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SIMILARITIES IN RESPONSES TO EXTREME AND UNREMITTING STRESS: CULTURES OF COMMUNITIES UNDER SIEGE[1]

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During World War II, eastern European ghettos served to contain and oppress ghetto residents. The organizational structures and processes that emerged within the ghetto are directly analogous to those in patients with Dissociative Identity Disorder (DID, formerly MPD). This article explores the analogues between ghetto organization and the internal worlds of DID patients. Complex DID patients, like ghetto residents subjected to extreme and unremitting stress, develop homeostatic systems characterized by competing forces that serve agendas of help-seeking, communication to outsiders about atrocities and utilitarian efforts to prevent destabilization. The ghetto analogue to DID is offered as a descriptive teaching device for both clinicians and patients.

This is the first of two articles which present a metaphoric view of the internal world of patients with Dissociative Identity Disorder (DID, formerly MPD).[3] DID is generally believed to develop primarily in children who are both high in hypnotic capacity and exposed to extreme and on-going abuse (see Putnam, 1989; Ross, 1989). These children are seen has developing alternate personalities in order to contain the physical and emotional pain as well as the memory of abuse experiences.

This article describes the development and descriptive value of the metaphor, while the second is concerned with treatment of the disorder. The approach taken here developed out of discussions the first author had with professional peers during study groups devoted to treatment issues with this highly complex population. It is based on the cultural mix found in Eastern European ghettos from 1939-1943, particularly those of Warsaw, Lodz, and Vilna. The cultural mix that developed in the non-clinical populations of these ghettos directly parallels the cultural mix of alter types found in the internal worlds of many patients with DID. This comparison holds implications for theory, research, and practice. It offers accessibility, understanding, and a demystification of the internal world to clinicians and patients working with DID.

Alters have been conceptualized as "highly discrete states of consciousness organized around a prevailing affect, sense of self (including the body image), with a limited repertoire of behaviors and state-dependent memories" (Putnam, 1989, p.

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[3] In recent years, attention to the understanding and treatment of DID has increased dramatically. That material is beyond the scope if this article. Interested readers are referred to works by Putnam (1989) and Ross (1989).

103). Amnestic barriers between alters are quite common, such that any given alter may or may not know of the existence of other(s).

The strength of the ghetto comparison lies in its clarification of internal dynamics, fine-tuning of alter types, and direct relationships to clinical strategy. It is offered as a teaching model for both clinicians and patients. It is an alternative to the listing of alter types found in textbooks on the subject of DID (Putnam, 1989) in that its focus is both within patients and between patient and clinician. It is not a substitute for alter system mapping (Ross, 1989), which is concerned with within-patient issues. The interface between ghetto metaphor and system mapping allows clinicians to understand patient dynamics more comprehensively and more clearly, offering a schematic structure not only of how inner forces may be grouped together, but also how they coexist, interact, and function with respect to outside influences.

The comparison involves an elaboration of the common tetrad of alter groups (persecutors, traumatized alters, and protectors, behind a host) described by Kluft (1987). It clarifies the common tetrad labels by emphasizing that all alter types are essentially protective. It also appreciates the complexity and heterogeneity of persecutory alter types. Finally, while traditional categories such as the common tetrad have focused primarily on interrelationships between alter types of the ghetto analogue extends this analysis of internal characteristics by exploring how the internal balance is affected by the external force introduced by a clinician in the treatment of DID. In many ways those familiar with the Fairbairnian approach to object relations theory will find the type of thinking involved with the ghetto comparison to be familiar. However, a more complete elaboration of the similarities is beyond the scope of this article. The interested reader is referred to works by Fairbairn (1954) and Bacal and Newman (1990).

Several caveats should be mentioned before proceeding: First, the authors are not aware of literature that supports any necessary connections between the organization of social groups and intrapersonal processes. The views expressed here are indeed metaphoric, and should be seen in that light. Further, readers should try to avoid the tendency to reify metaphoric concepts (e.g., it would probably be unhelpful for clinicians to ask—either themselves or alters with whom they interact—if a given alter represents a "bonding force," a "pro-bonding force," an "anti-bonding force," or an "independent force.") Rather, clinicians are well-advised to understand that such forces are often active in a DID system, such that interventions must be planned accordingly.

Third, clinical experience suggests that the ghetto analogue is not a universal for DID patients. In particular, it may be inapplicable to those DID patients who tend to be seen as high functioners (see Kluft, 1986). Its applicability is likely to be greatest with patients Kluft (1988) has termed "extremely complex."

Fourth, clinical experience suggests that some patients who present with memories of particular abusive experiences, but who later recant, saying that their "memories" were confabulated rather than corroborated, may nonetheless represent that their internal worlds are highly analogous to those found in ghettos. Whether or not such presentations reflect social contagion, and regardless of whether the recanting is motivated by clarity (the "memories" weren't "real") or fear (the patient recants in order to re-establish relationships with those who have been abusive), the nature of the caveat is that the relationship between abuse-related DID and an internal organization consistent with ghettos is correlative rather than causative. It would thus be unhelpful for clinicians to conclude that patients must have had a particular type of abuse history (or any abuse history at all), given presentations with apparent DID and ghetto types of internal organizations.

With the above caveats in mind, we turn to the ghetto analog and its development. The relevance of the ghetto as a metaphor for DID became apparent through a literature review of scholarly works on the subject of Eastern European ghettos that existed in the early 1940's. That review suggested that as a result of extreme and unremitting stress, the organization of ghetto residents involved particular components which developed in part due to captors' instructions and in part by spontaneous response to siege. Both the constituent components and the modes of interaction between those components are analogous to alter organization and interaction in DID.

I. Development of the Eastern European Ghetto

During the years 1939-1943, the Nazis orchestrated a plan to exterminate certain groups of peo-

ple. The first step of this plan was containment, which would provide management and control of the target groups. Contained areas, which later became known as ghettos, were created and policed. Depending on the relationships between ghetto residents and the broader community prior to ghettoization, the permeability of ghetto walls varied considerably. At one extreme was the Warsaw ghetto, where residents had already established valuable and productive relationships with the community. Here a great deal of transit took place under and through ghetto walls. At the other end of the continuum was Lodz, where relationships were poor, resulting in a ghetto that was "truly hermetically sealed, cut off from other Jews and non-Jews alike" (Dobroszycki, 1984, p. xxiii). (Permeability may have played a significant role in the course of ghetto responses to confinement, in that the Warsaw ghetto uprising stood in stark contrast to the apparent acquiescence of the residents of the Lodz ghetto. However, there were so many differences between Warsaw and other ghettos that it is impossible to have confidence in the relative importance of the permeability variable.)

The ghettos amounted to tiny pockets of land with astounding population density. For example, in the Warsaw ghetto (1.6 square miles) there were over 200,000 people per square mile and over nine people per room of living space (Gutman, 1989). This small area was encased by a 10-foot wall topped by barbed wire. The physical environment alone was an immediate and chronic source of stress in the ghetto community. The starvation and disease which resulted as a function of such gross overcrowding was widespread, deadly, and unremitting.

There has been some disagreement in the scholarly community as to whether the Nazi strategists purposely planned to use the ghettos as part of the process of rendering their victims docile and thus easier to exterminate. This type of tactic is mirrored in contemporary criminal justice where the environments created for death row inmates are designed to produce maximal compliance with prison procedures, with minimization of combative events at the time of execution. Some historians suggest that the use of the ghetto as a means of pacification for those about to be killed developed as a post-hoc implication rather than as an *a priori* intention (see Gutman, 1989; Hilberg, 1985). In either case, the dynamic that emerged in the ghettos was one of a society under siege where interests were divided along individual, family, and community lines. These conflicting interests led to the need for a delicate dynamic balance between a stabilizing utilitarian force that sought the greatest good for the greatest number and a destabilizing opposition that struggled to tell the world of the horrors taking place, even at the cost of self-destruction.

II. Cultural Components of the Ghetto

A. Group I

Since any opposition to Nazi rule, ranging from mild protest to overt rebellion, could result in immediate extermination of the entire ghetto, the first force represented in the ghetto culture was concerned with the minimization of such disruption. The dilemma faced by this first group was to find a set of strategies, both in principle and in practice, for avoiding immediate annihilation and for facilitating long term survival. Since the Nazis wanted to keep the ghetto environment self-sustaining if not self-destructive, ghetto leaders were forced to generate belief systems and implement policies that were at once imperative and impossible to maintain.

1. *The co-opted government: The Judenraten.* The Nazis initiated their overarching control of the ghettos via indigenous members of the target communities. They installed a co-opted government—a body of leaders chosen from the community and assigned the task of overseeing ghetto members and enforcing Nazi directives. These councils, known as the *Judenraten*, were composed of Jewish men who were obligated to respond to the unreasonable and inhumane demands and threats of the Nazis. These demands put Jewish leaders in a very difficult position, as they were required to forward large amounts of tax dollars to the Nazis, select members of their own community for forced labor, and even designate individuals for deportation and certain death (see Gutman, 1989).

The *Judenraten* were thus faced with an impossible paradox. Their adherence to a utilitarian model, seeking the greatest good for the greatest number, left them inevitably unable to satisfy both the Nazis and their own ghetto constituency. In Warsaw, the activities of the *Judenrat* "contributed to the alienation of the Jewish masses from its official leadership and a crisis of confidence in the council's representatives" (Gutman, 1989, p. 24). The hubris stemmed from the notion that

these Jewish leaders believed that they had the best interests of their respective ghettos at heart. In most instances they were simply responding to Nazi demands in order to avoid deportation and total destruction. However, members of the ghetto were hardly sympathetic to this group of leaders who took their money, offered them up as slaves, sacrificed them, and essentially appeared to betray them at every turn. Since the public had no direct contact with the Nazis, they were left with no recourse but to "direct their rage against their own representatives" (Gutman, 1989, p. 39).

In many ways the actions of the *Judenraten* in Warsaw, Vilna, and Lodz, can be seen as very normal responses to extraordinary circumstances. They performed a daily balancing act not only between groups, but also within themselves. The internal sense of morality of these leaders vacillated from "good" to "evil" in the space of minutes, leaving their identities shattered. The tragic nature of this scenario is most acutely exemplified by the plight of Adam Czerniakow, the leader of the *Judenrat* in the Warsaw ghetto, who "kept ready a potassium cyanide tablet which he intended to use, should he ever receive an order that went against his conscience" (Hilberg, Staron, & Kermisz, 1982, p. 23).

The circumstances in which Czerniakow found himself forced him to redefine orders that went against his conscience. To do this he employed the familiar psychological mechanisms of denial, suppression, and rationalization. When these failed, the unspeakable evil Czerniakow had to authorize left him a patriarch one moment and a potential suicide victim the next. In fact he did commit suicide, providing a testament to the impossible load he had to bear. It is here that not just historians, but all of us find sympathy for an individual who was ultimately powerless in the paradoxical power he was accorded.

In a manner tragically similar to the Scarecrow's song from *The Wiz*: "You can't win, you can't break even, and you can't get out of the game" (Smalls, 1975), the *Judenraten* had to find a mechanism to implement policies that would serve the utilitarian interest. This policy implementation revolved around compliance and had two components, one behavioral and the other cognitive.

2. *The Judenpolizei (ghetto police).* The task of ensuring behavioral compliance fell to the *Judenpolizei*. They had to make certain that the daily movements of inhabitants did not violate Nazi directives, including such prohibitions as "nobody leaves the premises," "nobody calls for help," and "nobody smuggles food in or out." As enforcers, the *Judenpolizei* were caught in a plight similar to that of the *Judenrat* itself. Given the thankless job of seizing their own people, "the behavior of the Jewish police at the gate—the searches and the beatings—made them and their commander the most hated group among the Jews of the [Vilna] ghetto" (Arad, 1982, p. 305).

The role of the police became so defined that they broke off and "evolved as an independent force in which the police chief and officers set the tone" (Gutman, 1989, p. 88). The Lodz police were described as "brutal and Gestapo-like," existing as a "class apart" (Dobroszycki, 1984, p. xxix). The sense of independence the police felt seemed to be validated by the immunity they were promised by Nazis as the inevitable deportation drew nigh. This resolved as a tragic delusion when the police were forced to reckon with their own vulnerable position in the ghetto as the goals of the Nazi authorities became clear (see Gutman, 1989).

3. *Loyalists: Self-blamers, and deniers.* The cognitive component of compliance fell to a third subgroup. Even in the ghettos there were groups that appeared to be loyal to the Nazis. Loyalists often took the form of spies who would gather information for the Nazis regarding destabilizing activities in the ghetto. These informants would curry favor with the Nazis, believing that they would receive immunity in return for the information they conveyed. For example, after receiving "information from agents planted in the ghetto" (Gutman, 1989, p. 178) pertaining to resistance activities in Warsaw, the Nazis murdered 52 inhabitants in a massacre that became known as the "Night of Blood."

There were also a large number of inhabitants who denied the severity of Nazi intentions. The very existence of a leadership made up of indigenous members of the community also served to reinforce illusions that nothing extraordinary would happen. For example, in Vilna "the reconstitution of an official Jewish representation, recognized by the authorities, added to the illusion of stability and security which the Jews felt upon entering the ghetto" (Arad, 1982, pp. 123-124). This denial was intensified by the outbreaks of typhus and other contagious diseases which occurred in the ghettos, notably in Warsaw. These

epidemic conditions led to self-blame and reinforced Jewish illusions that they were simply being quarantined in a safely contained location. Denial was also expressed in response to the belief that the "Nazis intended to uproot only part of the ghetto population—primarily refugees and those without a stable means of support" (Gutman, 1989, p. 227).

Even when news regarding realities on the outside did seep into the ghettos, psychological defenses were mobilized to contain and reframe such information. In response to the atrocities at Treblinka, Warsaw deemed it "simply not possible" and referred to it as a "bad dream, a nightmare that was destined to end" (Gutman, 1989, p. 226). These reactions have been conceptualized as a "Jewish repressive mechanism that was largely self-administered and automatic" (Hilberg, 1985, p. 303). In addition to being deceived by the Nazis, the ghetto residents "deceived themselves" (Hilberg, 1985, p. 301) and engaged in "automatic compliance" (Hilberg, 1985, p. 298). In its automaticity, this denial was largely a normal and expected response to events too terrible to acknowledge. As such, it characterized a substantial number of ghetto inhabitants. This precedent in turn worked in favor of the Nazis, as deniers were not prone to resist. Further, denial made it more difficult for those who did recognize the truth to gain support.

Denial existed at all levels of the ghetto structure. As Gutman (1989, p. 226) observes: "These psychological blocks and emotional defense mechanisms were as characteristic of public figures as of the average man in the street." Even Czerniakow repeatedly denied the intractability and futility of his position and the inevitable fate of the Jews. In the hours before his own death Czerniakow was "still deluding himself that there was some misunderstanding and that some possibility remained of averting the threatened evil" (Hilberg, Staron, & Kermisz, 1982). This kind of denial persisted and evolved into self-blame at the level of the Jewish leaders, as people like Czerniakow could no longer live with themselves and the decisions they had to make. Denial also served to increase the misery of the next group to be considered: the victims.

B. Group II

The second major group of people living in the ghettos were the victims. This group was by design the largest of the ghetto divisions and included laborers, artisans, and the many who were tortured and killed. In addition to victimization occurring immediately and relentlessly as a function of the physical surround, inhabitants were pulled from their professions and their homes to engage in forced labor. The situation in Warsaw exemplifies the horrible nature of this condition:

> "Working conditions were abominable. Most Jews were not accustomed to strenuous physical labor, and they also suffered from malnutrition and lack of proper clothing. Many of the young Nazi soldiers were not satisfied with merely humiliating the Jews. In some instances they forced Jews to remove their gloves and carry freezing lead pipes. . . ." (Gutman, 1989, p. 23)

Victims also included those craftsmen who were directly exploited in their existing vocations. They essentially assumed the role of working for the survival of the ghetto as a whole. The *Judenraten* sought to expand the efforts of these craftsmen, as this was "the only way to pay for the food and goods apportioned to the ghetto by the Nazi authorities" (Gutman, 1989, p. 74).

Besides being economically bound to the whims of the Nazis, the ghettos were forced to remain silent about the extent of their victimization. In Vilna, the massacre of hundreds at Ponar, which was supposedly a labor camp, was known only to a few doctors who "listened to their tale [and] kept it a secret" (Arad, 1982, p. 175). One individual who had witnessed the real events at Ponar was coerced by the ghetto police into keeping silent. The police admonished her: "Then don't say a word of what you saw. I'll help you get work, but just keep quiet. You saw and heard nothing" (Arad, 1982, p. 177). Even the *Judenrat* of Vilna adopted a "policy of silence" and "succeeded in concealing news of the Ponar massacres" (Arad, 1982, p. 182). In fact the *Judenrat* held the general belief that anyone who "carried information to the Nazi administration regarding illegal activities in the ghetto" would surely "bring disaster upon it" (Arad, 1982, p. 293).

Given the prohibitions against and consequences of breaking the silence, victims were forced to accept and cope with their horrible conditions. Many scholarly descriptions offer a way of capturing the general picture of ghetto life for these victims and laborers. A commonality across these horrible portraits is the presence of chronic and unremitting stressful conditions. Gutman (1989, p. 115) observes that ghetto conditions: ". . . left the public in a continuous state of anxiety, which left not time or strength to concentrate

on or analyze affairs from a broad and forward-looking perspective."

The ghetto inhabitants became hyperaroused and hypervigilant, as the Nazis kept them in "a state of suspense about their fate, thereby wearing on their nerves" (Gutman, 1989, p. 214). With this kind of chronic stress, there were frequent "outbursts" of impulsivity. For example, in Warsaw individuals known as "snatchers," usually "young people dressed in rags," would "ambush women leaving stores with baskets of food in their hands" (Gutman, 1989, p. 109). These snatchers actually fall into a fourth group and are described below in more detail.

As members of the ghetto became accustomed to atrocity, a numbing of emotional reactions developed. This contributed to the withdrawal and the scarcity of resistance that characterized the victims. Gutman (1989, p. 227) notes that "the steadily deteriorating circumstances paralyzed the will to live and the ability to resist." Hilberg (1985, p. 298) interprets a similar kind of "victim paralysis" when, during ghetto clearing operations, "many Jewish families were unable to fight, unable to petition, unable to flee, and also unable to move to the concentration point to get it over with. They waited for the raiding parties in their homes, frozen and helpless." This type of response to overwhelming trauma has been likened to animal responses to inescapable shock (van der Kolk & Greenberg, 1987)—responses that Seligman (1975) termed "learned helplessness." It is characterized by massive outputs of norepinephrine which results in corresponding alterations in neurochemical makeup, with such changes assumed to be responsible for the behavioral withdrawal that is observed (Bremner, Davis, Southwick, Krystal, & Charney, 1994).

Faced with unremitting tragedy and unable to get out of this horrible "game," a third force necessary to maintain the delicate balance of ghetto life had to develop. This force was one of hope and carried with it two concerns. The first was a hope for survival and the second a hope for a sense of purpose and meaning in the event of defeat (see Frankl, 1962, 1978).

C. Group III

The third group of ghetto members consisted primarily of the underground/resistance and social relief efforts that arose in response to the siege. This group included welfare workers who addressed the basic survival needs of the ghetto, political activists who strived to give a voice to and defend ghetto concerns, and archivists who kept a running record of the events that took place.

1. *Social aid.* To meet the basic survival needs of ghetto inhabitants, a nurturing force was needed that might balance the siege of the perpetrators. This force took the form of social service providers and childcare workers who dealt with instances of disease, starvation, and physical torture that plagued the ghettos. They sought ways to shelter, clothe, feed, and medically care for those most in need, especially children. In Vilna, social aid and welfare assumed distinctly restorative functions:

> "The Social Aid Department of the Judenrat and the Public Committee for Social Welfare were in charge of granting free meals at the public canteens and directing financial support, free medical treatment, and part or full ex-emption from paying rent for housing." (Arad, 1982, p. 312)

The social aid agencies were so instrumental during one year in Vilna that "there were no cases of death due to hunger or as a direct result of exposure to the cold in the ghetto" (Arad, 1982, p. 315).

Social assistance often took the form of relief specifically for children in need, primarily orphans (see Arad, 1982; Gutman, 1989). Beyond meeting the basic needs of survival for ghetto inhabitants, the social service providers also sought to improve the general quality of life in the ghettos. Efforts were directed towards salvaging some kind of continuing education for children amid the plight. Others attempted to sustain the ghettos by adding cultural vitality through sponsorship of library, theatrical, and musical enterprises (see Arad, 1982). Thus, the social aid efforts provided a source of hope that balanced the compliance and withdrawal of the victims.

2. *The Underground/Resistance.* In addition to practical and survival considerations, another force of political resistance also developed. This network, known as the "underground," held frequent assemblies for the broadcasting of information and the dissemination of various propaganda. This type of activity was directly contradictory to, and thus balanced, the prohibitions placed on victims concerning the disclosure of secrets. In Warsaw one underground faction, the *Ha-Shomer* activists, "telephoned secret contacts outside the ghetto, stamped forged documents, and obtained helpful information on the planned course of the [deportation]" (Gutman, 1989, p. 234).

Subtle resistance was not only fostered against the Nazis, but perhaps even more readily against the *Judenraten*. The underground eventually developed a sense of disdain for the *Judenraten*, "and dissociation from and denunciation of the *Judenrat* were common to all factions in the [political] underground" (Gutman, 1989, p. 128). This opposition, however, never translated into any concrete action, and the extent of such opposition was protest demonstrations held by the hungry in Lodz (see Gutman, 1989).

Members of the underground were more militant and in some cases separated themselves from more formal social relief efforts. For example, in Warsaw "the members of the youth movements took the personally painful step of detaching themselves from the familial framework" (Gutman, 1989, p. 235) of the larger underground operations. Groups like these were "dedicated to the cause of immediate armed resistance" (Gutman, 1989, p. 235). Despite the existence of such factions, they were generally too compartmentalized and disorganized to initiate a full-fledged resistance.

The Nazi authorities were essentially "indifferent" (Gutman, 1989, p. 178) to the underground and they "never related seriously to them and their potential" (Gutman, 1989, p. 131). Some scholars interpret this indifference as apathy and others attribute it to a lack of knowledge and awareness of the underground (see Arad, 1982; Gutman, 1989). In either case, they were never able to "discern the secret organizational activities in the ghetto, preparations for uprising, and the crystallization of the resistance forces" (Gutman, 1989, p. 131). At times the Nazis did learn of the destabilizing activities of the underground and demonstrated their disapproval of the resistance symbolized by this group. For example, the "Night of Blood," discussed above, was interpreted by most in the ghetto as "punishment because of the relative few who were operating in the underground" (Gutman, 1989, p. 178).

Although the underground's illicit activities, when exposed, were often objectionable to ghetto members, many of those in the ghetto were unaware of the underground's existence, in a manner analogous to the amnestic barriers between alters in DID. In Warsaw, "many did not even know that an underground existed [until] they saw proof of its deeds." On the occasion that they did learn of this "organized force" that was an "alternative to the *Judenrat*, hope revived in the hearts of the doomed" (Gutman, 1989, p. 319). Thus, the underground was at once a source of hope and of dismay and liability. While the actions of the underground placed the ghetto in a state of fear and vulnerability from time to time, the spirit of hope they fostered balanced the force of the perpetrators. The underground also balanced the action of the deniers by revealing the truth through the activities of the next subgroup: the archivists.

3. *The Archivists*. The underground sought to keep people outside the ghetto apprised of what was transpiring, with an emphasis on correcting myths about Nazi restraint. This type of information-seeking and distribution was often achieved through the "clandestine publication of newspapers" (Gutman, 1989, p. 125). There were other publication sources, such as the *Oneg Shabbat Archive* in Warsaw, which recorded events that transpired in the hopes that ghetto atrocities could eventually be revealed. *The Oneg Shabbat Archive* "adopted the aim of giving as much coverage as possible to the changes that had taken place during the period of occupation and the ghetto in Warsaw" (Gutman, 1989, pp. 144-145). Typical topics for archival sources included "shootings near the barbed wire fence surrounding the ghetto, suicides, arrival of food supplies and their rationing to inhabitants of the ghetto, prices on the black market and incidences of smuggling into the ghetto, matters of public health . . ." (Dobroszycki, 1984, p. xvi). Thus, these reporters made observations of all the cultural components and phenomena that existed in the ghetto.

The broader goal of the archivists involved a sense of purpose surrounding the plight of ghetto victims (see Frankl, 1962, 1978), as they had a "desire to transmit testimony from the age of extermination to posterity" (Dobroszycki, 1984, pp. xvi-xvii). This kind of record keeping was "done in secret and would have been dangerous to the author [archivist] and those around him if exposed," a circumstance which "indicates a conscious choice and a stance by the writer [archivist] toward the forces and events at work in his world" (Dobroszycki, 1984, p. xvii). This implication translated into a caveat against writing specifically about the Nazis as criminals: "The chroniclers seem to have adopted the following principle—since it is not possible to write about those who commit the crimes, we will speak of their victims, and in some detail" (Dobroszycki, 1984, p. xviii).

In reporting on the experiences of the victims, the archivists maintained a detached and emotion-

less style of data recording. In Lodz, the chroniclers "never reported what the victims think and feel about those who caused their tragedy, even when they are being sent to their deaths. There are only facts and the descriptions of events: how things really were, how the Jews lived and died in the ghettos" (Dobroszycki, 1984, p. xviii).

In Warsaw, the founder and guiding spirit of the archives, Ringlebaum, stressed a "sense of unity in the face of challenges of the day" (Gutman, 1989, p. 128). However, even the different archival sources varied in their manner of coverage and presentation, which worked to "dull the perceptions of the impending dangers and retarded somewhat the general organization of armed resistance" (Gutman, 1989, p. 128). This kind of disorganization was typical of the next group to be considered: the anarchists.

D. Group IV

The final group in the ghetto consisted of anarchists who did not side with any faction and functioned only for themselves. Included in this group were observers, thieves, food smugglers, and unorganized forms of resistance. Although there were spies and informants working for the underground, the *Judenraten*, and the Nazis, there were also those who functioned independently. They often reported ghetto transgressions to the police and Nazi authorities in exchange for food or money. However, observers of the anarchist group were not loyalists of any kind and operated only for their own personal gain.

Theft occurred on various scales, small and large. Most commonly it involved the impulsive acts of starving individuals, especially teenagers. Those who stole bread from people on the street became known as "snatchers." Stealing of clothing also occurred and usually involved needy individuals who were acting for their own survival. This kind of thievery was an alternative to the social aid efforts which were organized and directed at those most in need. As such, theft grew both out of the inadequacy of the social relief and from the impulsive reactions of individuals in extreme distress.

Food smugglers were more prevalent in Warsaw and Vilna, as the walls of Lodz were much less permeable. In Vilna, "there were times when food could be brought through the gate without difficulty, but at other times those caught were severely punished" (Arad, 1982, p. 304). In fact, the "murder of Jews for buying and smuggling food continued throughout the existence of the ghetto" (Arad, 1982, p. 306). Smuggling proliferated when food or supply lines were cut off to the ghetto. Although food smuggling may have occurred for altruistic or community goals, it often involved independent entrepreneurs who networked with many groups in the ghetto for their own gain: ". . . people engaged in food trafficking on a much larger scale for their own profit. These contrabandists had connections with the gate police, who, against due payment, helped them bring whole cartloads of commodities through the gate. Secret routes were sometimes used by the smugglers, including attics, cellars, and walls of houses adjoining the Aryan area and leading into the ghetto area" (Arad, 1982, p. 307). These smugglers were rewarded for their efforts, although they performed their activities with considerable risk and consequence.

In addition to food smuggling, other independent forces developed and functioned much like anarchists, loyal to no group or cause. Their exercises of resistance were not affiliated with the activities of the underground: "wildcat bands also began to make their appearance in the ghetto. These were armed groups that operated under the guise of being underground organizations preparing for an armed struggle, while the combat organizations maintained their secret character" (Gutman, 1989, p. 350).

Disdain for anarchists of all kinds developed as the ghetto community recognized how such groups placed the entire community in jeopardy. Ghetto residents "were hardly sympathetic to those who were playing around with outlawed politics and thereby invited further persecution and risks" (Gutman, 1989, p. 178).

The four groups discussed above coexisted to maintain a delicate balance in daily ghetto life: the *Judenraten* would solicit aid and the laborers would produce; the underground would propagandize and be chastised by the *Judenraten*; the anarchists would impulsively act on a whim and the rest of the ghetto would shudder in anticipation of the consequences; the archivists would record facts while the deniers would distort and reframe them. This interplay occurred almost automatically, with the ghetto constantly striving to achieve some approximation of homeostasis.

The homeostasis that the ghetto struggled to maintain was a direct result of competition that existed between the various subcultures. The ghetto became inward-focused, with its delicate

internal balance subject to mistrust and competition across the various groups inside the ghetto walls. Instead of reacting only outwards against the Nazis, the ghetto groups competed with one another and often saw each other as the "evil" force to be resisted. Each group reacted in a characteristic way to the victimization process and did not trust those who responded differently. Even within the same group there was further variation and dissent regarding the best course of action.

The mistrust between groups in the ghetto became salient when the Nazis initiated some course of action that effected only some of the ghetto inhabitants. For example, the Nazis would select people for deportation in a fairly arbitrary way. However, ghetto inhabitants attached meaning and significance to these acts according to the subgroup with which they primarily identified. Those in denial analyzed this arbitrary selection process in a way that supported their denial, while those who recognized the atrocities, like the underground, interpreted things in a way that supported their suspicions. These groups resented each other for their differing construction of reality, leading to a constant state of suspense and mistrust (see Gutman, 1989).

Nazi victimization thus had primary and secondary effects. The primary effects included starvation, exploitation, and torture that resulted from the Nazi imperative of containment. The secondary fallout resulted as ghetto inhabitants organized spontaneously in the face of unremitting stress. The individuating and separating nature of this spontaneous organization led to internal struggle, discord, and competition. The cultural mix found in the ghettos represented a diverse range of possible reactions to this unremitting stress. The dispersal of these reactions across groups in the ghetto was an automatic survival strategy.

However, for DID patients the implications of these survival strategies for long term functioning become critical and problematic as internal factions compete and resist each other. Thus, the reactive solution of fragmentation and specialization as an adaptation to unremitting stress becomes itself the problem both for the DID patient and the clinician after the traumatic period has ended (see Watzlawick, 1967).

III. Comparison of the Ghetto with DID

Fractionated internal organizations in the face of unremitting stress are common to both ghetto cultures and the internal cultures of DID patients. As in the ghettos, the typical alter groups seen in DID struggle for position in and control of the body, dictating the necessity for maintenance of a delicate internal balance. The characteristics within these groups, the interrelationships between them, and their dynamics with respect to external influences are similar to those noted above in the Eastern European ghettos.

To facilitate the comparative transition to the treatment of DID, it might be helpful to consider the following hypothetical scenario:

> With the war having come to an end before liquidation of the ghettos, an Allied soldier parachutes into the ghetto. The people in the ghetto are oblivious to the fact that the war has ended because of the tight seal formed by the ghetto walls. Knowing nothing of the coalitions and interrelationships in the ghetto, but knowing that the inhabitants needed help, the soldier asks the first person s/he sees: "Who do I talk to about liberation around here?"

This kind of encounter would probably meet with a range of reactions from the various subcultures, with fear and suspicion being the overwhelming sentiment. The ghetto residents may not know or believe that the Nazis were gone. The literature has described a long term fear of trauma victims that the perpetrator(s) will inevitably return, resulting in pervasive suspicion and hypervigilance (see Herman, 1992).

Ghetto inhabitants might interpret this outside agent in a number of characteristic ways depending on the subculture with which they primarily identified. The victims would be the most desperate and perhaps the first to approach the agent, in such dire need of help that any suspicion would be displaced. The social service workers would be hopeful for the victims, keeping them under their own watchful eyes as the victims approached the helper. The underground may regard the new element as a threat insofar as the individual might be a Nazi spy or an anarchist of some kind. The *Judenrat* would also be suspicious, thinking any kind of association with this outside agent preaching freedom would be dangerous and destabilizing, possibly invoking a Nazi backlash.

The impact made by the soldier inquiring about liberation is directly analogous to the clinician who seeks to help a DID patient. This kind of an addition to a balanced system has been discussed in the domain of family systems theory (see Minuchin, 1974, 1981). The resulting dynamic is tenuous at best when a helper enters the internal world of a DID patient and evokes a powerful

response. Just as each dyad, triad, and so on, reacts to the introduction of a new element in family therapy, so there will be a reaction among every permutation and combination of the forces in the internal world of a DID patient. One implication of this family systems analysis is that concepts that go beyond a description of the cultural components in relation to each other are needed; concepts that describe both those interrelationships and the new set of relationships that evolve as a result of a helping agent's introduction to the system. A more complete development of the comparison between the ghetto formulation and family systems thinking can be found in works of Guerin and Chabot (1993) and Shoham, Rorbaugh, and Patterson (1995).

In order for the ghetto metaphor to provide descriptors both for how the internal elements relate to each other and to the clinician, the category labels of the common tetrad might be revised. One set of possibilities is offered in Figure 1, where the traumatized alters are viewed in terms of a bonding force, because they are seeking to offload pain and to find someone to improve their lives; the protectors are seen in the context of a pro-bonding force, because their mission is to give hope and comfort and to disclose secrets of the trauma. The persecutory alters are viewed as part of an anti-bonding force because they are there to disrupt any bonding with the outside world (for fear of retaliation), and are themselves bonded to the perpetrators (see Graham, 1994). These categories in turn have direct analogs in the ghetto subculture, as indicated in Table 1.

The common tetrad also includes the "host" category. Relatively little has been said about the host in the ghetto culture because its function was not as crucial or articulated as it is in DID. It was a rare event that those who might disapprove of ghettoization would actually visit the ghettos, and thus a robust analog of the host was not a consistent necessity. A quick feeding and clothing of select ghetto inhabitants for meetings with such groups as the Red Cross could be executed on an

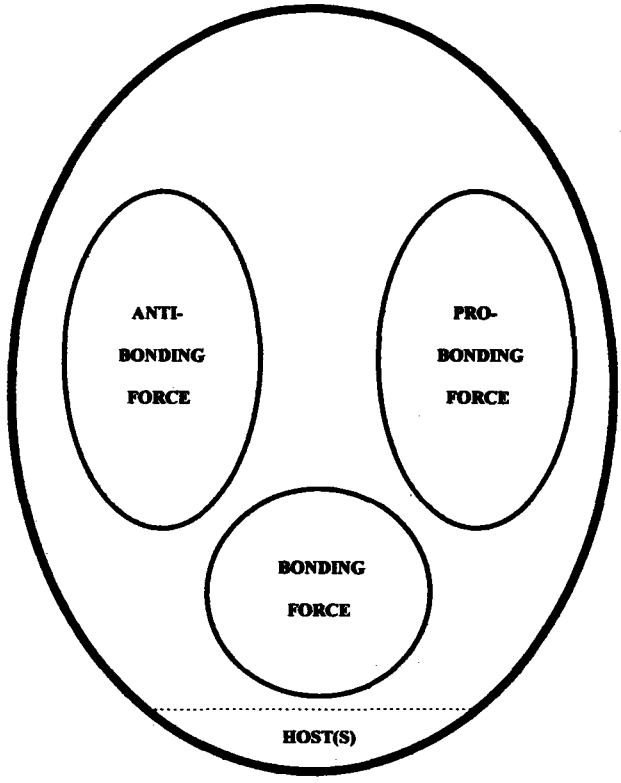

Figure 1. Modification of common tetrad, reflecting internal relationships between alters as well as potentials for relationships with clinicians and others.

TABLE 1. Comparison of Constituents of Eastern European Ghettos, the Common Tetrad and the Ghetto Metaphor of DID.

	Bonding Force	Anti-Bonding Force	Pro-Bonding Force	Independent Force	Host
I. WWII Ghetto Constituents	Victims; Laborers; Artisans; Children	Judenrat; Judenpolizei and their supporters	Social Service; Child-Care Workers; Archivists; Underground	Anarchists	None
II. Common Tetrad Constituents	Traumatized Alters	Persecutory Alters	Protectors	None	Host
III. Ghetto Metaphor Constituents	Victims; Adaptive Role-Players; Maladaptive Alters	Internal Leaders; Enforcers; Deniers; Self-Blamers; Approval-Seekers	Care-Takers; Disclosers; Archivists	Observers; Guides ("ISHes")	Host

as-needed basis. With DID, however, there is a consistent and recurrent need for such an alter(s) to interact with others in social, occupational, and family domains. As such, the host's role is well-developed and instrumental for the internal balance and general functioning of the DID patient.

The host is often (but not invariably—the host may present with a broad variety of complaints, and some DID patients have no consistent host) the depleted, depressed, anxious, and masochistic individual who presents for treatment and becomes identified as the "patient" prior to the diagnosis of DID (see Putnam, 1989). Although the host may know of the existence of other alters, s/he more commonly denies evidence of others in the system.

While the host may present for therapy with both psychological and somatic symptoms, it is the appearance of other alters which suggests the presence of DID. Anecdotal reports from some clinicians indicate that victim children are often the first alters to appear as DID patients begin to reveal themselves. They would probably be the most needy and anxious to receive help, seeking to make first contact with the clinician. Thus, the patient's neediness provides the pivot point for the major tension in the system: pro-bonding vs. anti-bonding forces.

The relationship with the clinician would be subject to the close scrutiny of pro-bonding alters. Their attitude toward the clinician is likely to reflect skeptical hopefulness (social service). These alters would thus be reacting to the internal needs to bond, seeking support and comfort for those in pain. They would also be concerned with reporting the injustices and victimization that occurred (underground).

The anti-bonding forces would be the most resistant to the establishment of any relationship to the clinician on the basis that it threatens the utilitarian interest of the entire system. They would react to any efforts at outside contact and any inclination to publicize the atrocities, seeking to balance and counteract these imperatives with their own agenda. DID patients, like ghetto groups that ultimately reacted more to other groups inside the walls than to external factors, show the same kind of inward focus and competition that gave the ghetto its fragmented and self-destructive characteristics.

While there are many specific pitfalls that are worrisome for clinicians entering the world of DID, the primary concern, as emphasized by the ghetto metaphor, is that all constituents of the culture are there and have been necessary for a balance. The clinician should keep in mind that all alter types are fundamentally protective, making it necessary to appreciate anti-bonding forces. Although the bonding alters may be the most apparently in need of help and the most amenable to aid, the clinician must consider the reactions of the other alter groups, which range from apathy to mild skepticism to direct opposition. Stabilization is increased by working with all groups.

IV. Implications of the Ghetto Metaphor for DID Alter Groups

The following outline traces the characteristics of the four alter groups, drawing on implicit and explicit comparisons with the Eastern European ghettos. The analysis is offered specifically with respect to how each group might react to a clinician's attempts to help, and is represented graphically in Figure 2.

A. The Anti-bonding Forces

The new category labels expand most significantly on the common tetrad's "persecutory" heading by placing this subgroup within the more general anti-bonding category, which includes a complex and heterogeneous group. Since there are many ways in which the requirement for cul-

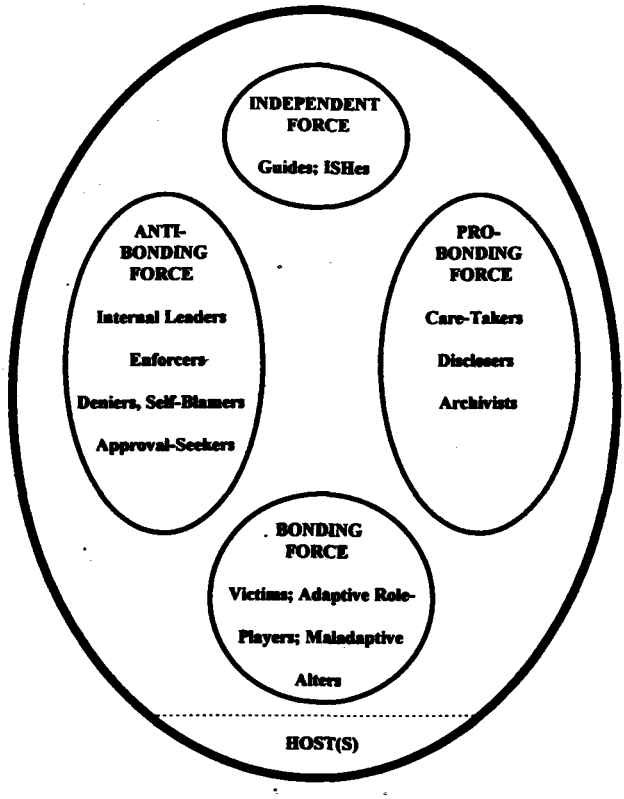

Figure 2. Complex alter system, with direct comparison to the cultural components of the typical eastern European ghetto, circa 1939-43.

tural stability can be implemented, persecutory alters[4] are just one of a larger group of anti-bonding alters, all with the same general purpose of stabilizing the culture, consonant with the demands of the perpetrators. The means by which each subgroup seeks to achieve compliance differs from others in the anti-bonding contingent.

Since utilitarianism is the guiding principle of the anti-bonding forces, these alters, as a group, disrupt any bonding with outside agents by both direct and indirect means. Indirect attempts to disrupt the clinician may be exhibited by inflicting pain on bonding alters and the host, seen as the classic symptoms of Post-traumatic Stress Disorder (PTSD): 1) hyperarousal and reactivity; 2) flashbacks and intrusions; and 3) numbing, appearing as anesthesia, and ultimately dissociation (see Herman, 1992; Pynoos, 1994; van der Kolk & Greenberg, 1987). In addition, the classic PTSD tendency to avoid discussing the trauma is seen as distraction and denial, overt characteristics which can also be orchestrated by the anti-bonding alters. This kind of purposeful disruption in functioning works to distract, discourage, and disrupt progress in treatment. Direct attempts to thwart the helper may include forewarning clinicians that they are intruding where they are not welcome, with threats of dire consequences for persistence.

The first anti-bonding subgroup is analogous to the co-opted leadership of the ghetto. As in the ghetto, these leaders generally set policy preventing the divulging of secrets and the cultivation of relationships and activities that will bring disaster on the entirety of the system. Thus, they will discourage the transfer of information to the helper, or distort it in some fashion. As in the

[4] Our clinical observations indicate that patients dislike the label "persecutory" and feel that "anti-bonding alter" is a more suitable and representative heading.

ghetto, this involves principle and practice aimed at maintaining stability in the internal world.

1. *Internal Leaders.* The internal leaders (Boon & van der Hart, 1995) are the dominant anti-bonding sub-group, and perhaps the most dominant group in the system. In ways analogous to the function of the *Judenraten* in the ghettos, this oversight committee will discourage a bond with the clinician on the basis that it will put the whole internal community in grave danger for the violation of various prohibitions: nobody talks, nobody seeks help, nobody misbehaves, and so on. "Strength" is defined as the capacity to tolerate great pain without complaint (leaders are quite often anesthetic to pain themselves). This translates into a concerted effort to extrude the destabilizing force embodied by the clinician.

As in the ghetto, there is great distortion and reframing of information and experience. Instead of seeing the misery of bonding forces as pain that needs to be remediated, the leaders come to see it as a sign of weakness and demand that those in apparent pain become more resilient and hearty. This kind of reframing has a family systems analogue: a rigid and demanding parent views anything other than dogmatic "party-line" behavior on the part of their child as weak. In turn, the rigid parent regards the other parent, who may have initiated psychotherapy, as also soft, weak, and ineffectual. This dynamic results in great resistance to and subversion of therapy by the rigid parent, as therapy validates the pain and suffering of victims rather than dismissing it. In DID, the leaders assume the role of the rigid and demanding parent who refuses to recognize the true pain and suffering of real victims.

A second form of distortion concerns the passage of time. Because this is a short term solution applied over a long term, the psychological mechanisms operative among the leaders result in a loss of the capacity to recognize that time has passed since the abuse period ended. Many anti-bonding alters still believe they are living in the "bad time."

A third example of distortion concerns issues of "good" and "evil." Many leaders resolve this dilemma through a combination of denial and wholesale adoption of the belief system of the perpetrators, as was seen in the ghetto leaders. The identities of the leaders are distorted to the extent that, by adopting the belief system of the perpetrators, their perceptions of themselves become consistent with the notion that they are, or were sent by, perpetrators. Seeing themselves this way provides a means for them to tolerate (and often forget) the greatest shame in an alter system, much like Czerniakow's position in the Warsaw ghetto. It is thus not uncommon to find them or their agents looking, acting, and talking like the perpetrators, discussed by Bettelheim (1943), Mahl (1971) and Schmolling (1984) as the phenomenon of "identification with the aggressor." Because they are forced to perpetrate, the leaders carry the greatest guilt and shame in the system. The work of healing that dissociative patients must go through applies most dramatically to this group. The leaders, along with the rest of their anti-bonding contingent, thus have the farthest to go in psychotherapy between their self-views at the beginning and end of treatment.

Given their role, the internal leaders would not be likely to make or encourage a warm welcome to a clinician who arrives on the scene. They might instead react to a "victim's" (see below) initial contact with the helper by forbidding the cultivation of a bond. It is this stance that dictates the need for any agent of change to obtain permission to be helpful. Thus, it is important that the clinician recognize the determinative role of the leaders and secure their consent prior to treatment interventions.

In addition to their negative reactions to contact between an alter(s) and a clinician, the leaders also prepare victims prior to contacts with clinicians. This may take the form of such preventative measures as stipulating rules, instilling denial, or ordering anticipatory punishment. To implement their utilitarian policies, these leaders need vehicles of both behavioral and cognitive compliance.

2. *Enforcers.* Enforcers, a group traditionally conceptualized as persecutory alters, assist in the behavioral component of compliance for the anti-bonding force. Like the leaders, enforcers tend to be anesthetic to pain and amnestic for the circumstances surrounding their original emergence into the system. They also hold the belief system that "it is good to be bad" and they behave according to hostile tendencies that are modeled after the perpetrators. Their acts are likely to be directly observable as behavioral disruptions in the DID patient.

Also like leaders, enforcers often appear as introjects of the original perpetrator(s) (see Put-

nam, 1989). However, they are more visible and active than the leaders, who remain hidden and dictate policy behind the scenes while enforcers intimidate and punish. Evidence of their activities is found in incidents of self-harm, hostility towards various alters, and re-experiencing of traumatic events via flashbacks. The enforcers operate at Kohlberg's (1984) second stage of moral development, whereby they punish those that are "caught," regardless of whether or not they deserve it.

In following the various injunctions of the leaders, the enforcers seek to control the system by force. In one of the most tragic examples of the paradox of faulty imitation learning, the enforcers operate with the perpetrator's belief that anticipatory punishment will be effective in eliminating undesirable behavior. Thus, they will punish alters as a way of preventing them from even considering prohibited behavior. While the enforcers have the intent of illustrating negative consequences for transgressions through anticipatory punishment, the eventual impact of this tactic backfires. When anticipatory punishment is administered, it sends shock waves throughout the system: bonding forces react with pain and pro-bonding forces protect. The synergy of these three forces results in rapid escalation. Such escalations comprise many of the acute emergencies that are seen with DID patients. Therefore, anticipatory punishment is one of the primary targets for treatment intervention.

Although enforcers are resistant and even hostile to an entering clinician, their assistance can and must be enlisted for treatment. Like the *Judenpolizei*—the ghetto police—they can be arrogant, challenging, and hurtful. However, given their power in the system from a practical day-to-day standpoint, it is crucial that clinicians actively avoid alienating them. Respecting them and recognizing their fundamentally protective role is a good first step towards constructive interaction. The enforcers can be influenced in useful directions, although any attempts to work with them must be executed slowly and carefully.

It is often helpful, if not imperative, for clinicians to gain permission from the leaders to work with enforcers, as leaders supervise enforcers in a far more demanding way than pro-bonding alters are watchful over bonding alters. At times, changes in enforcers can be achieved relatively easily, but this can result in heightened subversion and resistance by the clandestine leaders, much like the rigid parent who is not present in sessions of family psychotherapy for his/her spouse and children and denies the need for it, but counteracts treatment effects elusively from afar.

3. *Deniers, self-blamers and approval-seekers.* The third anti-bonding subgroup implements the cognitive/attitudinal component of compliance. If a given alter does make contact with a clinician, anti-bonding forces may engage in fall back plans designed to mislead and divert the clinician. Deniers and self-blamers often sew doubts about the diagnosis of DID, increasing apparent resistance to treatment. They frequently appear at times when traumatic material may be emerging into consciousness, seeking to discourage or distort its disclosure. Thus, deniers can signal a clinician that important material is surfacing. (For patients who later recant their "memories," deniers may actually be a reality-testing resource.)

For those DID patients who maintain relationships with perpetrator(s), deniers are often involved in the ongoing contact. Approval seekers carry guilt, finding it difficult to hurt perpetrators' feelings or to resist perpetrators' urgings for involvement. They seek the approval of perpetrator(s) through continued interaction, hoping to soften and appease with the cultivation of a bond. This is an example of the "Stockholm syndrome," whereby victims become bonded to their captors and the actions of the latter become softened (Graham, 1994). Bonding between captors and captives has been seen in events including the Iran Hostage Crisis and in the movie *The Crying Game*. It is normal, predictable, and expectable in the context of sustained trauma, as it maximizes survival.

The group of alters instills denial both inside the system, and between the DID patient and the clinician. Internally, denial and self-blame serve to keep the bonding process off-balance because the ongoing doubt prevents the patient from taking a stand and saying "this is the truth." Bonding and pro-bonding forces are left in a fearful, debilitated state of constantly questioning reality. Denial with respect to the clinician is often seen in the general difficulty of diagnosing DID. Patients often go undiagnosed for years as their social and occupational lives dictate the hiding of those in pain and those in need. The presenting alter may say "everything is fine, nothing's wrong," and so on.

Self-blame takes the form of making various alters among the bonders culpable for: 1) the trauma endured; 2) current functioning; and

3) the clinician's presence. Culpability is interpreted by self-blamers through the lens of Kohlberg's first stage of moral development. This stage regards people who have negative experiences as deserving of them (Kohlberg, 1984). Deniers instill this kind of self-blame in the bonders, who are acutely susceptible to it, given the childhood stage in which they are often frozen.

B. The Bonding Force

As noted above, victim children are often among the first alters to appear on therapy. These traumatized alters often present as children or infants who have been frozen in time and contain memories and affects associated with the original trauma (see Putnam, 1989). Among these alters are victims in pain, alters who carry the burden of daily living, and alters who are behaving maladaptively and self-destructively.

1. *Victims.* The first subgroup is the most frequently cited in the literature and is often conceptualized as "traumatized alters" (see Putnam, 1989). Similar to the ghetto inhabitants, the victims experience the classic symptoms of PTSD: hyperarousal, intrusions, and numbing. These symptoms correspond to physiologically based changes that result from chronic and unremitting stress. Affectively laden traumatic memories are neurologically stored in deviant ways, resulting in re-experiencing of events. Physiological reactivity increases as the physical readiness to respond to danger is continually facilitated. Some researchers have posed a diagnostic entity in and of itself that involves these characteristics and has been termed "physioneurosis" (see van der Kolk & Greenberg, 1987) and "disorder of extreme stress not otherwise specified" or DESNOS (see van der Kolk, 1994).

Hyperarousal is seen in bonding alters as reactive and fearful behavior in response to benign stimuli. For example, the sound of a door shutting in a therapy session can evoke an acute avoidance response, or "startle" reflex. Similarly, quick motion of any kind can be perceived as potentially threatening, producing a startle. The startle reflex seems to have both a neurophysiological and a psychological component. The former has been linked to physiologially based changes associated with repeated trauma (see van der Kolk & Greenberg, 1987), while the latter may be due to the fact that the perpetrator's presence is still perceived, even after liberation (Herman, 1992). The frequent state of hyperarousal that develops to compensate for such fears can often result in impulsive and harmful behavior. During abreactions child alters have been observed to writhe on the floor, re-enacting the experience, and throwing themselves into walls (see Putnam, 1989). Substance abusers and promiscuous personalities (see Putnam, 1989) are other examples of post-traumatic impulsivity that can often result in comorbid diagnoses for DID patients.

In addition to hyperarousal, victim alters also present with an overwhelming sense of helplessness from being exposed to trauma that was repeated and inescapable (see Bremner, Davis, Southwick, Krystal, & Charney, 1994; Herman, 1992; Seligman, 1975; van der Kolk & Greenberg, 1987). They report feelings of intense sadness and distress. These conditions often appear as anxiety and depressive disorders seen so frequently in DID patients.

Re-experiencing the trauma in the form of flashbacks, nightmares, and intrusions is also a frequent symptom seen among victims. Such experiences may be triggered by stress, and are often seen during sleep states. Evidence indicates that autonomic arousal may activate and potentiate certain susceptible noradrenergic pathways, leading to automatic retrieval and heightened awareness of memories (see van der Kolk & Greenberg, 1987).

2. *Adaptive role-players.* Alters who carry the burden of the symptoms include both those who are functioning somewhat normally and those who are behaving maladaptively. Like the laborers and artisans of the ghetto, certain alters engage in the challenges and routines of daily life. There may be some who assume a distinctly occupational role, performing work functions adequately enough to hide signs of the disorder. Others serve their primary roles in social and family settings. Thus, these role-playing alters address daily tasks, which helps maintain functioning but may simultaneously mask the presence of DID. Frequently, the bulk of such adaptive roles is expressed through the role of the "host."

3. *Maladaptive alters.* The flip side of these "normal" personalities consists of the wide range of psychological disorders which characterize the other victims. Like the sick, starving, and tortured victims of the ghetto, these alters include substance abusers, promiscuous personalities, and suicidal personalities (see Putnam, 1989). This group of presentations essentially spans the *Diagnostic and Statistical Manual of Mental Dis-*

orders (American Psychiatric Association, 1994) with their broad range of symptoms, including psychotic, characterological, obsessional, anxious, and depressive. This variability can make the diagnosis of DID difficult and delayed, and can lead to misdiagnosis.

The desperate neediness represented by the bonding force is balanced by the sustaining influence of the next DID subgroup to be considered.

C. The Pro-bonding Force

As the name of this force implies, these alters provide hope and comfort for those in distress. They have been conceptualized in some texts as protector personalities (see Putnam, 1989). In addition to their purpose of getting safe help, they may also have an overarching goal of disclosing the abuse history. They have an impetus to tell the world of the horrors that took place, thereby initiating justice against the perpetrators and "validating" the victims. This kind of secondary agenda directly contradicts the anti-bonding mission and provides one of the catalytic ingredients for the fundamental tension that exists in the system. Pro- and anti-bonding forces are in intense conflict, producing the fierce state of internal competition that characterizes the system.

1. *Caretakers.* The first pro-bonding subgroup is concerned with the basic needs represented by the bonding force, including economic security, sustenance, warmth, and ultimately, hope for a better life. One example of this caretaking capacity comes from our clinical observation:

> In one patient, the host was a depleted, lost child who had a caretaking alter that was in the image of her "good mother." When the system needed money, the caretaker would drive to a carwash. When it came time to pay for the carwash, she would burst into tears and exclaim that someone had stolen her purse. Everyone would then give her money, allowing her to pay for the carwash and still have money left over. The host would then reassume executive control of the body on the drive home, with a clean car and money in her wallet.

Caretaking also takes the form of nurturing and parenting those child alters who are most in pain and most vulnerable. Some do this very well, but others get caught up in caretaking to their own detriment as they become increasingly self-sacrificing. This can lead to co-dependency as they carry a limitless allegiance to those in need. In addition to fostering their own co-dependency inside the system, caretakers will also engage in similar relationships with outside people. They may get involved in relationships where they give and give, receiving nothing in return. They develop a tendency to want to help everyone, resulting in unfortunate oversights to their own needs.

2. *The Disclosers: the DID underground.* Within the pro-bonding force is a group of alters who have the desire to release details of the abuse history in the hopes that justice will be served against the perpetrators. These alters function much like the underground in the ghetto. In seeking righteous purpose, they may put themselves in grave danger. Their efforts are continually counteracted by anti-bonding alters, often in violent ways. A transcendental hope of passing on the truth for posterity may alleviate concern for their own demise.

Similar to the underground in the ghetto, the underground in DID subverts the efforts of both the anti-bonding forces and perpetrators. In their willingness to "go down fighting," the underground alters engage in extremely risky behavior. For example, they may arrange things so that a child cannot comply with a perpetrator's wishes, thereby thwarting the perpetrator. This mobilizes anti-bonding forces to retaliate by punishing the child, resulting in possible escalation and behavioral disruption. The DID underground may implement its mission more directly and overtly by cutting the body or initiating an array of symptoms in order to get attention from the outside world.

3. *The Archivists.* The analogue to the ghetto's archivists, termed the "memory trace personality" by some (see Putnam, 1989), may contain and articulate the complete abuse history. Because there is such great danger in holding this kind of information, these alters are often not easily or directly accessible. Sometimes, other alters, such as those of the underground, serve as envoys for the archivists and relate information to the outside world at considerable risk. As in the ghetto, the archivists may assume an emotionless style of data recording, logging events in a detached and automatic manner. The archivists can be very helpful because of their continuous memory of the traumatic history.

D. The Independent Force

The independents represent a force that trusts no one—inside or outside. While anti-bonding forces are loyal to outside perpetrators and pro-bonding forces are loyal to outside protectors, independents show no loyalty to any group or role

model. Anecdotal reports from some clinicians indicate that independents may present as adolescents who claim that they have been hurt to such a degree that they trust no one. They may tend to view an entering clinician as just another potential target to play with in the midst of their self-serving activities.

Independents have a broader overview of the system. With their wide angle perspective, they tend to have a special dispensation to move about the system with a kind of limited immunity. At times they disrupt, as when they report an incidence of bonding to anti-bonding alters. Sometimes they stabilize, as when they communicate to pro-bonding alters that an anniversary of a painful event is coming and that preparations should be made for the accompanying disruption. At times, the movement of the independents is tied to the overall survival of the system, as when they interface with outside people to benefit the system.

A subgroup of independents may relay information to others, pretending to have allegiance to various groups and individuals, including the clinician. However, they are totally self-serving and do not trust any of the sources to whom they report. The negative rippling effects of such behavior take the form of system imbalances and exacerbations of the already heated competition. In working intermittently for nearly every force in the system, they equalize the conflict between anti- and pro-bonding forces, thereby securing their own "employment and livelihood."

Independents may also disrupt the system by adding confusion through the impersonation of alters from other groups, creating havoc and discord upon provoking a clinician's response to their portrayal. They thus continue their internal disruption as they always have in addition to expanding their playing field to include the clinician.

The observational prowess of independents also represents a positive potential force, however. Their relative perspective on the entire system and the immunity that characterizes their status may outfit them for a role of therapeutic utility. For example, they may be excellent observers of therapeutic contracts clinicians try to forge between conflicting forces. Since the making and keeping of contracts becomes an integral part of stabilizing the system for treatment intervention, the role of independents as observers of difficulties in contract maintenance may be indispensible to the clinician. They will likely have no qualms about reporting these kinds of events because they are not loyal to any one group, and do not care if they evoke anger from a given group.

Beyond the specific capacity of observing contracts between groups, independents may function as keys to the internal world of DID in general. They often allege to know the needs and potential difficulties of all alters in the system. They may warn of impending problems, thereby helping those in the system in addition to serving as a guide for the clinician. When operating in this capacity they have been referred to as internal self-helpers or ISHs (see Allison, 1974; Putnam, 1989). These guides often possess a more continuous memory and can provide clues to internal activity and dynamics, potentially helping a clinician move about the system. While independents can act as guides or self-helpers, they may not engage in this type of activity until a sufficiently trusting relationship has developed with the clinician. Given the tendency of independents to be untrustworthy by nature, the self-help function may not appear until later in psychotherapy.

V. Conclusion

We believe that the structure and function of the eastern European ghettos provides a very helpful teaching tool with DID patients, as the forces that developed and operated within ghettos very much parallel the forces found in the inner landscape of DID. Complex DID patients, like ghetto residents subjected to extreme and unremitting stress, develop homeostatic systems characterized by competing forces that serve agendas of help-seeing (bonding forces), communication to outsiders about atrocities (pro-bonding forces) and utilitarian efforts to prevent destabilization (anti-bonding forces). The presence of a clinician serves to destabilize DID systems. Our hope is that by viewing DID systems as analogues to ghettos, clinicians can better understand destabilization risks and avoid some of the untoward consequences of failing to ally with all internal subgroups.

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