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Discussion

The online community: DID and plurality

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ABSTRACT

One significant gap in the professional literature is the online community of “Plurals”, united through support groups for Dissociative Identity Disorder. These have evolved over the years into a more organized state both linguistically and politically – making Plurality its own culture. There are three primary clinical issues with the online community which are discussed in this article. One is simply understanding the culture of the online community, so as to practice competently and with cultural humility when working with those patients who identify as part of that culture. This includes understanding various terminology often utilized, which may be different than historical dissociative language with which the therapist is already familiar. Second is simply whether or not to recommend these resources to client, and, if so, when to do so and within what parameters. Third is to understand the impact of the online community culture on treatment itself.

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One significant gap in the professional literature is the online community of “Plurals”, united through support groups for Dissociative Identity Disorder. It is to be noted that this author has lived experience and is the voice behind the podcast “System Speak: A Podcast about Dissociative Identity Disoder” as well as the author of the memoir, *if tears were prayers* and the workbook *Me, Not-Me, and We: A Lived Experience Workbook for Phased-Recovery from Complex and Relational Trauma with Dissociative Identity Response*. Because of these roles in the community, this author is aware of and witnessed the development of the Plural community as it evolved over the years into a more organized group both linguistically and politically – making Plurality its own culture as described below. To be clear, this author is not advocating for Plurality as a lifestyle in this paper, but rather describing the history of how the Plural community developed online and how it is distinguished from traditional traumagenic DID.

There are three primary clinical issues with the online community which are discussed in this article. One is simply understanding the culture of the online community, so as to practice competently and with cultural humility when working with those patients who identify as part of that culture. This includes understanding various terminology often utilized, which may be different than historical dissociative language with which the therapist is already familiar. Second is simply whether or not to recommend these resources to client, and, if so, when to do so and within what parameters. Third is to understand the impact of the online community culture on treatment itself.

Online community as culture

The online community refers to a broad spectrum of internet platforms and the people who utilize them, and includes internet users around the world in many languages. In this paper, online community specifically references the variety of dissociative disorder support groups which moved to Facebook since the original groups on Yahoo two decades ago, the dissociation hashtags on Twitter (including the organized #DIDChat that happens weekly with live and organized interaction), similar hashtag use on Instagram, as well as discussion threads on Reddit, Discord, and private servers such as those hosted by Criss Ittermann’s United Front (online individual and group coaching and classes for people with dissociative disorders) and The Plural Association (international nonprofit with dissociative disorder warmline). In addition to these, there is an extensive network of YouTube and TikTok channels presenting as people or “systems” with Dissociative Identity Disorder, some of them with hundreds of thousands of subscribers to their channel and some of those videos with more than three million views. The primary focus on this aspect of the online community is identification with and support for the current, ongoing, experience of “Plurality”, a term coined to be more inclusive than only that of traumagenic multiplicity as described below.

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A different aspect of the online community is that of those attempting to provide resources focused on healing trauma. The many number of memoirs and conference speakers with lived experience are an example of this. More recently, there are some podcasts which have become part of the online conversation of lived experience and both how to cope with and how to treat trauma. Beauty After Bruises is an organization of support for treatment of complex trauma in the United States. An Infinite Mind hosts the "Healing Together" conference every January, bringing together speakers for sessions geared toward survivors and those who treat them.

These resources and events add to the in-person (pre-pandemic) and shared experiences of the online culture, making it more three-dimensional than only being online virtually. Further, connections made through these shared experiences have given birth to more intently focused experiences organized by Plurals themselves, such as the now-annual Plural Positivity World Conference (PPWC). These online support groups, discussion threads, resources, and shared experiences have evolved over the years into a more organized state both linguistically and politically – making Plurality its own culture – which will be discussed below.

This organization as a community developed not only through shared experiences online and at conferences, but also in the therapy office itself. The shift from the abreaction-based therapy of the 80′s and 90′s to the staged-approach of the late 90′s and 2000′s developed into the more recent structural dissociation emphasis on communication, cooperation, and collaboration. Plurals worked so hard to apply these principles within themselves that they easily accepted these principles as rules of society collectively, creating trust amongst groups where there had not been before, communication amongst leaders of the community where they had competed before, and collaboration amongst groups which had previously been isolated. In essence, Plurals took what they had been asked to do internally to develop safety and stability and implemented it externally to create a community in a way that had never before existed.

"Culture plays a significant role in the vulnerability to, experience of, and recovery from mental health sources of distress, including interpersonal trauma" (Bryant-Davis & Ocampo, 2005, 2019). Culture refers to "shared values, practices and beliefs of a group of people" that characterize the diversity in social groups (Chiao et al., 2010) and is tractable in all people and groups around the globe (Kitayama & Cohen, 2007; Norenzayan & Heine, 2005). Further, individuals within a collective group are unique such that stereotyping anyone becomes both ineffective and inaccurate; so also, the reader is reminded that culture is dynamic rather than static, meaning that just as our understanding of the online community is different today than it was twenty years ago, this will continue to shift and evolve into the future as well. In addition, as already documented in research, the different online social media platforms each have its own culture as well, which lends to some distinctions amongst the online community. That being stated, there is a general "meaning-making process" that happens when social groups interact with each other – and emotion, specifically – which creates "new and binding understandings of social responsibility" (Alexander et al., 2004). This, collectively as a culture even with its own use of language, impacts how "trauma survivors hold multiple identities simultaneously that influence their conceptualizations of trauma, therapy, and the recovery process (Brown, 2008 in Bryant-Davis, 2019).

Clinical implications

There are three primary clinical issues with the online community. One is simply understanding the culture of the online community, so as to practice competently with those patients who identify as part of that culture – including understanding various terminology often utilized, which may be different than historical dissociative language with which the therapist is already familiar. Second is simply whether or not to recommend these resources to client, and, if so, when to do so and within what parameters. Third is to understand the impact of the online community culture on treatment itself.

First, regardless of years of experience or knowledge of models and technique, it is difficult for the clinician to ethically treat a patient from a culture of which the clinician is unaware or denies. The APA's (2017) Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults specifically states that attention to cultural context is a required component of trauma-informed mental health care. Courtois and Brown (2019) responded to the limitations of these guidelines with an emphasis on "a more ecologically-informed model" that accounts for the "body of research on the psychotherapy relationship, psychotherapy process, and a broad range of psychotherapy outcome". Adding to this, Henning and Brand (2019) reported that the Guidelines do not "adequately address aspects of treatment that are crucial to training about trauma, such as considering the client's cultural and individual needs." This call to cultural competence via prioritizing awareness, knowledge, skills, and "cultural humility" (Harvey & Tammala-Nara, 2007) is a critical part of the ethical treatment of trauma survivors.

Linguistics

In the last decade especially, there has been a movement toward "person-first language" in effort to emphasize the whole person rather than traits that might identify them, such as disability diagnosis (University of Kansas, 2013). It became a matter of respect from the clinician and dignity for the patient to shift from "DID client", for example, to "person with Dissociative Identity Disorder". In more recent trainings, however, there has been an added push against even that stigma to provide a more non-pathologizing approach in dropping the "disorder" and simply using the phrase "person with Dissociated Identities" (Coy, 2020; McMaugh, 2021). Along with this has come the use of "DI" instead of "DID", as well as the more casual term "multiple".

While appreciative of these advances, the online community has generally responded to this shift with two more linguistic developments. First, that "dissociated identities" maintains a diagnostic-based orientation, which feels both confining to the therapeutic setting (which, in reality, is an experience of privilege not afforded to many for long) and limiting to the specific timeframe of being in therapy, in contrast to the lifetime of lived experience. Secondly, it excludes those who are not yet diagnosed, those who consider themselves multiple but not disordered (discussed below), and those who consider themselves multiple without any history of trauma (also discussed below). For this reason, the broader and more person-centered term of "Plural" was formally adopted in 2018 with extensive collaboration among support groups online, a variety of proposals submitted from Plurals themselves, and then actual voting across the different support groups and a variety of platforms – which was, in itself, a historical moment for Plurals as they organized together in a way they never have previously. More than 23,000 votes were cast.

Once the community had established an overall umbrella term with which they could identify themselves with collectively, the online community recognized its progress in collaborating together despite their difference. With this came agreement on common goals: increasing the safety of online support groups, calling out misrepresentation in movies and other entertainment media, a push against stigma via the development of DID Awareness Day, and a call to be more inclusive in support groups of those who are not yet diagnosed or who have other dissociative disorders besides DID.

With that came the PPWC, for which I was asked to take a general, public survey designed by them (through voting) for their own use as a community (not research approved by any internal review board). This is not uncommon in that culture, with online public opinion polls and annual surveys as an optional part of registration with the

Healing Together Conference. The results of this survey were shared, as requested by and with permission of participants, as a Poster Session in the 2020 Annual Conference of the International Society for the Study of Trauma and Dissociation (ISSTD), and publicly posted on the System Speak Podcast website (Christensen, 2020).

Interesting to note is that even after voting to adopt “Plural” as the term of choice, 35% of respondents instead identified as DID, only 27% identified as Plural, and 22% still identified as Multiple. This is significant in that it indicated less than a third actually prefer the term “Plural” despite the advantages agreed upon in voting to adopt the term the year before. This, in-part, reflects adopting the term “Plural” as an appropriate umbrella term to be inclusive of the entire community, but not necessarily a term reflective of one’s identity or self-expression in reference to current progress in treatment.

Another significant piece of data that came out of the survey was that only 3% of respondents stated their goal for therapy was “integration”, while a majority of 78% reported their goal for therapy was “functional multiplicity” – the new buzz phrase that describes making progress enough in therapy to be able to communicate, cooperate, and collaborate, but without requiring integration as an imposed objective (though it may happen naturally or by choice). The clinical foundation for this concept is from Steinberg and Schnall (2001), who wrote about “functional cooperation” (p. 256). Related to this, 5% of respondents reported their therapist was insisting on integration as a treatment goal, 20% reported their therapist had never discussed it at all in any way, 12% did not think their therapist knew what functional multiplicity was, and 50% reported that their therapist agreed functional multiplicity was a reasonable and healthy goal.

Exploring this data and these responses is what led this author to present at the 2021 ISSTD conference. There, it was presented and recommend shifting the three-phase model to a four-phase model, moving phase three to phase four and adding “functional multiplicity” as phase three. This would allow the work of phase four to happen more naturally, and give more time and space for systems to practice functional multiplicity. This parallels the addition of safety and stabilization in the early 2000′s after the reported experiences of distress following the abreactive focus of the 1990′s. Systems with lived experience are declaring the jump from phase two to phase three is too much, and that they need more time and practice with functional multiplicity. This author recommends slowing the pace for more time in identity development and cooperative practice. Details of this will be discussed in another paper.

Another part of what came out of that survey process, and after nearly a year of discussion and voting, was language-identifiers regarding etiology of Plurality defined by Plurals themselves. Of these responses, answers included the following (Christensen, 2020):

- “38% Traumagenic-Adaptive (I am this way because of trauma, and still use dissociation adaptively to deal with life but not necessarily intentionally and not as part of my intentional cultural expression.);
- 34% Traumagenic (I am this way because of trauma.);
- 13% Traumagenic-Cultural (I am this way because of trauma, feel mostly in control of my symptoms, and have intentionally adapted to it as a cultural lifestyle.);
- 2% Endogenic (I was this way before I was born, but not because of trauma.); and
- 1% Exogenic (I was this way since I was born or grew up this way, but not because of trauma - that I know of yet.).”

It is noted that these last two categories were identified and labeled as such by the community itself, rather than being terms utilized from research studies previously. It is also noted that it has not been documented that one knows their own psychological state at birth, as referenced in those latter two categories. These are the terms as used by the Plural community.

From this, it is of clinical significance that this generally and naturally divides the Plural community into three notable groups. One group, more familiar to clinicians, includes those with dissociative disorders of traumagenic origin who are currently in treatment. A second group falls between the other two, and may include those aware of their symptoms but not yet in treatment, those awaiting an accurate diagnosis, those with an accurate diagnosis but waiting for an appropriate clinician.

The third group that may be less familiar to clinicians, includes those identifying as Plural, but not considering themselves “disordered”. This group may include those with philosophical or spiritual practices that lend to an experience of multiplicity but do not consider themselves traumatized by this, as well as those who have chosen functional multiplicity as a goal for treatment rather than integration – and who do not consider themselves “disordered” because they are functioning and not distressed by symptoms. This will be discussed further below.

This brings up the concern of online presentations of Plurals who do not have traditional, traumagenic DID adding to the prejudices of clinicians already erroneously critical to the concept of DID. While this is beyond the scope of this paper, it is a sociogenic phenomenon already noted with the Tik Tok platform and other disorders such as Tourette’s (Olvera et al., 2021; Muller-Vahl et al., 2021; Vera et al., 2021). Thus far in literature specific to DID, it has been described as false positives for DID (Pietkiewicz, Bańbura-Nowak, Tomalski, & Boon, 2021), with clinical findings we will return to later in this paper.

This third group tends to have a very developed sense of political identity as Plurals and they present very differently in session than those with dissociative disorders. In exploring a clinical profile for this population, some distinctions include presenting in the clinical setting with self-diagnosed DID or OSDD1b (OSDD being Other Specified Dissociative Disorder, and 1b indicating “without amnesia”, which would correspond to “Partial DID” as ICD-11 6B65 by World Health Organization, 2020), demands for specific models of therapy, upfront discussions about clinician’s views of integration, specific requests for functional multiplicity as a treatment goal rather than integration, and very high numbers of alters and “sub-systems”, of which they are already aware and with whom they are able to communicate or interact with in a variety of ways – including internal relationships, where alters may date or even marry each other, raise families together (including birthing new alters and having pets).

This group often has a very elaborately developed inner world with relationships rich in detail where all parts of the system seem to have knowledge and access, as well as awareness to where they do not have access and why. They are likely to have a high number of “fictive” alters, which is explained below, but included extensive and detailed backstories from movies or video games. Often, the development of the inner world and relationships between parts is something that Plurals enjoy and find soothing, which is distinguished from those with dissociative disorders, who are generally phobic of both their internal world and interaction with other parts. This description may be their experience of plurality, but does not fit the clinical definition of DID, partial DID, or OSDD1b. It does correspond with what Eli Somer has described as “Maladaptive Daydreaming” (Bigelsen, Lehrfeld, Jopp, & Somer, 2016; Soffer-Dudek & Somer, 2018; Somer, 2002; Somer, 2015; Somer & Jopp, 2016). Somer is actively researching these connections, as well as responding directly to the Tik Tok and Plural community.

There is also a significant intersectionality of trans and autism populations in this group. This could be further understood in future studies. Katherine Reuben has published on this first, and her ongoing research explores the developmental trauma experienced by these populations due to misattunement, neglect, bullying, and related traumas (Reuben et al., 2021). This population has also contributed to the development of Plural politics and advocacy (discussed further below).

As the online community collaborated across platforms to develop the survey for the PPWC, other more politically correct terms were agreed upon during the voting process prior to the survey. Specifically, the need was to identify terms for certain types of alters ("parts") that are frequently misunderstood in the clinical setting. One type of alter that needed a more appropriate term was what clinical trainings and presentations often refer to as "animal alters" or "alien alters". The Plural community decided that it was more appropriate to call these "non-human alters" to be more inclusive, decrease stigma, and make fewer assumptions about them.

Another alter needing a new label for its type was termed "fictive" – a word that describes an alter that is what books and manuals would have referred to as an "introject" in the 1980′s – which was forty years ago, and before more than half of the online community was even born. This, however, has become a distinction between those with dissociative disorders, who may have an "introject" as a psychodynamic process related to family of origin abuser or experience, and a Plural who has an internalized "fictive" that mirrors a character from media such as movies, anime, or video games.

The appearance of fictives in the community is significant. In part, it simply reflects a change in cultural references. It has been four generations since the diagnosis was formally established, and young people now provides a very different presentation than those who grew up in the 1940′s or 1950′s or 1960′s, but this makes them no less legitimate. However, this author proposes it also reflects the relational ruptures due to the shift in parenting practices over the last two decades – while primary caregivers may be abusive in some cases, as has always been true, there is a higher population with relational trauma due to neglect and some of these children create imaginary inner worlds to deal with the lack of presence of attachment figures (Sándor et al., 2021). In this way, fictives are, in part, at times, substitute introjects, and then the related rich inner worlds are further developed through maladaptive daydreaming (Somer, 2002, 2015, 2016a, 2016b).

Politics

As with any group or community that organizes, politics played an early part in the Plural community. Sub-groups of the Plural community may include, among others, a high number of individuals with disabilities (increased accessibility virtually), individuals who are autistic (preference and processing online rather than in person), and individuals of the LGBTQ+ community (connecting via virtual landscape rather than local geography). It was from these historical rights movements that the Plural community formed its politics.

These politics gained momentum through the summer uprisings and protests during 2020, giving the online community language for what they had experienced in their own therapeutic journeys. Reinders (2020) reported that in the average time from seeking treatment to receiving a correct diagnosis of DID, the average person receives four incorrect diagnoses, spends seven to twelve years in mental health services, experiences years of inefficient pharmacological treatment, and endures several experiences of hospital admission. Each of these experiences add to the trauma of lived experience, and those years of isolation from appropriate and effective treatment are a collective, historical trauma experienced by survivors that feels reminiscent of the dyadic trauma dynamic.

The question, aside from the experience of plurality, becomes "Who am I while I wait for correct treatment?" This does not even include the time it takes for good therapy, which can even be decades for relational trauma. Plurality provides a whole-life encompassing identity with which one can identify, and with which identities or selves one can agree, regardless of the wait.

Further, while Plurals wait for treatment, they now have access to each other in the online community. In a podcast interview with Kluft (2020), the discussion included how therapy used to be a single-point focused experience. Kluft described the dynamic of decades past as the therapist's office being the only outlet and safe space for a survivor to "do" therapy. In contrast, now there is a diffused-focus experience of therapy, because the survivor also has access to published works, online resources, virtual support groups, social media, YouTube, TikTok, blogs, podcasts, conferences, and organizations. This access to knowledge, emotional processing, and somatic practice on their own time empowers Plurals in a way different than any other therapeutic generation.

Yet Plurals also have access to more advocacy work than any other generation. Herman (2015, p. 9) wrote that "The systematic study of psychological trauma therefore depends on the support of a political movement… powerful enough to legitimate an alliance between investigators and patients and to counteract the ordinary social processes of silencing and denial." That is the goal of the System Speak podcast that began in 2017, to bridge the gap between clinician and client, and that was the goal of the Plurality movement that began to organize in 2019 – starting with what advocacy they already knew how to do through other political movements.

The motto became *Nihil de nobis, sine nobis*, a Latin slogan used to communicate the idea that no policy should be decided by any representative without the full and direct participation of members of the group(s) affected by that policy. Historically, this involves national, ethnic, disability-based, mental health, and other marginalized groups. The phrase originated in Central European political traditions in 1505 (*Nihil Novi* in Poland) (Bentley, 1860; Smogorzewski,1938), and then again in the early 1970′s by disability advocates in South Africa. It was next adopted in English in the 1980′s by James Charlton (1998) for disability activism in America before being taken up specifically by the GLBT community during the HIV/AIDS crisis.

Within this framework, the Plural community called for collaboration with the clinical community to prevent and reduce ruptures in the therapeutic alliance, to co-lead solutions, and to accept lived experience as the best understanding of barriers to treatment. They also formally requested to be included in the revising of treatment guidelines, as well as giving fair compensation and credit for their participation in research. Australia proved an example in response, involving Cathy Kezelman, a person with lived experience and co-author of Blue Knot Foundation's 2019 Practice Guidelines for Clinical Treatment of Complex Trauma, as well as providing advance copies for review and endorsement to community leaders prior to their release (Kezelman & Stavropoulos, 2012; Kezelman & Stavropoulos, 2019a; Kezelman & Stavropoulos, 2019b). While ISSTD is currently updating treatment guidelines, and has invited this author with lived experience to be included on the committee, the online community has had a great deal of discussion about whether or not the ISSTD team currently updating guidelines for adults and writing new guidelines for transitional age youth and children will reach out to the community at all or not, and what support they will give or withdraw if that does or does not happen. "Clients recognize that they have the opportunity to become active agents for change in their own behalf" (Jackson et al., 2009, p. 255). That being said, the subgroup of the Plural community who identify as Plurals but are neither distressed by this nor experiencing impaired function would not be "disordered" according to diagnostic standards, and so excluded from the need for or review of treatment guidelines (Christensen, 2020; Barach, 2021).

Cultural humility and clinical implications

When applying an ethical framework to these population, foundational principles still apply: doing no harm; promoting welfare; self-determination and autonomy; fidelity, faithfulness, and keeping promises; justice, equality, and fairness; and veracity and truthfulness (American Counseling Association, 2014). Doing no harm is nonmaleficence, while avoiding the doing of harm by promoting welfare is beneficence. Autonomy references the client's right to choose their

own course of action, which could be referenced developmentally as self-determination. Fidelity has to do with honoring commitments made to clients, which includes adhering to the other foundational principles as described above. Justice means providing equal treatment to all people, which includes the work of acknowledging our own bias and privilege in both the therapeutic relationship and the therapeutic process. Veracity refers to being truthful and acknowledging errors rather than deceiving or participating in the microaggressions of oppression, the misattunement of dismissing lived experience from the patient's perspective or failing to grasp the impact of the patient's cultural perspectives and meaning. These values are common to all the helping professions (Corey et al., 2010).

While many patients may have little to no interaction with the online Plural community, an increasing number of them will, due to younger generations' organic fluency in the online world. Lacking awareness of the development of the online community as culture for trauma survivors, and Plurals specifically, at this point could be considered maleficence, while educating oneself on the dynamic of the online community becomes simple beneficence.

"The therapist must avoid assuming [they] know the correct answer in advance. The therapist's role is not to lead the client to a particular conclusion [even with treatment goals, such as integration], but to walk the client step-by-step through the process" (Gold, 2009). Clinicians need to consider Plurals' increased awareness of their own autonomy even in treatment goals, such that functional multiplicity ought to be included as an option along with or instead of integration. Many already practice this in their offices, but without it in the literature or guidelines, Plurals continue to endure microaggressions from therapists poorly educated or overly-focused on their own agendas, and may themselves become verbally aggressive toward therapists in this defense.

In the stage-based approach of treatment, functional multiplicity will happen naturally, prior to and/or regardless of any kind of fusion or integration. Giving a name to the experience of breaking through the confusion and chaos by the process of communication, cooperation, and collaboration solidifies it, giving shape to tangible healing in a way Plurals can safely lean into or hold onto as a resting place — without the anxiety or big feelings regarding what happens to whom with fusion or integration. Much like how spending more time focused on Phase One increases safety so that the Plural has stability and capacity to later do the work in Stage Two, it seems that perhaps Stage Three should be moved to Stage Four for the same purpose. This gives more space for Functional Multiplicity as a Stage Three experience, with the time to practice it, much like skills at Stage One. It is a simple thing to add the phrase to clinical literature regarding the process of healing, yet has significant impact on improving quality of care experienced by Plurals in treatment.

Finally, the Plural online community has a love-hate relationship with the Theory of Structural Dissociation (Van der Hart et al., 2006; Boone, Steele, Van der Hart, 2011). It is normalizing to understand everyone is born with parts, and to learn that trauma interferes with normal integration as part of development relieves some of the shame Plurals carry by default. The Plural community appreciates these revelations being documented. But there is misattunement in structural dissociation's break from the traditional view of multiplicity, which results in the new (debated) assumption of one personality (divided into parts), which attempted to dismiss four millennia of conceptualizing more-than-one personality, ultimately attempting to shift the concept from "multiplicity" to "divisibility" in only two decades (O'Neil, 2021). More so, many who support and utilize the good aspects of structural dissociation's model do not recognize this is part of what has happened, causing unspoken rupture in relationship between therapist and Plural-who-is-not (because no multiplicity). This one aspect of structural dissociation feels incongruent with lived experience, and causes miscommunication when people are using the same words for different things, This is still being reviewed, with Steele (2021) returning to more ego state language and van der Hart (2021) shifting to "degrees" of dissociation and reporting that "dissociative parts of the personality may comprise any number of psychobiological states, which implies that labeling them ego-states or self-states is giving them a too low degree of reality."

Malingering, pretending, or maladaptive daydreaming

Traditional, traumagenic cases of DID have been well-documented and well-researched, with recommendations for treatment that include a phase-based and psychodynamic treatment model according to current guidelines. Cases of sociogenic plurality are only just now being discussed in literature, are distinct from traumagenic cases, and current guidelines do not apply for those reasons. However, as clinicians provide ethical and compassionate care, understanding the culture and community provides improved context for treating related issues for which these people may seek treatment.

As to the question regarding people online who may be "faking" or pretending, maliciously or not, Barach (2021) has reminded the clinical community that a factitious disorder is when someone simulates symptoms or claims to have a diagnosis they don't have in order to get treatment, and that malingering is when someone fakes a condition to get money or avoid legal responsibility, etc. Discerning this is part of clinical assessment, already. Updated research in regards to the online Plural community will enhance the tools we already use and provide new ones specific for their needs. Likewise, the online community continues to grapple with balancing support and inclusivity with the damage done by those imitating DID, all of which impacts both stigma and clinical care, as discussed further below.

There are several options immediately available to online resources in addressing these issues. One idea is that of "wait rooms" where people are added to an introductory group prior to being admitted to the main group, so as to first discern safety and traumagenic or sociogenic DID in effort to connect people to the group that most reflects their experience. Other groups focus on one or the other, such as the System Speak community focusing on traumagenic DID specifically or the Plural Association focusing on Plurality generally. There is also some level of community agreement needed to maintain safety due to triggers, maintaining focus (on healing and support, rather than "trauma dumping"), and redirection for any aggressive parts to keep people and participants safe. Clear boundaries and group purpose are also beneficial.

As for those who may identify as Plural but report no trauma history, there is valid concern on several counts. One, is that reports of Plurality without traumagenic origin could undermine the most recent research that defends DID as a trauma-based disorder against those who have dismissed it for far too long, despite so much research and evidence already. However, even within the Plural community, Plurality is a broader concept than DID, and that is understood by Plurals who claim no trauma history. Furthermore, the research confirming DID as a trauma-based disorder is doing just that: confirming traumagenic DID, the disorder, not Plurality, the identity. Reinders' (2020) research demonstrating diagnostic capability with fMRI differentiates already between DID and personality disorders, as well as DID and malingering, as do the common assessments available for dissociative disorders. Distinguishing between the two does not need to invalidate either.

As to those who identify as Plural but report no trauma history, there are three clinical responses. One is that some of these are not aware yet of their own trauma history, or may otherwise be explained by neonatal or epigenetic factors in way the patient does not yet understand but research is just discovering. A second is that the patient may be overlooking the impact of relational trauma, which we know now is more damaging neurologically than even

physical or sexual abuse (Reinders, 2020). A third is that those for whom really have no trauma history, but still identify as Plural, are not “disordered” because they are functioning and not distressed by their expressed identity (Barach, 2021). Any of these groups may be distressed by other things for which the clinician can offer treatment, such as anxiety or depression or other stressors.

Discussion and conclusion

In the online community, there appear to be three main groups: people with traumagenic, traditional, clinical DID or partial DID or OSDD; people with false positive DID, malingering, factitious DID, or imitating DID, or sociogenic DID; and people who identify as “Plural”, though they neither suffer from DID nor are distressed by plurality, but who find it helpful to refer to themselves as "Plurals". The bulk of research is for the first group, and research is only just now being published on the latter two groups. However, all three groups should still receive appropriate clinical treatment according to current research and guidelines specific to their presentation.

Further, in knowing whether or not or which resources to recommend to clients, it is helpful to know the group in which that particular client falls. While not all clients coming for treatment will have been exposed to the online community, they are likely to be exposed to it to some degree once receiving a diagnosis. Internet safety would be an appropriate psychoeducational issue to address, including issues such as not providing personal information about themselves or their internal system or world, not sharing personal contact information, and what boundaries look like online. It would also be appropriate to discuss that exploring available resources to understand one is not alone or to learn appropriate terminology and how this is different from the virtual world becoming a primary source of social interaction. It is important to understand the difference between a group that is focused on healing and support, and a group where people virtually gather for the purpose of talking about trauma details, presenting in crisis, or connecting as part of a lifestyle. Clinicians can encourage clients to seek out groups with clear focus, boundaries, and some level of moderation or responsive administrative team.

There are some Plurals who may be malingering or fictitious and not have DID or a cultural expression of plurality, but only faking DID to receive support. Clinicians may be overly concerned about the instances of such cases, with Plurals under-concerned about such cases. The balance is found in considering what a person has endured already, to need to go to such lengths in order to receive the support they need? Even clinically, if support is what a client needs, that is a simple treatment in response. Other cases may involve a rich inner fantasy life that is not the same as experiencing plurality, but the person may not have other ways to express it or other people who understand that experience, and so resonate with the Plural community.

Plurality may be a relatively new clinical experience, but is more than a passing trend at this point, and one that is increasing as the phenomenon spreads. Despite the challenges, there are also clear benefits to this, including reducing stigma and increasing support amongst survivors. Failing to recognize these culture aspects, regardless of which Plural group your client may be in, may cause significant misunderstandings. While misattunement will always be a rupture in the therapeutic relationship, even slowing down or interfering with treatment, it is always the repair that both tends to the person and models healing for the past. “To hold traumatic reality in consciousness requires a social context that affirms and protects the victim and that joins victim and witness in common alliance” (Jackson et al., 2009). Plurals need allies in treatment, not more stern parents. ““This is particularly salient in the treatment of patients with complex traumatic stress disorder, because the “injury” for which they seek treatment is essentially an interpersonal one…” (Jackson et al., 2009).

In contrast, Michael Salter and Heather Hall wrote:

“Dignity describes the felt experience of being valued while the innate human vulnerability to shame and injury is acknowledged and addressed… Dignified environments and processes are those in which both human value and human vulnerability are acknowledged and accommodated simultaneously, producing the experience of being recognized, understood, and treated with safety, fairness, and accountability…. Shame is the emotional correlate of attachment failure, child abuse and neglect; however, it is also a socially located and politically structured experience that is exacerbated by public policy, professional practice, and government decision-making” (Hicks, 2011, 2015 in Salter & Hall, 2020).

This applies even to goals for treatment, such as whether or not to choose fusion and integration. In the podcast discussion, Kluft (2021) referenced David Caul saying in the 1970′s that “it is most important to help an MPD patient become functional and safe, whether that is as a one owner business, a partnership, or a corporation.” He also cautioned about integration being a battleground early in treatment, and that “achieving safety, continuous contemporary memory, and addressing dysfunctions and distresses of all sorts should be preliminaries to integration - and may be all the patient can or will pursue”. Positives of integration include increased access to all aspects of experiences, past and present, and research reports increased safety with increased awareness (Bailey & Brand, 2017; Brand et al., 2019). Some of these benefits can be experienced with non-integration when more time for improved functioning is given in the latter stages of treatment, rather than subversing them by pushing integration too early or without client consent. In that context, this author recommends a Four-Phase Model, with phase three of Functional Multiplicity as a better stepping-stone for a season. “The role of the therapist in this enterprise is to guide the client through the process of thinking something through to a conclusion, while leaving the outcome or actual conclusion in the hands of the client” (Gold, 2009).

Part of future treatment will include dignity for Plurals. This means the increased advocacy of Plurals themselves, improved access to autonomy within the treatment room, and increased connection with others like themselves… all of which relational research says is healing and empowering. “Playing an active role in their own recovery can be especially important for individuals with complex trauma histories, because their symptoms can reduce individual autonomy and self-direction” (Jackson et al., 2009, p. 244). Maybe the question, then, is whether we can consider Plurality as “radical acceptance” in the treatment process, and not just because of it. “To accept is not to be passively resigned or hopeless, but to be actively involved in understanding things as they are, rather than as one wishes or demands they should be” (Follette et al., 2009, p. 272). Understanding things as they are will be a big part of future research in the field of trauma and dissociation.

Declaration of Competing Interest

I have no funding conflicts.

Disclosures

I am a clinician with lived experience. This is public information.

I wrote a memoir about my lived experience, which is public information, but unrelated to this paper.

While a part of the plural community because of my diagnosis, I do not identify as plural in the political sense. This is public information.

I am the voice behind the podcast “System Speak: A Podcast about Dissociative Identity Disorder”. This is public information and intersects with this article due to previous projects.

These public facts make it difficult to de-identify myself in this paper for reviewers, but I have no (known) relationship with reviewers.

I am the Professional Training Program Administrator for ISSTD, which is simply taking attendance for their CEU programs offered and is not a conflict in presenting this paper. I am not in any way representing ISSTD or working for them in writing this paper. My opinions are my own.

The survey results referenced in this paper were presented in the 2020 ISSTD Conference poster session as requested by and with permission of participants who consented in these results being shared publicly in papers like this one.

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