, and real dissociative parts, but also significant differences. Overestimating the commonalities and underestimating the differences is bound to have serious clinical, theoretical, and empirical consequences.

Dissociative parts and minimal constraints on consciousness

Having detailed that worthwhile concepts imply artificial boundaries, that conceptual boundaries are relative to their intended use, and that there are differences between dissociation/dissociative parts and other kinds of integrative limitations or deficits, I now turn to Ross' question regarding the boundaries of dissociative parts in TSDP. Dissociative parts in TSDP are defined as conscious subsystems of an individual's personality. It is this feature that distinguishes these subsystems from other subsystems that make up an individual and that may not be beautifully integrated. For example, an individual's personality as a whole organism-environment system encompasses a host of subsystems such as cells, synapses, neural networks, organs, the blood circulation system, the sympathetic nervous system, the ventral vagal parasympathetic system, and the dorsal vagal parasympathetic nervous system.

To illustrate the idea of a rudimentary EP, here is a short description of Rita (pseudonym), a young woman with recurrent nightmares and related dissociative episodes. She said: "I do not have a clue as to what the nightmares are about. When I have them, I'm terribly scared, but don't know why. Something is coming at me, something bangs against my head, and it feels as if I'm about to die. The last thing I know is that my body rises and screams. Then I find myself back in the living or in the streets. My friend tells me I'm rushing out of the bed, bump against furniture, and stumble down the stairs. I'm not aware of what I'm doing, but find myself back in the living room or in even the street". Fearing the nightmares, Rita had developed a phobia of sleep. Due to a major lack of sleep she had become exhausted, and constantly irritated, which made her lose her job. Apart from being deadly tired and irritated, Rita also met the criteria for depersonalization disorder. We decided to examine what or who screamed, rushed out of the bed, ran down the stairs, thus controlled her body and behavior during the nightly episodes. Since whatever or whomever it was that took full control over her consciousness and behavior, 'it' might react to Rita's and my questions using particular fingers or thumbs as signals for 'yes,' 'no,' 'stop,' and 'don't know.' It appeared that 'it' was a single fragile EP that regarded herself as 3 years old. As ANP, Rita knew she experienced a car accident when she was 3 years old. However, she did not feel that this incident was associated with her nightmares and all (see Nijenhuis 2015a). But it was. As this EP, Rita seemed hardly, if at all, aware that during the nightly dissociative episodes she was *re*-experiencing and *re*-enacting the accident. The EP's phenomenal conception of self, world, and self-as-a-part-of-the-world were focused on this traumatizing event. Her experiences and conceptions did not include much more than experiences and ideas of being a child playing with a ball, of noticing that a car is coming at her, of being utterly scared, of falling, of receiving a blow against her head, of hurting, of the world turning dark. As this EP, Rita was not in touch

with her other existence as ANP – or else she would have experienced and known that she had in fact survived the accident, that she had grown to become an adult, etc. As the depersonalized ANP she initially resisted to integrating "the child" and the accident in which this EP was stuck. With the detection of this EP and ANP's mental avoidance and hate of the EP and the traumatic experience in which this EP was fixed, it thus also appeared that the patient had PTSD (a constellation of negative and positive dissociative symptoms in proximate association with a nonintegrated and recurrently re-enacted traumatizing event).

Since, according to TSDP, the lower bound of the concept of dissociative parts is that they are conscious structures, determining rudimentary and more evolved dissociative parts calls for formulating the minimal constraints on the concept of consciousness. In this regard, I follow Metzinger (2003)'s idea that the limits are global availability, phenomenal now, and transparency.

Global Availability: There I s a World. From a phenomenological perspective, the concept of global availability involves the notion that the contents of states of consciousness do not stand alone but are found and integrated in a single phenomenal world. It consists of at least several connected but differentiated components that are unified in a whole. A conceived world, in this sense, involves a highest-order situational context in which the individual embeds the phenomenal contents of his or her different conscious states. The contents of these states can be globally available to them in a variety of ways. A somewhat crude classification is that the involved contents can be globally available for guided attention, cognitive reference, and control of behavioral action. In some cases, phenomenal contents exist less in the form of explicit phenomenal concepts (i.e., as contents one can think and categorize) than as phenomenal presentata, that is, as experiences.

Dissociative parts meet this criterion. They live in a world they experience and conceive, and they embed their experiences and conceptions in this global, highest-order frame. For example, Rita's fragile EP experienced and knew herself as a particular child, as a girl, as her parent's daughter, as someone living in a particular house. She knew what balls and cars are, what playing is, and what playing is like. She experienced and knew that she was playing, that cars can be dangerous objects, and that a particular car approached her, overtook her, and hit her. She also experienced intense fear and pain with respect to these events. The fragile EP also experienced and knew that the accident was an inherent part of her life.

Phenomenal Now: This World is Now. Whatever we experience, we experience it now. This now is not some formal now, or a now shared among different individuals. It rather constitutes our subjectively experienced present, our phenomenal now. The phenomenal now generally encompasses a couple of seconds, and it may be displaced in 'objective' (clock) time. Clinical observations strongly suggest that all dissociative parts of the personality experience their living in a present, and that all naively believe that their sense of the present – their phenomenal now – is equal to the actual now. For example, during her re-enactments, the fragile EP presented above lived the phenomenal "now" of the accident. Her very limited existence beyond the accident also included a phenomenal now, such as experiencing that she was talking (with finger signals) with another person (i.e., with me as the therapist who invited her to respond to simple questions with finger signals for 'yes,' 'no,' 'don't know,' and 'stop').

Phenomenal Presentata. Dissociative parts sometimes merely have experiences and

implicit conceptions (i.e., phenomenal presentata) when they, for adaptive reasons, would better also know explicit conceptions. This deficiency exists, for example, when they re-experience traumatizing events. Dissociative parts that are fixated in these events do not recall these events as autobiographical, narrative memories, that is, as simulations of the past. Rather, they experience and know reactivated traumatic memories as phenomenal presentata occurring in their phenomenal now. Re-enactments of traumatic memories—one might also say, reactivated traumatic memories—are not like common autobiographical memories. They are not symbolized and explicit personal narratives pertaining to phenomenal past events. They are iconic, involuntary, mostly nonverbal sensorimotor and in many cases highly affectively charged experiences that are insufficiently condensed in time (Janet 1928a; Nijenhuis 2015a, 2015b; Van der Hart et al. 2005; Van der Kolk & Van der Hart 1989). Some re-enactments, however, do not involve hyperarousal but hypoarousal. To the degree that traumatic memories involve phenomenal presentata, they are commonly unavailable for cognitive control. This implies that dissociative parts with such memories have very little cognitive control over them. To repeat, they do not conceive the horrific past as the past (or as "passed"). As they re-enact their traumatic memories, they live this third-person past in the mode of their first-person present.

Transparency: This World Is. Individuals do not necessarily have introspective epistemic access to their mental actions that generate their phenomenal states, i.e., through introspection. Lack of this introspective access is known as autoepistemic limitation. It is an absolute limitation to knowing how mental states are generated (Northoff 2003). Somewhat counterintuitively, autoepistemic limitation is also known as transparency (McGinn 1989, Metzinger 2003). Due to this transparency, conscious beings experience the world and themselves as given, real, and undoubtedly existing (Metzinger 2003) to the degree that they are not depersonalized, perceive their environment in an unreal fashion (i.e., derealization), or emotionally or physically numb (degrees of experienced and perceived reality is also a useful constraint on the concept of consciousness and self-consciousness; see Nijenhuis 2015b, Chapter 12). For example, as the fragile child EP that recurrently re-enacted the car accident Rita undoubtedly felt: "I exist, there is a world, I am part of that world, and the world is the way I experience and conceive it".

Minimal constraints on self-consciousness: phenomenal self-conception and phenomenal conception of an intentionality relationship

According to Metzinger (2003), a conscious system becomes a self-conscious system when an information-processing system develops a phenomenal self-model under the transparency constraint. For a variety of reasons, I disagree that human beings 'process' [objectively existing, subject-independent] 'information.' For example, the concept of 'information' does not explain meaning, ownership, and agency (DiPaolo et al. 2010; Hutto & Myin 2013; Nijenhuis 2015a, 2015b; Thompson 2007). We are not some fancy computers. We are organism-environment systems that actively and – dreamless sleeping aside – continuously make meaning and continuously create a sense of ownership and agency. Any awake or dreaming individual continuously phenomenally *conceives* of himself or herself, that is, creates a phenomenal *conception* of self (PCS) rather than *modeling* "something" that exists separately from him or her. We do not craft a model of ourselves

as a kind of thing in itself, some model of the 'real thing' we 'actually are.' Our 'I' is rather the one we experience and conceive we are. This experiencing and conceiving goes on continuously when we are awake or dreaming. Without these actions, we would not phenomenally 'have' or 'be' an 'I.'

In this sense each dissociative part of the personality generates his or her own PCS when they are awake or dreaming. The PCS of each dissociative part may have particular features in common with the PCS that some other dissociative part generates, but it will also differ from this other PCS in one or more crucial regards.

Individuals and dissociative parts of individuals commonly also generate a phenomenal conception of another individual or group of individuals, one or more other dissociative parts, and one or more objects, events, and, more generally, of the global world as they experience and know it. When individuals or dissociative parts of an individual who generate a PCS are also consciously aware of and relates to another subject, a group of subjects, an object, or a constellation of objects in a particular way, they can be said to engage in a *phenomenal conception of an intentionality*[2] *relationship* (PCIR), that is, of the particular way in which they relate their experience and idea of who they are with their experience and idea of that which they are conscious of and that they do not regard as a part of themselves. These are phenomenal and intentional 'I-You' and 'I-object' relationships, respectively. To the degree to which two or more dissociative parts are at least slightly consciously aware of each other, each will experience and think "I'm me, I'm not the other".

According to Metzinger (2003), we require the first-person perspective for the phenomenal experience of being someone, for the control of our actions, for becoming the object of our own attention, and for cognitive self-reference. This perspectivalness is also needed for creating a link between ourselves as a phenomenal subject, and the phenomenal world. When this link exists, we can appreciate that we are acting and experiencing subjects of the world as we experience and know it. Dissociative parts meet this criterion. Their PCS and PCIR essentially encompass this perspectivalness.

A dissociative part that is awake or dreaming can thus be defined as a subsystem of an organism-environment system that meets the requirements of global availability, phenomenal now, transparency, and, perspectivalness. They continuously generate their own PCS and associated set of PCIR. These involve their different person perspectives: first-person ('I,' phenomenal experience), quasi-second-person ('I-me, myself, mine' relationships involving phenomenal judgment), second-person ('I-You' phenomenal relationships), and third-person ('I-object' physical relationships).

Dissociative parts need not be verbal

TSDP's constraints on the concept of dissociative parts do not include the requirement that dissociative parts have their own *explicit* conceptions of self, world, and self-as-part-of-the

[2] Every mental act has a mental content, and this content pertains to a perceived and conceived 'object'. Every perception, belief, desire, etc., has an object that it is about: the perceived, the believed, the wanted (see http://en.wikipedia.org/wiki/Intentionality). This 'aboutness' is what the philosophical term 'intentionality' stands for. It stems from the Latin intendere, which once referred to drawing a bow and aiming at a target. As Thompson (2007) holds, in phenomenology consciousness is seen as intentional by 'aiming toward' something beyond itself.

world. For example, some EPs are unable to speak, articulate their identity, or tell how they differ from other dissociative parts. That is, their PCS and PCIR can remain nonverbal. Nonverbal perspectivalness is all but abnormal in itself, as it can also apply to mentally healthy individuals. For example, preverbal children certainly generate a PCS and PCIR, that is, a point of view involving a phenomenal subject-subject and/or subject-object relationship. Even prenatal twins seem to be focused first on their own developing body, and only later (i.e., from the 11th week of gestation, and increasingly more between the 11th and 18th week of gestation) they also direct their attention toward the twin brother or twin sister (Castiello et al. 2010). They also seem to relate differently to the twin and the uterine wall, which might be an early form of subject-other subject versus subject-object distinction. Also, our earliest memories are not cognitive but experiential and embodied. In the words of Krueger (2010, pp. 66-70),

> . . . fundamental affective structures . . . scaffold basic forms of social understanding, support the emergence of sensorimotor skills enabling this basic understanding, and. . . motivate our most fundamental sense of self. [Hence,]. . . why not speak of our earliest intersubjective engagements as involving a kind of affect-laden, but nonconceptual (i.e., nonrepresentational) understanding?. . . even our earliest interactions are bathed in feeling – that is, exquisitely tuned feeling-relations that attune us to others in fundamental ways, and which provide the inter-corporeal scaffolding both supporting and motivating the growth of our capacities and competencies for social engagement, as well as the development of our sense of self.

PCSs are strongly body-oriented, perhaps because the body is a steady frame of reference (Metzinger 2003). As Spinoza (1677/1996) stated: "the human mind does not know the human body itself, nor does it know that the body exists, except through the ideas of affections by which the body is affected" (Spinoza 1996, Part II, propositions 19-29). Consciousness starts with sensing, and subsequently perceiving and conceiving of the living body when the body is affected by some cause. Cognition is grounded in experience; cognition does not cause experience. Schopenhauer would agree: The will becomes a motive for the intellect; the will precedes the intellect. As Spinoza continues in proposition 26, objects ("external bodies") appear for us when they affect our body, and when we, as a whole organism, notice that affection:

> The human mind does not perceive any external body as actually existing, except through the ideas of the affections of its own body. Demonstration: If the human body is not affected by an external body in any way, then the idea of the human body, that is the human mind, is also not affected in any way by the idea of the existence of that body, in other words, it does not perceive the existence of that external body in any way.

Minimal dissociative parts, minimal contents

The existence of a dissociative part may be limited to a traumatic experience/traumatic memory or even to a particular element or phase of the traumatic experience/traumatic memory.

Reactivation of this part, then, implies a re-enactment of the involved traumatizing event. Even this kind of re-enactment includes a particular PCS and (set of) PCIR. Such EPs re-enact a particular subject-object relationship, often without knowing that they are re-enacting it. Although EPs experience themselves, their world, and themselves-as-a-part-of-that-world as given, and although most experience themselves as undoubtedly existing and real, this does not imply that they can verbalize and reflect on their PCS and PCIR. Their level of mental efficiency may not enable them to engage in these verbal and reflective actions. Dissociative parts that cannot verbalize or reflect on their PCS and PCIR may, however, still (be able to) engage in self- and world-oriented conceptual actions, however implicit these conceptions may remain in some cases. Clinicians who have observed traumatic re-enactments can testify that even nonverbal EPs engaging in reflex-like actions generate a PCS and set of PCIR. They experience and conceive of an 'I,' particular objects (and, perhaps, other subjects), this 'I' as related to these objects and subjects in the framework of a particular event, global world, and phenomenal Now. These clinicians may have seen, for example, how individuals who re-enact a traumatic memory ward off perceived threat, how they tremble and hide, cover their head or eyes, scream perhaps, how they flee, freeze, fight, or play dead.

To have an autobiographical memory, someone must remember and personify it

I agree with Schimmenti and Caretti (2015) that individuals can become classically conditioned with regard to previously more or less neutral cues that signal(ed) or refer(red) to the traumatizing event. This signal, referential, and evaluative learning is in fact an explicit component of TSDP (Nijenhuis et al. 2002; Van der Hart et al. 2006). However, I disagree with Ross (2015), and Schimmenti and Caretti (2015) that traumatic memories can be just 'memories' (e.g., mere implicit, procedural structures)[3]. Rare exceptions aside involving a temporary loss of any phenomenal conception of self (for an example, see Nijenhuis, 2015a, 2015b), traumatic re-enactments do not exist in an impersonal void, but are associated with someone who re-enacts, with someone whose re-enactment it is. Re-enacted traumatic memories, thus, concern *someone's* experiences and actions. They include at least a minimal experience (i.e., a presentatum) and minimal PCS (i.e., a conception of self). For example, triggered by a classically conditioned cue, say a knife, a re-enacting patient may as an EP writhe in pain and scream: "Don't hurt me". To the degree that the patient as a whole individual does not synthesize, personify, and presentify the re-enactment, the subsystem of the patient that does not integrate the re-enactment (e.g., an ANP) remains dissociated from the subsystem of the patient that engages and commonly recurrently re-engages in the re-enactment (i.e., an EP). The involved subsystems of an individual's personality qualify as dissociative parts precisely *because* they meet the criteria of global world, phenomenal Now, transparency, and perspectivalness: They generate a PCS as well as a more or less limited set of PCIR when they are reactivated. When latent dissociative subsystems of the individual's personality become manifest, they thus start and continue to engage in actions that include the actions of being an 'I' as a part of a 'world.'

[3] The presumed existence of memory traces is a most problematic idea (e.g., Braude 1995, 2006; Bursen 1978; Heil 1978).

Assessment of dissociative disorders and the accessibility and assessability of dissociative parts

Ross is concerned that it may be impossible to assess the existence of a dissociative part. This difficulty can certainly exist in some cases or phases of treatment. The existence of dissociative parts is not instantly noticeable in particular cases. However, the inherent difficulty in assessing the formal cause of trauma (i.e., a particular organization of the personality as an organism-environment system) does not mean that this organization does not exist, and that this organization cannot be assessed at a later point in time. In the case of Rita given above, it took therapeutic work to discover the existence of a child EP and to get in touch with this part. Does this mean that clinicians cannot assess the existence of a dissociative disorder in cases involving dissociative parts that have not been formally met? I do not think so, at least not in an absolute sense. Clinicians often provisionally diagnose dissociative disorders on the basis of a constellation of dissociative symptoms (see below). They do not need to instantly know the formal cause of the patient's condition, that is, the dissociation of his or her personality, but may presume its existence given the symptoms. Similarly, diagnostic instruments for dissociative disorders assess a constellation of symptoms rather than dissociative parts, although it is diagnostically most helpful to become acquainted with two or more dissociative parts. For example, dissociative disorders of movement and sensation in ICD-10 (WHO, 1992) such as dissociative stupor and dissociative convulsions are diagnosed on the basis of dissociative symptoms. DSM-5's Chronic and Recurrent Syndromes of Mixed Dissociative Symptoms (CRSMDS) – the former DSM-IV example 1 of Dissociative Disorder Not Otherwise Specified – are also diagnosed on the basis of a constellation of dissociative symptoms rather than on the assessment of a dissociative organization of the personality.

This diagnostic practice is not at odds with TSDP because according to our definition of dissociation in trauma, dissociation of the personality manifests in positive and negative cognitive-emotional (psychoform) and sensorimotor (somatoform) dissociative symptoms (Nijenhuis & Van der Hart 2011a, Van der Hart et al. 2006). These symptoms thus suggest an underlying dissociation of the personality. It is more the rule than the exception that this organization, this formal causality of the disorder, only becomes clear(er) with treatment. This is why in many cases dissociative disorders can only be provisionally diagnosed. The disorder becomes formalized following the consistent observation of one or more dissociative parts. Because of this observation the clinician can conclude that the one who came to assessment and treatment is also a dissociative part of the individual and not the complete person. For example, certainly not all dissociative parts in individuals with DID present themselves during clinical assessment, and in some cases the existence of dissociative parts can initially be only suspected. Many individuals with CRSMDS[4] typically do not directly present dissociative parts during assessment apart from an ANP who presents dissociative symptoms. This ANP may report and

[4] CRSMDS is another one of those 'not otherwise specified' (NOS) diagnoses in DSM-5. The proposal of the dissociative disorders advisory committee for ICD-11 is to lift this dissociative disorder, which may be the most prevalent of all dissociative disorders, from an NOS-status to a regular diagnosis under the name of complex dissociative intrusion disorder (CDID; Nijenhuis et al. 2014).

show intrusions (e.g., hearing child-like voices) of what later appears to involve EPs. But the existence of EPs can often only be suspected in a diagnostic phase.

Detecting the existence of dissociative parts may in some cases take time, sometimes even a lot of time. To illustrate: A woman with depersonalization disorder did not seem to encompass dissociative parts. Her condition was hard to treat. After 4 years of uselessly trying to lessen her depersonalization symptoms, it became apparent that she included a child EP who was stuck in a singular rape by her father. When the ANP integrated the traumatic memory and the associated fragile EP, her otherwise intractable depersonalization disorder swiftly and fully remitted. With this work it appeared how much she had previously been functioning as an ANP. From being an individual with a distant and quite superficial presentation, she turned into a warmhearted, differentiated woman. Other patients with depersonalization disorder do not encompass dissociative parts, so that according to TSDP and Nijenhuis and Van der Hart's (2011a) definition of dissociation in trauma they do not have a dissociative disorder. The condition of these individuals rather involves a persistent unduly low level of personification of personal experiences, not a dissociation of the personality.

Detection of rudimentary EPs in PTSD (and other dissociative disorders)

Ross asks how a rudimentary EP can be detected in PTSD. As mentioned above, dissociative parts do not need or be able to verbally express themselves as subsystems involving their own person perspectives. However, the presence of these person perspectives can be assessed with a reasonable degree of certainty by preferably consistent and recurrent clinical observation and by the use of deductive logic that runs as follows: PTSD includes negative and positive symptoms. Formulated in PTSD Criterion B in the DSM-5, the positive symptoms are intrusion phenomena. The intrusions stem from one or more conscious and self-conscious subsystems of the patient's personality, because traumatic memories (and autobiographical, narrative memories) do not exist in a personal void. To remember an autobiographical experience and event, an individual must engage in an action, that is, in the act of recollecting a portion of his or her personal past. No action, no memory. A memory is thus always someone's memory. A traumatic re-enactment is not a common autobiographical memory, but someone's sensorimotor, cognitive-emotional, and behavioral reenactment. The re-enacting subsystem or subsystems are conscious and self-conscious, because they meet the minimal criteria of consciousness, as well as include PCS and PCIR that are not or not sufficiently shared by one or more other conscious and self-conscious subsystems of the patient. This lack of integration of the individual's personality can be logically deduced from the fact that PTSD patients temporarily, and more or less completely, lose their PCS and global world (i.e., a large coherent set of PCIR) that pertain to their present life (i.e., orientation in time and place, idea of personal age, other features of their present identity, relationships), and replace it by a different PCS and set of PCIR. This PCS and these PCIR make up the traumatic re-enactment. They involve an orientation in time, space, identity, relationships with objects and other subjects that are phenomenally present, but that are, in the second-person and third-person perspective of observers, not actually present. In that sense, the PCS and set of PCIR that make up the re-enactment are hallucinatory. Observers are thus generally able to

notice that someone is engaging in a more or less complete re-enactment. The 'one' who re-enacts and who intrudes on the PTSD patient's current existence (i.e., his or her current PCS, globally available current world – his or her coherent set of current PCIR--and phenomenal now that match the third-person present) is clearly a conscious and self-conscious existence oriented to and stuck in the traumatic past (i.e., in 'trauma-time'). The intruding 'one' is clearly dissociated from the individual's present existence, from the 'one' that is intruded. For if the intruding part were integrated with the patient's conscious and self-conscious present existence, the re-enactment would stop. *If it were integrated, the intruding and intruded on parts would know and realize that they are safe, that the thing happened in the past, that objects and subjects that were once dangerous are no longer present or dangerous anymore.* But re-enactments and intruding re-enactments do not lead to this integration for the duration of the disorder. This lack of integration and the continued existence of two (or more) conscious and self-conscious subsystems is the core problem of PTSD as well as of all other dissociative trauma-related disorders.

The following example serves to demonstrate the point. The focus is on a shift in the patient's second-person and third-person perspective regarding individuals and objects that once presented a major threat, but that, in the eye of third persons, are no longer threatening.

> A married couple was severely tortured for hours by two burglars who wore helmets. As ANP, the husband knew that policemen who ride a motorbike and for that reason wear a helmet are generally trustworthy (present PCS and globally available world). As ANP, he thus did not have an abnormal reaction to policemen. However, when stopped by a helmeted policeman while driving his car, the sight of a helmeted head that looked at him through the side window of his car (a set of classically conditioned stimuli) instantly took him back to the past that then became his phenomenal present. This reorientation implied the regeneration of a former first-, quasi-second-, and second-person perspective, as well as a former goal-orientation regarding helmeted men (fragile EP; flee when you can). The reactivation of the fragile EP went along with the loss of the PCS and set of PCIR that marked the ANP. As the fragile EP, the patient perceived the policeman as one of his torturers and felt his very life was at stake (reactivation of a former second-person perspective regarding his and his wife's torturers; loss of the second-person perspective regarding a policeman). He panicked and pushed the throttle (behavioral re-enactment; flight fitted the third-person past, but not the third-person present). A dangerous pursuit followed that culminated in an upsetting arrest. The patient did not integrate the fragile EP and this part's horrible experiences as ANP during or following the event, so that his PTSD persisted (cf. Nijenhuis 2015b).

By affectively attuning to their patients and by carefully observing them, clinicians can, at least in principle, phenomenally judge in second-perspective (I, clinician – You, patient) and physically judge in the third-person perspective (I, clinician – the patient as an object of my study), that the patient encompasses two or more conscious and self-conscious subsystems. Although talking with an EP assists them in reaching this conclusion, verbal exchanges with an EP are not the only way to phenomenally and physically judge that the patient includes more than one conscious and

self-conscious subsystem (in the above example, one ANP and one fragile EP). The clinician can ask the PTSD patient what (s)he experienced during the re-enactment. When the patient does not recollect the re-enactment, the clinician receives a first indication that the 'one' who does not recollect it could constitute an ANP. The patient may alternatively have had the feeling that (s) he was intruded on by a traumatic memory, and/or that not (s)he but 'something inside' was re-enacting past horror. This lack of personification is another powerful indication that it is an EP that is re-enacting the traumatic experience, and that an ANP does not or not sufficiently personify the re-enactment. In sum, clinicians can commonly examine and judge the features of the re-enactment with their patients as it happens, as well as de post facto.

Dissociative amnesia as a disorder

To reiterate, the structural and functional organization of the personality of individuals with dissociative disorders is often not instantly accessible, hence assessable. This circumstance also applies to dissociative amnesia both as a symptom and as a disorder. Like basically any dissociative disorder, dissociative amnesia as a disorder is provisionally diagnosed on the basis of particular symptoms that strongly impress as dissociative phenomena. Dissociative amnesia as a symptom and as a disorder clearly involve the difficulty or inability to recollect (particular or even most or all) past experiences, life events, and still other autobiographical components such as the individual's past PCS in part (e.g., selective dissociative amnesia) or in full (i.e., generalized dissociative amnesia). However, it cannot be immediately physically judged that a particular memory problem that an individual is experiencing is dissociative in nature. It might well be a different kind of forgetfulness. The presenting memory problem can only be definitively diagnosed as dissociative amnesia after detection of one or more dissociative parts that recall what one or more other parts do not wish or are unable to recollect.

Dissociative amnesia as a disorder can be understood as a division of the personality between an amnestic conscious and self-conscious subsystem of the personality and a conscious and self-conscious subsystem that encompasses or includes the episodic, semantic and perhaps also procedural memories that the amnestic subsystem has not integrated (Van der Hart & Nijenhuis 2001). It makes no sense to talk about *dissociative* amnesia when the memory loss is not dependent on the existence of dissociative parts. If this type of forgetting would be called dissociative, any forgetting and any forgetfulness would be dissociative. This conceptualization would not only be far too general, it would also mask important phenomenological, theoretical, clinical, and scientific/empirical differences between dissociative amnesia and other kinds of forgetting.

Depersonalization disorder

According to TSDP, depersonalization disorder can but need not include dissociative parts of the personality. Hence, it can, but need not, be a dissociative disorder (Steele et al. 2009). Ross suggests that all cases of depersonalization disorder involve such parts. One possibility, he proposed, is an organization involving one present, depersonalized ANP, and a premorbid personalized ANP.

One problem with this view is that the premorbid personality cannot be described as 'apparently normal' and as a 'part' of the individual's personality. When the individual's premorbid personality was previously mentally healthy, it was not apparently normal, but truly *normal*. At some point, this healthy structure stopped engaging in the actions of personification to some degree (and for whatever reason[s]). The premorbid healthy personality does not involve a dissociative part, but was the integrated individual as a whole conscious and self-conscious organism-environment system. In this case recovery of depersonalization disorder does not seem to involve a reactivation of the premorbid healthy personality and the integration of the depersonalized ANP with this structure. The premorbid personality was not somehow still in existence, waiting to be reintegrated with the depersonalized ANP. It would seem more fitting to say that the recovering depersonalized individual starts to re-engage more in the actions of synthesis (e.g., perceiving and integrating bodily and emotional feelings) and personification (e.g., owning these feelings). If one would call a development from a premorbid healthy personality to a morbid personality dissociation of the personality, and recovery of this dissociation the integration of two dissociative parts, then *any case of emergent (psycho)pathology would involve a dissociation of the personality, hence, would qualify as a dissociative disorder*. A major problem with this conceptualization is that it clearly fails to meet the requirement of specificity that Schimmenti and Caretti (2015) described so well, a requirement that goes back to the pre-medieval Plato and the post-medieval Kant (see Schopenhauer 1818/1844 [1958], quoted in Nijenhuis 2015a).

Ross (2015) distinguishes a second type of depersonalization disorder that involves the existence of an ANP-EP organization of the personality. The existence of this type is fully consistent with TSDP as well as with clinical observations. In these cases, an ANP commonly requests treatment. Prior to the detection of one or more EPs, clinicians have no way of knowing that the presenting depersonalization disorder is of the dissociative kind and, thus, that the presenting patient is functioning as an ANP. In other words, the dissociative nature of the depersonalization becomes only clear when after a shorter or longer delay one or more EPs are detected (as applied to the case of depersonalization disorder I briefly described above). In my experience, the EP (or EPs) is usually stuck in traumatic experiences, but is not depersonalized. The ANP's integration of the traumatic memories and the associated EP(s) leads to a resolution of the disorder. With this integration, the personality becomes integrated and the individual regains mental health.

A third possibility that Van der Hart (personal communication, January 24, 2015) called to my attention is that all existing dissociative parts may be so exhausted during a shorter or longer episode, that they lack the energy and will to engage in the actions that are required to generate the (full-blown) phenomenal experience and conception of being someone.

A spectrum of dissociative disorders

Ross (2014) asked whether still other diagnoses in DSM-5 than PTSD that are in this system not classified as a dissociative disorder in my perspective constitute a dissociative disorder. Apart from acute stress disorder (ASD) and cases of dissociative psychosis, in my view, but certainly not only in my view, the domain of dissociative disorders does include conversion disorder (see e.g., Brown et al. 2007; Nijenhuis 2015a, b; Sar et al. 2009; WHO 1992). DSM-5 is quite

inconsistent in its conceptualization of sensorimotor (somatoform) dissociative symptoms (see, e.g., Nijenhuis 2014a). The system acknowledges the existence of these symptoms, but it does not include sensorimotor (somatoform) dissociative disorders. It rather speaks of conversion disorders. However, in ICD-10 (WHO 1992) these disorders are classified as dissociative disorders of movement and sensation. Additional and related problems are that DSM-5 does not define conversion, and that it suggests that sensorimotor (somatoform) dissociation and dissociative symptoms are different from conversion and conversion symptoms without exactly saying how or why.

Mental disorders not categorized as dissociative disorders (e.g., agoraphobia, depression, psychosis eating disorders, obsessive-compulsive disorder,) may in fact involve a dissociative organization of the personality. This applies when they encompass a dissociation of the personality in which context one or more dissociative parts but not all dissociative parts are agoraphobic, depressed, psychotic, et cetera). In these cases, the involved symptoms qualify as dissociative symptoms, and the disorder as a dissociative disorder. When all dissociative parts of an individual are agoraphobic, depressed, psychotic, et cetera, it can be said that agoraphobia, depression, psychosis, et cetera, is co-morbid to a dissociative disorder.

Dissociative disorders in DSM-5 and DSM-6

Ross (2015) fears that if TSDP is correct, this would require a complete rewrite of the DSM-5. This idea is in my view an exaggeration. What is, however, urgent is the formulation of consistent and viable concepts of dissociation, dissociative symptoms, and dissociative disorders to replace the current confusion in DSM-5 and literature more generally (see Dorahy & Van der Hart 2015; Nijenhuis 2014a, 2015a, 2015b; Nijenhuis & Van der Hart 2014a, 2014b). This need exists whether TSDP is true, true or false in part, or even completely false. The core problem thus is the current confusing, inconsistent, partly over-inclusive and partly under-inclusive conceptualization of dissociation and dissociative disorders (Nijenhuis & Van der Hart 2011a, 2011b). *Particularly but not exclusively in the light of TSDP, what would be fitting and helpful is a revision of ASD, simple and complex PTSD, DSM-5 conversion disorder, and the DSM-5 dissociative disorders in one category under the name of "dissociative disorders".*

TSDP describes a range of dissociative disorders that vary along a dimension of complexity of dissociative division of the personality. It is simple in simple ASD, PTSD and sensorimotor (somatoform) dissociative disorders; it is more complex in complex ASD, complex PTSD (that is to be included in ICD-11), and complex sensorimotor (somatoform) dissociative disorders. In many cases of CDID it is still more complex, and the dissociation of the personality reaches its summit in DID. This conceptual integration and differentiation can be seen as a next step in the integration of the trauma-and stressor-related disorders, the dissociative disorders, and DSM-5 conversion disorder (in ICD-10 conversion disorders are already classified as dissociative disorders). These various diagnoses can be mainly described and assessed in terms of negative and positive cognitive-emotional (psychoform) and sensorimotor (somatoform) dissociative symptoms. The background understanding of these symptoms is that they are manifestations of an underlying structural and functional dissociative organization of the personality. When

this organization, this formal causality, becomes accessible, and hence assessable, a dissociative disorder diagnosis provisionally given on the basis of symptoms can become definitive on the basis of the then known dissociative division of the personality.

However, if the field were to follow the idea that dissociation (of the personality) is a core feature of a host of mental disorders, then, it seems to me, *that* stance would require a major revision of DSM-5 and ICD-10.

Hippocampal volume

Ross (2014) is right that small hippocampal volume is not specific to PTSD and (other) dissociative disorders. I did not hypothesize that small hippocampal volume is specific to trauma-related disorders, but that PTSD and DID are associated with similar structural brain abnormalities, because they are family-related mental disorders. The fact that the hypothesis holds, and that hippocampal volume is negatively correlated with degree of traumatization and dissociative symptoms (Chalavi et al. 2014) clearly does not allow for the conclusion that hippocampal is small only in individuals with PTSD or DID.

That said, there is a need for studies regarding small hippocampal volume and other structural brain abnormalities in other mental disorders such as schizophrenia and schizoaffective disorder (e.g., Arnold et al. 2015) to include differential diagnosis of dissociative disorder. To date, this differential diagnosis is basically lacking in neurobiological and other studies of schizophrenia and schizoaffective disorder. If only given the overlap in first-rank symptoms in schizophrenia and complex dissociative disorders (Ellason & Ross 1995, Kluft 1987, Yu et al. 2010), there is serious reason to question the validity of studies on schizophrenia that do not include this differential assessment.

Imperfections of TSDP

My co-authors and I concur with Ross (2014) that TSDP is not perfect. Even the best of theories are mere tools. They do not reflect an objectively existing (i.e., subject-independent) reality, and the search for knowledge and wisdom is forever. This is what the term "wijsbegeerte", the Dutch word for philosophy, expresses, the desire (begeerte) to gain wisdom (wijsheid). I am thus open to incessantly improving TSDP. For example, I initially followed Metzinger's (2003) idea that the human 'I' involves a phenomenal self-model (Nijenhuis 2012). I now feel that the term 'phenomenal conception of self' is better. The point is that there is not an objectively existing 'I' that is modeled. Rather, there is an 'I' that an individual as an organism-environment system phenomenally conceives of in the framework of subject-object co-constitution, co-dependency, and co-occurrence (Nijenhuis 2015b). This complex proposition is grounded in philosophical and psychological reflections that for reasons of space cannot be detailed here, but that interested readers may wish to examine in The Trinity of Trauma, Vol. I and II.

Nonstructural dissociation?

Ross (2014) holds that there exists both structural and nonstructural dissociation. This statement is hard to evaluate. First, Ross' concept of structural dissociation does not seem to have a lower bound. He even feels, if I understand him properly, that a lower bound is not required. Second, Ross does not define nonstructural dissociation. This implies, I fear, that there is no way of knowing what should count or not count as a case or disorder of structural dissociation, how structural dissociation would differ, if at all, from nonstructural dissociation, and how nonstructural dissociation would be different, if different at all, from various other and ubiquitous lapses or features of consciousness that Van der Hart, Steele, and I do not regard as dissociative in nature (Steele et al. 2009). (We do *not* feel that structural dissociation is one kind of dissociation, but regard it as the only kind.) For example, Ross states that structural dissociation is characteristic of many mental disorders. However, as mentioned above, how are we to decide what mental disorders do and do not involve this organization of the personality if there is no lower bound on the concept of dissociative parts?

Like Ross (2014) Schimmenti and Caretti (2014) suggest that there are different kinds of dissociation than a division of conscious and self-conscious subsystems which manifests in dissociative symptoms. They feel that the "process of dissociation" may be ubiquitous, that it is a key feature of any kind of psychopathology, and that it relates to "the logic of survival". Their brief formulations raise many questions, some of which were addressed above. For example, do they mean that the concept of dissociation has no lower bound or that there is no need for a lower bound? Would anyone dissociate once in a while, sometimes, or frequently? If so, then how are we to know what common and pathological phenomena are and are not dissociative in nature? If dissociation is a key feature of any kind of psychopathology, would the concept not lose all specificity, hence all usefulness? If all mental disorders are primarily characterized by dissociation, does dissociation then become a synonym for general psychopathology? And what would be dissociative in individuals with, say, major depression, social phobia, schizophrenia, or avoidant personality disorder whose personality is not dissociated? What kind of mental action or different mental actions would the "process of dissociation" entail? And if dissociation as "process" is ubiquitous, is this ubiquitous phenomenon related to the logic of survival, and if so, how? How would ubiquitous occasional absorption, narrowed consciousness, low levels of consciousness, imaginative involvement, engagement in fantasies, forgetfulness, and dreams serve survival?

If the concept of 'dissociation' captures a host of phenomena, as many authors suggest (e.g., Dalenberg & Paulson 2009; Dell 2009, 2011; Ross 2014; Schimmenti & Caretti 2014), clinicians stating that "the patient dissociates", or that "the patient is dissociated" might mean any, or any combination of, the following:

The patient:

--mentally avoids becoming consciously aware of something (e.g., something that the individual regards as threatening);
--does not pay attention or pays too little attention;
--is wide awake, and highly concentrated on some task;
--is absorbed in some activity, but is not very concentrated;

--is drowsy;
--is day-dreaming;
--is engaging in a fantasy;
--is having a nightmare;
--is engaging in tonic immobility as a defense;
--loses track of time;
--is forgetful (but does not encompass dissociative parts);
--displays a mood shift;
--is functioning in a particular 'mode';
--is functioning as a particular 'ego-state';
--is functioning as a dissociative part of the personality.

The list could go on. How, thus, should statements on 'dissociation' be understood if the term can stand for all these phenomena--and more--and if the clinician does not clarify what (s)he actually has in mind when using the term?' Common practice is, however, not to provide such clarifications. This confusing situation is not imaginary; it is *very real*. For example, many participants in courses on dissociation in trauma and dissociative disorders complain that the term can stand for a host of many different things in clinical and scientific literature. They feel completely (and rightly) confused.

Similarly, a researcher stating that "dissociation is correlated with fantasy proneness" can mean many and very different things. For example, it may mean that "absorption is correlated with fantasy proneness", that "imaginary involvement is correlated with fantasy proneness", or that "the existence of different dissociative parts of the personality is correlated with fantasy proneness". It may also mean that "DES scores are correlated with fantasy proneness", "emotional and physical numbing, and hypoarousal are correlated with fantasy proneness", or still something else. The problem must be resolved, because like clinicians researchers seldom state in what sense they intend the term 'dissociation.'

Should we be content with and reinforce these common clinical and scientific practices? Should we continue to adhere to a term that can mean so many different things? Is it really valuable or necessary to have a domain of dissociation that encompasses several different dimensional phenomena? Is it clinically and scientifically helpful (and, if so, in what precise sense?) or required (and if so, why?) to gather the following dimensional phenomena and perhaps even more under the singular heading of 'dissociation' (the list may not be exhaustive)?:

--level of consciousness: being unconscious, hardly conscious, drowsy, somewhat awake, clearly awake, alert, extremely alert;
--intensity of experience: very weak, weak, fair, high, very high;
--degree of forgetfulness (i.e., forgetfulness that does not pertain to a dissociation of the personality, thus, forgetfulness that does not involve dissociative amnesia): extreme, moderate, minor;
--field of consciousness (i.e., the reach of an individual's domain of global availability; see above): being conscious of very restricted, restricted, fair, substantial, high, or very high

number of cues;
--phenomenal judgment of the reality of one's personal existence: perceiving oneself as very unreal, unreal, somewhat real, quite real, very real;
--phenomenal judgment of the reality of one's perceived outer reality: perceiving outer reality as very unreal, unreal, somewhat real, quite real, very real;
--phenomenal judgment of the (mis)match between one's phenomenal contents (perceptions, ideas, hopes, et cetera) and outer physical (third-person) reality: a dimension stretching from (i) taking a hallucinated, fantasized, or dreamed world for the real world to (ii) taking the real world for a hallucination, fantasy, or dream;
--as a subtype of the previous dimension, phenomenal judgment of one's phenomenal now in comparison to the third-person physical present;
--degree of division of the personality in different dissociative parts (e.g., primary, secondary, and tertiary; see Van der Hart et al. 2006).

Empirical evidence shows that compiling perhaps related but different phenomena in one conceptual category can be unwarranted or problematic. For example, the Dissociative Experiences Scale (DES; Bernstein & Putnam 1986), a widely used self-report questionnaire, was originally designed to evaluate the severity of phenomena that, according its authors, might address dissociation. In terms of TSDP, however, the DES includes items evaluating the severity of cognitive-emotional dissociative symptoms, as well as items that pertain to absorption and imaginative involvement which in the view of TSDP are not dissociative in nature. Absorption as measured by the absorption subscale of the DES was prominent among patients with a dissociative disorder, but it was also high up among those with a different mental disorder (Leavitt 2001). Further, absorption and imaginative involvement were more strongly related with severe psychopathology (Allen & Coyne, 1995) and general distress (Allen Coyne, & Console 1996) than were depersonalization and dissociative amnesia.

Absorption and imaginative involvement, thus, do not seem to be specific to any particular kind of mental disorder, whereas symptoms of the existence of a dissociation of the personality are specific to dissociative disorders. To illustrate, as mentioned above, sensorimotor dissociative symptoms are specific to DSM-5 and ICD-10 dissociative disorders as well as to PTSD, but not to other mental disorders such as anxiety disorders and major depression (i.e., when the latter disorders do not in fact involve a dissociation of the personality). Schimmenti and Caretti's (2014) proposition that dissociation is a key factor of psychopathology in general, thus, only seems to hold if one a priori includes absorption and imaginative involvement in the domain of dissociation, and if one overlooks or ignores that manifestations of a dissociation of the personality are specific to DSM-5 and ICD-10 dissociative disorders and PTSD (under the restrictions alluded to above). Here is a clear example of the problems of an overinclusive dissociation concept and a lack of specification of the kind of phenomena one has in mind when using the term 'dissociation'.

Apart from the indicated phenomenological, theoretical, conceptual and empirical problems, it is unclear why a broad set of different phenomena *must* be gathered in one conceptual domain. Why not distinguish between dissociation of the personality and its symptoms (i.e.,

the manifestations of the existence of this division), and other kinds of altered consciousness? It would be most worthwhile to give each of these other kinds their own name and conceptual domain (e.g., absorption, imaginative involvement, narrowed consciousness). This approach would highlight each of these, as well as clarify different aspects of consciousness and the troubles each can involve. It would foster the examination of their probable dimensional structure, and it will bring forward more refined and sophisticated clinical and scientific theories and hypotheses. In a word, making these distinctions would advance clinical practice and science of consciousness and self-consciousness. For example, undue absorption, undue imaginative involvement, and undue dissociation of the personality (not all dissociation of the personality is pathological; e.g., Moreira-Almeida et al. 2008) require different clinical interventions.

It is a major development that Eve Carlson (2014, March), one of the two authors of the DES, now asserts that phenomena pertaining to absorption and imaginative involvement are better removed from the domain of dissociation. The authors of TSDP are, thus, no longer the lone voices stating that the present domain of dissociation is overcrowded.

In the light of the conceptual and empirical problems listed, we have objected to an in some regards overinclusive and in other regards underinclusive concept of dissociation (Nijenhuis & Van der Hart 2011a, 2011b; Steele et al. 2009; Van der Hart et al. 2006; Van der Hart et al. 2004). To remedy the situation, we have proposed to distinguish between: (1) dissociation of the personality in dissociative conscious and self-conscious systems, (2a) negative and/or (2b) positive dissociative symptoms, that is, symptoms that are manifestations of the existence of these dissociative parts, (3) dissociation as a mental action, that is, the action of creating and maintaining a particular dissociation of the personality, and, more specifically, (4) the action ('phobias') of avoiding experiencing, knowing, and integration other dissociative parts and their mental contents (e.g., traumatic memories), and (5) phenomena in trauma and various other phenomena that do not pertain to a dissociation of the personality (e.g., absorption, imaginative involvement).

In this way, we have tried to develop a concept of dissociation that is clear and distinct, and that is not almost a huge transcendental concept "like Being, Thing, and Something" (Spinoza, 1677 [1996], p. 56). As Spinoza explains, transcendental terms

> arise from the fact that the human body, being limited, is capable of forming distinctly only a certain number of images at the same time … If that number is exceeded, the images will begin to be confused, and if the number of images the body is capable of forming distinctly in itself at once is greatly exceeded, they will all be completely confused with one another. (p. 56)

In closing, I reiterate my gratitude to Drs. Ross, Schimmenti, and Caretti for challenging TSDP, as well as for offering their own ideas and proposals regarding the domain of dissociation. Their comments and criticisms prompted a serious re-examination of some of TSDP's basics. My commentators' thoughts on the concepts of dissociation, dissociative parts, and dissociative disorders also invited a benevolent consideration of their points of view. Upon rethinking some basic concepts of TSDP, and examining my discussants perspectives, I have come to the

conclusion that, whatever limitations or flaws TSDP may include, they do not pertain to this theory's lower bound of the concept of dissociative parts of the personality. The criterion that dissociative parts include their own at least rudimentary phenomenal experience and conception of self is a clear and distinct idea that, in a prototypical sense, distinguishes these parts from other insufficiently or imperfectly integrated subsystems of an individual's personality. More generally, dissociation is an integrative limitation, but not every integrative limitation is an instance of dissociation.

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