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ARTICLE

Trying to Keep It Real: My Experience in Developing Clinical Approaches to the Treatment of DID

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In contrast to those who have attempted to accommodate DID and its treatment within extant paradigms, extend extant paradigms to encompass DID, infer treatment approaches from theoretical models and research in areas thought capable of offering relevant perspectives, and promote particular treatment techniques as complete psychotherapies, I have endeavored to develop methods of treatment derived from the study of DID itself and the monitoring of ongoing DID psychotherapies. The result, a flexible and pragmatic therapeutic stance, has demonstrated considerable effectiveness. Here I trace and explain the evolution of selected aspects of my thinking and describe some of the strategies and tactics that have emerged from that effort. I illustrate my ongoing learning process by discussing how my study of two new potential strategies convinced me to adopt one as an elective modification of my practice and to reject the second.

KEYWORDS   dissociative identity disorder; psychotherapy; dissociation; hypnosis; trauma

THINKING ABOUT THINKING ABOUT HOW WE THINK ABOUT TREATING DID

My early experiences in treating Dissociative Identity Disorder (DID) left me inclined to begin with the individual patient and see what theories, if

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any, proved consistent with my findings in my encounter with that individual patient; and which methods, if any, seemed match my individual patient's unique range of needs, preferences, and tolerances. My approach starts with clinical material and gradually discovers whether a use for a particular theory or application makes itself evident along the way. I find that approaching any patient with an intention to use any particular paradigm of understanding or treatment may place a barrier between me and those to whom I am trying to relate.

This stance is far from unique. In his obituary for Charcot, Sigmund Freud (1913/1952) recounted an anecdote about his former mentor. Some students had returned to Paris after studying with a prominent German authority. Charcot was demonstrating a phenomenon on rounds when one of the returning students observed that, according to the theories of the German authority, the phenomenon being demonstrated could not exist. Freud appreciated Charcot's nonpunitive, nonauthoritarian response... Charcot remarked that a theory is a wonderful thing, but it does not prevent other things from existing.

Bill O'Hanlon offers a contemporary restatement of this sentiment (personal communication, December, 2016). Luigi Boscolo, a founder of the Milan System of family therapy (see Boscolo & Cecchin, 1988), would warn his students, O'Hanlon among them: "Don't marry your hypotheses!" O'Hanlon (2009) authored his own variation: "Don't marry your hypotheses. In fact, I would beware of even dating them."

My own approach to dealing with dissociative phenomena in therapy for the treatment of DID makes little use of models of dissociation that fail to address many or all of the core features of DID, are extrapolated from abstract theories, or have been inferred from research that has not studied clinical populations of DID patients (Kluft, 2013b, 2016). Some of the ideas I developed in the early 1970s have stayed with me, but here I will express in terms and understandings that in most instances are more contemporary, clear, and helpful than the cruder and relatively uninformed formulations characteristic of my private thinking 40 years ago:

1. Most mental functions, structures, and processes that appear to be unities consist of many elements which, when functioning well, are coordinated or "flying in tight formation." They are aggregates functioning as, and giving the appearance of, a single cohesive entity.

2. When these elements fail to function well, maintain coordination, and are (whether subtly or obviously) failing to "fly in tight formation" they may be described as disaggregated. They no longer function as, or give the appearance of, being a single cohesive entity. I thought of this as "mental disaggregation," the way Janet described dissociation in some early writings.

3. Among the causes of mental disaggregation is trauma.

4. If we wish to treat human behavior with psychotherapy, it is helpful to consider that the clinical phenomena we encounter make sense, even if it is not apparent immediately, or for a sustained period of time, what kind of sense they make. These are the two basic premises of clinical psychoanalysis: that behavior makes sense, and the sense it makes may not be apparent or available to the conscious mind (H. Cohen, personal communication, 1972).

5. From Assumption 4., it follows that a successful therapy should proceed on the basis of discovering what sense the patient's phenomena are trying to communicate, even in face of the patient's mind's efforts to maintain its defensive dissociation and obscure the full meaning of its phenomena's communications.

6. From these assumptions, it follows that models and metaphors that do not embrace a search for meaning are potentially distracting and irrelevant for the purpose of the therapeutic encounter.

7. From these assumptions follows the caveat that the therapist must take care to avoid the imposition upon the patient of any frame of meaning remote from the patient's clinical material and the therapeutic encounter.

Further, the understanding of dissociation I use in my clinical work acknowledges what was obvious from my first encounters with DID patients, that they are a group characterized by high hypnotizability. This was confirmed by the research of Frischholz, Lipman, Braun, Sachs (1992). Highly hypnotizable individuals have a powerful capacity for what has been called normative dissociation (Butler, 2006), characterized by the focusing of attention toward some material in which the person becomes absorbed, and away from other material, which can become dissociated (Spiegel & Spiegel, 2004). I work from the assumption that normative dissociation becomes enlisted in the service of maintaining the superficially disruptive but profoundly defensive aspects of pathological dissociation.

It follows naturally from the above that when I read D. Spiegel's (1986) terse definition of dissociation, I found it was consistent with, or at least not contradictory of, my own ideas. It expressed a concept of dissociation that blended well with my sense that my patients' symptoms and communications made sense. It shared a vision of the traumatized mind working to protect itself rather than becoming reduced to a pile of shattered and fragmented mental shards.

Let me illustrate why I find this approach so helpful:

Mrs. Nancy Farmer (pseudonym) is a married but childless-by-choice woman in her mid-50s recently transferred to my care after the death of her previous therapist. She was the veteran of nearly 40 years of treatment. Her DID diagnosis was established ten years into this odyssey. After several false starts, she began to work with the skilled and DID-savvy therapist whose death occasioned her transfer to my practice.

To outward appearances Mrs. Farmer was a well-dressed mature professional woman. However, after several months a chance remark revealed that she and her husband ordered either takeout or precooked dinners virtually every night. Mrs. Farmer had never abdicated her nonprofessional adult responsibilities... She never had assumed them. Mrs. Farmer revealed that she maintained the pretense of being an adult by her adolescent alters' efforts to play at being an adult, and "act out" [her term]. That covered her work and her marital sex life respectively. Her oldest alters were 17 years of age. There was no history of traumatic events that would explain either the proliferation of 17-year-old alters or a fixation at that age. My predecessor had assumed a major but still dissociated traumatic event had occurred around that age.

To my mind, my predecessor's hypothesis was an inadequate explanation for either the pervasiveness of the 17-year-old issue or the absence of alters able to leapfrog that moment in time. What would be the "rule" of the "relatively rule-bound manner" described by Spiegel? What did this "symptom" express? Clearly, there was a need to dissociate the entire notion of growing beyond 17. What was the communication? The rule? The wish? The dynamic?

Further exploration revealed consciously available memories of her sadistic parents telling Mrs. Farmer she would die by the time she was 30. But 30 was not 18. What then? I asked Mrs. Farmer if she had voted in the last election. She had not. She had never voted. It was not difficult to put together that when Mrs. Farmer was being exposed to her parents' hateful threats, the 26th Amendment was being debated and voted into existence. The age at which Americans attained full rights of citizenship was being lowered from 21 to 18. When Mrs. Farmer was being threatened that she would die when she was an adult of 30, the onset of adulthood was dropping to meet her even sooner. Being 17 was not traumatic per se. It was a sanctuary and compromise. To be 17 forever was her desperate attempt to preserve her life and to be able to function as an almost adult.

To become 18 meant becoming an adult, well en route toward age 30 and death. Ergo, her dissociative pattern was not a devastating fragmentation. It was an orderly fortification of her sense of self/selves and her psychological life that made perfect and cohesive sense. Within moments of absorbing this insight she muttered, "So I'm not stuck forever!" She began to challenge her own iron-clad dissociation of all things adult, and was grateful for the insights provided.

The key issue in understanding the nature and function of an alter system and/or the phenomena within it in cases of clinical DID is coming to understand its internal rules, the alternate realities those rules support, and the objectives pursued in consequence (Kluft, 1988a). The alters are the delivery and maintenance system of multiple reality disorder. They exist to rationalize and support the reframing and revision of intolerable realities and to embody and sustain methods of coping with them (Kluft, 1991).

THE ORIGINS OF MY CLINICAL APPROACH: FOUNDATIONAL CONCERNS AND ADDRESSING TWO SUBDIVIDABLE TASKS

When I began to treat dissociative disorder patients, two of the first challenges I faced were 1) grappling with the phenomena clustered under that mysterious term, dissociation, and 2) figuring out how to work with a condition that shared many phenomena with those of hypnosis, and had often been treated with modalities facilitated by hypnosis.

1. Grappling With Dissociation

Clinical experience and the historical record of DID cases that were observed more than treated because the personalities in classic cases were so infrequently and unreliably present (Ellenberger, 1970) convinced me that I needed to develop an active and exploratory stance as devoid as possible of presuppositions about what I might or might not, should or should not, expect to encounter. As noted above, I was wary of risking letting expectation determine outcome.

My developing approach was derived from my psychoanalytic training (which was heavily influenced by Margaret Mahler's [Mahler, Pine, & Bergman, 1975] and Henri Parens' [1979] observational research on child development), my reading (which included the work of Kernberg and Kohut), hypnosis, and what I had learned in my family of origin. I reasoned that if it was beneficial to address and explore the entire mind, and the distribution of mental contents, attention, and patterns of behavior were distributed over a number of aspects of mind, I either had to find a way of relating to my patients both as single entities and as collections of entities, or resign myself to doing therapies in which access to alters was unpredictable, unreliable, and inefficient, and in which I was unable to define the range and scope of the therapeutic work to be done.

Some of my first DID patients told me about alters that never came out, that were "dead," that had disappeared, that would not talk, that could not talk, or that had not been heard from or responded to efforts by other alters to contact them for many, many years. If the observing ego was distributed in some manner, I had to find ways both to engage it overall and to focus selective attention in a manner that facilitated therapy.

If every alter had proven receptive to my initial approaches, conversational and hypnotic, achieving such objectives would have been easy. However, as stated earlier, I found that the alters were more accurately understood as selves (centers of initiative and experience [Kluft, 1988a; Kohut, 1971, 1977; Kohut & Wolf, 1978]) than as personalities or identities. Hence my long and unsuccessful advocacy on behalf of using the term, "disaggregate self state" (e.g., Kluft, 1988a).

Addressing the alters under the rubric of self solved some real problems, but presented novel challenges as well.

The problems it solved were those related to endless ruminations about how to consider the alters, and whether or not to interact with them. Theoretical meanderings were irrelevant. If I was dealing with an entity that had a firm sense of its own self, I had to deal with it rather than attempt to bypass it with some variety of magical thinking, inflicting a wound to that sense of self in the process. Imposing an injury to an entity with its own sense of self, a narcissistic wound, a shaming dismissive treatment instead of a welcome, seemed the quintessence of bad manners (P. Kluft, infinite reiterations of personal communications from my birth through 1993; R. Kluft, 2006) and empathic failure (e.g., Kohut & Wolf, 1978; Kluft, 2007). Reinforcing, reifying, and creating alters, the usual meditations of skeptical scientistic critics and serious sociocognitive scholars alike, might be of theoretical interest, but in the clinical encounter entities with a firm sense of themselves react poorly both to neglect and to being treated dismissively. Just plain good manners solved myriad clinical problems and salvaged countless crisis situations (e.g., Kluft, 2006).

However, novel challenges arose. How could I talk to a plurality of selves in a manner simultaneously respectful of all their subjectivities and mindful of their constituting a single person, especially when they may or may not acknowledge or care to relate to me and/or to one another?

One readily available approach was to request the attention of a part or of all parts of the mind, with or without facilitating hypnotic suggestions. I usually encountered initial success only to find myself regarded by my patient as a bull in the china shop of his or her mind. Without a context in which such an intervention could be prepared for, offered, and received more positively, I risked my patients' experiencing my efforts as unwelcome intrusions, and (in some cases) dangerous ones at that.

I appreciated that in order to make clinical use of any access techniques I might develop for clinical use, I had to make my presence more agreeable and forge a therapeutic alliance across alters that made sense to both my patients and to me as a clinician.

Educators talk about cognitive, affective (or attitudinal), and instrumental domains of learning. I appreciated that it was the affective or attitudinal domain that required my attention.

Unlike many if not most of my contemporaries at that time, I found no reason to postulate a core or original personality or to press my patients to work toward a consistent uniform self-presentation in session. As far as I could understand, all of the personalities were involved at some level as principals in the therapy and had to become actual participants in the work. From this perspective, it was imperative to respect them as such if their participation and collaboration was, as I thought, crucial to the therapy. Absent that respect and acknowledgment, things could easily miscarry (Kluft, 2006). One of my patients had been analyzed by a well-regarded and well-intended training analyst who had helped her in many ways. However,

whenever she used another name or said "we," he had insisted that she use her own given name or the first person singular. Other colleagues assumed that the presenting personality or the one with the legal name was "the real patient," tried to keep it present, relegating the other alters to the level of unwelcome and dispensable nuisances. Some felt good personalities should be kept, and bad ones extruded or otherwise removed from the patient's mind. In many instances, therapists considered some alters important and others less so, thereby creating an apartheidlike situation in the therapy. Circumlocutions that avoided dealing with alters individually that felt right to therapists often were poorly received by patients.

Once one learns that alters can become fatigued and step or be pulled back from the surface, and that another or others can take their places, and this is the norm, often going unrecognized (see Kluft, 1985; Loewenstein, Hamilton, Alagna, Reid, & DeVries, 1987), one is arguing against solid clinical evidence if one tries to do therapy by addressing attention to some rather than all of the alter system. Considerable patience and energetic effort may be required to get a sense of the alter system and how it works, but the importance of such information to the treatment is incalculable.

Absent such knowledge, interesting and sometimes challenging surprises may occur. My favorite illustration of surprise in the absence of this kind of awareness occurred during the classical psychoanalysis of my first control case, whom I did not even know suffered DID. "Different" behavior had been regarded as regression in the transference. After several years on the couch, she abruptly turned toward me, stood up, and announced, "You can analyze her... But I'm leaving." There had been no prior evidence to suggest either trauma or DID. I replied, "You misunderstand. You are in analysis too. Please return to the couch and say whatever goes through your mind, holding back nothing." To my utter amazement, she did. One cannot count on such good fortune twice in a lifetime.

Similar moments may occur without prior notice in established DID cases. Assuming that everything of importance is there to be seen is not safe until years of stable integration have passed, and sometimes not even then (Kluft, 1986, 1993).

For example, many clinicians make the mistake of thinking that a given name denotes a particular alter. Back in the early 1970s, I confronted an alter about her not acknowledging a prior conversation. She replied, "Oh, that was a different Katie." When I asked how many Katies there were, she replied, "Oh, there are five of us." By the end of therapy, I had met and integrated seven Katies.

Returning to the main thrust of this argument, my own reasoning was first expressed in the literature by Philip Coons (1980, 1984): the personality of a patient with multiple personalities is to have multiple personalities. Brenner (2001, 2004) has expressed a similar view from a psychoanalytic stance. From this perspective as well, because it seemed that if all of the

alters, regardless of their subjective sense of separateness, together constituted the superordinate entity that was the patient, treating any entity with anything less than complete respect would, at some level, be disrespectful toward the patient as a whole and countertherapeutic.

Beyond confronting alters afraid of speaking, alters unwilling to speak, mute alters, and alters blocking access to and/or speech by other alters, what was I to do when parts might not be listening, comprehending, understanding where they were and with whom, failing to identify the situation as therapeutic, obeying injunctions not to speak to strangers, or just not grasping or caring that I was talking to them? And the list goes on from there... what of those who had spoken different languages as children, spoke different languages in different alters, or were one of two identical twins and had spent most of their childhood conversation in a completely unique language and communicative mode?

When I try to explain that many of my ideas were derived from certain life experiences, I usually get the sense that I am not being taken very seriously. That notwithstanding, a lot of what I do is derived from what my parents, primarily my mother, drilled into my mind as "good manners."

Invitational Inclusionism

Given a mind with several selves responding to their own experiences and motivations, and given the premise that together they form a system of mind, it seemed that the effort to engage as much observing ego and as many aspects of self as possible in the treatment should involve and would require an ongoing effort at outreach. This does not imply that all parts should be engaged all the time, but it does mean optimal communication is essential. For example, if a therapist wishes to work with one alter and protect the others from the pain of that process, it is essential to be able to communicate that plan and to do the necessary interventions with the others to make such an intervention possible.

If we appreciate that inattention to one's self constitutes a narcissistic insult, it follows that a therapy that is not in an ongoing outreach mode toward the entire alter system is inflicting an incessant series of narcissistic insults upon all parts of the mind not actively engaged in the therapy, who may feel they are without or bereft of a relationship with the therapist. That is, a failure to offer engagement to all parts of the mind is likely to be experienced as an implicit and often explicit devaluing of the unengaged parts. Further, because the affect of shame involves the experience of being considered unworthy and shorn from the herd (Nathanson, 1992), that failure of outreach is a continuous invalidation (T. Lewis, personal communication, 2015), a passive decree of exile from what is good and acceptable. All too often in consultation I am presented with situations in which after years of a good relationship between the therapist and the most frequently presenting parts, therapy is still compromised if not stalemated because many

parts of the mind perceive the therapist as not caring about them, as having no interest in them, and as relegating them to a very low status (see Kluft, 1988, c & d).

I describe my ongoing outreach efforts as "invitational inclusionism." It can begin as gently as adopting "you all" into my remarks. I do not use the "y'all" pronunciation, which is too prone to be heard as a regionalism when spoken by a true American Southerner, or as an affectation if used by others. I make side comments such as, "this may be of interest to you all/more of you than those I'm talking to directly." Less subtly, one can say, "I invite all of you to listen in to this. It affects all of you." Of course, I can always simply address remarks to parts not currently in executive control; i.e., "talking over" (Kluft, 1982). For example, I could say, "Lucy, this may concern you, too," or "Whoever bought three yellow bikinis and five kids' pop-up books at the mall last week, we need to talk. I'd really like you to accept this invitation to discuss the situation. Nobody really likes it when we have to start rummaging around in your head rather than just talking back and forth."

My mother's family members included many accomplished linguists and scholars. Many immigrant enclaves in which English was a second language and might not be spoken at home dominated particular neighborhoods in my home town. My father was a prominent physician. Refugees, Holocaust survivors, and foreign medical graduates, members of our medical community whose first language was not English, were frequent visitors.

On occasion I would find myself in a living room full of people, several of whom could not talk directly to one another. My mother, who later became a teacher of English as a second language, deftly arranged for one person to translate a second person's contributions to the conversation to the others present if she could not do so. She made sure no one was left out of the conversation.

My mother's ability to transcend communicative barriers that at first seemed insurmountable was a powerful model. It was a short step from what I observed my mother do at home to studying which personalities could/would overhear one another, sense one another's feelings, understand those that spoke different languages, enter empathic attunement with mute or nonverbal alters, etc., and convey otherwise inaccessible messages.

The essence of therapeutic communication with DID alters involved respectful, empathic, indefatigable attention and outreach even when no response was given or all efforts to communicate were repudiated. The more entrenched the refusal to engage, the more crucial it was to maintain the elements of invitational inclusionism. Good manners and determined courtesy worked more effectively in terms of keeping DID treatment sessions safe and contained than any more elegant theory or clever technique.

Invitational inclusionism brought with it the benefits of avoiding the infliction of unnecessary narcissistic insults. Appreciating the importance

of self psychology in the early phases of treatment blends nicely with the insights into shame dynamics as described by Nathanson (1992) that became part of my therapeutic approach in the early 1990s, and my more recent interest in diplomacy. I am still working to bring Donna Hicks' (2012) emphasis on dignity and her principles of respectful communication into my therapeutic efforts. We have much to learn from the masterful diplomats whose forte is addressing disputes dealing with hostile and embattled parties who would rather destroy one another than compromise, but have realized, albeit reluctantly, the importance of transcending hatred and violence (Brenner, 2006; Ramzy, Alderdice, & Brenner, 2007).

The Corollaries of Invitational Inclusionism

Many of the hypnotic techniques I developed followed naturally from invitational inclusionism. They were designed to keep the conversation flowing in the treatment, and make sure that just as I saw my mother make sure everyone who wanted to say something got heard, I was able to help parts become welcomed into the conversation, and frustrate efforts to exclude and sequester less well-accepted alters. My hypnotic techniques are described elsewhere (Kluft, 1982, 1988b, 1989, 1994a, 2012e).

Hypnosis

In the early modern era of the diagnosis and treatment of DID, the adroit application of hypnosis and hypnotic techniques constituted an integral part of the therapeutic armamentarium. Scholars like Braun (1983) outlined the similarities and parallels between hypnotic phenomena and those of the dissociative disorders. Series of patients treated with psychodynamic psychotherapy and hypnosis were published, with noteworthy results (Coons, 1986; Kluft, 1984, 1986). However, in the era of the memory wars, unwarranted attacks against hypnosis became commonplace. The dissociative disorders field has moved forward, trying to develop modalities that do not involve hypnosis, and that disregard the biological data linking hypnotizability to DID. The controversies surrounding memory, trauma, dissociation, and hypnosis are too complex for review and discussion here. The interested reader is referred to Brown (1995) and Brown, Hammond & Scheflin (1988) for thoughtful overviews.

Because I was conversant with the science regarding these matters, I did not change course. While many clinicians fled the field, and others abandoned hypnosis, I continued to use hypnosis as I had before, and continued to get excellent results (see Brand et al., 2009 a & b). Hypnosis is a facilitator of treatment interventions, not a therapy or treatment in itself. Conflating therapeutic hypnosis with memory retrieval was and is an unfortunate mistake. In my work, most memory retrieval occurs without the use of major hypnotic techniques, and most of the therapeutic interventions I facilitate

with hypnosis are in the service of facilitating communication, containment, and integration.

Newer contributors to the field often display little awareness of the literature of hypnosis and, consequently, overlook or marginalize its importance. Several of them have promulgated theories that omit consideration of hypnotizability (a biological aspect of the condition) and therapeutic hypnosis. In conversation, the authors of several recent books on dissociation told me that they did not know that DID is associated with high hypnotizability (Frischholz, Lipman, Braun, & Sachs, 1992), did not know about the series of DID patients treated to integration in therapies using hypnosis. Many believed many of the inaccurate myths about hypnosis that hypnosis-savvy clinicians routinely address in preparing their patients for hypnosis. Several of these authors were also unaware that by conflating DID with Complex PTSD, they were bypassing much of what is unique in the successful treatment of DID.

These problems bring with them an unfortunate consequence. When therapists fail to learn approaches of value because they are not part of newer theories and/or models, the opportunity for a fruitful bringing together of the old and new is forfeit. DID patients are forced to pay the price for therapists' failures to optimize their knowledge and skills. For example, much of what is discussed as body-oriented therapy was anticipated in the hypnosis literature. Braun's (1988a, 1988b) permutations of his BASK (Behavior, Affect, Sensation, and Knowledge) model include a tremendous amount about the treatment of somatoform dissociation.[2]

2. Determining What Works

The next several sections address stances and matters I have found constructive and made part of my approach to the treatment of DID. However, because they are quite diverse, I have separated several out, in some instances rather arbitrarily, for particular commentary.

When I began my explorations, I started with psychodynamic ideas and hypnotic techniques. I determined what worked based on how often I called upon a technique or idea in my clinical work. That method risked distorting my count in favor of any unrecognized biases or tendencies toward favoring particular techniques, but it surely picked out the ones I rarely found useful. I admire D. Corydon Hammond (1990) for his insistence upon the importance of making note of what we actually do in sessions. All too often, when colleagues consult me about a case, they can tell me a lot about their ideas and concerns, but cannot recreate what has actually taken place.

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[2] A recent summary of my contributions to therapeutic hypnosis techniques for use with DID is available (Kluft, 2012e).

My efforts were nowhere near as well grounded as scientific studies can be. I had no funding, no academic (or any other) support, and had good reason to believe I would never be published. I had resigned myself to improving my own clinical work, with little prospect of anything more. However, perhaps because I was looking at such crude and self-evident variables, I was able to reach some interesting and insights.

I tabulated the frequencies with which I used various hypnotic techniques in a series of treatments. By the time I broke into print in 1982, I had the largest series of DID patients ever reported and a larger series of successful integrations than I could find elsewhere in the literature.

This allowed me to assemble a core of approximately 20 techniques I could teach in workshops based on their demonstrated clinical utility.

Approaching Abreaction and Session Closure

Studying the hypnotic interventions I used most frequently in treating DID, I observed that not only were many devoted to enhancing access and communication, but that another large cluster involved efforts to contain, channel, and manage disruptive material. Although I tabulated them as hypnotic interventions, I noted that they often could be applied without formal hetero-hypnotic induction by making use of the patient's auto-hypnotic or spontaneous trance phenomena (Kluft, 1982).

Although spontaneous abreactions are often deemed more pristine, and less subject to distortion by suggestion, the price of privileging such events seemed unacceptable. In unpublished research, I discovered that the spontaneous abreactions of a mixed group of DID and non-DID outpatients began, on the average, five to seven minutes before the scheduled end of the session. Although it is understandable that it might take a long while for difficult material or painful affect to emerge, it is also possible that problematic dynamics might be at play. In either case, the emergence of powerful material when a session is nearing its end is neither safe nor optimal for processing traumatic material.

Therefore, I modified techniques I had learned in workshops and developed additional methods as well to begin, control, direct, and curtail the flow of material. This allowed three very important innovations: the rule of thirds, the fractionated abreaction, and bringing sessions to more safe and collected closures. They are all designed to achieve maximal safety and stability at the end of the session. Because they are geared to make things go more slowly to prevent crises, they paradoxically speed up the treatment by working to minimize the disequilibrium, apprehensiveness, and chaos that must be contended with when the therapy moves into trauma work at too rapid a pace. They speak to a second of my clinical axioms: "The slower you go, the faster you get there."

The Rule of Thirds/Kluft's Rule of Thirds (Kluft, 1991)

It is dangerous to let trauma work/abreaction continue to the end of the session, interrupt it, and imagine all will be well. The rule of thirds states that if trauma work is planned, it should be begun in the first third of the session, continued through the second third, and brought to closure, reserving the final third for restabilization and processing. Therapies conducted with this precaution in place offer patients the security of knowing that time has been reserved that is dedicated to preserving their safety. Many hypnotic techniques are available to facilitate the closure of trauma processing (Kluft, 1982, 1994a, 2012e, 2013a).

The Fractionated Abreaction Technique (Kluft, 1988b, 1990, 2013a)

This technique uses the dissociative talents of the patient and hypnotic interventions to reduce trauma exposure to tolerable limits and process it gradually. Its origins owe much to Beck's (1979) cognitive therapy and Wolpe's (1973) systematic desensitization, and its further development is indebted to Braun's BASK model (1988a, 1988b) and Fine's perspectives on tactical integrationalism (1991, 1993).

In this approach a traumatic scenario is broken down to a fraction of its original power along several dimensions, and after the patient has abreacted/processed an initial small portion of the narrative and a diluted +/− partial intensity of the discomfort, the patient may be ready for exposure to more of the narrative and more of the dysphoria. Typical dimensions suitable for fractionation involve the temporal dimension or time line, the percentage of the intensity of the original discomfort to be faced, dissociation of emotion and sensation so that each form of discomfort can be addressed individually, and the number of alters involved in experiencing the original trauma.

For example, processing a horrible assault involving both terror and physical pain that lasted approximately 20 minutes and was experienced by six alters might be approached by agreeing to review the first 30 seconds at under 5% of full intensity with physical sensations dissociated and five of the six involved alters in hypnotic sleep. It might be initiated with an affect bridge (Watkins, 1971) and curtained by an intervention like Beck's (1979) thought stopping. Exposures can be slowly increased upward in duration and intensity. Although this approach can be maddeningly slow at the beginning, the usual course is that the patient, after a fitful start, becomes an active partner, eager to break the hold of the past on the present and working well with the therapist to achieve this. Fine's (1991, 1993) approach of working with clusters of alters that have much in common, usually one at a time, blends well with the fractionated abreaction approach and is part of her use of this technique.

The fractionated abreaction technique is the subject of a specialized monograph (Kluft, 2013a). It has been well accepted and, when used with the rule of thirds and the session closure techniques discussed below, rarely leads to a prolonged or difficult clinical situation. I encountered no more than a handful of brief and easily managed unwanted effects. However, it might be somewhat less problem-free if it were not used in connection with the rule of thirds and specialized closure techniques.

Terminating Sessions Safely—The Three Truncations

When DID patients are having difficulty pushing past dissociative symptoms and barriers to return to the here and the now, it is customary to turn to grounding techniques to restore their orientation. Generally, efforts are made to anchor patients in the present by focusing them on their sensory perceptions of their environment. This is a concept and approach I have found inadequate.

A patient may be reconnected with the texture of a couch, some other object, familiar sounds, smells, and sights, or with the patient's body in motion. However, it is questionable whether this is adequate reorientation, especially if alters are still actively engaged in other situations with different temporal, geographical, and interpersonal coordinates. Bringing the patient back to the here and now in this manner may satisfy the therapist and some alters, but often proves far from satisfactory.

Bringing more restabilizing closure to a session for any trauma patient, but especially for a DID patient, can be more complex such "grounding." First, the trauma processing must be brought to an end. Second, the inner turmoil of dysfunctional arousal, distress, and switching must be controlled. Third, and finally, the patient must exit trance. Hypnotic interventions facilitate these processes very well (Kluft, 2013a).

Grounding, by comparison, is a very superficial concept. At best, it brings a patient more or less into the here and now. However, although a patient who is grounded may give the appearance that all is well, appearances can be deceptive. Elsewhere I have reviewed how many individuals who appear to be restored to baseline status have not, in fact, achieved genuine restabilization (Kluft, 2012a).

In a 2013 publication, I describe the tasks essential for true restabilization as the three truncations (Kluft, 2013a; also Kluft, 2012e): the truncations of trauma, turmoil, and trance. When patients report they have returned to the here and the now, that does not mean they have left a state of duality, in which they are both in the present and in the trauma at the same time. This is a major reason for prolonged postsession distress. Many techniques are available to curtain and contain the trauma experience (e.g., Kluft, 2012e). Whereas relaxation and meditational techniques have been advised, they may be calming at some levels without sequestering the trauma effectively. Further, in some instances, they may lead to a sense of dyscontrol.

Even if trauma is curtailed, the affective dysphoria and autonomic hyperarousal may persist. Again, hypnotic techniques are available to bring these under control (e.g., Kluft, 2012e, 2013a).

Finally, because DID patients have high hypnotic capacities, it is important to realize that even if trauma is curtailed and distress is contained, the patient may remain in an altered trance-driven state and walk out of a therapist's office in a highly vulnerable and suggestible state. Eye closure is an expression of a metaphor commonly used in hypnosis, that of an artificial sleep. However hypnosis can be induced and utilized with a subject's eyes wide open. Elsewhere (Kluft, 2012a) I have demonstrated that most observations used to conclude that a subject is out of trance are derived from metaphors (i.e., open eyes mean the subject is realerted) and are without a solid foundation. They may constitute a *folie a deux* between the hypnotist and the subject (Kluft, 2012a, 2012b, 2012c, 2016).

Hedy Howard, M.D., (2008, in press; see also Kluft, 2012a, 2012b, 2012c, 2013a) developed an instrument useful in estimating whether or not a patient remains in trance. She thereby solved a problem that had vexed hypnosis for two centuries. With a mind free from preconceptions, she rapidly appreciated that unless a baseline measure is established, it is challenging, if not impossible, to determine whether or not a return to that baseline has been established. Her argument is so compelling that I use her approach in the majority of my trauma-processing and medical hypnosis sessions, and many others as well.

When the patient's mind is cleared of trauma and dysphoria, and returned to baseline alertness, the patient is far more prepared to leave the therapist's office in a stable, contained, and safe state than he or she would be without my taking these steps.

SHAME: AN INITIATOR, AUGMENTER, AND PERPETUATOR OF DISSOCIATION

Shame is one of the most important issues in the treatment of the traumatized. I read the proofs for my friend Don Nathanson's *Shame and Pride* (1992) over one weekend, walked into my office the following Monday, and suddenly discovered that I had become a much more effective therapist overnight.

Attention to shame-related issues rapidly became central to my work. Earlier studies of shame were overburdened by the complexity of their theories, but Nathanson got permission from Sylvan Tompkins to translate Tompkins's Basic Affect Theory into a more accessible set of formulations, and added his own insights. Nathanson succeeded in developing a version of Basic Affect Theory that was crisp, helpful, and very easy to use in clinical situations and for psychoeducational purposes.

Here are some of the ways it proved useful:

1. Psychoeducation—explaining the different families of shame scripts helps DID patients both to understand their phobic reaction to certain topics and situations, and helps them enter a dialog about how shame contributes to their withdrawal, isolation, self-attack, and yearning for chemical relief. It thereby helps alleviate many problems in daily living.

2. DID patients are almost universally able to discuss their shame-related behaviors, even early in treatment, and this helps them be more open in therapy even when they want nothing to do with trauma concerns.

3. Work on shame opens the door to their understanding of how others' empathic and additional failures left them with a profound sense of their imperfection in every possible dimension, except in serving the (often unsavory) expressed needs of others.

4. Work on shame introduces the DID patient to the difference between reluctance and resistance and thereby facilitates many aspects of therapy, including memory retrieval, as an example. Resistance refers to unconscious matters. Because most unavailable information is known to one alter or another (of course, some may be dissociated per se, a Dissociative Amnesia phenomenon within a DID patient, without a connection to a particular alter or alters), although they may be unwilling to talk about it, the reduction of shame, and with that a better appreciation that the agents of their abuses were not within themselves. This often allows alters to offer spontaneously material I had found far more difficult to access, even with the use of many techniques, prior to shame reduction efforts.

5. As I began to make shame reduction central to my early work with my patients, I discovered that a significant component of my DID patients' fears of doing trauma work were related to the attendant humiliation and mortification, sometimes more difficult to tolerate than the trauma itself. With the shame reduced, the fear of doing trauma work was reduced. My patients became both less afraid and less avoidant, knowing their traumatization was unrelated to their shortcomings, despite their abusers' efforts to convince them to the contrary. I will return to this under a separate heading.

6. Successful preliminary shame work reorients trauma work away from an embarrassing exploration of personal failure to an appreciation of one's surviving the malevolence of others. This reorientation is far from complete, but even a partial reduction of the initial self-depreciation is very helpful.

7. As shame work allows alters to see that the actions and feelings of some of the alters they most loath and try to suppress and avoid in fact serve the purpose of containing and expressiing the shame of the whole person, alters experience a reduced sense of the "otherness of the others" and begin rebuild the interpersonal/interpersonality bridges (Nathanson, 1992; Kluft, 2007), the destruction of which left many alters "shorn from the herd" (Nathanson, 1992). This facilitates the development of mutual empathy across the alter system, which in turn paves the way for integration (Kluft, 2006).

REFUSING TO ABDICATE OR DENIGRATE MASCULINITY

My therapeutic efforts are characterized by a complete refusal to go along with trenchant global attacks by commission or omission upon either gender. I make rather undisguised statements to that effect. The evidentiary basis for this stance, however weak, is that I have never seen an instance in which either the overt endorsement of a nasty gender prejudice or the covert endorsement implicit in a failure to address such a thing has benefited rather than compromised a treatment.

The literatures of the dissociative disorders field and the treatment of victims of sexual abuse tends to veer from the objective in a number of areas. Often contributors to the field become overly focused on issues in the mother-child relationship and relegate their remarks about men in the lives of their patients to discussions of absent fathers and vile perpetrators. The importance of the father in the development of the child's sense of self is bypassed all too frequently. In a good number of papers, books, and presentations positive mention of fathers and other males is completely absent from the discourse. Both fathers and men remain unmentioned in the indexes of several major publications in our field.

This is a tragic oversight. Many DID women are "supported" in a way that influences them to see all the men in their lives in a disparaging, dismissive, and contemptuous manner. In their zeal to "defend" the DID female, some therapists may "defend them out" of what might have been a salvageable and even constructive relationship by supporting stances and choices that undermine both the relationship as it stands and its potential for improvement.

I have seen over a hundred DID women who left or severely compromised their intimate relationships, often because they either reframed or were induced to reframe those relationships as abusive. I have followed too many such situations to their usually unhappy aftermaths, often reducing these DID patients to loneliness, poverty, and deprivation.

Encouraging or leaving unchallenged attitudes that sever a person from half of the human race is a dubious stance. Many who unashamedly rail against men would be outraged if they overheard similar global disparagements based on race, religion, or other gender-related issues.

Preserving our patients' present and future quality of life options requires a nonjudgmental and circumspect stance. Therapists must put their sexual politics and comfortable stereotypes aside and remember that if one group of alters in a DID patient's alter system is eager to leave a partner and doesn't even claim to be a participant in that relationship, that does not mean that there are no counterbalances, no groups that cherish that same relationship. The same applies to strongly stated aversions to sexuality. Approach/avoidance and doing/undoing are common DID patterns.

Such situations argue strongly for mapping the alter system and eliciting the thoughts and feelings of as many as possible.

If a patient comes to me presenting him or herself as miserable and abused in a marriage or significant relationship and eager to leave it, I consider it essential to refuse to accept that wish at face value until explored both at length and in depth. It may not represent the wish of the total human being, and people may change their perspectives in the course of therapy.

I find it useful to recommend that DID therapists review Kohut's thoughts on the importance of the father as an idealizing object to develop a firm sense of self-esteem (e.g., Kohut, 1979). Another component of many successful outcomes in my work with DID has been my refusal to allow the demonization of the male gender without in any way defending relevant demons who happen to be of the male gender. While many therapists remark in workshop settings that a happy relationship with a man is not likely for a woman with DID, I have not found this to be a universal or even generally predictable outcome. Avoiding the slippery slope that leads toward demonizing the masculine is not easy, but it often pays gratifying rewards in the long run. This is true even for DID women with a committed gay orientation. Gender-based hatred, akin to hatred based on race, religion, ethnicity, sexual orientation, identity, etc., is not a constructive state of mind. It narrows a person's world, and often begets hatred in return.

If I allow myself to yield to or play along with the denigration of either gender, I covertly undermine myself as a helper and a source of strength and security to my patients. If I were to accept the depreciated view of men so often voiced among those who treat sexually victimized individuals of either gender, I would fail to offer my self-hating patients an acceptable idealizing object. Instead, I offer them an opportunity to experience a transmuting internalization laden with further self-loathing and self-depreciation, an identification with someone who conveys that he does not like himself or his gender identity very much.

TESTING PRAGMATIC OBSERVATIONS IN THE SEARCH FOR NEW INTERVENTIONS

Perhaps the best way to illustrate my style of participant-observer on the job learning is to discuss a series of unpublished clinical projects I pursue simply to improve the quality of the care I render. I have presented some findings from them in workshop settings.

I have always followed up DID patients as long as it is possible and practical to do so. Although the relocation of my practice and changes in the health care delivery system brought my systematic follow-up efforts to an end, I continue my follow ups as best I can. They include patients who have enjoyed up to 38 years of steady integration.

    I collected a series of DID patients followed for at least 15 years after their Dimensions of Therapeutic Movement Instrument (DTMI) treatment trajectories (Kluft, 1994a, 1994b) had been firmly established. Its dimensions have been utilized in an instrument under development by Brand and her associates.

    These patients could be divided into three groups. Fifteen achieved and had maintained stable integration. Twelve continued to run a rocky course, but made slow, irregular, incomplete, and/or lurching fits and starts toward recovery. Eight had forfeited all hope of a definitive therapeutic outcome, but were being sustained in supportive treatments augmented with psychopharmacology.

    The largest group (15 patients) had achieved stable complete integration by the criteria used in my earlier outcome studies (Kluft, 1984, 1985, 1986; see also Kluft, 1993) prior to entry into this series and maintained it for at least 15 years. The second far-from-uniform group seemed to be locked into "forever therapies," making slow but not necessarily steady progress. Refractory comorbidities, intrusive third parties, prioritizing family bonds or concerns above treatment, or complex life circumstances had impacted their treatments. On further follow up, four finally achieved successful integration after long and rocky courses, but one of them suffered a horrific relapse. Her pastor had urged her to forgive her abusers. When she returned home to do so she was brutally raped and suffered a catastrophic regression and relapse. For many years it has taken my most energetic efforts simply to keep her alive. The third group consisted of individuals who proved either unwilling or unable to pursue a therapy designed to cure their DID, and could not reach or would not work toward a reasonable resolution. Some dropped out of definitive treatments and some remained in supportive therapies. The unwilling group struggled with concerns like fear of trauma work, investment in their DID adaptations, comorbidities that compromised ego strength, interference by partners or clergy, unrevealed ongoing abuse by individuals from whom they deemed separation intolerable, traumatic bonding to abusers, a perceived need to protect abusers, etc.

    Certain findings were present at first assessment or manifested early in treatment in all members of the group that attained and maintained integration and a good quality of life for over 15 years, but were absent in the other two groups.
  1. Consistently Good Therapeutic Alliance
  2. Enjoyable to the Therapist as People
  3. Active Learning Beyond Required Education
  4. Awareness of the World (Beyond Turmoil and Trauma)
  5. Good Sense of Humor (Beyond DID Humor and *Schadenfreude*)
  6. Individuation from Family of Origin
  7. Willingness to Make Decisions
  8. Some Retained Interest in Sexuality

   9. Has Made and Retained Friends Who Were not "Psych Patients"
10. Sense of Self-Efficacy
11. Good Employment or School Attendance, or Successful Retirement
12. Counterphobic Stance > Avoidance
13. Reasonable Anger; Had a Temper
14. Unequivocal Response to Psychopharmacology

These observations suggested the possibility of a series of projects. In recent years many approaches to ego building, psycho-education, resource installation, relationship building and other preliminaries designed to both strengthen and prepare the individual patient have been proposed to facilitate trauma treatment in general and DID work in particular. However, those recommendations and approaches have been drawn from whatever conceptualizations of DID and/or the traumatized prevailed at a particular time and/or in a particular school of thought. Although these approaches ultimately may be determined to be helpful, to date their approbation has been derived from their conformity with favored models, practices, and the opinions of respected authorities.

Fiction writers live and die by that everpresent impetus to imagination, "What If?" Combining my concerns as a clinician with my imagination as a novelist, I asked, "What if I try to identify which prognostic group a new patient most resembles, select those new patients who lacked the characteristics of the best prognosis group, and attempt to teach or inculcate in them the characteristics of those who did best?"

I will summarize two of my pilot efforts, one that appears to have considerable promise and one that proved counterproductive. The second project provides further evidence that "Murphy's Law" remains one of the most powerful forces in the universe.

THE GIFT OF LAUGHTER

If patients who did best had good senses of humor beyond DID in-jokes and *Schadenfreude* (pleasure in the pain of another, in DID usually manifested in the pleasure of some alters at the pain and despair of other alters), was it worth trying to help my grim and overwhelmed patients learn how to laugh, and how to find the life-saving balm of humor amidst the anguish and pain of their lives and their uncomfortable experiences in treatment? However, I was aware of a potential downside to the use of humor, and was determined to proceed with caution. On the one hand, Norman Cousins (1981) wrote a wonderful account of how he used humor to fight a crippling illness, and Dabney Ewin (2016) argues persuasively that it is difficult, if not impossible, to laugh and feel pain at the same time. On the other, I was mindful of Laurence Kubie's (1971) dire warnings about how the aggressive component of most humor might prove upsetting or even hurtful to a patient.

On a personal level, I had very little confidence in my ability to be funny in a constructive manner and on a sustained basis with deeply wounded individuals without risking making them feel that I was laughing at them. The therapeutic use of humor requires accurate empathy and exquisite tact. I hit on one piece of the puzzle's solution rather rapidly. Although I dared not mount what might be misperceived as an attack on the patient's self/selves, I could model a good-natured acceptance of being joked about, with occasional moments of self-depreciating humor.

I remained puzzled about how to proceed in an organized rather than opportunistic manner until some remarks by Stanley Coen at a professional meeting led me to his brilliant 2005 article, "How to Play with Patients Who Would Rather Remain Remote." Coen was writing about schizoid patients, but I reasoned that because most aspects of the minds of my DID patients, at least initially, preferred to remain remote, Coen might have something important to teach me. Coen's approach to playfulness proved to be a caring, nontraumatizing, and well-received avenue for introducing smiles, chuckles, and finally laughter into my therapeutic work. It's not that I wasn't making patients laugh before, but Coen helped me tame my humor into a therapeutic tool.

My experience with the gentle introduction of playfulness setting the stage for humor has proven rapidly successful with almost all of my new patients. Further, it revitalized several ongoing long-term therapies. When one of my most ill-treated, therapist-exploited, humorless, and refractory patients progressed from smiles to chuckles to laughing at my comments to making me laugh at hers, and realized that she was progressing in every other one of her problem areas and passing along wisecracks (some not too kind) from alters within who had refused to talk to me for over a decade, she remarked, "I hope you're doing this with everyone you treat!"

This little therapeutic experiment convinced me that the use of playfulness and humor with DID patients deserves further exploration.

MOVING BEYOND THE TRAUMATIZED SELF

My efforts to operationalize active learning and curiosity about the world in DID patients were undertaken with the hope that an involvement with the wider world would be beneficial to those entrapped in their inner worlds of pain and their matrices of dysfunctional relationships I hoped to: 1) redirect the attention of some of my overwhelmed trauma patients away from their internal preoccupations; 2) encourage their alter systems to be more savvy about a world in which they often felt lost and confused; 3) let external world interests spread throughout their alter system to improve orientation to the here and now; and 4) develop conflict-free areas of conversation through which connection could be maintained in the manner Coen (2005)

and others have found is useful in work with withdrawn schizoid patients unable to talk directly about themselves for protracted periods of time. When I began a series of efforts to encourage this sort of strengthening, the world was a different place. I did not anticipate how changes already well under way, such as the Internet and various social media, might impact both the world at large and my therapeutic work in particular. However, year after year of televised images of human brutality, terrorist atrocities, the public hypocrisies of major religious institutions, the rise of right-wing forces, and increased public tolerance of moral failings and overt mendacity have been major elements of news coverage. My newly curious patients encountered an Internet full of often destabilizing chat groups, disinformation, and virulent attacks against their condition, their treatments, and, unfortunately, even against their therapist.

That horrendous current events might retraumatize the traumatized was no surprise, but I never anticipated the massive surge or the devastating ferocity of their onslaught. Nor had I anticipated the power with which it would contaminate my therapeutic work. I treat many therapists, and many DID patients, whether professionals or not, become scholars of the DID literature. Several discovered that many authors were critical of me or discussing topics about which I had written, but had not cited my work. This led to a number of very difficult situations, some that culminated in abrupt terminations when patients assumed what they found or did not find on the Internet indicated some form of collegial disapproval.

The presidential election of 2016 dealt the final blow to any hope that efforts to interest my patients in the world at large might prove helpful interventions. The contending candidates evoked intense traumatic transferences and profound fear in virtually all of my traumatized patients, reinforcing their fantasies that the world indeed was as awful as they feared, if not worse!

I reached the reluctant conclusion that the intended goals of this form of intervention were based on outdated and inaccurate assumptions. I have discontinued pursuit of these efforts. When the outer world lurches toward becoming isomorphic with one's own terrifying fantasies, it no longer offers a constructive alternative engagement of attention, a beneficial diversion from one's internal horrors.

CLOSING REMARKS

I chose to write this more personal essay for the inaugural issue of *Frontiers in the Psychotherapy of Trauma and Dissociation* with a rather transparent agenda. I would not be surprised if some clinician-readers walk away from this article thinking, "Well, sure this guy took a lot of grief along the way, but a lot of the things he did were based on just keeping his eyes and mind

and heart open, tracking what caught his attention, and being willing to read a lot. I could have done that." These readers get it.

Who knows from where and from whom the next useful clinical advances will come? Note, I specified useful clinical advances, not trendy, intellectually showy, aesthetically pleasing, politically congenial, or ostensibly scientific bling. Their proliferation, sadly, is all too predictable. Instead, I am specifying serious rather that theoreous (Yes, that is a neologism!) contributions, the things that help therapists help patients rather than help therapists experience the false security inherent in knowing more of what has not been demonstrated to provide more.

The next colleagues to make unique and lasting contributions, those willing to enrich what is new with the accumulated wisdom of the past, will be those with open eyes, open minds, open hearts, the determination to observe and track clinical phenomena, and the energy to read a lot. They just might be among those who come across this essay. If you recognize yourself in those words, you probably realize that I wrote this essay to encourage you. The next chapters of this book are not mine to write... They are yours.

As an undergraduate at Princeton, I arrived at the first lecture of Professor Walter Kaufman's course on Existentialist Philosophy (see Kaufman, 1957) wondering what I had gotten myself in to. Kaufman began by confronting us with a challenge. Fifty-two years later, all I can do is share my best approximation of what he said.

"Why are you taking this course? (He paused.) The authors we read are more intelligent than I am. The books they write are better written than mine are. You could just stay home and read them. (He paused.) The only reason to take this course is to bear witness to how one man grapples with the ideas of great minds."

Here I have tried to convey how one man grappled with the challenge of understanding and treating Dissociative Identity Disorder, a challenge far beyond his ability to master completely. Perhaps that will be somewhat informative, useful, and interesting. Perhaps not.

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