This thesis is dedicated to Audrey and Leslie,
my proud parents, and to My Children,
all of whom have been my teachers.

DISSOCIATIVE IDENTITY DISORDER IN THE UK: COMPETING IDEOLOGIES IN AN HISTORICAL AND INTERNATIONAL CONTEXT

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ABSTRACT

This thesis reviews both the UK and International literature on Dissociation, and in particular Multiple Personality Disorder (MPD), or as it is now known, Dissociative Identity Disorder (DID), in an historical context from the early seventeenth century to the present day. The prevailing published view, of Psychiatrists and Psychologists in the UK, that DID does not exist in Britain and is a US phenomenon, is critically explored. Cases are traced throughout many countries of the world and across this historical period, showing that US hegemony is a modern phenomenon. Two areas of original contributions to the topic are presented and discussed in this thesis. The first is presented via a case study of the author's psychotherapy with a young woman diagnosed with DID. This account permits an extended critical analysis of the diverse theoretical issues surrounding DID and, as an original contribution, provides a discussion regarding treatment issues, raised in relation to the specificity of DID as well as highlighting the need for professional training and supervision. The second original contribution is the construction and analysis by the author of a nationwide survey sent to all Psychiatrists (registered with the Royal College of Psychiatry) and Clinical and Counselling Psychologists (registered with the British Psychological Society) in the UK, which is discussed and analysed. Further analyses focus upon variations in professionals' response rates and patterns of identification of the disorder. Age and gender profile of reported cases were found to be comparable to other psychological conditions.

SYMBOLS & ABBREVIATIONS

ABA	American Bar Association
APA	American Psychiatric Association
BASK	Behaviour Affect Sensation Knowledge – Braun
BJP	British Journal of Psychiatry
BPD	Borderline Personality Disorder
BPS	British Psychological Society
BRMS	British False Memory Society
CSA	Child Sexual Abuse
DDNOS	Dissociative Disorders Not Otherwise Specified
DID	Dissociative Identity Disorder
DSH	Deliberate Self-harm
DSM	Diagnostic & Statistical Manual
ESK	Event Specific Knowledge – Conwey and Pleydell-Pearce
ESTSS	European Society for Traumatic Stress Studies
FMS	False Memory Syndrome
ICD	International Classification of Disease
ISSD	The International Society for the Study of Dissociation
ISSD(UK)	International Society for the Study of Dissociation in the United Kingdom
ISSMP&D	International Society for the Study of Multiple Personality & Dissociation
ISTSS	International Society for Traumatic Stress Studies
MPD	Multiple Personality Disorder
PET	Positron Emission Tomography
PTSD	Posttraumatic Stress Disorder
RCP	Royal College of Psychiatry
SAE	Stamped Addressed Envelope
SPR	The Society for Psychical Research
UK	United Kingdom
UKSSD	UK Society for the Study of Dissociation
WHO	World Health Organisation

Dissociative Identity Disorder in the UK:
Competing Ideologies in an Historical and International Context

CHAPTER ONE

INTRODUCTION

1.1 Introduction to the Thesis

The phenomenon of multiplicity, in modern times called Multiple Personality Disorder (MPD) and later renamed Dissociative Identity Disorder (DID) (DSM-IV, 1994), is described when a person experiences themselves as comprised of distinct and un-cohesive self-parts, to the extent that they experience themselves as more than one person. This phenomenon came to my attention first in 1987, when for several months I had been seeing a client, who I shall call Marian. I had recognised at assessment that the case was complex, and had engaged an external supervisor, who raised the possibility of multiplicity. My response had been very sceptical, and the following day a letter arrived in the post from Marian, saying "We need you to know there are others of us in here. She brings us to see you but doesn't let us out". Although very shocked and bewildered, I felt it important that my scepticism did not impede my ability to understand the experience of the client and to gain access to her perception.

I acknowledged receipt of the letter, to the client, who responded both as if she knew nothing about it, and also by acknowledging sending the letter and telling me more about being multiple and needing help. I adopted a similar approach to that used when dealing with thought disorder or cognitive distortions; I accepted that this was the way Marian was experiencing herself. As with other clients in the past, I never assumed the client was deliberately lying, although I continued to keep in mind that there is always a difference between subjective and objective data and that all data contains distortions that need to be understood. I reality tested clinical material, as I would with any other client, by reflecting any incongruities in the data and cross-referencing data from different sources, where available. As with any therapy, there was much data that could not be externally cross-referenced, but could be assessed for congruence.

I worked with Marian for approximately three years, during which time she reported achieving some co-consciousness between self-states that she had previously reported to be amnesic. That is, she was able to reduce some of the amnesia between some of her self-parts. She also reported that she experienced reduced loss of time, in the self-part that mainly lived her daily life, and was able to obtain information from other self-parts retrospectively, when amnesia did rarely happen. She was still subject to occasional crises, and on one occasion reported that she had sought additional help, through a charismatic church leader, who had performed an exorcism. I never established the objective truth of this statement, but at that time there seemed to be a distinct deterioration in her functioning, and some of the therapeutic gains that she had previously made were reversed. It took several months to regain the former progress and then to go further, in improving her functionality.

Marian had to have her therapy terminated with me when I changed posts and was unable to continue seeing her. Unfortunately, this was experienced by her as great betrayal, probably, in part, because I had not understood how to ensure that I did not, inadvertently, give the impression that I could always be there for her. The transference and especially the counter-transference issues have a very intense quality in clients with a poorly developed sense of self, and I had not been trained adequately, either as a clinical psychologist, or as a psychotherapist, in how to deal with this intensity. My supervisor had provided rational and helpful support, and I then appreciated the pronounced need for supervision with such cases, and the need for specific training in meeting the needs of clients with this level of difficulty. During subsequent years as a clinician, supervisor and trainer, I have become acutely aware of how poorly clinicians are trained and supported in this kind of work. Therefore clients who are very vulnerable are unable to access adequate services at will. This impressionistic data will be examined further below.

In attempting to make sense of my clinical experience with Marian and other clients presenting as multiple, to provide adequately for my clients, and to support other professional colleagues similarly faced, I researched the available literature in this area. However, I was handicapped by the lack of informative literature in the UK. Anecdotal evidence suggested that, because of a lack of free and open professional

discussion, often such professionals found themselves caught between ethically providing a service to clients and facing undermining or sometimes even hostile attitudes from other colleagues (Discussions at ISSD UK Conferences). The idea of multiplicity seemed to evoke strong reactions from all sides. These cases sometimes exacerbated the differing theoretical stance between professionals. There was an obvious lack of training for health professionals regarding trauma issues generally, including sexual abuse issues. Dissociation was a topic of which most people were unaware, or about which they had not received training. I did find some of the international literature on the subject informative, and some intervention guidelines and training events, provided by the International Society for the Study of Dissociation, to be of great benefit (*ISSD Guidelines for Treating Dissociative Identity Disorder in Adults*, 1994). It helped me in maintaining clear boundaries and in promoting maximal safety and functioning in my clients. Despite my initial scepticism, I began to wonder why the UK professional press, and apparently some UK publications, mainly by psychiatrists and psychologists, were so dismissive of data pertaining to the issue of dissociation and multiplicity, writing it off as iatrogenic and an American phenomenon. This certainly did not match my experience or the anecdotal experience of some other UK professionals, or clients for that matter. I thought it important to obtain some objective data to ascertain the perceptions of a wide circle of mental health professionals on multiplicity, and their experience of this phenomenon.

In examining the polarised opinions, epitomised by the exchanges in the British Journal of Psychiatry in 1993[1], it is necessary to examine briefly what attitudes are and how they are formed, and to determine the attitudes and beliefs of professionals and clients. Atkinson et al (1990) describes attitudes as 'likes and dislikes', attraction or repulsion in relation to something. Kleinman (1988) has noted that

[1] The controversy of whether MPD/DID exists was debated in the British Journal of Psychiatry in 1993, with Spiegel (1993) and O'Dwyer & Friedman (1993) indicating that it did exist and indeed was a complex but important area of psychopathology. They suggested that the documented evidence on MPD supported their opinion. Merskey (1993) and Aldridge-Morris (1993) on the other hand were sceptical at the existence of MPD as an independent disorder and suggested that there was not a single piece of evidence that was unequivocal in the diagnosis of MPD. They suggested that no reported case could ever fully exclude the possibility of artificial production, due to intentional or accidental suggestion, or prior preparation as a result of widespread publicity. In support of his argument, Aldrigdge-Morris (1993) also stated that the existence of MPD was disputed in the American Journal of Psychiatry in 1987 by Paul Chodoff.

psychiatric diagnoses derive from categories that themselves result from 'historical development, cultural influence and political negotiation'. Atkinson et al (1990) point out that the question is whether attitudes are logically consistent with one another, with their associated beliefs, and with their associated actions, but that inconsistency is more prevalent than consistency. Attitudes are not even accurate predictors of behaviour, though strongly held beliefs and attitudes are the better predictors, but the best predictor of all of behaviour are attitudes based on direct experience. Where cognitive dissonance occurs, attitude change is motivated by the wish 'to avoid looking bad' (Tedeschi and Rosenfeld, 1981). Newnes et al (1999) argue for the need for openness and empathy, and not rigidity, when treating clients, if therapy is to produce change and not rigidity in the client.

In an influential paper, Harold Merskey (1992) asserted that MPD (DID) is rarely, if ever, found in Britain. Most published opinion that was oppositional to Merskey, came from outside of the UK, thus appearing to confirm Merskey's contention (Spiegel, 1993). However, there was no research evidence in the UK to support or challenge Merskey's claims. This thesis attempts to provide some of the necessary UK data to test how representative these published opinions are of both the historical literature in the UK and the perceptions and experience of key professions. The writer has taken an historical perspective, to integrate theoretical discourse in order to clarify and extend the debate further and to inform clinical practice in this field. To this end, this research will present a single case study of a young woman diagnosed with DID, and a nationwide survey of relevant professionals to provide two distinctly different sources of data regarding the UK.

1.2 Introduction to the Literature Review

Despite a rich historical seam of literature discussing dissociative disorders, the status of DID remains a controversial topic and, at times, as this literature review will document (see especially **Chapter 4**, the third part of the literature review), has prompted lively contemporary debate. Part one of the literature review (**Chapter 2**) examines the published data from the late sixteenth century to 1880, and identifies social, political and historical factors that, it is argued, have promoted or hindered the recognition of DID and resulted in fragmented professional opinion.

Dependent on the authors' acceptance, or otherwise, of the validity of the diagnosis of DID, previous reviews have charted the historical evidence for dissociative disorders (eg Hacking, 1991; Carlson, 1981, 1984) or proposed alternative diagnostic categories for this evidence (Merskey, 1992). The present study however, in placing the literature within a socio-political historical context, and locating it within the framework of the emergence of psychology as a discipline, explicitly examines the factors that have hindered or promoted the recognition of DID. In taking an international perspective, and reviewing the more recent literature, the way in which this context has impacted or failed to impact upon the contemporary status of DID amongst professionals will be examined.

Before further outlining the structure and content of the present review, it is first necessary to orientate the reader and provide a basis for the evaluation of sources by offering an account of the defining qualities of DID and related dissociative phenomena. Primarily, DSM-IV criteria (SCID-D-R, Steinberg 1994) describe dissociation as "a disturbance in the integrative functions of memory, consciousness, and/or identity", which is evidenced by such dissociative symptoms as: amnesia (blank periods or blackouts); depersonalization (feelings of detachment from the self, feeling like an outside observer to one's own body or mental processes); derealisation (the altered perception or experience of the outside world as strange or unreal); identity confusion (subjective feelings of uncertainty or conflict regarding one's own identity); and identity alteration and disturbance (rapid mood changes, age regression and flashbacks). These diagnostic criteria permit the differentiation of types of dissociative disorder, for example Dissociative Amnesia and Depersonalization Disorder, whilst Dissociative Identity Disorder is diagnosed in such cases that "the presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self)" (op cit, p82) is evidenced.

The literature is discussed in three chronologically defined parts (**Chapters 2-4**). In the first part, material up to 1880, all available published sources have been accessed, and the inclusion of these sources within the review was determined by relevance to the research questions. In the subsequent sections, 1880-1980 and 1980-present, selection was necessary due to the proliferation of material. In these final two

sections of source material, all relevant UK publications, and those published in the non-UK press by UK authors, or regarding UK subjects, have been prioritised. Where there has been a concentrated period of activity in countries other than the UK, such as that in France at the end of the nineteenth century, it is included because of its importance to the developing concept of DID. Also included are representative examples of case studies or research reports, from other countries, in order to maintain the international context for the UK situation and, in particular, to explore the way in which it relates to UK opinion at the time and in the present. The structure of these sections reflects this proliferation of sources and the increasing complexity of concepts and models. The literature review, most notably section three, is subdivided to provide focus to the material. Despite this imposed structure however, there are, of course, continuous themes that emerge and develop, and may be traced throughout the review. To orientate the reader, two major themes concern the distinct and separate development of the traditions of psychology and psychiatry, and the emergence of the belief among published mental health practitioners, in Britain, that DID can be considered a North American phenomenon. Beyond this necessarily selective approach, this review seeks to adhere to the methodology described by Ellenberger (1970, pv), by attempting to "never take anything for granted, check everything, replace everything in its context, and to draw a sharp distinction between facts and interpretation of facts."

Following this review of the literature, the present research study aims to address further the issues regarding the status of the diagnosis of DID, by gathering much needed data, in a UK context, through the presentation of both a single case study and via a nationwide survey of two relevant professions.

CHAPTER TWO

REVIEW OF LITERATURE: PART 1

The pre-1880 period

The authority of faith and the medicalised proto-scientific account

2.1 Introduction

Ellenberger (1970, pvi) asserts, "a continuous chain can be demonstrated between exorcism and magnetism, magnetism and hypnotism, hypnotism and the great modern dynamic systems [of psychiatry]". It is not surprising then, given the historical context of the late sixteenth and early seventeenth century, that the first descriptions of dissociation and DID, in the literature, are set in the paradigm of witchcraft and possession. The opinion that such descriptive accounts, as will be discussed here, are evidence of dissociative phenomena is expressed by a number of authors, including Slovenko (1989), who believed "the phenomenon of 'possession,' or demon possession, frequently reported for many centuries, could well be considered as the expression of one variety of multiple personality".

2.2 The Case of Mary Glover

An early report, in Britain, of a case of alternating states with amnesia, is to be found in Jorden (1603), reproduced in MacDonald (1991). This describes the case of Mary Glover who, at the age of fourteen, at the end of April 1602, "fell ill following a dispute with Elizabeth Jackson" (MacDonald, 1991, px). Mary Glover, the daughter of a shopkeeper, was accused Jackson of fraud, telling tales to one of her mistresses about Jackson's begging. Thus accused, Jackson was enraged with Glover, imprisoning her and berating her with "terrifying and malevolent curses" (MacDonald, 1991, px). The impact was immediately felt by Glover, who became unwell, and three days later, in the presence of Jackson, she experienced constriction in her throat and then became blind and dumb. She was reported not to eat anything for eighteen days, but did not suffer any related symptoms. Later she developed

unconsciousness and contortions in response to the presence of Jackson. Other accounts of Mary Glover are provided by Swan (1603) and Bradwell (1603).

MacDonald (1991) highlights the context of this case as being a struggle for power and influence between leading religious forces and the alternative rational conceptions of scientific medicine and less puritanical ecclesiastics. The former camp espoused the Devil as a living entity, and supported the concept of possession and witchcraft, as well as employing extreme and partisan administration of justice and punishment. Hunter and Macalpine (1963, in MacDonald, 1991, pvii) credit Jorden, a rationalist physician, acting as expert witness for Jackson, with introducing the concept of hysteria into English Medicine, whilst Ilza Veith (1965, in MacDonald, 1991, pvii) goes further and suggests that "Jorden's transfer of the seat of all hysterical manifestations from the uterus to the brain constitutes a major turning point in the history of hysteria." However, this development, as early as the beginning of the seventeenth century, will later be ignored by Dewar (1823) (see section **2.5**).

Thus these seventeenth century opinions, expressing the view that this case illustrates, show the challenge that an emerging scientific approach presented to the dominant religious explanatory framework, and prompt further investigation of the cultural context. Torn between belief in the supernatural and scientific knowledge, even the physicians were insecure and confused in their philosophical paradigm, never mind the public and non-scientific professions. MacDonald reminds the reader that "Most Elizabethans believed that curses could kill" (MacDonald, 1991, pxi) and various physicians had, in the case of Mary Glover, failed to bring about a cure. Indeed, after two months of failed medical intervention, the doctors seemed divided between physical and supernatural explanations, thus demonstrating the degree to which such methods of understanding pervaded thought, and so too the fact that science was yet to achieve separation from religious orthodoxy. It exemplifies also the prevailing human tendency to regress from higher or newer learning to more fundamental and even magical or supernatural thinking under conditions of stress.

This recourse to supernatural explanations has parallels with the switching between medical treatment models and morally loaded reasons for treatment failure, as are

evident later in this section, and exemplified by some modern mental health perspectives. It could be argued that hybrid models are employed such that medicine can take credit for successes, but is absolved in the event of failure. Drug and alcohol models can be seen often to operate in this fashion. Biological models of dependency are confused with moral models, and when medical treatment fails the client/patient can find herself dismissed as reprehensible and non-compliant "... society and its agencies have always had a consistent response, in that in the same breath they are able to say the homeless alcoholic is 'sad, mad *and* bad'" (Cook, 1975, p172, in Orford, 1985, p292).

In the Glover case, an orchestrated petition by Jackson to the College of Physicians did, on this occasion, result in the majority deciding against the idea of witchcraft. The outcome of the investigation however, did not rest solely on medical opinion. The system of Legal investigation of witchcraft lacked the objectivity strived for by its modern counterpart, and employed various public events that constituted something between idiosyncratic legal process and circus entertainment. The final judgment appears to have relied on the concept that a natural disease must be naturally curable and the only alternate explanations are fraud and the supernatural. It is argued that this dichotomous thinking regarding dissociation can be seen to have a modern counterpart within biological psychiatry, and this will later be examined.

In conclusion to the Glover case, Jackson was found guilty of witchcraft and given the maximum sentence of one year's confinement with periodic pillorying. Fortunately for her, witchcraft did not become a capital offence until 1604. In fact Jackson was quickly released from prison because of the influence exerted by, in MacDonald's terms, "powerful supporters" (MacDonald, 1991, pxviii). He further suggests she probably received a royal pardon (op cit, pxix). Glover's condition continued until exorcised by "Puritan divines and godly laymen" (op cit, pxix) through prayer and fasting. Succinctly summarizing the significance of this case, MacDonald (op cit, pxix) describes Glover as having become "the central figure between religious truth and official persecution."

Further illustrating the solidity and enduring influence of religious views, MacDonald states "Exorcism had been controversial ever since the mid-sixteenth century, when it

was struck out of the English rite by Protestant reformers". This reformist view was however in opposition to the Catholic perspective and "The demand for spiritual remedies for supernatural afflictions did not diminish merely because reformers had foresworn exorcism" (op cit, pxix). As mentioned in my introduction, clinical experience indicated that modern approaches to DID can also attract similar resort to spiritual and religious methodology.

Thus the case of Mary Glover provides not only an early case study that can be interpreted within the modern framework of DID, but also an illuminating insight into early seventeenth century perspectives on the status of religious and scientific knowledge – more specifically the dominance of religious explanatory frameworks. Jorden's (1603) standpoint is significant, not only because he failed to resort to supernatural explanations in the face of opposition, but also because he implicated the brain as the seat of the disturbance. However, as regression to religious explanation is evident in this account, so too later examples of regression on this anatomical issue are found below in this literature review.

A further issue to note in consideration of this account, and indeed all contemporaneous sources, is that in order for a case to be recorded at this period of history, it would need to come to attention within a sphere of literacy such as medicine, religion or the law. As with all methods of data collection, bias is unavoidable, but must be acknowledged in the interpretation of this and the following collection of sources.

2.3 Early European Reports and the Contribution of Mesmerism

The earliest recorded cases suggestive of DID are not confined to Britain. This will become of importance, as issues emerge later in this historical review, regarding the cultural specificity of DID, and as we have already demonstrated, early cases are certainly not located in the USA. To illustrate, the French case of Jeanne Fery in 1584 is a recorded incidence of possession that may be understood through modern eyes as a case of possible DID. The identity fragments, switching of control between alter personalities, amnesia and childhood trauma of this 25-year-old Dominican Nun in Mons, France, was documented in some detail in 1623, republished in French by Bournville, (1886). Pierre Janet, one of the most significant figures in the field of

dissociation, to be discussed below, knew Bourneville, and he also diagnosed this case as "doubling of the personality". While in Italy, in 1623, Bernadetta, abbess of a Thatine convent (Brown, 1986) demonstrated both male and female personalities, some with different facial expressions, dialects and amnesia. Behavioural details include sexual activity with a young nun, self-mutilation and eating disorder. Her parents were reported to be possessed, her behaviour had become uncontrollable after the death of her father and she had been sent to the convent at age nine. For detailed comparison of these cases see van der Hart et al (1996). These two early cases appear to have had several alternating states that were quite well developed and, in many other respects, have much in common with modern cases and descriptions of MPD/DID.

In Germany, in the eighteenth century, new discoveries would make it possible for such cases to be recognised in a new way, moving from the idea of possession, to a more psychophysiological theory. Franz Mesmer (1779) was influenced by the fact that "some English physicians were treating certain diseases with magnets" (Ellenberger, 1970, p58), and experimented by making his patient swallow an iron preparation and then attaching magnets to her body. His patient was freed of her ailments, at least temporarily, and Mesmer, again illustrating the confusion between physical science and metaphysical or perhaps ego-centric perspective, concluded that it was his animal magnetism that had brought about this effect. He conceived of animal magnetism as a powerful universal fluid that was channelled and focused by the use of magnets to effect cures (Ellenberger, 1970). Marquis de Puysegur (1784) witnessed Mesmer's demonstrations and tried this concept out one day on a member of his staff; as a result, the man fell into a sleep. Thus it was that Puysegur discovered magnetic sleep that would later come to be known as hypnotism. It was thought that this might permit greater lucidity and communication with what he called the World Soul (Ellenberger, 1970).

This recognition of a divided experience of self, then to be called magnetic somnambulism, provides the framework for the prevailing paradigm of the period that Adam Crabtree calls the "Magnetic Sleep Period" (Crabtree, 1993, p67). Seven years later, this would be the context that would permit Gmelin (1791), one of the German mesmerists, to report a case that may be more clearly recognised as

multiplicity, (summarised in English in Ellenberger, 1970, p127). This account is set in the context of the arrival of aristocratic refugees in Stuttgart, fleeing from the French Revolution of 1789.

> "In 1789, at the beginning of the French Revolution, aristocratic refugees arrived in Stuttgart. Impressed by their sight, a twenty-year old German young woman suddenly "exchanged" her own personality for the manners and ways of a French-born lady, imitating her and speaking French perfectly and German as would a French woman. These "French" states repeated themselves. In her French personality, the subject had complete memory of all that she had said and done during her previous French states. As a German, she knew nothing of her French personality. With a motion of his hand, Gmelin was easily able to make her shift from one personality to the other."

The use of hypnotic techniques was not confined however to this historical period. Their use, and the importance of their role, in the development of, and challenges to, the concept of multiplicity or DID, will be discussed further in the following section.

As with many, but by no means all of the cases reported before the twentieth century, Gmelin's case is one of two states with apparently complete memory within state and apparently complete amnesia between states. Retrospective analysis of these early cases is limited by the lack of adequate data, thus there is the danger of projecting labels and interpretations onto ambiguous data. This has permitted different opinions regarding diagnosis. For example, Morton Prince, a scientific investigator in the USA, in the early part of the twentieth century, diagnosed another case of dissociation, that of the Reverend Ansel Bourne (Fahy, 1988, p599), but Fahy, and also Hodgson (1891), prefers the diagnosis of fugue state. This differential opinion regarding diagnosis is a recurring theme. Analysis is made more problematic by the fact that, in the opinion of some authors, modern psychiatric labels are not scientifically derived, nor mutually exclusive, and obfuscate their function to align psychiatry with medicine and science (Boyle, 1999). Thus this permits a number of possible psychiatric labels, such as Conversion Hysteria, Borderline Personality, and Schizophrenia, amongst others. Further, it is important to note that alternatively proposed diagnoses such as hysteria are often themselves complicated, and a product of a number of complex influences, such as the emerging physiological knowledge, patriarchy and a reductionist, biological approach to psychosocial factors in mental

health. Even today, in many publications there is little evidence that modern interpreters are controlling for subjective bias in their retrospective labelling process, thus explicit acknowledgement of speculative interpretation is important to ground analysis.

The data does permit a parsimonious interpretation in the light of modern understanding of dissociation and DID. The defining features of these early cases that are suggestive of DID, and are not characteristic of other labels, are the switches between distinctly different self-states accompanied by amnesia between states. The other potentially common feature is the possible presence of trauma. In the Glover case, inescapable trauma is extant; in the case reported by Gmelin (1791) there was war trauma and dislocation. Similarly, in the Fery case there had been childhood trauma (Onno van der Hart et al, 1996, p18), but in the Italian case (Bournville, 1886) trauma is less clearly identifiable (van der Hart et al, 1996, p19), although it may be asserted that Bernadetta could have been traumatised by the death of her father when she was very small, by being placed in a convent from the age of nine, or the frightening prospect of having 'possessed' parents. Indeed, generally speaking, it was not unusual for women to enter convents to seek solace from personal and public trauma. Van der Hart et al (1996) report that Jeanne Fery's order, the Beguines, was a proto-feminist force, with laywomen taking temporary vows for protection and support during the Hugenot Wars. Furthermore, David Lewis (1971) examines the possible function served by spirit possession in allowing the expression of impulses and opinions that would not be acknowledged because they were theologically dangerous; thus trauma may have resulted from the oppression experienced in religious institutions.

In considering the limitations of data and analysis, it is informative to place material in the macro-context of scientific progression. The linear view of human, cultural, and therefore scientific development is challenged by some scholars (West, 1993). Robinson (1995) has also shown the convolutions extant in intellectual history. The scientific method of detailed objective data collection has not benefited from steady progression over the millennia or even over the past few centuries. At least the modern Western era provides a disappointing lack of detail regarding DID on which the modern scientific mind can build. In these early cases, personal hobbyhorses and

fashionable trends, as well as levels of knowledge and awareness, can be seen to influence interpretations. What is less clear is that this also limits the type of data perceived, collected and recorded. Our modern era is no less prone to such cultural and political influences, but distance lends enchantment and perhaps clarity to our historical view. In Western Science, Psychology is a relatively young discipline, and so these early Western cases are tantalisingly lacking in the descriptors we now desire. When psychological perspectives do occur, as we will see later, they often emerge as adjuncts to medical data.

2.4 The Case of Mary Reynolds

To return to the chronological appraisal of sources, despite modern perceptions of DID as a North American phenomenon (later discussed in part three of the Literature Review, **Chapter 4**), the first American case reported is actually of a British woman, born in Birmingham, UK, who subsequently emigrated to Meadville, Pennsylvania, USA, with her Baptist family. It is the first case to be explicitly and contemporaneously labelled as double consciousness, and is reported second-hand by Dr Samuel L Mitchill, in the US journal *Medical Repository*, in 1816. The first hand account was provided to Mitchill by Major Ellicot, professor in Mathematics at the United States Military Academy, at West Point, who was related to the woman, named as Miss R. This is the often-cited case of Mary Reynolds, who was reported to have had two alternate states of consciousness, each with amnesia for the other. Her problem appears to have settled spontaneously into the second state from the age of about 35/36 years. This case, in common with the Glover case earlier discussed, lends itself to more detailed consideration as it is reported from multiple sources. As such, not only do these cases permit consideration of the key issues of the age, they also permit the reader to make comparisons with regard to the progression of knowledge and scientific investigation.

Timothy Alden (1816), quoted in a report by Sherman Day in 1843 in the Historical Collections of Pennsylvania, provides more detail of Mary Reynolds. Alden (1816) described her as "a worthy young lady" (Sherman Day, p254) whom he had seen the evening before she first displayed "two distinct consciousnesses" (op cit, p254) and whom he had seen the following evening when she did not recognise him. She had initially become blind and dumb for approximately five weeks, and it was twelve

weeks before she woke one morning having forgotten all that she knew. She then continued to alternate between these two states, that appeared intact but with amnesia between them, for a number of years. He reported that she spent more than three-quarters of her time in the second state and, when learning to write, in this state, wrote from right to left. Day reports that by 1843, having settled into the second state, she had had "no return of her peculiar insanity for many years" and that she "is of sane mind and in good health, and is a teacher in a school" (op cit, p255).

In 1860, in *Harper's Monthly Magazine* (May), the Reverend William S Plumer provides an even more detailed account of the Mary Reynolds case, from several sources available to him at that time. This includes quotations from an account written by Mary Reynolds herself. The alternating states lasted for about 16 years and, having ceased at approximately 36 years of age, this problem of alternating consciousness never returned. She died aged 62 years. She and her family appear to have regarded her situation as an affliction, and she herself reported fearing the switches of state and loss of control. The distress expressed in this first hand account resonates with the reported experiences of those affected by DID in my clinical experience. Plumer describes much detail of Mary's condition, reporting that Mary gradually became aware of the imminence of switching from the second state to the first, but the transition the other way round was always following an unusually profound and elongated sleep. She appears to have slept and eaten little in the second state, which became the dominant state. She was also reported to have quite different handwriting in the two states. Upon switching states she was inclined to carry on from where that state last left off.

Plumer (1860, p812) concludes,

> "That the case was a genuine one admits of no doubt. The leading facts are authenticated by a chain of testimony furnished by witnesses of unimpeachable character, covering the whole period. Mary Reynolds had no motive for practicing an imposture; and her mental and moral character forbids the supposition that she had either the disposition or ability to plan and carry out such a fraud; and had she done so, she could not have avoided detection in the course of fifteen years during which the pretended changes alternated and the subsequent quarter of a century, during which she professed to pass wholly in her second state."

Plumer's (1860) opinion thus demonstrates that, although rejected, artificial production of symptoms for secondary gain was at this time considered as a possible explanation. S Weir Mitchell (1888) is more equivocal in his acceptance of Ms Reynolds's presentation. In his highly physiological discussion he quotes at length from the Rev John Reynolds, nephew of Mary Reynolds, and from the writings of Mary Reynolds herself. Mitchell takes issue with the observation that Mary's handwriting differed in her different states, reproducing photographs of the writing in the two states and submitting them to an expert who concluded they did not differ significantly. Plumer describes the differences in Mary's character and habits as being wholly different.

> "In her first state she was quiet and sedate, sober and pensive, almost to melancholy, with an intellect sound though rather slow in its operations, and apparently singularly destitute of the imaginative faculty. In her second state she was gay and cheerful, extravagantly fond of society, of fun and practical jokes, with a lively fancy and a strong propensity for versification and rhyming, though some of her poetical productions appear to have possessed merit of a high order. The difference in her character in the two states was manifested in almost every act and habit." (Plumer, 1860, pp 808/9)

Perhaps the code of conduct in such a religious household gave less permission for the more sociable character of the second state than did Mary's condition. Mary herself said of her second state "I cared for nothing but to ramble about, and never tired of walking through the fields and woods" (op cit, p808). Given that the Reynolds family lived in previously unsettled territory that was still subject to attacks from the indigenous population and wild animals, modest young ladies of that period might be expected to be more sedate and less exploratory. Indeed there is uncertainty as to how her condition came to be caused. She was found far from her home out in the fields in a state of "utter insensibility" (op cit, p807); from the perspective of modern theories this is potentially suggestive of a trauma.

The Reynolds case has become a landmark case, probably in part because it was reported in multiple sources, and because it provides a wealth of description compared to other early cases, but most likely because of the superior bibliographic availability in the United States. Observations are quite extensive and symptoms are explicitly discussed, documented as comprising alternate states with mutual amnesia

between states, and sleep and appetite disturbance. There is some continuity with modern accounts; the notion of secondary gains is considered and scepticism is evident, as is the discussion of competing medical diagnoses such as epilepsy and hysteria (see further discussion below; section **2.8**). It lends itself to easier recognition as a potential case of MPD, albeit possible dual, compared to the Glover case, which was presented as possession. It is also perhaps interesting to consider that the Reynolds case has received greater attention because it has been considered an American case, and therefore was more easily identified by American authors, although she originated in Britain. Because of language barriers, for English speaking authors, it was much later that the early European cases began to be recognised and resurrected in connection with MPD, notably by Jean Goodwin and Onno Van der Hart, who are multilingual. Later sources are more easily identified by literature searches, and this is another likely reason for the greater difficulty in identifying earlier cases. Another interesting selection bias in modern British accounts is the way that, although the Reynolds case contributes to the idea that DID is a US phenomenon, it has been largely ignored by British writers and was overshadowed by the supposed influence of the film *The Three Faces of Eve* (Nunnally Johnson, 1957), thus sparing commentators the need to address the full historical evidence for Multiple Personality Disorder and its relationship to Britain.

2.5 The Lens of History

To return to discussion of competing historical forces, we have observed how emerging medical knowledge was required to struggle against the previous religious paradigm, but from the twenty-first century perspective it can more clearly be seen to be steeped in patriarchal influences that serve to impede progress, as will be highlighted below, in the **General Discussion**, **Chapter 11**, and modern counterparts examined, in **Chapters 4 and 6**. Relatedly, it is also interesting to consider whether competition between religious and scientific explanations continues to be a factor in the development of knowledge about DID at this nineteenth century stage. Mary Reynolds's family members were stated to be Baptists; additionally, Mary's nephew, who provided much of the account from which S Weir Mitchell drew his information, was a reverend (Plumer, 1860). There is also explicit religious content to some of Mary's dreams/hallucinations, and in her recovered memory of the bible; indeed she lived in a household frequented by clergy and preachers (op cit). Mary's two states

were very different from each other; in one she was quiet and sedate, in the other strong and opinionated and often had to be restrained by "prohibitory commands" (op cit, p809). It could be conjectured that the Reynolds case is an example of the consequences of the religious and social control of women and the way in which an assertive, exploratory, challenging young self-part finds expression and validation through surreptitious and perhaps unconscious and psychosomatic means (Lewis, 1971). Such an interpretation shares much with the earlier discussed explanation regarding the oppression of women by theological doctrine, and the possible functional advantage of possession states, in this period thought of as duality of mind (Ross 1989). It may be conjectured that the decline in the need for such a split in personal presentation with age accounts for the decline in Mary's alternating states of consciousness in later life, as her increased age and status would have provided sufficient vehicle for assertiveness. Indeed, evidence can be found to suggest that DID may decline with age; measurements utilising the Dissociative Experiences Scale (Bernstein and Putnam, 1986) were shown to demonstrate a reduction in dissociation with age (van Ijzendoorn and Schuengel, 1996).

Further tracing the concept of DID through nineteenth century publications, we find contemporaneous evidence of the influence of a patriarchal paradigm. Despite Veith's (op cit) earlier discussed assertion that Jorden (1603) had established the brain as responsible for hysteria, two centuries later Dewar (1823) published a paper entitled, *On Uterine Irritation, and its Effects on the Female Constitution.* The subject of Dewar's paper is a report by Dr Dyce of Aberdeen, to the Royal Society of Edinburgh, about a sixteen-year-old girl who "immediately before puberty" developed "divided consciousness, or double personality", "and which disappeared when that state [puberty] was fully established" (op cit, p365). At times it was clear that this young woman thought she was a clergyman; at other times she had no knowledge of her behaviours and assumed herself to have been asleep. These states were assumed to be the same alternating personality, but the descriptions are suggestive of more than double consciousness. In corroboration of the proposed analysis of the Reynolds case, this report is also suggestive of the contribution of developmental factors to DID.

Providing further evidence of observations of these phenomena, Dewar (1823, p376) also referred to the anonymous case of a

> "simple girl in the neighbourhood of Stirling, Scotland, who, in her sleep, talked like a profound philosopher, solved geographical problems, and enlarged on principles of astronomy, detailing the workings of ideas which had been suggested to her mind, by over-hearing the lessons which were given by a tutor to the children of the family in which she lived. The originality of the language which she used, shewed [sic] something more than a bare repetition of what she had heard."

In this case, the double consciousness permitted the expression of intellectual ideas usually associated with men rather than women, and certainly not associated with servants. Dewar also mentions that another case had been reported in the newspapers in the years recent to this case. At the end of this paper Dewer concludes, "It would be interesting to have a copious collection of well authenticated facts" (op cit, p379). Indeed, as Dewar recognised in the early nineteenth century, more information is needed to explore fully issues of gender and maturation in DID, a need reiterated by Merskey (1992) over 150 years later, as he states it remains to be differentiated whether DID is a natural phenomenon related to gender or a social product. Thus, Dewar's publication constitutes an interesting source as it demonstrates the confusions and contradictions of the age: Dewar both identifies the need for a systematic analysis of such phenomena, hinting at the need for new types of data beyond the confines of the medical model, and yet the limits imposed by the patriarchal influence are also clearly evident.

2.6 Nineteenth Century Knowledge: Analysing the Issues

Set in the context of the rise of surgery from its roots in hairdressing, and therefore in the light of a specific focus on anatomy, these discussed cases demonstrate that, as medicine struggles to develop a medical paradigm to account for these phenomena, interpretations are clearly predicated upon emerging physiological knowledge, and still are in conflict with religious views. To illustrate the anatomical focus, in appraisal of the Reynolds case Dr Charles Mills (1888, p367) concluded that Mary's "first attack was an epileptic seizure" and added that "different methods of functioning of the different levels of the general cerebrospinal axis" could account for the condition. An important implication of this physiological stance was the way in

which it effectively confined DID to a consideration of duality, despite earlier cases of multiplicity. This model was based upon the concept that, as psychological factors are not independent of organic/biological factors, a brain with two distinct lobes must therefore equate to two personalities. Such thinking constitutes an appealing, if simplistic, explanation that co-occurs with the fact that any new concept tends to develop dichotomously before acquiring greater degrees of specificity. Child development, memory development, and concept development proceed from the simple, dichotomous to the more complex (Cowan, 1997), and so it is with professional models and theories (Kuhn, 1962).

Despite the limitations of this two-brain theoretical opinion, one may posit that firm advances in knowledge have been made, as the consideration of a hemispheric explanation in some of the preceding cases could lead to the conclusion that theory and investigation have now become centred on physiology rather than demonic possession, and the brain rather than the womb. However, the convoluted history of DID and the failure of clinicians and other professionals to build on past discoveries, as discussed earlier, is aptly demonstrated by Dewer's publication (op cit), which harks back to sixteenth century thinking, implicating the uterus as the seat of the problem. So too, the use of medical terms in order to describe observations, for example "fits of somnambulism", may colour the observational data – in other words, forcing psychological phenomena into a medical framework. As the above two examples also show, the likening of seemingly dissociative phenomena to sleep disorders has resulted in accounts that are difficult to penetrate in terms of current understanding of dissociative phenomena, and again permitted contradictory interpretations of these accounts.

Considering the observations of dissociative phenomena in terms of these sleep-related formulations, the lack of scientific data collection makes retrospective analysis problematic. However, it is interesting to return to the theme of the social control of women, as discussed earlier. Thus, it may be that the relatively compliant role required of women is either consciously or unconsciously relinquished under conditions of less control, such as sleep, thus allowing more assertive and adventurous characteristics to emerge. As noted earlier, the concept of demon possession was considered a culturally available release; so too sleep may provide an

outlet for repressed material that is within the realm of ordinary experience. The social context would not have encouraged full development and integration of such challenging characteristics, and they may have remained at a regressed level as polarised opposite presentations of self. This may also account for the child-like or male stereotype presentation of some alternate states (referred to as alters in the modern literature), for example a clergyman, or a philosopher. Historically, in the West, women have attempted to gain equality by emulating men, and indeed in some instances assuming a male identity has provided some women with access to power and adventure they may otherwise not have secured. An example was the male *nom de plume George Eliot*, used by Mary Ann Evans (1819-80) that allowed her to achieve publication at a time when women found it difficult, if not impossible, to get into print. This is the same period in which Mary Reynolds's condition permits her to display a more outgoing alter personality as discussed above. As early as c1690, a case of a woman dressed as a highwayman in England gave rise to many traditional folk songs but, as if to demonstrate a theme of this review, namely the pioneering spirit of Britain, in 1735 (*The Gentleman's Magazine)*, it is recorded that a highway woman, who apparently did not dress as a man, conducted a robbery. Again, it is tantalising to speculate as to her psychological state, but alas there is no data.

2.7 Male Case Reports

A number of sources demonstrate how, as discussed, evidence contradicting the dominant or received account of dissociation failed to over-turn it. This is consistent with Kuhn's (op cit) idea that science ignores data that contradict existing paradigms until a paradigm shift is inevitable. To illustrate, Upham (1840) presented a male case that therefore challenged the female uterine focus of DID, but nothing is made of this in his account, nor was this point taken up by other writers. His case of a farming man presents itself rather obviously to the somnambulist label, describing a farmer in Massachusetts who was astonished upon waking to find that he had thrashed a great deal of extra rye during his sleep.

This report of a male case is not isolated; Wayland Francis (1854) reported a case of male somnambulism he had encountered in London, although the reported event had taken place during the war in France. So too, T W Mitchell (1912) cites the case of an itinerant minister in Rhode Island who experienced what would now be considered

a dissociative fugue episode. A further early British report of a male case appeared in 1843 in the Lancet. Dr John Wilson, a physician at the Middlesex Hospital, described a case of a 14-year-old boy with an eating disorder who had two alternating presentations, in each of which he had no memory for the other. The boy presented in a consistent way over three different hospital admissions. Additionally, in 1845, Skae (1845a), a Fellow of the Royal College of Surgeons, reported in the *Northern Journal of Medicine* that the "late Dr Aberchrombie" described a prominent medical doctor in Edinburgh who experienced alternating states. He also reported another case of an unmarried gentleman connected with the legal profession who, following many years of over-exertion mentally and physically, began to experience emotional, cognitive and physical ailments, including loss of reality and "double existence", alternating "between hypochondriasis and mental alienation". He moved between these two states on alternate days with no memory for the altered state.

One wonders how it is possible to integrate these findings with the gender bias in the modern reading of the history of dissociative presentations, and with a tentatively proposed developmental model. If trauma, self-development and self-identity are at the roots of the genesis of DID (Curtis, 2000; McIntee and Crompton, 1996), it would be likely to occur disproportionately in unemancipated groups of people such as women and children. Thus, the position of women in society at this time, that is subordinate to male dominance, must also be considered as a factor. Indeed, evidence suggests that a tendency for women to occupy the patient role more often than men continues to the present (Holmshaw and Hillier, 2000, in Kohen Ed 2000, p43). Periods of identity change, such as puberty, would also be likely points at which suppression and self-control may be weakened, perhaps representing traumatic change for some woman, either the psychological impact of biological changes or the contemporaneous change of status and, in particular, increasing restriction. This may cause increasing stress that draws a parallel effect to the onset attributed to trauma and stress in reported male cases of DID. Thus some of the implications, in the cases considered so far, may continue to be influential in differing ways in modern times.

2.8 Further Nineteenth Century Sources: The Emergence of a Psychological Perspective

Further reports of dissociative phenomena continued throughout the mid decades of the century. Despine (1840), reported in English by Ellenberger (1970) and Fine (1988), described his treatment of an 11-year-old Swiss child, Estelle, who was resident in France. She displayed several alternating states, with some amnesia between these states, and her multiplicity was extant before Despine's use of magnetism (hypnosis). Her treatment was said to be incomplete but she was much recovered when she returned to Switzerland. Later, in 1845 in the *London Medical Gazette*, Mayo, a London physician, reported the 1831 case of Elizabeth Moffit, aged 18 years, of Tunbridge Wells. She had swallowed Ungentum Lyttae, and after recovering physically, was left with two different states that alternated suddenly. Mayo (op cit) reported her to have loss of memory for family and friends, but to be "at no time incoherent". He examined and dismissed the possibility of faked symptoms and distinguished her condition from that of mesmerism, defending magnetism (or hypnotism) as a possible route for helping people. He concluded:

> "Unless we propose to establish a new theory of the value and effect of testimony on belief, or of the utility and desirability of adding to our means of subduing pain and irritation, it is our *duty* [author's emphasis] to give a patient and candid enquiry into this subject, and to profit by it, if we may" (Mayo, op cit, p1203).

Thus, having traced the historical shift from the religious perspective on possession to the development of a materialist medical approach, an acknowledgement of the need to address treatment issues is now evident.

Early aspects of treatment are discussed by van der Hart et al (1996) in reviewing the cases of Jeanne Fery and Bernadetta, but with Mayo there now emerges a positive step in terms of acknowledging the duty of the practitioner to his patient to investigate fully and consider the conditions with which they present. It is also an acknowledgement of the consequences for the individual. However, these examples also lead us again to the problematic issue of the historical role of hypnotism in the history of DID. Although the use of hypnotic techniques is reported in this period, discussion of the implications of their use is deferred until the following section,

where hypnosis was employed as an empirical tool in a period of systematic experimental investigation.

As the nineteenth century progressed, a proto-psychological perspective, or an emergent medical model that denotes a shift from a conceptualisation of soul versus anatomical brain to a fledgling materialistic view of mind, can be detected in the literature. In 1842, Braid, a Manchester physician, began the paradigm shift from the metaphysical concept of magnetism to the concept of hypnosis embedded within a psychological model, and his development would make its influence on the French writers such as Azam (1876, 1887, 1893). In 1844, Wigan published a book in London on "*The duality of the mind proved by the structure, function, and diseases of the brain and by the phenomena of mental derangement, and shown to be essential to mortal responsibility*". Wigan (1845) also published several articles in *The Lancet* during the following year, reporting having seen many cases of double consciousness from as much as thirty years earlier. In these articles he expressed various aspects of his theory that the mind is a process or, as he names it, a "unison" (op cit, pp 367, 561) of structures. He tends to suppose this is in particular the unison of the left and right brain. His view is one of emergent materialism and he conceives of the mind being created with consciousness emanating from the pineal gland. Although the function of the pineal gland is still not fully understood, it is unlikely that Wigan was right in this respect. It is likely that the little understood pineal gland offered itself as a tabula rasa for projections. Wigan's account appears to be a thorough, scientific and deductive analysis, considering divided consciousness from the common experience of parallel process, such as reading, whilst thinking of something separate, to cases of dual consciousness or identity with amnesia between them. In this period, Wigan's theory is quite seminal in his attempt to distinguish mind from soul, and process from brain structure, and in the way in which he embeds his theory of dual consciousness within a continuum from normal dissociative experience.

Wigan's theoretical position also influenced his contemporaries. Ward (1849), a British doctor, described a 13-year-old female, Mary Parker, who he saw in 1836. At the age of seven she had had measles with a consequent cough and pain in her side. At age 12 years she had been "seized one evening with rigors, followed by an epileptic attack, in which she struggled violently, and attempted to scratch and bite

the bystanders". Ward (1849) adopted a simplistic version of the model by Wigan (1844). His perspective was based on the view that the brain is a double organ with double consciousness. With reference to the observed case, he concluded that:

> "Double consciousness is now established, for while delirious, she has little or no recollection of persons she has seen, or events which have occurred during the state of sanity, nor does she complain of any bodily pain or suffering. In the opposite state, on the contrary, she is extremely depressed, incompetent to any exertion, complains of pain in her head, side, and stomach, and is equally forgetful of all that had passed during the delirium." (Ward, op cit).

and:

> "The change in her disposition from bashful timidity to audacity and impertinence, must be regarded as identical with the violence and mischievous tricks of maniacs, who thereby clearly exhibit (in an exaggerated degree, however) what are the impulses of our nature when uncontrolled by reason and religion" (op cit).

The above source draws together a number of themes of interest, both those already discussed and novel issues. Firstly, by the mid nineteenth century, as the previous source evidences, authors are reporting observations of increasing numbers of cases of probable dissociative phenomena, with Wigan (1845) purporting to have observed many cases of double consciousness, particularly amongst French war patients. So too, what is clear from the previous source is that the authors are becoming increasingly aware of each other's opinions and case reports, thus marking a shift from earlier individualised accounts. Ward also neatly exemplifies, as observed in previous accounts, the mixed rational, moral and religious philosophical basis to his physiological model.

A further interesting feature of Ward's account is his report that a Dr Pritchard knew of similar cases connected with epilepsy of hysterical origin, thus further suggesting the presence of what would perhaps now be labelled pseudo-epilepsy. Modern reports of DID describe co-morbidity with pseudo-seizures (Braun and Kravitz, 1997); thus, from the roots of understanding of dissociative phenomena entrenched in religious beliefs, one can now observe notable continuities in understanding and observations from the mid nineteenth century to the present. Yet one must also be

mindful of salient differences. To illustrate, Ward also offers further medical information that he considers relevant for inclusion in his case notes, namely the girl having earlier contracted measles. Although useful in analysis of the case, such information again underlines the medical perspective and alerts the reader to consider what psychological factors may have been omitted from his report as a result of this perspective.

John Elliotson (1840, 1846) presented several cases of dual consciousness, and also recorded the same Dyce case as Wigan. He contemporaneously discusses the consequences of the confused models and labels of this period, reporting the case of "a lady, who in her mesmeric sleep-waking, and then only, has a very great appetite" Elliotson (1846, p164). He offers a sharp rebuke to those practitioners who would dismiss such observations of dissociative phenomena. He discusses at length, and with great emotional expression, his revulsion at the fact that:

> "too often medical men are lamentably ignorant of them [these kind of cases], and, when they have an interesting case of this kind, regard it as a strange piece of business, and are at a loss what to do, and so torment and physic the patient without mercy, and think no more about it; or perhaps, to save meditation, declare it was all imposition" (op cit, p160).

These comments starkly illustrate the issue of divided opinion, which continues today, more than a century later, with regard to the validity of the diagnosis of DID and its relationship to a professional duty of care

It may be argued that the lack of a scientific course to the understanding of DID and the resulting muddled models and trend-led theories provide a socio-political climate that creates competition and attack rather than consensus and collaboration. Defensive medical attitudes can give rise to attacks upon the patient/client. In the UK in particular there has historically been a class base to the medical profession, and this has led, in some cases, to a confusion between patient/client needs, the needs of the medical profession and the needs of the ruling or corporate bodies (Illich, 1995, pp76-88; Newnes, 1999, p23). As already discussed in the **Chapter 1, Introduction**, the influence of professional attitude, culture and politics upon diagnosis was reported by Kleinman (1988). That is not to dismiss the issue of malingering, which is clearly a

real issue in some cases, but can also become a means of attack or defence. Determining factors can be personal or public, and often relate to issues of resources. Indeed, this issue was addressed contemporaneously, in 1869, when Reynolds wrote in the British Medical Journal, in October and again in November, of the need to distinguish the genuineness of presentations of paralysis following trauma, especially relating to railway accident compensation. The issue of malingering developed as a result of a few rather obvious cases, but also as a response to the increasing financial implication of compensation claims. This issue will be reflected again in modern times.

Jackson (1869), an American medical professor, illustrated the struggle between the medical and moral models. He reported four cases of double consciousness, and also referred to the Mary Reynolds case and Dewar's (1823) report. Incidentally, one of Jackson's cases was of an English girl, living in America, who was cured by a family holiday back to England. Bird (1999) has shown that immigrants are more at risk of developing mental health problems, and this issue will be discussed further in the conclusion section of this thesis. Since Jackson regarded consciousness as a tabula rasa, he concluded that the term double consciousness is a misnomer, and that "The symptoms are only those of sudden spontaneous mental action, uncontrolled by the will." Jackson's work demonstrated a changing emphasis in investigations, providing a transition to the work discussed in the following section. Jackson used cases as evidence to consider the nature of consciousness and draw theoretical conclusions, as do the investigators, referred to in the next section. However, Jackson was not so proactive in his investigations as the figures we are about to consider, such as Janet and Binet, who systematically apply experimental techniques and, in the case of Janet, utilise the evidence gained to construct a detailed model of mind from the conclusions drawn. Additionally, Jackson was described as a medical professor whereas the authors in the following section were recognised as figures in the emerging discipline of psychology. Indeed Ellenberger (1970, p331) describes Janet as not only a philosopher and psychologist, in addition to his skills as a medical man, but also as "the first to found a new system of dynamic psychiatry aimed at replacing those of the nineteenth century". Thus, despite the advances documented in this section, no such grand statements can be claimed of the figures discussed thus far.

2.9 The Pre 1880 Period: Thematic Review

Before moving on to examine the evidence of this period, it is necessary to consider the themes evident in this first historical period of review, and to summarise and appraise this body of knowledge. Firstly, by the nineteenth century, there had been few US reported cases of DID, but several UK cases, especially in Scotland, and several European cases, particularly in France. Crabtree (1993) notes the particularly high level of sexual crimes against children under thirteen, recorded in France during the period 1860-1890, and suggests that the modern link between MPD/DID and child sexual abuse may have earlier antecedents. The examination of these early cases has revealed many features found in the modern concept of DID. These features, most saliently, include sudden and unexplained distinct changes in self-presentation, often with amnesia between states, but a continuity of all aspects of self-structure between episodes of the same state. Differing levels of knowledge and skill between states were also observed. Sleep disturbance was clearly a feature of cases discussed during this period, and many cases were presented within the taxonomy of somnambulism. Epilepsy, or perhaps pseudo-epilepsy, and headaches relating to switching between self-states, as implicated in the Reynolds case, as well as eating disorders, as documented by Elliotson (1846), were further factors evident in these sources. Additionally, some cases discussed individuals who, despite duality and multiplicity, in some states lived functional lives.

With regard to assimilating this information into an independent scientific framework, science has achieved an emerging degree of freedom from the earlier constraints of a dominant religious/metaphysical explanatory framework. Yet separation is by no means complete, as religious methodology and beliefs still interact with and exist independently of science. At the turn of the eighteenth to nineteenth centuries, there is in fact direct conflict between anatomists and religious institutions, with anatomy rising out of the knife skills of barbering. The developing profession of anatomy requires a steady supply of dead bodies and becomes associated with grave robbers, hindering the paradigm shift in the minds of the worried public. Returning to the specific issue of DID, in some cases accounts are more systematic and more equitable with modern methods of observation and theorising. However, the quasi-medical model is dominant. Thus, most do not provide all the information that would be collected from a modern, distinctly

psychological, or even a holistic, perspective, and there remains a preoccupation with anatomy and physiology. Indeed, this preoccupation could be said to be evident in modern psychiatry, expressed as an emphasis on biological or organic factors, with the evidence of social factors leading not to psychological theories but to accusations of malingering or iatrogenesis. To illustrate how dominant modes of thinking within a quasi-medical framework may have impacted upon the conceptualisation of DID at this time, we may turn to the hemispheric explanation of the divided experience of self. By equating the phenomenon of dissociation with the duality of the physical structure of the brain, many investigators during this period constrained their understanding to a two way splitting of experience, unable to accommodate the multiplicity of mind actually extant in some case studies in the historical literature. In conjunction with the hypothesis confirmatory style of reasoning, evident in some early scientific accounts, we may conjecture that multiplicity, if observed, would have been recorded as duality in order to uphold the dominant explanatory framework of the period.

Despite this focus on physiological symptoms, there was a continued struggle for the medical profession to harness this data in order to generate a cohesive explanatory model of DID. The prevailing approach was not generally data driven and scientific. Opinions meandered according to prevailing trends and new ideas. Thus, despite a number of British cases, already extant at this stage in the history of DID, and relatively few US cases, an indication that a range of phenomena may exist and that cases are found in a range of ages and in both males and females, it appears that the seeds of modern explanations for DID have not been recognised, either then or now, in the UK, in large part because of prevailing ideologies or particular political or personal dominance.

Finally, as has been demonstrated above, the historical progression of knowledge of DID is not linear, and some regressions are evident, for example Dewar's (1823) publication returning focus to the uterus as the root of symptoms. Psychology is widely acknowledged to have emerged as a recognisable discipline in the nineteenth century, and the roots of this new discipline are clear, but it was yet to develop its own paradigm – a shift prevented by anecdotal reporting and selective data used in the service of hypothesis confirmation. The clear and verifiable methods of scientific

data collection evident in the following part of the Literature Review (**Chapter 3**), 1880-1980, would permit psychology to develop further an independent perspective. Discipline and diagnosis take shape.

2.10 Interim Summary: Principal Issues and Findings

- Due to the seventeenth century dominance of religious explanatory frameworks, early possible cases of multiplicity are embedded within accounts of demon possession

- The dichotomous thinking of the Seventeenth century period is evidenced by recourse to supernatural explanations in the face of failure to identify "natural", or organic, causes of disease

- The early documented European reports of multiplicity challenge later claims of North American cultural specificity

- The work of Mesmer, and other investigators within a somnambulist paradigm, resulted in the recognition of the divided experience of self

- The nineteenth century case of Mary Reynolds marks an explicit contemporaneous report, from multiple sources, of "distinct consciousnesses"

- Features common to the modern understanding of multiplicity are documented, including switching between states, and amnesia between states, yet interpretation of cases continues to be limited by a lack of distinctly psychological data

- Proto-psychological accounts of dissociative phenomena appear, yet hemispheric theories demonstrate the dominance of a pseudo-medical paradigm

- The perpetuation of the belief that dissociative phenomena may be explained by distinctly female characteristics or biology, in the face of counter-evidence, demonstrates the patriarchal nature of society and of the medical gaze, and the way in which prevailing ideologies are resistant to challenge

- ❖ The beginnings of systematic, psychological investigation are evident at the end of this period

Dissociative Identity Disorder in the UK:
Competing Ideologies in an Historical and International Context

CHAPTER THREE

REVIEW OF LITERATURE: PART 2
1880 – 1980. Discipline and diagnosis take shape

3.1 Introduction

As touched upon at the close of the previous section, this period in the documented history of DID is characterised by the emergence of a more concerted scientific method, with an emphasis on objective data collection and empirical methodology. Indeed, this rather extensive period witnessed the diversification of psychology, the proliferation of scientific and other professional journals, and a shift to a more scientific approach evidenced by published articles. With particular reference to dissociation, many authors have commented on the significance of this historical period. Crabtree (1993) calls this period the "Dissociation Period" because of the greater emphasis on states of consciousness, whilst Alvarado (2002) has noted the seminal contribution made by The Society for Psychical Research (SPR), in the later decades of the nineteenth century, particularly in the persons of Edmund Gurney and Frederic W H Myers, in promoting the systematic study of dissociation in Britain. The SPR, founded in 1882 in the UK and still active, was responsible for extremely high quality parapsychological research and, in particular, examined the issue of dissociation, with one third of its papers and notes devoted to the topic. Whilst Britain was a hive of valuable activity at the beginning of this second period, it is towards the latter part of this era, in the USA, that the pivotal event of information concerning dissociative phenomena entering the public domain also takes place, most notably with the publicity surrounding the case of Eve (Thigpen and Cleckley, 1957) and the subsequent widespread distribution of the film (Nunnally Johnson, 1957).

3.2 Thematic Overview

Of course, systematic methodology was not universally employed and, as documented in the preceding section, the history of dissociative phenomena is consistent in its convolutions. In his review of the historical literature on DID, Ross

(1989) acknowledges these historical twists and turns, describing the period of 1880-1890 as the establishment and elaboration of MPD, yet labelling the period 1910 to the present (ie 1989), as encompassing "maturity and rapid decline", "resurgence of interest" and "modern scientific study", thus illustrating an undulating rather than linear progress.

Despite these major developments however, the early part of this period is still coloured by the nineteenth century struggle between the metaphysical views of religion and the materialist view of science, a struggle which, it must be noted, has never been resolved and may never be so. In this way, historical continuity is observed in the continued tensions between the development of new ideas and the constraints of prevailing epistemological frameworks. Thus, science focussed on systematising its knowledge base, but did so within the limited perceptions of the time. To illustrate, returning to the theme of the subjugation of women, scientific endeavour was predicated upon:

> "a society that not only perceived women as childlike, irrational and sexually unstable but also rendered them legally powerless and economically marginal" (Showalter, 1987, p73).

To illustrate the excesses of such prejudice against the equality of women, Otto Weininger's views found popularity throughout Europe; "Woman is only sexual", "Man has a penis, vagina has the woman" (Weininger, 1903, in Ellenberger, op cit, p789). Ellenberger (1970) states the inference to be drawn from these opinions, "Therefore the 'abstract female' is alogical, amoral, has no ego, and should be kept out of public affairs". Weininger's views clearly demonstrate the profound patriarchal flavour of dominant views regarding the status of women, and add credence to the view that polarised presentations of self may have served as a form of expression of socially unacceptable characteristics. This prevailing social attitude also allows the reader to consider how much more easily female behaviour may have been pathologised, in comparison to that of men as rational beings with purpose and motive behind their actions. On a cultural note, perhaps it was the pioneering spirit of the women of America that assisted an earlier feminist challenge to these views than was found in the UK. It can be seen from reviewing the historical cases that

MPD provided self-parts that could promote assertive, wild or angry behaviour that would otherwise have been quite unacceptable.

Key sources and the work of the major figures of this time are discussed below, along with significant interwoven themes. Indeed this discursive period begins with a very high profile case, which clearly demonstrates how the phenomenon of multiplicity played an important role in the development of the discipline of psychology. Sources no longer consist of isolated descriptive reports, but constitute evidence that fed into an understanding of the fundamentals of the human condition. It must be noted that the location of much academic activity differs from the previous section; more specifically, this historical era began with a great deal of published activity in France, which appeared to have had only a modest impact in the UK. Meanwhile, Britain made its own valuable contributions.

3.3 The Contribution of Eugène Azam

In 1876, Eugène Azam, professor of the medical school at Bordeaux, published three papers with rather similar titles. In the paper *Amnesie periodique, ou doublement de la vie,* published in *La Revue Scientifique*, he reported the case of Felida X, a 16 year old girl, in whom he observed two alternating states with amnesia. Azam's work had direct input into one of the major scientific debates dominating the period, which saw a philosophical challenge to the concept of a unitary mind or consciousness. As Hacking (1991, p143) explains, Azam's case supported the positivist view that "the self and personality are a construct of memory, experience and consciousness", whilst simultaneously discrediting the neo-Kantian position that "there is a fundamental transcendental ego, prior to and necessary for consciousness". In consideration of multiple personality, the ego cannot be conceived of as distinct from conscious states, but rather self-identity is seen to arise from the complexity of experience. The phenomenon of DID thus made a huge contribution to the philosophy of psychology. Other authors have, however, seemed to imply that this contribution somehow weakens the evidence itself. Merskey (1992, p336) states that:

> James, Azam and Janet were concerned with somnambulism, awareness, automatic behaviour, attention, memory, dissociation, and, ultimately, recognition of the self and awareness of the self ... They continued into the 20th century (eg Myers, 1903; Stout, 1919). The discussion centred

on ways to understand the operations of the mind, in quite another direction from the issue of multiple selves.

Beyond these opinions, such evidence clearly marks a shift to a psychological concept of self. Thus, from a belief in mind as a soul-like entity, capable of separating from the human body, and illness resulting from loss of this soul, Western scientific thought now reached a conceptualisation of psychological illness as an estrangement from the self, or ego impoverishment. This change again shows the impact of the wider societal ideology on thinking, and demonstrates continuity in the conceptual similarity between these sets of beliefs, but a relative freedom from religious and medical frameworks.

Reports of multiplicity continue steadily throughout this late nineteenth century period, with the majority of sources being European, indeed largely French and British in origin. Terminological issues continue to be of some importance at this time, firstly, because a confusion of medical diagnoses or psychological definitions is evident in the literature, and authors employ a variety of descriptors. To illustrate, Camuset (1882) details a young man of 17 years who experienced 'hysterical' paralysis and convulsions and contrasting states, one of which was a feminine alter. This young man is also treated and reported by Bourru and Burot, and also by Voisin, amongst others. In the preceding section we have already noted the problematic usage and vagaries of the diagnosis of hysteria. Secondly, terminological shifts are evident at this time; Dufay (1883) published a letter to Azam in *Revue Scientifique*, entitled *Le doublement de la personalité*, in which he recounts another forensic case of dissociative amnesia, in a young woman who is quite conscious of her dualism, and one personality speaks in the third person about the other.

3.4 Shifting Perspectives: The Contribution of Theodule Ribot and his Contemporaries

A very systematic description and experimental report of Louis V comes from Bourru and Burot (1885) who described him as a boy institutionalised from the age of ten, following an accusation of theft. By working on his physical state with metals and magnets, distinct corresponding mental states could be demonstrated as corresponding to different personality states. These are experimentally controlled,

precise and constant relationships between mental and physical states, compared to the spontaneous switching reported in other cases. Voisin (1885) also treated and reported on Louis V, as did Camuset, in his French paper, using the term double personality. This switch from consciousness to personality is significant. Although originally suggested by Dewar in 1823, it only really appeared consistently in the literature from the 1870/80s onwards (Hacking, 1991). This may be considered a new perception of the phenomenon by authors, in shifting from a moral/biologically reductionist focus on character and physical illness, signified by the assumed relationship between consciousness and the brain, to an independently psychological focus on personality, providing enriched psychological data. This aids the modern investigator in appraisal of recorded cases, allowing some consideration of DSM criterion C (see **Appendices**); each individual personality is complex and integrated. Furthermore, this emerging consensus in the literature on the term "personality" underlines the greater standardisation of the period.

What characterises this period, however, is not only the continued publication of descriptive or personalised case studies, but the application of the knowledge gained. The shift towards a scientifically independent discipline of psychology is shown by reviews of cases, which may be construed as a meta-analysis of evidence and constructions of models of mind, based on controlled observations. To illustrate, Ribot (1885) examined various manifestations of amnesia, concluding that consciousness is not a uniform entity, but is composed of constellations of consciousness. He understood the central or underpinning aspect of consciousness to be bodily consciousness, positing a major distinction between somatic and psychological consciousness. This theme was also explored by Janet (1907, 1920) and later became adumbrated, until its modern revival by Nijenhuis et al (1997). In 1900, Janet founded the Institut Psychologique International under the sponsorship of an international committee, including William James, Frederic Myers, Theodore Flourney and Theodule Ribot.

Ribot was professor of experimental psychology at the College de France, and was succeeded in 1902; both Pierre Janet and Alfred Binet were considered as successors, and Janet was appointed. Ribot was a major influence on Janet's experimental psychology, and his theories are of further relevance to a theoretical understanding of

dissociative phenomena, as he discussed not only consciousness, but also conducted a thorough examination of memory as a product of physiological processes. Two of Ribot's outstanding features were how systematic his experiments and observations were, and his dedication to describing and classifying the phenomena he studied. Ribot was mainly interested in the study of personality (including multiple personality), will and memory. He was particularly interested in psychogenic illnesses. Ribot (1885) identified laws of memory, positing that memories are acquired in a prescribed order, from simple to complex, and from concrete to abstract. Similarly, memories are lost systematically, from complex to simple, and from recent to past. Ribot also proposed laws determining the order in which regression of memory occurs, namely new to old, complex to simple, voluntary to automatic, and least organised to best organised. These theories find some resonance with perspectives in the modern literature, discussed in the third part of the Literature Review, **Chapter 4.**

Although neglected and obscured in the later period, this era of French psychological investigation was seminal, and Ellenberger (1970) considers Ribot's papers to be among the best accounts of dissociation. Ribot's contribution to experimental psychology, in the particular areas of personality, will and memory, is of such significance in the present context, as he illuminates the concepts and phenomena that fundamentally underpin the experience of multiple personality and dissociation. Though limited by today's standards of technology, knowledge of physiology and biochemistry, through deductive reasoning and the application of scientific methodology, Ribot was able to achieve significant advances in knowledge, notably providing the physical explanation of how conscious awareness can be bypassed (Ribot, 1885, p25). This issue will be raised later in the context of the modern debate as to whether experiences can be separated from conscious memory, to be discussed in part three of the Literature Review, **Chapter 4**.

3.5 The Contribution of Fredric Myers: Systematisation and Synthesis

Demonstrating the greater dissemination and spread of ideas within the scientific community, authors published comment on a range of cases, permitting theorising based on a wider appraisal of evidence. Consideration of the work of Myers (1886)

demonstrates the discussed advances of the period and, as does the work of Ribot, offers the reader a contrast to the more idiosyncratic approaches of the earlier period.

Myers, an English classical scholar and co-founder of the Society for Psychical Research, is credited in Murphy's introduction to Myers's volumes as "the first in the English-speaking world to describe systematically the phenomena of subconsciousness or unconsciousness" (op cit, piii). Myers conceived of personality as being like an iceberg, with consciousness as the tip. He regarded multiple personality of interest, because its study afforded a glimpse into the highest and most complex nature of man. He reported in English on Voisin's and Camuset's patient, Louis V, as previously outlined. Louis V's multiple personalities had developed after being bitten by a viper at the age of fourteen. Thus, Myers presents further evidence of connections between trauma and dissociation.

Louis V was examined across six experimental conditions and Myers tabulated those in which an association between physical and mental state was observed. This is consistent with Ribot's theory of consciousness, as discussed above, as being predicated upon the somatic. In the experiments with Louis V, the situation was acknowledged as interactional, ie a physical state can be induced by a psychological trigger and vice versa. In another paper of the same year, Myers (1886) adopted the idea that the separate hemispheres of the brain can account for duality of consciousness, and suggests that the left hemisphere is associated with higher functions and greater development, whilst the right hemisphere may be associated with more child-like experiences. Here may be seen some inkling of a quasi-developmental model of dissociation, amalgamated with the two brain theory.

Myers approached these tentative theories whilst still considering available data. It is possible that, although he had developed the idea that the different hemispheres may relate to a hierarchical division of consciousness, he may have been on the verge of a multiple rather than dual concept as he also talked of "the *multiplex* [my italics] and mutable character of that which we know as the Personality of man, and the practical advantage which we may gain by discerning and working upon this as yet unrecognised modifiability" (op cit, p496). In his approach, Myers is announcing a spirit of enquiry in the field of dissociation that characterises that age, which appears

to be lacking in opponents of the field at the end of the twentieth century in Britain. Myers made an attempt to make sense of, and to categorise, the data of available cases. He recognised specific and proscribed amnesia, enduring alternating states with mutual or one-way amnesia, and a loss of control of sensory information without loss of behaviour and vice versa. Modern theories such as Braun's BASK model (Braun, 1988b), which will be described in the final part of the literature review (**Chapter 4**), have returned to such analyses in order to examine similar dissociations between sensory modalities.

Additionally, beyond his experimental approach, Myers directly considered the issue at the heart of the religious-scientific divide, the survival of the personality after death. Thus, Myers's contribution was significant as an early example of the synthesis of data and theoretical perspectives from medicine, philosophy and psychology. Indeed, Myers may be considered the bridge between the metaphysical and the scientific, in his application of systematic study to fundamental questions at the intersection of these disciplines. Yet, despite the improvement in detailed observational data and enlightened new theories of mind, suggestive of multiplicity rather than duality, the idea of Double Personality continued to persist.

3.6 Pierre Janet and Sigmund Freud: Effects of Trauma, Models of Consciousness

Having discussed the work of Myers, an English practitioner, to provide an exemplar of the work of the period, we must now turn to the work of the other key figures of importance to the history of psychology. The contribution of these figures will be outlined in turn, and followed by a summary analysis of their achievements. Pierre Janet (1886), a French psychologist, was one of the most influential and prolific writers in the history of dissociation. Janet's work again exemplifies the more integrative approach of this period in its synthesis of data from child and adult psychology, psychopathology, ethnology and animal studies. In addition, Janet was academically rigorous; he was extremely systematic in his approach to the literature, his experimentation and his reporting. Janet's influences, amongst others, extended from Ribot and Wundt, in respect of the use of psychometrics, to Taine in France, in respect of psychopathology. Janet was also influenced clinically by Charcot at the Salpetriere, and in magnetism by the Caen group.

As a result of this diverse base of influences and approaches, Janet developed a vast and complex conceptual model of the human mind and its functions, distinguished between the conscious and the unconscious, and was concerned both with case analysis and research, but also with treatment or intervention. Further, Janet actively investigated the issue of religion, and treated various cases of religious stigmata. His investigations were never aimed at challenging religion, an important early influence on Janet, but at explaining many factors in terms of his psychological knowledge, again representing an integrative approach and the application of psychological knowledge. Janet labelled his early multiple cases as somnambulist. He made careful observations of the behaviour and physical sensations of his patients, and was able to effect both partial and total improvements, usually through the use of hypnosis. He developed his ideas about consciousness and its complexities in his book *L'Automatisme Psychologique*. In his later book, *The Major Symptoms of Hysteria,* he recounted his thoughts to date in English, thus furthering the influence of his work.

Janet and Freud were contemporaries and were both influenced by Charcot at the Saltpetriere. Although Freud is one of the most seminal figures in the history of psychology, he did not study MPD/DID specifically and his contribution to its study has been more particularly in terms of the concept of mind, conscious and unconscious, as well as the issue of repression and traumatic memories. Freud studied at the Saltpetriere between 1885 and 1886, but never focussed on dissociation and multiple personality, as did Janet. One possible explanation is that Freud did not have general experience of a wide range of clients; his time with Charcot was influential but brief. Freud's intellectual and clinical pursuits were powerfully influenced by his self-analysis and his tendency to over-generalise from subjective data. Further, Freud rejected, from analysis, anyone with Dementia Praecox (Schizophrenia), which is often confused with Multiple Personality, thus reducing the possibility of encountering this phenomenon. Despite this hypothesis as to why Freud failed to focus on dissociation to the same extent as Janet, Ross (1989) suggests that, at the time of publishing Studies on Hysteria with Breuer, most of the case material was about dissociation, with Breuer's patient, Anna O, being considered by Ross as DID. He also emphasises the likeness of Freud's ideas to those of Binet, Janet and Prince, at that time, but that, later in their careers, what most diverted

Breuer and Freud from dissociation was their fear of the issue of sexual abuse and Freud's repudiation of the seduction theory (Jones, 1953). Mollon (1996) suggests that Breuer acknowledged that Janet and also Binet were describing not just splits between the conscious and the unconscious but actual splits in consciousness, but that Freud was inclined to ignore this and both he and Breuer inappropriately dismissed Janet's work as being about weakness in consciousness compare to Freud's interest in the strength of repression. Mollon concludes that there was considerable competition between these theories. Nemiah (1989) quotes Morton Prince's opinion that 'Freudian theory has flooded the field like a full rising tide and the rest of us were left submerged like clams buried in the sands at low water' (Nemiah, p1527, Prince, 1905/1978).

What Freud and Janet notably have in common is the discovery that trauma, particularly traumatic affect, can be repressed or excluded from memory, but will find an indirect, often physical way to be expressed. Despite their different areas of focus, and separate conceptual explanatory hypotheses, their initial treatment conceptions were very similar, in that hypnosis, amongst other methods, could reveal the original trauma or conflict that was giving rise to the distressing phenomena, and revelation brought about cure. The discovery of the link between trauma and hysterical phenomena was directly related to Freud's development of his theory of unconscious phenomena (Freud, 1911, 1915, 1940 (1938)). Freud's concept of the unconscious was as a distinct entity from the conscious. The unconscious was not directly available to the conscious mind, and had instead to be inferred from dreams, symptoms, parapraxes and other related phenomena (Freud, 1940 (1938)). Both Janet and Freud included the concept of repression with all kinds of mental experience being excluded from conscious memory, but their concepts overlap rather than directly contrast or equate (Hart, 1910, pp351-371).

Anthony Storr (1998) writes that, before Freud's concept of repression became widely used, the same phenomena were known by the term dissociation. Jung and Janet continued with dissociation as a central concept, whereas Freud's focus was on repression, a term he used to describe the unconscious motivation to keep something unconscious for reasons of psychological defence, thus he uses this term in a similar way to Janet's use of the term suppression. Freud clarifies that only things from the

unconscious can be repressed (Freud, 1915 p76). He uses the term suppression to indicate the prevention of the development of an emotional charge and says that suppression is the aim of repression (Freud, 1915 p60).

Kihlstrom (2006) summarises the distinction between Repression and Dissociation as follows:

> In the contemporary literature, the terms *repression* and *dissociation* tend to be used interchangeably to refer to a lack of conscious awareness of trauma and conflict (Singer, 1990). In fact, Janet believed that repression was merely a special form of dissociation. But Freud held that dissociation was utterly trivial, and repression was a separate process with its own ontological status. In fact, the two concepts do seem to be different. As Hilgard (Hilgard, 1977, 1986) noted dissociation entails a vertical division of consciousness, while in repression the division is horizontal. For Freud, available memories are located in the System *Cs* and the System *Pcs*, while repressed memories are buried in the System *Ucs* beneath a barrier of repression. For Janet, dissociations occur among memories that are normally available to consciousness. For Freud, repressed memories have special emotional and motivational properties, being closely bound either to trauma (in his early theorizing) or with primitive sexual and aggressive impulses (in his later work). For Janet, any kind of memory at all can be subject to dissociation.
>
> For Freud, repression is motivated by considerations of defense – the whole point of repression is to prevent us from becoming aware of threats and impulses that would cause us great anxiety. But in Janet's theory, dissociation *just happens* as a result of some weakness, or excessive strain, in the stream of consciousness – much the way a chain, when stretched too tightly, will break at its weakest link. Further, Janet appears to believe that one could gain access to dissociated ideas directly, by techniques such as hypnosis that bridge the dissociative gap. By contrast, Freud seems to argue that repressed mental contents can be known only indirectly, by inference: hence Freud's abandonment of hypnosis and subsequent emphasis on the interpretation of dreams, and of symptoms as symbolic expressions of underlying conflict. In this respect, at least, modern recovered-memory therapy – while certainly inspired by Freud's ideas about repression – is closer to Janet's ideas about dissociation.

Kihlstrom's thesis is based in the examination of psychological theory and evidence from memory research, and the gap between what is thus established and demonstrable and that which is clinically observed and theorised. As will be seen in examination of a clinical case study, presented in **Chapter 5**, clinical presentations may be illustrative of a more complex situation in naturally occurring phenomena,

with a greater number of variables than experimental psychology can accommodate in single studies. The case study presented by the author in this thesis will illustrate that both Freud and Janet may have been right and their theories, rather than competing, both contribute to a more complex model of mind. The problem for the scientist practitioner may well reflect that of the DID client, where data is too complex to be fully integrated at both the micro and the macro levels of analysis, and for these reasons overwhelming complexity, not to mention emotional defences, may result in coherent encapsulations that are difficult to translate to macro levels. Even the so called 'hard sciences' find that scaling up causes anomalies to occur, despite controlled conditions, explained by Nonlinear Dynamics (Gleick (1987); for the clinician, the client's life is far from controlled.

As also explained by Kihlstrom above, Janet understood things lost from consciousness as "*a lack of synthesis*, or a weakening of consciousness" (Janet, 1907, 1920, p288). Whilst being a dynamic theory, Janet's concept also owed a lot to perceptual and information processing concepts and research data. Janet says "the symptom I wish to describe to you is not inattention; it is a suppression of all that is not looked at directly" (op cit, p298) and he perceives dissociation as the "retraction of the field of consciousness" (op cit, p303). Like Freud, Janet conceived of a hierarchical structure, not of consciousness per se, but of functioning at different times and under different conditions;

> "... it is easy to summarise, in a word, these general disturbances of neuropaths. It is a mental depression characterized by the disappearance of the higher functions of the mind, with the preservation and often with an exaggeration of the lower functions; it is a lowering of the mental level. So we may say, in short, that hystericals present to us the following stigmata; a depression, a lowering of the mental level, which takes the special form of a retraction of the field of consciousness" (op cit, p316).

Freud also conceived of repression in terms of intensity, what he called the 'economic' aspect of repression. It was this aspect of repression associated with emotional intensity that he thought could be prevented from developing and suppressed, rather than merely diverted. He believed the actual aim of repression is to suppress the development of emotion, and its work is not complete until this aim is

achieved (Freud, 1915). The concepts of Janet and Freud will be discussed further below in considering the contribution and opinion of Hart. The issue of the traumagenic roots of dissociation will be examined further in section **3.10**, examining the data from war trauma.

3.7 Comparison of British and French Perspectives

At this time, France and the UK are the centre of scientific investigation in the field of dissociation. The somewhat contrasting British and French perspectives are exemplified by the following case, on which two authors published an analysis. Jules Janet, brother of Pierre, published a paper in 1888, entitled *L'hysterie et L'hypnotisme d'apres la theorie de la double personality*. Myers (1889) reported on Jules Janet's paper, in English, discussing the same case, that of Blanch Witt. Blanch had been extensively hypnotised and exhibited by Charcot and Féré; she presented with two states with one-way amnesia, and demonstrated "lethargy, catalepsy, and somnambulism" (op cit, p216). Myers and Janet differed in regard to their subscription to differing schools of hypnosis, Myers distinguishing the hypnotic manifestations reported by Janet from those found by the English school of Braid (1843). Further, Myers and Janet differed in the conclusions drawn from this evidence. Janet concluded that every man has two personalities, one conscious and one unconscious. Whereas Freud's focus was on the related concepts of consciousness and unconsciousness, psychic material permitted to enter consciousness and those defensively repressed and suppressed, Janet's concept is more of disintegration of the aggregated and associated faculties called personality. Although Freud and Breuer (1893) also conceived of dissociated conscious states, Janet's concept was that normally these two personalities of man are equilibrated, but in the hysteric, one is weak and one is strong. Myers (1889, p218) was critical of Janet's use of the term and concept of weakness, and preferred the explanation of "some hypertrophied group of nervous elements, - some *idée fixe*, existing - like a tumour - in quasi-independence of the mental organism as a whole". Myers stated "Hysteria is not a lesion but a displacement: it is a withdrawal, that is to say, of certain nervous energies from the plane of primary personality; but those energies still potentially subsist, and they can again be placed, by proper management, under their normal control" (Myers, 1889; p219). Beyond demonstrating the development of divergent European traditions, Myers's analysis is striking in its conceptual

similarity to modern accounts of DID as a functional development of self-parts, a theme espoused by Hart, to be discussed below.

Binet (1889) acknowledges this independence of French and English investigation and credits Edmund Gurney, an English psychologist, with being "the first in England to recognise the double personality" suggesting "he conducted his researches without any knowledge of those which were in progress in France about the same time." Gurney (1884b) utilised experimental methods to demonstrate that, despite conscious amnesia in double personality, there is psychological unity unconsciously. In his own work, Binet rejected the notion that the duality of consciousness equated to the duality of cerebral hemispheres, and contended that personality is a thing of relative synthesis, which may be manifested in very varied degrees of completeness. Referring to the spontaneous study of similar phenomena in different countries, he stated, "It is proved that in a great many cases and in diverse conditions the normal unity of consciousness is broken up and several different consciousnesses are formed, each of which may have its own system of perceptions, its own memory, and even its own moral character" (Binet, 1896, p355).

Binet too advocated an empirical approach to the study of the phenomena, and distinguished between successive personalities with apparent amnesia between states, and coexistent personalities where amnesia is more relative. He also noted the relationship between physical dissociation and psychological dissociation, utilising empirical methods to demonstrate Gurney's view that, although with successive personalities there is conscious amnesia, there is at least some unconscious integrity. In 1890, Binet published his book *Double Consciousness* in English, in which he described a systematic empirical approach to the study of double consciousness, and concluded, "the genesis of a personality or of a simple synthesis of phenomena can not be explained by the association of ideas" (op cit, p351). He concluded that associations are subordinate to higher influences; that memory is not personality but only retrospective consciousness; that amnesia is the psychological corollary of physical anaesthesia, and is the barrier that separates co-existing personalities. He argued that consciousness is, in essence, multiple. The significance of Binet's publications is clear, synthesising experimental and theoretical data and strengthening the conclusions of Ribot and Gurney. Binet's work goes beyond a double

conceptualisation of personality to a multiple one, from a reductionist to an emergent model. Thus Binet's concepts are consistent with modern theories of mind.

Barkworth (1889), a further English investigator of the period, also examined the similarities between different states of consciousness in hypnotic conditions and in natural circumstances. He cited both natural occurrences and experiments to support his opinions, including asking a man hypnotically to write a sentence backwards, and finding that even the letters were reversed and the whole thing written fluently without visual feedback. He also cited another case where a man had written a passage under hypnosis whilst pages were removed. The subject continued to position his writing on subsequent pages as if writing continuously on one sheet. Barkworth concluded that consciousness is best thought of as both active, controlled by conscious volition, and passive with varying degrees of amnesia. He supposed that the active consciousness proceeded in a linear constructive way, and that passive consciousness was holistic. Barkworth likens the passive consciousness to the ability to perform high-level skills, such as music or improvisation, where a holistic approach produces the desired result but conscious thought interferes with production.

Barkworth (op cit, p84) comments explicitly on the use of hypnotic techniques, declaring that "no result can be produced experimentally in an organism of which the causes and the constituents are not pre-existent in it". Barkworth also made explicit the utility of studying atypical phenomena in order to explore the typical. Of this comparison, he stated "I am inclined to think that one of their chief points of interest will prove to be the directing of attention to corresponding normal features, laws, and operations of the mind" (op cit, p84). He also emphasised the advances in knowledge, gained via hypnotic techniques, adding, "without these and similar investigations, the Unity of human consciousness would have remained a dogma unshaken and almost unchallenged" (op cit, p84).

3.8 The Hypnotic Paradigm: Diversion and the Charge of Iatrogenesis

Despite Barkworth's positive appraisal of the contemporary methodology, and although the experimental method was a major factor in the progression of understanding, the use of hypnosis has, in some respects, served to obfuscate scientific study and debate. Firstly, there are examples of failure to capitalise on

other interesting formulations due to the dominance of hypnotic emphasis, for example Ribot's (1885) concept of bodily consciousness; whilst, more fundamentally, it is the aspect of patient submission to the medical power, and the fact that it has frequently been confused with sleep, that has made hypnosis vulnerable to adverse criticism. Though this view of hypnosis has more in common with some early examples, and most particularly with stage drama, it has a powerful influence on general perception, and this has allowed the views of some modern commentators to be accepted uncritically. Tracing the movement from the religious philosophy of possession to the development of a materialist medical approach, the use of hypnosis can be negatively construed as a return to the introspection of earlier philosophy in some respects, and a dipsychic view of mind. Whereas before, an agent of God, the priest, exorcised the bad or dysfunctional out of the soul through his power, now the medical authority figure engaged directly with the unconscious, somnambulant self, and it is his magnetism that has the power to heal. This power differential between healer and healed, whether involving a priest or a medic, has been largely enhanced by a patriarchal influence of a man treating a woman or younger person.

Although investigators at this time employed hypnotism, as an empirical tool, as explicitly stated by Barkworth, an influence from somnambulist conceptions of dissociation remains. Most importantly however, the (mis-)use of hypnosis has formed the main tenet of the argument for DID as an iatrogenic phenomenon. Although this simplistic view of DID is appealing, so long as the full historical data and other professional knowledge remains unknown or selectively attended to, this argument does not bear out. The theme of iatrogenesis, as we will see, does however extend into the present day, and will be returned to later in the discussion sections. Further, as a result of this discrediting of hypnosis, many interesting phenomena have been only partially investigated to this day. For example, Binet's assertion that an induced alter could only be called out by its creator (Hacking, 1991), if critically examined, had, at that time, the potential to assist in settling the debate regarding iatrogenesis.

To illustrate both of these criticisms of hypnotic techniques, and data loss in view of their discredit, we may consider the work of Morton Prince. Prince's case of Miss

Beauchamp may be considered the most famous study on multiple personality of the turn of the century. Documented in detail, Prince (1905) reported her to have four personalities. Modern authors however, have asserted the opinion that Prince himself was instrumental in the formation of these personalities, indeed Merskey (1992) reproduces Princes's account of one hypnotic session with Miss Beauchamp, describing "the birth" of an alter, Sally. He outlines the ways in which he considers Prince to have encouraged the formation of multiple personalities by asking for names of hypnotic personalities, and not ignoring, but reinforcing the subject's usage of the third person to refer to her waking self. Although, as McDougall (1948) states, the possibility of Prince's moulding of the course of development of this case can not be denied, this is surely a call for caution, not dismissal. Indeed, other of Prince's publications have received less attention, perhaps in part due to the rejection of evidence gleaned through hypnotic methods. This has resulted in a lack of focus on the important data that was provided. Prince (1890), through experimentation using hypnosis and deductive reasoning, demonstrated that secondary consciousness was not confined to reflexes, and involved both the brain and volition, thus suggesting a similarity between DID and the normal separation of consciousness/unconsciousness. These opinions represent the idea of DID being on a continuum with normal experience, an idea undeveloped in the contemporaneous literature, again evidencing a failure to build on investigators' insights.

Scepticism and claims of iatrogenic influence are documented in contemporaneous accounts at this time. In a record of professional discussion documented in the *British Medical Journal* (1896), Dr Albert Wilson of Leytonstone "showed a girl, aged 12" who appeared to have two major states of consciousness, with the possibility of two additional states. The accuracy of this report was attested by Dr Althaus, who had witnessed Dr Wilson's case, and commented, "somnambulism" was frequent in children, "especially girls". As if to confirm the patriarchal influence, he went on to report a case of a "girl" of 24 years of age, whose alterations in personality "continued for years". In the same publication, Dr Robert Jones refers to a French case of a young woman, with double consciousness lasting a year. He does not identify this case, but draws the general conclusion that they result from suggestion.

Furthermore, Hart (1910, 1912), a lecturer in Psychiatry at UCH Medical School and the Assistant Medical Officer at Long Grove Asylum, wrote in the *Journal of Mental Science* of a "*Case of Double Personality*". This concerned a 28-year-old mail clerk, John Smith, who alternately behaved appropriately and sent threatening telegrams. In line with earlier reports, he was said to be coherent, yet had no memory for the altered states. He had also suffered previous fugues where he was found wandering, and for which he had amnesia, but Hart concluded that these did not constitute the same phenomena as the multiplicity occurring during treatment. He named the emerging alter the 1/5th man and noted that this character, or characteristic, took on a more rounded manifestation with repeated contact. He considered the 1/5th man to be the crystallisation of resistance, as are negative alters in the modern literature. He considered that his case responded to analysis, and integrated functioning was achieved. Later critics have taken his observations as confirmation that alters are iatrogenically formed, or at least developed, because of the attention provided by the clinician, but this is to use the data selectively and to ignore the integration that followed. This issue of development of alters in relationship to therapy will be expanded upon in the **Case Study, Chapter 5.**

3.9 Functional versus Spatial Conceptions

As the twentieth century progressed, authors in Britain continued the integrative trend, locating their theorising in relation to the dominant views of the period. Ross (1989, p28) describes this period as the abandonment of serious study in dissociation after 1910, and perhaps that was the case in the USA, but in Britain important concepts were being developed that are still relevant today.

Hart (1926), writing for the benefit of professional colleagues in the *British Medical Journal*, analysed the *"Conception of Dissociation"*, referring to his patient John Smith as illustration. Hart compared and contrasted his own functional concept with Pierre Janet's spatial conception of Dissociation, as well as Freud's concept of the conscious and unconscious. Janet's concept maintains that the non-integrated parts of consciousness are separated off from general consciousness.

Various medical commentators responded to Hart's thesis. T W Mitchell (1912), who had previously considered the nature of the unconscious and also of dissociation, challenged Hart and stated;

> "It cannot be too often repeated and insisted on that we have absolutely no knowledge of any such isolated material. If normally an experience that passes out of consciousness is conserved as a psychical disposition, it is as a psychical disposition that is part of *some* personality ... Its dissociated status has reference to the supraliminal consciousness and to that alone. It is not cut off from the structure of the mind, but only deprived of those associative connexions which would permit its emergence above the threshold. It is dissociated from the supraliminal consciousness, but is still an integral part of the mind beneath the threshold."

Mitchell demonstrates the struggle with the concept of dissociation and theory of mind. This idea of how separate, separate personalities actually are will resurface again in modern times and contribute to errors and solutions in treatment, as well as to the debate on iatrogenesis and malingering. Mitchell and Hart are not at odds when the totality of their concepts is compared, but in this partial consideration of Hart's new theory, Mitchell emphasises this important concept that separation of personalities or of consciousness is predicated upon a greater underlying unity.

As Hart notes, psychology has always been concerned with the divisions of mind, and especially those processes that are not easily accessible to consciousness. Hart's emphasis was on a functional conception of dissociation, laying stress on the existence of a synthesizing agent comparable to personality, but being driven by function. Hart saw dissociation as a lack of integration.

> "The spatial and functional conceptions of dissociation are radically distinct from one another in their angle of approach to the phenomena which they seek to describe. The former regards the dissociated consciousness as built up by the accretion of elements, the simplest example being provided by the cases where only a few such elements are dissociated, hysterical anaesthesia for instance, while the more complex cases are produced by the addition of more and more elements to the dissociated mass, until finally that mass attains dimensions to which the term 'personality' may reasonably be ascribed. The functional conception, on the contrary starts at the other end. It lays stress on the synthesizing activity which brings the elements together, and regards this as the essential feature rather than the mere agglomeration of elements.

> Instead of seeing in personality the final result of an unusually extensive agglomeration, it assumes that some synthesizing agent comparable to personality is present in every case." (Hart, 1926, p247).

This very insightful theory has much in common with Jung's (1902) concept of the striving for integrative functioning in the psyche, and functional nature of split off aspects of the self in the avoidance of self-conflict, and with modern concepts and clinical experience. This argument will be returned to in **Chapter 6**, of this thesis.

The work of Breuer and Freud, on hysteria, held promise for the study of dissociation and established a traumagenic cause and, though their subjects demonstrated dissociative behaviours, these were not systematically investigated in respect of dissociation. Ross (1989, pp30-36) suggests that fruitful investigation was derailed by Freud's abandonment of the seduction theory for personal and political reasons, leaving Freud with little alternative than to be restricted to a horizontal conception of mind (Ross, op cit; Spinelli, 1994).

Hart believed that Janet and Freud merely differed in technique and framework of analysis, suggesting that the absence of reciprocal amnesia between alters is explained by variations in thresholds. This is again consistent with the later ideas of Jung (1939). Hart felt that Janet's subconscious was concerned with phenomenology, whereas Freud's unconscious was concerned with concepts, and so long as this distinction is held clear there is no conflict between their views of things lost from consciousness - although he acknowledges they differed considerably on other issues (Hart, 1910, pp351-371).

Hart's view, though impressive in its conceptual synthesis and relevance to the current models of DID, did not go unchallenged. Ernest Jones, present at the reading of Hart's 1926 paper, found Hart's distinction oversimplified, he felt that psychoanalysis is integrative and that Freud's 'unconscious' is not purely conceptual, but observable when brought into consciousness. One of the major problems in comparing these different theorists and commentators is that, with a few exceptions, they do not develop clear data driven models, but present overlapping concepts from deductive reasoning and both first and second-hand clinical snippets. Other authors' objections, perhaps representing a minimising perspective, demonstrate a move

towards locating dissociative phenomena in relation to normal experience, reflecting the idea of a continuum of dissociative phenomena, as previously implicit in Binet's ideas, and explicitly mentioned in the contribution by Prince.

William Brown, present at the reading of Hart's paper, presented a sceptical view and concluded that alters are merely artefacts, since he claimed there are no World War One cases of MPD (this issue will be examined below in the work of Myers). Brown postulated that amnesia and fugues are numerous, but they are also integrated quickly. He then appeared to reach a conclusion that is hard to distinguish from Hart's in that he says the problem is association versus dissociation, integration versus disintegration. Edward Glover, pushing the minimisation defence to the ultimate, expressed the view that dissociation is normal and therefore not suitable to be specified as a psychiatric category. The defining characteristic of this general discussion is the way in which participants predicate their dismissal of Hart's extensively researched and developed exposition of a very complex area, by selective attention to partial data. It appears that this is done negatively rather than in an attempt to clarify and refine Hart's theory. The modern controversies are replete with similar simplistic and destructive criticism and methods, as will be noted below in considering the North American Psychiatric Meeting of 1988 (section **4.7**).

Ross (op cit) suggests that dissociation went into decline during this period because theories to date were conceptually flawed. He explains this decline as based on two major flaws in Janet's and Prince's work. He describes Janet's concept as being traumagenic, but also biologically determined, and associated with degeneration. Ross does not explore the mixed philosophical base of this concept, that appears to have moral as well as medical aspects to it and, as is demonstrated in modern times, this use of hybrid models permits the expression of opinion rather than fact. Ross suggests that Prince (1905, p489), and later Thigpen and Cleckley (1957), based their treatment on the annihilation of unwanted alters. Such an approach can still find expression in modern times. Ross likens this to medical exorcism. Whilst Ross's views provide useful critical aspects, they do not do justice to the positive contribution by Janet and Prince, nor to the continuing development of data and concepts, particularly in Britain in the early part of the twentieth century, as will be explored further.

In summary, Hart provided an extensively developed and scientifically based concept of dissociation, DID and the relationship to the theory of mind, consciousness, memory and personality that has stood the test of time. He made useful comparisons with the work of Janet and Freud, but not with that of Jung (1921, 1928), with whom he had much common ground. Jung conceived of personality as being normally multiple, not in the sense of dissociated personalities, but in the sense of a lack of integration in character, so that distinct differences could occur in a person's character under differing circumstances and in different contexts, something Jung called 'persona' or 'mask'. Hart's scientific legacy to the study of dissociation in general, and the history of the subject in the UK in particular, is still relevant today and is much neglected.

3.10 War Trauma and Dissociation

Janet, Freud and Jung, amongst others, had established the traumagenic basis to dissociation. The history so far has documented a wide range of types of trauma and this period sees a contribution to the advance in study, through the impact of the First World War. Myers (1915, 1916a, b, 1940), a British army psychiatrist, studied trauma cases from World War One and identified a split between "emotional" personality and "apparently normal" personality. The former endured 'hypermnesia' [sic], whilst the latter had partial or complete amnesia for the trauma. Following on from the work of Janet, Myers identified "psycho-physiological-shock" in his war patients, who would often alternate between these states. Challenging the uninformed response of William Brown to Hart, Myers gives several case examples that are later re-examined in detail by van der Hart et al (2000).

McDougall (1926), described by Kardiner (1926) as an Instructor in Psychiatry at Cornell, with "a prolonged experience with war neuroses and other clinical material", recommended that academic psychology move away from atomistic and mechanical models, and instead suggested that neuroses were trauma-based and "arise independently of the sex instinct" of Freud (1905). Kardiner found McDougall's dismissal of Freud to be too cavalier, and his extrapolation from war cases to be too narrow. Valid criticism perhaps, yet McDougall's elaboration of the concept of DID achieves striking resonance with modern accounts.

Thus, as communication between investigators increases and makes collaboration and the synthesis of data more possible, it also produces theoretical wrangling and professional competitive and destructive behaviour. This period may be seen not only as the differentiation and competition of authors' opinions, but as characteristic of a significant period in the development of psychological knowledge and of MPD/DID, for example, Binet's rejection of introspective methods and of biological reductionism along with other major figures at this time (Robinson 1995, pp323-326), and Hart's functional theory of MPD/DID.

3.11 Interim Summary: Progress and Challenge

Whereas previously there had been development from the ascendancy of the metaphysical model to that of the medical/materialist and a hint of the psychological model, this period of the last two decades of the 19th Century and the first two of the 20th Century witnessed a more definite shift to the psychological model of mind. A ferment of activity in France ushered in a more scientific approach to the observation, experimentation and reporting of case studies, with embryonic peer review and increased communication in the professional literature. The term *personality* is introduced (Dufay, 1883; Voisin, 1885; Azam, 1887) and models of mind, associated with emergent materialist philosophy, describe dissociation as a psychologically functional concept that can also be shown to relate to physical substrates. Prince (1890) demonstrated that secondary consciousness requires psychological and not merely physical processes.

In the UK, the highly influential Society for Psychical Research was established (1882), and its founder, Myers (1886), hovers on the brink of recognising multiplicity rather than merely duality, something that Binet (1896) explores even more explicitly. Binet attests the importance of the UK work, especially crediting Gurney, (1884) who emphasised the unconscious unity in DID. Barkworth (1889) also showed prescience of the two way information processing model of Craik and Lockhart (1972), who conceived of conscious awareness being controlled by the brain as well as deriving from perceptual input. Barkworth describes consciousness as both active and passive, both linear and holistic, and bringing a further challenge to the concept of a unified consciousness or sense of self. Hart (1910, 1912, 1926), an extremely

important UK contributor, demonstrated the rounded development of dissociated alter personalities, through interaction with external experience, but still considered that the acquisition of personality was not merely associative but subject to an overarching functional organising principle. This top-down organisation of personality or self-identity, versus associationist concepts, would be taken up again a century later by Morton (1985), with his Headed Records challenge to associationist models of memory, and applied to DID (to be discussed in the third part of the literature review, **Chapter 4**).

Much is done, around the onset of the 20th Century, to demonstrate and analyse normal consciousness as well as that which manifestly exists outside of awareness. Freud (1915) developed his theory of a hierarchical consciousness, adopted by other researchers and authors, eg Myers (1886), and both Janet (1920) and Freud (1940) demonstrated that traumatic impact could be excluded from memory but would seek indirect expression, and both clinicians utilised hypnosis as a remedy.

Although at this period hypnosis was widely used as an investigative tool, it's dominance perhaps adumbrated other fruitful areas of investigation, such as Ribot's (1885) concept of bodily consciousness, and in modern times hypnosis would become the major explanation utilised in the claim of iatrogenesis in DID. The importance of external interaction in the development of alters also served later to support the idea of their complete iatrogenesis, with Prince's very important case study used as an example of bad practice. Even at the time of Hart's seminal theoretical presentation, challenge ranged from critical analysis, such as that of Jones (1926), to scepticism and dismissal (Brown, 1926), lacking the evidence later provided by Myers.

Overall, as a result of the shift to a more psychological paradigm of the mind, the traumagenic basis of dissociation was recognised. In addition to this, more thorough, objective data was gathered, and for the first time clinicians began to apply the knowledge that was gained previously, thus furthering the development of the psychological knowledge of DID. This, however, also led to the differentiation and competition of researchers' opinions that was, at that time, destructive to the advancement of this knowledge. Indeed critics were often selective in their attention to research opposing their viewpoint, and focused and argued against partial details.

3.12 From Theoretical to Treatment Models & First Incidence Study

While debaters contested for supremacy, authors interpreted data in terms of their chosen models, and these models implicated different treatment modes. Whereas Burnett (1906) had utilised forcible suggestions to establish memory links, Riggall (1923, 1931) used a psychoanalytic approach. In 1923, Riggall reported a case of an adult male, married with three children, who was from an authoritarian background. This patient had dissociated fugue episodes and hypnosis was used. Riggall interpreted the fugues to be the result of parental fixations, which he later assumed to have been transferred to him, as the analyst. He concluded that hypnosis had permitted integration of the altered states but had not resolved the underlying neurosis, which he predicted would require lengthy psychoanalysis. In *The Lancet*, Riggall (1931) appeared to have a similar dilemma with a female adult patient from Devon, where fusion of the eight altered states was achieved, but this time, because she was of modest estate and not disposed towards lengthy psychoanalysis, he regarded the underlying neurosis as still not cured. Riggall is notable as his work refocuses on treatment, an issue still neglected in the UK literature today (for a history of the treatment of MPD, see Crabtree, 1993, pp69-70). Further, it comes from the UK, and not from America, refuting the modern contention, discussed in part three of this review (**Chapter 4**), that DID was imported into Britain as a North American phenomenon (Aldridge-Morris, 1989; Merskey, 1992).

A case with a similar number of alters to that reported by Riggall, was later reported in the USA by Wholey (1933). Wholey's paper, published in the *American Journal of Psychiatry*, takes the form of a thorough discussion of the philosophical roots of the concept of personality. After referring to Morton Prince's Miss Beauchamp, he presented Mrs X as having 8 personalities, of whom 4 were male. This case is difficult to evaluate since it is detailed that the patient was living in a household in which numerous exorcisms had taken place, and was further exposed to some level of suggestion. More systematically, US authors Ables and Schilder (1935) give the first thorough incidence study of amnesic fugue patients at Bellevue Hospital, New York, and in doing so refer to a small number of multiple personality presentations. Specific incidence studies in the UK will be discussed later in the thesis.

Although these US reports are acknowledged, it must be noted that reports of DID from the UK and other nations are not confined to one historical period, and continue steadily throughout the ensuing decades. In the UK, Mann (1935) gave a paper at Guy's Hospital in which he attempted to apply the phenomenon of multiplicity and dissociation to the question of models of mind. Influenced by McDougall and Janet, he concluded that the human mind is composed of levels of functioning. At the basic level are innate instincts, at the next super-ordinate level are conditioned reflexes, and the highest level is some sort of integrative executive facility. He expressed the wish to find anatomical explanations for these levels of functioning but his paper remains speculative and vague on this aspect, although modern neuropsychological data would suggest he would not have been too much at odds with modern knowledge and thinking.

Around the same period, also in London, Forsyth (1939) reported a First World War case of an Englishman stationed in the Middle East who had lost consciousness following a shell explosion. Having been delirious for two weeks, he regained consciousness in the desert amongst a group of Arabs. In his previous training he had learned Arabic and spent long service in native hand-to-hand fighting and underground activity. He lead these Arab followers in similar pursuits, eventually meeting up with his old CO. Instead of being the hero he expected, he found he had been ignorant of the fact that the war had ended three months previously, and his escapades were to bring impending court martial. The anticipatory anxiety was so great, he became amnestic for the whole of this period of some six months of his life. Twenty years later, Forsyth used psychoanalysis and then hypnosis to recover the lost memories, and described the case as "one of Amnesia as a result of a Dissociated Personality". He concluded by recommending that hypnosis be employed experimentally to shorten the length, and thereby cost, of analysis.

Similarly, Laubscher (1928), a General Practitioner in South Africa, provided a detailed description of the physical and psychological condition of his patient, as well as a detailed analysis of psychological dynamics leading to her condition and improvement. He concluded that his patient had been sufficiently traumatised, by her cruel second marriage, to have become psychologically split into two personality states, one normal and lively, the other crushed and submissive. He stated there to be

an executive or higher state, that he called the original self, into which he, via hypnosis, integrated the split off parts. He made the point that hypnosis was used for economy of time, and that there would have been more he could have done.

Thus these cases highlight the role of trauma in dissociative phenomena, and the successful intervention that was possible. Forsyth's case returns to the theme of war trauma, as discussed by McDougall (1926), and also illustrates the concept of motivated forgetting and repression of memories. Laubscher's evidence extends the range of traumata associated with the onset of dissociative symptoms into the domestic arena, an area of dissociation and posttraumatic stress that Herman (1992) aimed to bring to focus in the modern era. In anticipation of discussion of modern perspectives on treatment, to be found in Part 3 (**Chapter 4**), it is interesting to note here that, these early twentieth century authors report having successfully utilised hypnosis, as an adjunct to psychoanalysis, and that its use had been integrative, in contrast to the claims of iatrogenic splitting of the personality.

3.13 Life Reflecting Art or Art Reflecting Life: Evidence and Confusion

The 1950s saw one of the most significant events in the modern history of DID. In 1954, Thigpen and Cleckley (USA) gave a cautious account of their patient, published as the Three Faces of Eve in 1957. Their account described Eve White and her alter personality Eve Black. One of the reasons that this report made such an impact was the systematic way in which the authors assessed the differential states with a range of tools and methods, both psychometric and projective, together with the systematic recording of behaviours. So too these investigators exploited new technological advances. Thus, as Morselli (1946, 1953) had found recorded EEGs to be different in alter personalities (cited in Ellenberger, op cit, p141), so too Thigpen and Cleckley utilised EEG assessments, as well as handwriting analysis and physical appearance, including pupil dilation, in their investigations. This scientific impact was soon accompanied by the feature film depicting Eve's life. Although it has been less easy to dismiss the scientific report, the film has come to symbolise the bedrock of the claim that popular knowledge renders all cases factitious, as Merskey (1994) will later claim.

Following Thigpen and Cleckley's publication, reports continued in the 1960s and 70s, and the investigative flavour of the period continued with the publication of further studies employing new methodologies. To illustrate, Condon, Ogston and Pacoe (1969) examined the film data of Eve, frame by frame, and concluded that differentiated eye movements were found in Eve Black, the dark side of Eve's character.

In 1970, US researchers, Brauer, Harrow and Tucker published an article in the *British Journal of Psychiatry* documenting their study of Depersonalisation and Derealisation, concluding that they are both different aspects of the same thing. They proposed that Depersonalisation and Derealisation result from the ego failing to modify or regulate internal and external stimuli. This publication merits some comment as these categories of dissociative phenomena are apparently accepted by British psychiatry, and do not attract the same attention, attack, or allegations of iatrogenesis and malingering. Thus, in the UK, although the idea of MPD/DID is to become adumbrated by the dominant idea of faking, and there is a dearth of publications, research is published on other forms of dissociation disconnected from the rest of the continuum of dissociation presentations, and in isolation from the DID debate. Similarly, although there is a lack of explicit publications in the UK regarding DID, the general issue of dissociation is again found embedded in other problem foci, for example, some modern theories of dissociation believe it to be a disruption to attachment (Fonagy et al, 1996).

Returning to the timeline of sources, case reports continued gradually and the issue of disrupted attachment, with specific reference to DID cases, arises in the work of Horton and Miller (1972) in the USA, who give a cautious report of a 16 year old girl who had 4 personalities, and was relatively integrated, but developed the alters as a result of the loss of significant others and subsequent disruption of attachment. Psychodynamic therapy appeared to assist integration. In other sources, malingering continued to be considered and some case reports attempted to cross-check data across modalities. A very thorough study of the famous forensic case of Jonah was reported by Ludwig et al (1972). Jonah was considered a poor candidate as a dissembler, because of socio-economic and educational background, as well as a prior history of amnesia for altered states and distinct characteristic presentations,

documented by others. Ludwig et al conducted a range of clinical, psychological, psychophysical and neurophysical measurements on each of four personalities, as well as on a hypnotised state. Their data suggest some correspondence between the subjectively reported functions of the personalities and objective measures. To exemplify, the personality Usoffa, whose function was to be a fearless protector, was able to bear pain without feeling it.

Although the publication of reports and theoretical perspectives continued throughout the early to mid twentieth century, the accounts discussed during this period could be viewed as a further regressive step in the history of DID. To clarify, from the experimental advances of the 1880s and 90s, a return to case studies, though detailed and presented from a psychological perspective, seems to have eclipsed more comprehensive data gathering, with notable exceptions, such as Ludwig et al and Thigpen and Cleckley. The pattern of unresolved conflict over the interpretation of data, followed by clinical therapeutic endeavour, becomes a theme in the history of dissociation. In considering the full range of dissociation, useful incidence data comes from some military sources. In 1973, Kirshner published an historical case review of psychiatric files of dissociative reactions noted within other diagnoses. Examining 1,795 admissions at Wright-Patterson Air Force Base Medical Centre, from 1968-70, he found an incidence of 1.3% for dissociative reactions, compared with Ables and Schilder's (1935) finding of 0.26% 'loss of personal identity' (amnesia that would correspond to depersonalisation) at Bellevue Hospital, New York. This incidence of 1.3% dissociative amnesia was also compared with amnesia in 'hysterical' patients of 6% (Purtel, 1951). Several other studies recorded higher levels of dissociation, including Henderson and Moore (1944), who reported 5% of military patients during World War Two as having dissociative responses - but this sample was more likely to have been in acute combat situations, in contrast to the Wright-Patterson sample. Kirshner (1973) concludes that:

> 'Dissociative episodes were not associated with hysterical traits or conversion reactions, although this relationship was more frequent in seven females. Findings suggest that amnesia is a culturally defined role utilised adaptively by the ego to repudiate unacceptable behaviour, conforming to Spiegel's concept of the transitional social role.'

Kirshner's conclusion is compatible with Forsyth's war case of repressed memory.

Thus, in drawing to the end of this period, empirical and case study reports co-exist in the literature, such that theory may be considered a product of data, and the profile of DID had been boosted by the presentation in the mass media in the 1950's. Yet, although substantial progress had been made at this time, in that hypnosis and psychoanalysis had produced successful treatment outcomes, and dissociative phenomena were pivotal in shaping psychological models, progress was not to continue smoothly, and the close of this section must acknowledge the voices of dissent.

3.14 Multiple Personality in the Cultural Consciousness

During this period, discussion of dissociative phenomena had not remained in the confines of academia, but entered and influenced cultural consciousness, introducing a further set of themes into the history of the development of the concept of DID. In common with the raised profile of other issues, such as alcohol abuse and schizophrenia, achieved by other films and literature, it may have been assumed that the growth of awareness about MPD/DID would be positive in terms of diagnosis, resources and so on. However, commentators view this watershed differentially. Ross (1989) considers the case of Eve to fall within the historical period in the study and understanding of MPD that he labels as "decline", as he contends that this case was regarded as an "extravagantly rare curiosity" (1989, p44), and Eve White was thought to be the only living case of DID in the late 1950's. Merskey (1992) believes the films, *Three Faces of Eve* (Nunnally Johnson, 1957) and *Sybil* (Daniel Petrie, 1977) disenfranchise any later cases from veracity because of the widespread influence on the general public. He uncritically applies this logic to MPD, but not to other psychiatric conditions, when he states:

> "No case has been found in which MPD, as now conceived, is proven to have emerged through unconscious processes without any shaping or preparation by external factors such as physicians or the media ... no later cases, probably since Prince, but at least since the film The Three Faces of Eve, can be taken to be veridical since none is likely to emerge without prior knowledge of the idea" (op cit, p335).

Not only is this opinion unsupported by research and clinical data, if this were to be a concept accepted in psychiatry and other services it would preclude the veracity of most clients' self-reports, since films have been made about most, if not all, mental health problems, yet this disbelief of the client appears only to be recommended in the case of MPD/DID. Indeed, Kluft (in *Mesic,* 1992, p122) enquires, "If these patients are so suggestible, why can't we suggest they get well and have them do it?". Further, this view is contradicted by both Ross's opinion that DID was viewed as a rarity, and by the following discussion of an already existing historical awareness of DID in the public domain.

Parallel to the scientific elaboration of the concept of DID, an increasing cultural awareness of dissociative phenomena was both portrayed and furthered by popular literature, most notably in the late nineteenth century. Ellenberger (1970) documents this phenomenon, citing both well-known examples, such as that of Stevenson's *The Strange Case of Dr Jekyll and Mr Hyde* (1886), and less remembered works, including Lindau's theatrical piece, *The Other* (1893). Ellenberger relates the incidence of these themes to an exploration of the "mythopoetic function" of the unconscious, that is, a region in which "inner romances" are formulated and may be expressed under certain conditions, such as hypnotism, trance, or delusion. Such themes relate also to the development and influence of psychoanalytic schools of thought at this time. Thus, although dissociative phenomena may not always have been so prominent in the cultural consciousness, the publicity following Thigpen and Cleckley's (1957) work was not the first occasion that science and society had simultaneously considered the issue of dissociation.

3.15 1880 – 1980. Discipline and Diagnosis Take Shape: Thematic Overview

In overview, throughout the period, reports of DID continued from numerous sources. Moreover, this historical account has shown that both the earliest reports and the beginnings of scientific study come from Britain and Europe, whilst the USA came to dominate the dissociation field only in modern times. The reasons for this will be more fully explored in the discussion sections of this thesis, but largely centre upon the relatively earlier rise of both the independent discipline of psychology and the emancipation of women, further aided via the Vietnam War and the study of the associated field of Posttraumatic Stress Disorder. Indeed, before this modern

phenomenon of American dominance, as Alvarado (2002) has described, Britain, via the Society for Psychical Research, was not only seminal in its study of dissociation, with 39% of its 1882-1900 papers being on this topic (op cit, p13), but because it welcomed foreign members, its influence spread, most notably to France and Germany (op cit, p25) in contemporary times.

In reviewing the tensions underlying the publication of sources, a major struggle evident in this period was one within psychiatry itself, a struggle for hegemony between biological psychiatry and that of psychoanalytical psychiatry. Ross (1989, p39) suggests "There has been an ideological dichotomy in psychiatry over the last eighty years, which is not resolved. Initially the Freudians were on one side and the 'biological' psychiatrists were on the other ... the unitary Freudian camp has since been replaced by a welter of diverse schools" but "reciprocal morbid phobia" of the two camps is evident. The seeds of the modern antagonism between biological psychiatry and a psychosocial approach, utilising selective data in hypothesis confirmation, are extant. Destructive arguments are less intellectually taxing than constructing theories that can account for all of the available data. As will be seen in relation to war trauma, discussed later, although the pioneering attitude of the Society for Psychical Research has been noted, it may be that this early constructive leadership is adumbrated in modern times by the characteristics of the British that gave rise to the political policy of "splendid isolation" (Lord Salisbury, in Steele 2001), impeding our full collaboration with international data and scientific endeavour. Even this hypothesis does not account for the modern selective amnesia for even the UK historical data on dissociation.

Finally, in summary, although the period discussed in this section may be characterised as a period of growth in knowledge, and the integration of that knowledge into the framework of an independent and scientific discipline of psychology, in particular with the emergence of the first incidence studies, for which America can be credited, progress was not linear. The history of DID again became convoluted, with some failures to progress, for example, the relative "derailment" caused by the linking of dual hemispheres with dual personalities and double-consciousness. The perseverance of deductive reasoning and selective attention to the availability of data, fails to lead to clarity in concepts of mind and dissociative

phenomena. Beneath the progress and integration also appear the seeds of disharmony and confusion that can be traced to this period, ie specialisms and differing perspectives emerging from within psychology, and factions hardening within psychiatry. Voices of dissent also emerge as dissociation "goes public", and these opposing views become more irreconcilable, as demonstrated in the next part (**Chapter 4**, ***1980 - present. The growth of professional recognition and controversy).***

3.16 Interim Summary: Principal Issues and Findings

- The historical subjugation of women, war in Europe and the development of US hegemony set the context for the rise of psychology as an independent scientific discipline and the more collaborative and systematic study of dissociation

- This period sees the formulation and refinement of a psychological concept of self; within this development, the study of multiplicity and dissociation contributes to philosophical debate regarding the nature of consciousness

- The application of controlled, experimental methodologies in the collection of psychological data; a shift in focus to a consideration of 'personality'; and the formulation of models of mind mark the rise of the independent discipline of psychology

- The work of Ribot illuminates the concepts at the heart of an understanding of multiplicity: memory, personality, and consciousness, exemplifying the importance of the period and highlighting the turn of the century dominance of the field by European investigators

- The work of Janet and Freud, and their respective diverse influences, exemplify the synthesis of ideas that typifies this period, explicitly considering dissociation in terms of the nature of mental functioning, and of the conscious and unconscious mind and the role of trauma

- British and French theorists lead the world, but in relative independence from each other; striking parity with modern accounts of Dissociative Identity Disorder is found in Myers's description of 'quasi-independent' self-parts; the work of Binet firmly establishes the '*plurality* of consciousness and personality'; Binet and Gurney both focus on unconscious integration underpinning conscious dissociation; while Barkworth's study of the *atypical to illuminate the typical* places multiplicity on a continuum with normal experience, as does the work of Prince and Binet

- Not all of the knowledge gained in this period is capitalised upon, as claims of iatrogenic influence arise from the application of hypnotic techniques to the study of dissociation, though often it is successfully employed in integrative treatment

- Hart developed an elegant functional model of DID to challenge the spatial concepts of Freud and Janet; contrast, conflict, and debate regarding opposing theoretical stances is evident within now established academic psychological and medical communities

- The understanding of dissociative phenomena is broadened by a consideration of treatment models and the collection of incidence data

- A consideration of military cases reinforces the link between the experience of trauma and the onset of dissociative symptoms; a more diverse range of traumata is recognised, including the impact of disrupted attachment and domestic violence

- Although dissociative phenomena have historically been represented in literature and theatre, the veracity of accounts is challenged as cases of multiplicity are represented in the mass media; academic polemic is to result

CHAPTER FOUR

REVIEW OF LITERATURE: PART 3

1980 - present. The growth of professional recognition and controversy

4.1 Introduction

The examination of the literature thus far has charted not only the emergence of a developing social and political role for woman, and seen psychology develop as an independent discipline, but has also demonstrated the important contribution that the phenomenon of multiplicity has played in differentiating and shaping models of mind. Although the idea of the mind as lacking unity was not new, an early example being St Augustine, who described the struggle between his Christian waking self and his Pagan dreaming self (Encyclopaedia Britannica, 1952), the views and theoretical stances adopted as a result of the consideration of the phenomenon of multiplicity have been major influences on the debate surrounding the nature of consciousness. Furthermore, multiple personality and dissociative phenomena were not only firmly located within the body of psychological knowledge, but had become elaborated and studied in their own right. So too, it seemed that a tentative case for the role of trauma as a factor precipitating dissociation could be made. From these foundations then, one may assume that the more recent history of dissociative phenomena would be one of continued study and a commensurate growth in understanding. Indeed this period begins very promisingly with scientific studies (Bliss, 1980; Coons, 1980; Greaves, 1980). However, particularly in Britain, the evidence to be presented here suggests that the earlier convolutions and hurdles discussed in this review have yet to be fully circumnavigated, and new challenges to the diagnosis of DID have become evident, though the possibility of resolution is tentatively discussed, and some possible resolution may be imminent. The material in this third part of the literature review has required even greater selection and organisation, in response to the myriad of opinions and approaches reviewed.

4.2 The development and influence of interest groups

The introduction to this thesis identified a lack of informative modern UK material on dissociation, so too in the early 1980's interested professionals, mainly in the US, had begun to network and look for training and information. In response, the International Society for the Study of Multiple Personality and Dissociation was formed, and began holding annual meetings and conferences from 1983. This organisation was based in the USA and was centred firmly in an American perspective. Conferences were occasionally arranged elsewhere, in addition to the American conferences, for example conferences were held in the Netherlands (1992, 1995) and in the UK (1996). The society was instrumental in providing the awareness and research that led to the inclusion of dissociation in DSM-III. Later the term MPD was changed to DID, and the society changed its name to the International Society for the Study of Dissociation (ISSD). A regular journal was produced; the original journal, *Dissociation,* was later superseded by the journal *Trauma and Dissociation* symbolic of the way in which dissociation studies were integrating with the stress literature. Overlapping and joint conference sessions were held between ISSD and the International Society for Traumatic Stress Studies (ISTSS), a sister society also formed in the mid eighties. A European branch of ISTSS was formed (ESTSS), and conferences were held in different European countries, including Britain. The UK component of ISSD, ISSD(UK) was formed in 1994, and began to hold annual conferences between 1995 and 1999, when the organisation gradually went into decline, through lack of continued leadership. Despite the lack of central organisation, some proliferation of ideas and the integration of the concept of dissociation into other areas of study, such as Posttraumatic Stress Disorder (PTSD) and Attachment, continued. This integration of dissociation into other areas perhaps reflected the maturation of understanding of the areas from one of splitting to one of integration, perhaps also a normalisation of the concept, but much more likely a move by practitioners towards low-key clinical practice in the face of threatening controversy. This issue will be expanded upon in the discussion sections of this thesis. The national organisation of a component group of ISSD in the UK was resurrected in 2002, under the name UK Society for the Study of Dissociation (UKSSD), with the explicit aim of prioritising training, and has recently begun to host conferences. In the mid 1990's, Valerie Sinason and her colleagues set up the Clinic for Dissociative Studies in London, also with a strong training focus.

In the late 1980's the Australian Association of Trauma and Dissociation and the Australian Society for Traumatic Stress Studies had been formed. A similar component group of ISSMP&D had been formed in New Zealand, composed of roughly equal numbers of psychologists and psychiatrists. Component groups also formed in many other countries throughout Europe, Australia and other parts of the world, with various vicissitudes and some common impediments.

4.3 Psychiatric diagnostic systems

The First Edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-APA - first edition, 1952) emerged, following the Second World War, and identified hysterical trauma reactions, that would now be thought of as replaced by dissociation and PTSD. The "political" effort on the behalf of practitioners mobilised expertise and resources in order to increase awareness of dissociative conditions. Their efforts were, as mentioned, a major factor in the inclusion of dissociative disorders in the DSM. Multiple Personality Disorder and posttraumatic stress disorder were introduced into DSM-III in 1980. DSM-III-R (APA 1987) contained classification for dissociative disorders: psychogenic amnesia, psychogenic fugue, MPD, depersonalization and Dissociative Disorders Not Otherwise Specified (DDNOS). Further refinement of the concept of MPD, then relabelled Dissociative Identity Disorder (DID), was achieved in DSM-IV (APA 1994). The World Health Organisation International Classification of Disease (ICD) introduced the concept of Multiple Personality Disorder in ICD9 (WHO 1975), but only added the term DID in 1987.

4.4 Competing and complementary diagnoses

In view of the inclusion of DID in the DSM, and in view of the effort of practitioners in disseminating material and furthering knowledge, let us now consider the result of these developments on the wider scientific community. Flemming (1987) in Canada contended that MPD is probably underdiagnosed, and suggested that sleep disorder clinicians would do well to understand that MPD may manifest as somnambulism, and go undetected. In contrast, other authors disputed that a rise in cases in the 1980s reflected greater awareness and more accurate diagnosis. Fahy (1988) discussed the recent rise in reported cases of MPD, and stated "There is little evidence from genetic

or physiological studies to suggest that MPD represents a distinct psychiatric disorder", thus displaying the biological basis to his argument, but also a lack of awareness of the physiological research on DID. He concluded that MPD is a hysterical disorder, and echoed Slater's (1965) belief that this may be both a delusion and a snare. He noted the need for research on imitation of psychiatric disorders, and cited Philips (1986), who investigated suicide and found a stronger impact from non-fictional sources than from fictional depictions. Thus, although equally sceptical, Fahy's discussion somewhat undermines Merskey's claims of media fictional influence. While there was a plethora of talk show programmes in the USA, there was little in the UK, thus such factors should not be considered universal.

When DID was not being summarily dismissed, it was apt to be re-interpreted. Fahy, Abas and Brown (1989, p154) report a case of "so-called multiple personality disorder" and propose it be viewed as "a non-specific psychiatric symptom". Merskey displayed a preference for the concept of hysterical personality, and was critical that it was dropped from DSM-III, despite the conceptual problems with this term due to its varied historical application. Alam and Merskey (1992), reviewing the literature relating to the development of hysteria, regard DSM-III as avoiding the concept and the term hysteria by the use of new categories such as Somatoform Disorders and Dissociative Disorders. They regard the concept of the hysterical personality as having undergone three stages of development: the first, an expansion of symptoms culminating with Janet; secondly, a phase that emphasised emotional disturbance as central; the third phase emphasised the avoidance of negative bias and the reduction of the idea of simulation and malingering.

4.5 Confusion with Schizophrenia

Have you heard the one about the chap who thought he was schizophrenic but he could not make up his mind? This well-known, though not politically correct and certainly inaccurate, joke demonstrates the layperson's, and perhaps some professionals', understanding of schizophrenia. In 1980, Rosenbaum examined the rise and fall of reports of multiplicity from the nineteenth century to date, and proposed that Bleuler's introduction of Dementia Praecox (Schizophrenia) in 1916 adumbrated reports of MPD. Jung (1939, p34) conceived there to be great similarities between Schizophrenia and MPD, both being traumagenic, but differing

in terms of ego strength, with MPD having greater ego strength and development than Schizophrenia. Other commentators have supported Rosenbaum's analysis, and Ross's (1989, p39) somewhat charged reaction to this further barrier to the recognition of DID, aptly demonstrated the tone of this and following decades. Ross countered, "Could it be schizophrenia that is the fad, one driven by biological reductionism ... Why is MPD singled out for the criticism of iatrogenesis by mainstream psychiatry, but not schizophrenia? Because of data? No. Because of ideology". Whilst earlier evidence has hinted at the tensions emerging between psychology and psychiatry, such comments from a practising psychiatrist are indicative of tensions within modern psychiatry, namely a challenge to biological supremacy. This raises the issue of whether such comment may be construed as indicative of an impending paradigm shift that may affect mental health issues in general. It appears that a trauma-based paradigm is gaining ground very firmly in the USA and, perhaps at least under the label of Posttraumatic Stress (see below), the UK will be unable to ignore the growing volume of scientific research, especially the integrated research such as that by Schore (2001) to be discussed in **Chapter 6**.

4.6 Psychometric and Structured Clinical Instruments

Following DID's inclusion within DSM and ICD, and in response to a need for practitioners to be able to both diagnose and differentiate dissociative conditions from other potentially confusing diagnoses, psychometric and clinical instruments were developed. This review seeks only to provide a brief record of such development, and the list is selective, to reflect the early history of these tools and to highlight those that have become prominent and consistently used in epidemiological studies. Instruments include self-completion screening tools, clinician administered interview schedules and clinician observation records.

Ross and Heber (1989) devised the Dissociative Disorders Interview Schedule (DDIS), demonstrated to have 0.68 inter-rater reliability, specificity of 100% and a sensitivity of 90%. This instrument distinguishes dissociative disorders, somaticised disorders, major depressive episodes and borderline personality disorder. It has additional items addressing substance abuse, childhood physical and sexual abuse and secondary features of MPD.

Later, in 1993, Steinberg, a US psychiatrist, developed the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D), with a Revised version in 1994. There are a number of established clinical interview schedules in the SCID series, utilised primarily by psychiatry. The SCID-D also specifically addresses the differential diagnoses between dissociation and other conditions, such as schizophrenia. This diagnostic tool established good inter-rater reliability and discriminant validity, both in the USA and in the Netherlands. Utilising this tool, Steinberg (1994c) found that subjects with schizophrenia and schizoaffective disorders had less durable episodes of dissociation and scored in the none-mild-moderate range on the SCID-D, compared to MPD/DID subjects who scored in the moderate-severe range. The limitations of this instrument are the circularity of diagnosis and small sample size. The former criticism is of course common to the devising of many measures of other conditions. An improved version, *SCID-D Revised*, Steinberg, M (1994b), is now in current use.

Screening instruments were required and the Questionnaire of Experiences of Dissociation (Riley, 1988) was developed. The low number of subjects in the original research was rectified by Dunn et al (1993), but this never became a widely used instrument. More widely used has been the Dissociative Experiences Scale (Bernstein and Putnam, 1986), having good reliability and the development of norms. The scale has however been shown to produce false positives, especially in non-clinical populations and highly suggestible subjects (Sandberg and Lynn, 1992). This scale was revised to the DES II (Carlson and Putnam, 1993) and analysis refined in the DES-Taxon by Waller and Ross (1997).

Armstrong et al (1997) developed an adolescent version of the DES, called the A-DES, for use with children aged 11-17 years. Smith and Carlson (1996) found the A-DES to be reliable and valid. Putnam (et al 1993, 1996, 1997) developed the Child Dissociative Checklist, to be completed by an appropriate adult. Silberg (1996) developed the Dissociative Features Profile to provide structured recording and analysis of clinican observed behaviour in children during assessment.

There was a proliferation of instruments relating to the identification of dissociation associated with PTSD, such as the Peritraumatic Dissociative Experiences

Questionnaire-Rater Version (Marmer et al 1994) and the Adult "Step-Wise" Assault Interview protocol (Yuille, 1990); for a review see Carlson (1997).

Vanderlinden (1993) developed the Dissociation Questionnaire (DISQ), a 63 item, 5 point scale, self-report measure designed to measure psychological dissociation. It contains four subscales, Identity confusion (eg "It happens I have the feeling I am somebody else"); Loss of control (eg "There can be sudden complete change in my mood"); Amnesia (eg "It happens that entire blocks of time drop out and that I cannot remember what I did then") and Absorption (eg "I notice that I watch myself closely in everything I do"). Internal consistency was alpha = 0.96 for identity confusion; alpha = 0.88 for loss of control; alpha = 0.88 for amnesia; alpha = 0.81 for absorption and alpha = 0.97 for the total score. Scores have been found to be stable over time, and the measure has been found to have good discriminant validity. The DIS-Q correlates with the DES at r = 0.85.

Nijenhuis et al (1996, 1997) developed the Somatic Dissociation Questionnaire (SDQ). This has two forms, the SDQ-20 (Nijenhuis et al 1996) having 20 items, and the SDQ-5 (Nijenhuis et al 1997), condensing the 20 items down to a shortened form using factor analytic techniques. The SDQ-5 has an internal consistency alpha = 0.6. Scores of 8 or above are thought to warrant further assessment. This makes it an extremely quick and useful screening tool.

The development of screening and clinical instruments in the field of dissociation has followed a similar path to that of any other mental health problem. Instruments are firstly devised for adult populations, and then child and adolescent versions for professional or parental completion follow. Eventually some child completion measures are developed. In the early days of determining a new area of study, the parameters of the problem under scrutiny have to be delineated and differentiated from other conditions. Measures have to be valid, reliable and easy to use. Despite these developments these standardised instruments co-exist with the continuing controversy over the concept of DID, in the psychological community.

4.7 Controversy in the modern era; impediments to treatment

Thus following from the political effort of practitioners in the formation of interest groups and the research effort, culminating in validated clinical instruments for assessing dissociative disorders, one may assume that the recent history of dissociation, from the mid 1980s to the present, would constitute further study, and elaboration of the concept. However, controversy is again evident when, in 1984, Thigpen and Cleckley, the authors whose work was pivotal in raising the public profile of DID, concluded that MPD is actually extremely rare, and that their report of Eve in 1957 had been the only one they had encountered in 25 years of practice. They therefore warned against over-diagnosis, and encouraged consideration of secondary gains, suggesting, in line with Alam and Merskey (1992), the consideration of the hysterical basis of the symptoms. The authors point to their own experience of patients who imitated symptoms to gain attention, and advise that careful diagnosis will reduce a false epidemic of cases. Although seminal, Thigpen and Cleckley's account is not without its limitations. They too were highly selective in their reading of the history of DID, as Crabtree (1993) has pointed out.

In the years following this statement by Thigpen and Cleckley, the professional journals, especially in the US, document a wide range of opinions on the subject of MPD. In 1988, in the Journal of Nervous and Mental Disease, there is debate on the subject of professional scepticism regarding MPD. The article (Bliss, 1986) makes it clear that not only was controversy evident, but also open hostility and the rejection of journal articles on MPD. A small-scale, professional survey disclosed a variety of opinions, such as "the absolute need for scepticism as a necessary part of scientific endeavour" (Bliss quotes from his respondents). Another issue raised was the polarisation in psychiatry, such that "Biological psychiatry, dedicated to psychopharmacology, neurobiology, and neuromediators, has little tolerance for the 'irrational'. In turn, psychoanalysis accepts the unconscious and the irrational, but cannot fit multiplicity within cherished concepts". Such statements are an explicit acknowledgement of the historical tensions, discussed throughout this review. Other respondents, demonstrating strongly expressed but un-evidenced opinion, claimed that MPD was "known" to be rare or manipulative: "Many patients appear to be avoiding responsibility. They are theatrical if not deceptive. Suicide attempts are often flimsy, involving only superficial cuts and insufficient pills". Others suggested

iatrogenesis; "Gullible professionals have created the process. Suggestible patients are being compliant" (quoted from respondents in Bliss, 1986).

Bliss himself (1988) promoted the counter-argument that the negative thesis of some professionals often developed from false premises, and that a scientific explanation for MPD does exists. He suggests that MPD is likely to involve auto-hypnosis (Bliss, 1986). It is argued that self-hypnosis is an easily available protective psychological strategy, applied in childhood to avoid traumatic affect. Children unwittingly use the capabilities of deep hypnosis "to produce amnesias, imaginary companions (personalities), and other potentials of hypnosis" (Bliss 1988). Bliss (op cit, p534) refers to Bramwell's (1903) summary of some of the many capabilities of deep hypnosis; "catalepsy, paralyses, flaccidity ... Vision, audition, smell, taste, touch, pressure, temperature and pain could all be made more acute, diminished, or arrested". Indeed clinical psychologists specifically train clients in such skills for the purpose of pain management, without labelling the process as dissociation. Melzak (1973) has proposed a gate control theory of pain, where a neural gate in the spinal cord is controlled by the brain. People can utilise self-production of endogenous opiates to control sensory input, as well as control physical and cognitive conditions through the use of placebo (Carlson, 1977, p211), thus demonstrating arguably similar mechanisms to those used in dissociation.

From his hypnosis premise, Bliss (1988) provides an interesting estimate of MPD.

> "The hypnotic capability for deep hypnosis occurs in perhaps 40% of children, (London and Cooper, 1969). Furthermore, physical, sexual and psychological abuse of children is not rare. Let us take the figure of 10% that many would consider low (Russell, 1986). The number of individuals at risk for MPD then becomes 4%. Even if only one quarter of the 4% at risk develop the syndrome it would still be equivalent to the number of people with schizophrenia and would not include individuals with less flagrant self-hypnotic problems".

In the same publication, Hilgard (1988), an eminent psychologist, is highly cautious but generally supportive of the concept of MPD, stating however that any more than a few personalities undermines the credibility of the diagnosis. Hilgard's expertise lay with hypnosis, rather than with MPD, and his central role in academic psychology is

likely to promote a very cautious but informed opinion. Spiegel, Hunt and Dondershine (1988) conducted careful research into hypnotisability, and concluded that PTSD subjects differ in their results, on a hypnotisability scale, from other psychiatric categories, such as schizophrenia or bipolar disorders. They suggest that there is good evidence that MPD is a form of PTSD, again suggesting the link with trauma.

A particularly heated and direct clash, regarding MPD, took place between psychiatrists in Montreal, at the annual psychiatric meeting in 1988. Kluft estimated the prevalence to be 1 case per 10,000 of the general population. Frankel did not dispute the existence of alternate personality, but thought the number of cases to be biased by hypothesis confirmation in advocates. Orne erroneously claimed that "all histories upon which MPD are based" have been obtained by hypnosis. Frankel, in a more balanced tone, was concerned about iatrogenic production through leading questions and suggestibility. Spiegel pointed out that the small numbers of DID reports are a red herring and that other rare conditions, such as "lupus", are not claimed to be manufactured. Spiegel was also concerned about iatrogenesis, but offered research to establish that the same symptoms were documented by two groups of psychiatrists, one familiar with MPD and the other not. He pointed to the natural occurrence of MPD and its persistence over centuries and, referring to neurological matters, suggested it was quite an accomplishment "to experience all that goes on in our brain with a sense of unified personality". Orne, appreciative of Spiegel's position, agreed, "The notion that we are one person is really not true ... It is an epiphenomenon brought about by remembering the past". Assessment and intervention techniques became the focus of concern, and Orne thought that Borderline cases, treated as MPD, might facilitate splitting. Orne called for more detailed research and cautious diagnosis, and Spiegel pointed out the danger of misdiagnosis, "What do we label them instead? We call them schizophrenic ... They are put on anti-psychotic medications ... their symptoms often do not improve, and they run a 1-in-5 risk of developing tardive dyskinesia ... There is a price to be paid for not recognising the appropriate diagnosis". Spiegel pointed out the unity of MPD, and the false premise being argued because therapists do not treat patients as a series of different people. There was some agreement on the need for therapists to teach patients to control their splitting and lack of integration.

In 1989, Aldridge-Morris, a British psychologist, published his book *Multiple Personality: An exercise in deception*, in which he also put forward the argument that MPD is a *culture-bound* variant of hysterical psychosis, occurring in highly hypnotisable individuals. He proposed that it was unhelpful to regard MPD as a discrete clinical entity, and that it is grossly over diagnosed, especially in North America. Aldridge-Morris prefers the explanation of role-playing. His book, though skilfully written, does not do full justice to the history of MPD/DID, or the variety and individual differences in presenting cases. For example he takes it as a universal truth that switching between self-parts causes headaches, but this is an overgeneralisation as will be seen in **Chapter 5**. Kampman (1992) concludes that "The book provides an abundance of information in a concise form … the work is of great merit, provided the reader can be as critical as the author himself". The danger, encapsulated in the title itself, is that it provides an easy if not fully representative access to the subject, and an opinion that appears to be objective to an uncritical reader, who would then be likely to fail to see any necessity to enquire further. This publication is significant, as it explicitly demonstrates the trans-Atlantic tensions that have become entrenched with regard to the issue of DID, and represents an early incidence of the accusation that DID is a North American phenomenon, a charge which has since been often reiterated but not researched.

By 1992, Merskey moved the debate to a new contentious level in his article *The Manufacture of Personalities: the Production of Multiple Personality Disorder*. The central tenet of this article is "not whether or not these patients need treatment - they do – but rather under what label and with which ideas". This exemplifies a categorical approach to intervention that implies a top-down process of imposing labels (without regard for their origin as social constructs) onto clients' presenting data, rather than beginning with accurate data collection and applying a functional analysis or empirical methodology to that data. Merskey stated that the clinical picture of MPD sanctioned by the Diagnostic and Statistical Manual on MPD (DSM-III-R) "has many supporters in North America but is viewed with scepticism by others and is rarely, if ever, found in Japan (Takakashi, 1990) or Britain". Merskey is selective in his reporting of the history of MPD in Japan, whereas Umesue et al (1996) provide a full account. Interestingly, Merskey's view of Britain is entirely an

unsupported opinion, and is indeed unreferenced. He quotes other critics, such as Hacking (1986), who stated MPD "was largely invented by doctors, but later became a spontaneous way in which to express unhappiness", and Aldridge-Morris (1989), as discussed above. It can be argued that Merskey's opinion is based, not on data, but on opinion, and moreover one may contend that Merskey presents a skewed view of the literature supported by other sceptics. To illustrate, explicitly demonstrating the unscientific nature of his approach, Merskey states "Diagnosis in medicine is heuristic and variable" (1992, p329), and Merskey sweepingly concluded that "it is reasonable to reject those diagnoses which most reflect individual choice, conscious role playing, and personal convenience in problem solving, provided we have alternatives which are less troublesome intellectually, and at least as practical socially and therapeutically, and not morally objectionable" (1992, p329). It is quite astounding for Merskey to say that diagnoses should be made on the basis of their being "less troublesome intellectually" but perhaps it is also less taxing to avoid basing opinion on hard data.

Leuder and Sharrock (1999), two British psychologists, reviewed in essay form Hacking's (1995) sceptical book *Rewriting the Soul.* They recommended the book, but examined the difficulty of the issue of social construction in psychiatry, and explain why it has no power at all to settle the issue of the reality of DID one way or the other, on the basis that it is the argument itself that is a social construct rather than specific positions within the debate. They point out "Even if consensus were to emerge that dissociative identity disorder is a biologically based phenomenon, this would not in any way diminish its status as a 'social construct'". The reviewers make some interesting statements during the course of their argument, including, "Schizophrenia for instance is a real illness", when others, such as Boyle (1990) would challenge this assumption, asserting that there is no evidence that the condition schizophrenia is based on scientific data. Leuder and Sharrock may have better expressed themselves by stating schizophrenia is a real phenomenon and a social construct. Van der Hart (1996) exposes several inaccuracies in Hacking's account, particularly his undermining of the important role played by Janet.

Beyond debates on the status of scientific knowledge however, it is important to remember that, while dominant opinion dismisses the validity of DID, clients

continue to present and clinicians are faced with decisions regarding their treatment. Similarly, while the opinion that DID is a North American phenomenon gains credence, this stands in contrast, not only to documented history, but also to the experience of mental health professionals elsewhere in the world, as will be evidenced below. It does attest though to an attitude reminiscent of Nelson who, not wishing to follow a particular course of action, said "You know, Foley, I have only one eye – I have a right to be blind sometimes ... I really do not see the signal" (1801 in Chambers Dictionary of Quotations, Jones (Ed) 1996). This attitudinal blindness or unwillingness to see was demonstrated when Miller (1989), an American psychiatric resident working at the Maudsley Hospital in London, reported a single case of DID. He states,

> "I shared my impression that she had multiple personality disorder with the staff who remained sceptical, but were intrigued with my perceptions. I tried to impress upon them the need to secure a therapist for this woman as individual therapy had not been a part of her treatment during her hospitalisation." Miller (1989)

As Spiegel (1988) had already outlined, such experiences raise ethical issues relating to the potential failure to diagnose, or correctly identify, DID, and the failure to offer appropriate treatment/intervention. The continuing controversy adumbrates the clinician's duty of care to clients.

4.8 Controversy and Consensus

Controversy peaked in the scientific press in the final years of the twentieth century, when the debate on DID became enmeshed with debates which focused on recovered memories and False Memory Syndrome (British Psychological Society, 1995). However, as this issue extends beyond the immediate concerns of this thesis, it will not be expanded upon further. Although DID remains a contentious diagnosis, practitioners identifying and treating cases build and publish knowledge, although this is largely US lead.

DID has been recorded in modern times to be closely associated with childhood trauma and, in particular, though not exclusively, with child sexual abuse (CSA), (Kluft, 1985). DID and CSA are both associated with the issue of repressed

memories and incomplete or distorted information processing (Putnam, 1997, p197; Williams, 1994; Bowman, 1996). Towards the end of the twentieth century, the journal *Dissociation* had become dormant and backlogged in publication and, after a hiatus, the new *Journal of Trauma and Dissociation* was launched by ISSD. In its first issue, Chu and Bowman (2000) reviewed the previous twenty years and concluded that these two decades had built upon the work of Janet and Freud; it had been notably predicated upon the success of the women's movement in the 1960's and 1970's, and the publicising of the issues of incest and rape, and further enhanced by the "undeniable traumas of American War Vietnam veterans" (Chu and Bowman, 2000, p5). Having survived the "post-memory-backlash era" (op cit), they suggested the trauma and dissociation field was "at a point of unprecedented theoretical sophistication and burgeoning research" (op cit).

For complex socio-cultural reasons, in modern times, the USA had led the UK in the recognition, and discussion of sexual abuse and related issues. It is likely that issues relating to the lack of class structure, relative advancement of psychology, and feminism are of relevance. Indeed, Kluft (1992) is quoted as saying "One reason for the increase [in reports of DID] is feminism. Not until women's complaints were taken seriously did we begin to recognise the prevalence of incest and abuse and understand the disorder".

4.9 The neglect of the international data

As polemic battled with scientific and reasoned debate within the North American literature, in the UK many authors failed to acknowledge the contributions being made in a wider international field. As we have seen historically, reports of dissociative phenomena were worldwide, thus, looking beyond controversy, we would expect these reports, and hence investigation, to have continued outwith the hotbed of debate.

DID and dissociation have been reported in a very wide range of countries. For reviews, see Taylor and Martin (1944); Coons (1986a); van der Hart et al (1993). The dearth of co-ordinated and generally published data makes an accurate review difficult, but an attempt is made here to record the spread of data currently identified from all possible sources, published and unpublished.

In **Latin America,** Martinez Taboas (1986, Puerto Rico) reported 68 documented cases of DID. In **Australasia,** Williams (1994, New Zealand), reported her work with DID clients (in *Dissociation*), and Middleton and Butler (1998) reported an incidence study in Queensland Australia and concluded:

> "Patients fulfilling diagnostic criteria for DID are regularly seen in Australian inpatient and outpatient settings. The dissociative symptomatology of the patients examined in the present study represents a significant component of a complex syndrome associated with a history of severe ongoing developmental trauma dating from early childhood."

In **Japan,** Umesue et al (1996) reported a range of dissociative disorders, with one case of MPD. Hattori (1997), a psychologist, reported two Japanese cases of women in their twenties. He provides detailed data on these quite differing profiles. He states that 8 cases had been reported in Japanese research literature since 1919, but identifies a culture-specific hurdle to diagnosis, due to some confusion in the Japanese language, as "kairi" means both dissociation and "a lack of family bond", and "kairisei" means both dissociative and "dissociative family". Hattori also identified a poor level of awareness and training in Japan, and discussed the difficulty posed by the media image of DID, namely the association with the criminals Billy Milligan and Tsutomu Miyazaki. Contrary to Merskey's (1992) statement therefore, DID is found in Japan, and moreover the relative paucity of cases may be explained by linguistic-terminological problems, rather than an absence of cases. Gangdev and Matjane (1996), South African psychiatrists, reported five cases of black patients spanning the range of dissociative disorders, including one case of DID.

Cases were reported throughout **Europe;** in the **Netherlands and Belgium** 60 cases of DID had been identified by 1991, and by 1993 the figure was 400. A psychiatric inpatient incidence study found 5% DID cases (Boon and Draijer, 1991, 1993). There seems little evidence of enthusiastic overdiagnosis however, since the 1993 figure is contributed by 250 clinicians. Nijenhuis (1996) reported a forensic case of DID. In **Hungary,** utilising the DIS-Q, a rate of 2.6% DID was found (Vanderlinden et al, 1995), reporting similar findings to both Europe and America. Modestine, from **Switzerland,** in a letter dated 1992, asserted that MPD occurs relatively rarely

outside of the USA. In **Switzerland,** consecutive inpatient studies found a rate of 5% DD and 0.05%-1% DID (Modestine 1992) Karilampi, from **Sweden,** wrote to the *American Journal of Psychiatry,* challenging Modestine to produce evidence, to which he replied with the same challenge. **Norway and Sweden** held a collaborative conference with the Netherlands, in 1991, and a DID treatment programme was set up in Laxso, with another Dissociation centre at Stravanga. Case reports and a history of the Norwegian interest in dissociation are outlined by Hove et al (1997), and it is noted that both concentration camp experiences and oil rig disasters have heightened professional awareness of trauma and dissociation. Hofmann and Rost (1995), in **Germany**, reported the establishment of an inpatient programme, and that psychiatrists were beginning to see DID as a part of Borderline Personality, and that ICD-10 was less sceptical than previously. Huber (1995), a psychologist, wrote a book about MPD in German and, with Boon, translated the SCID-D into German. In a letter to the *American Journal of Psychiatry* (1995), Darves-Bornoz, from **France**, reported a small scale incidence study in an intra-family rape group with 30 subjects, utilising the SCID-D. He found four cases of DID (14%), and suggested that French psychiatrists would find cases of DID if they were "looked for in appropriate populations". In **Italy**, Cagiada et al (1997) reported a war trauma child who had dissociation related to psychogenic coma lasting two years. Miti and Chiaia (1998), examining the attachment theory model of dissociation, conducted an incidence study with psychiatric inpatients in Rome, Italy, and examined extensive data from Dissociative patients, Borderline Personality Disorder patients and other psychiatric patients as a control group. They also took extensive data from the subjects' mothers about the period of the subjects' birth. They found that trauma severely intervened in the emotional availability of the mother at the crucial early period of life, and this distinguished Dissociative clients more than the other two groups, but was also found to be present in notable percentages of the other two groups.

Zoroghu et al, in **Turkey**, presented five child cases of DID, three female and two male. Sar et al (1996) reported that DID was mostly diagnosed as hysterical psychosis, which Turkish clinicians believed to be trauma based and a "Turkish phenomenon", based on a particular famous case, the "Helpless Anatolian Woman". This serves as another example of how narrowly concepts can be defined, and scientific endeavour sidetracked. Sar et al found dissociative disorders in

approximately 10% of psychiatric patients in a university hospital. About 5% met the criteria for DID. Tutkun, Sar et al (1997) also conducted a prevalence study for childhood abuse in psychiatric patients, finding that 59% reported at least one form of abuse, and 21.1% reported sexual abuse, with 10.2% being incest. They found no gender differences related to types of abuse, and found dissociation, self-mutilation, suicide behaviour and abuse to be inter-correlated. Sar et al (1997) also compared adolescent and adult DID profiles, and found them similar. Sar and Unal (1997), using neuro-imaging, found replicable patterns of blood flow between alternating personality states.

Meanwhile, in **Canada**, Ross et al (1991) conducted what he considered to be the first large-scale incidence study of psychiatric inpatients in Winnipeg, Manatoba, achieved with screening instruments. This research was methodologically sound, incorporating a control group and blind interviewing. He found a rate of 3.3% for MPD. Mai (1995) assessed the attitude of all Canadian psychiatrists, by postal survey, and obtained a 61.2% return rate. He found that 27.8% doubted the existence of MPD. A substantial majority agreed that media publicity and the psychiatrist's own belief system affected the identified prevalence of MPD. He concluded there was a split in the Canadian psychiatric population over this issue. It was generally the opinion that Canada was affected by the UK scepticism. Merskey, of Canadian origin, had strong associations with Canada and had given speeches there. Having attended conferences in Canada, it appears to me that Canada tends to share an identity more closely linked with the UK than with the USA, and both share anti-American attitudes that may be relevant in how DID is perceived. Horen et al (1995) conducted an incidence study in Kingston, Canada, utilising the DES and the SCID-D, and found 6% DID, 8% dissociative amnesia and 2% DDNOS in an adult psychiatric inpatient population.

Other reports came from **Israel**; Somer and Weiner (1996) and Somer (1997) report dissociative cases, and Somer noted some culture specific adherence to possession theories by clients in the **Middle East**. Many personal communications have been received from patients and their families, or from professionals, from all over the world, including **Argentina, Brazil, Trinidad, Nigeria, Gambia, Zimbabwe, Kenya, South Africa, Russia, Ukraine, Kuwait, Pakistan** and many from **India**

and **Ethiopia**. Such enquires are evidence that, not only are individuals experiencing and presenting with dissociative symptoms, client and practitioner needs are not being met. This evidence suggests that other nations are at the beginning of the process in terms of recognising and understanding dissociation, and it will be informative to see how the situation advances in other contexts in view of the controversy evidenced here.

4.10 Emerging integration in the UK Literature

In overview, while acrimonious debate peaked with the controversy surrounding FMS, internationally, research into dissociative phenomena continued. This lack of integration is ironic given the subject matter, yet some UK authors were attempting to create coherent discourses on the topic of dissociation. In 1989, McKellar, a psychologist who, unlike Aldridge-Morris, had actually worked with some cases of Multiple Personality, published his book, *Abnormal Behaviour*, in which he devoted a chapter to the *Dissociation of Personality*. Perhaps McKellar, having worked in New Zealand, Scotland, England and the United States, is better placed to provide a different and more comparative view of the cultural determinants of this phenomenon. Perhaps too he is less likely to be central to the UK cultural perspective and any anti-American bias. McKellar is catholic and integrationist in his psychological enquiry generally; he is interested in naturally occurring and experimentally generated experiences, and is extremely eclectic in his sources for data and perspective. He is particularly focused on the way in which pre-existing schema of the mind determine what one sees. He relates this to what he calls the Koffka Principle (Koffka, 1935), which is "the notion that experience and behaviour relate to the environment as it is perceived and believed to be" (McKellar, 1989, p22). McKellar considers subjective experiences of all kinds, including those in altered states of consciousness and therefore dissociation. He sees dissociation, not as the repressed but more as the return of the repressed, and he conceives of human personality as consisting of subsystems organised both by sentiments (organised emotions), and complexes (conflicting emotions) and integrated by some overarching sense of self that is missing in the case of Multiple Personality. McKellar prefers to think of consciousness as a complex manifold struggle for attentional focus, and sees Freud's hierarchical system as unnecessarily causing association of depth and darkness. He sees therapy less in terms of excavation than of integration. McKellar

provides a representative review of the history of Multiple Personality in the professional press, and also examines the representations of dissociation in literature, from Dostoevsky to the autobiographical work of Shirley Maclaine. He integrates this evidence with the psychological and psychiatric literature, as well as the philosophical, examining objectively the dipsychic model of mind and the polypsychic view. McKellar is also interested in how madness and sanity are hugely overlapping, and labelling, especially in psychiatry, is greatly influenced by the subjectivity of the professionals and the professional culture.

UK prevalence and case reports were scanty: a study of personality and dissociation by de Silva and Ward (1993), who found dissociation to correlate with neuroticism; Everill and Waller (1995), who found a relationship between dissociation and eating disorders; one paper on the cognitive phenomena underpinning dissociation (Waller et al, 1995); and Bauer and Power (1995) who conducted a survey of students and found similar levels of dissociative experience to those in other European and North American reports.

From the inauspicious beginnings of my own encounter with Multiple Personality Disorder, I had published my own understanding of the phenomenon in a booklet (McIntee, 1992) and had two chapters included in books relating to working with children (McIntee and Crompton, 1997; Mulholland and McIntee, 1999).

Fonagy presented his attachment disruption theory of dissociation to the ISSD(UK) conference in 1997. Fonagy has shown that mothers who are unable to develop metacognition are likely to induce dissociation as a psychological defence in their children.

> "Many of the symptoms of dissociative disorder may be understood in terms of a defensive strategy of disabling mentalizing or metacognitive capacity.
>
> 1. Their failure to take into consideration the listener's current mental state makes their associations hard to follow.
> 2. The absence of concern for the other which may manifest as extreme violence and cruelty, arises because of the lack of a compelling representation of suffering in the mind of the other. A key moderator of aggression is therefore absent. The lack of

a reflective capacity in conjunction with a hostile world view may predispose individuals to child maltreatment but such inhibition may be a necessary component of all violence against persons. [Military training has the apparent and explicit aim of fashioning men into machines and the enemy into an inanimate or sub-human object. Seeing the other as imbued with thought and feeling very likely imposes a break.] [Author's square bracket]

3. Their fragile sense of self (identity diffusion to use Kernberg's term), may be a consequence of their failure to represent their own feelings, beliefs and desires with sufficient clarity to provide them with a core sense of themselves as a functioning mental entity. This can leave them with overwhelming fears of mental disintegration and a desperately fragile sense of self.
4. Such patient's mental image of object remains at the immediate context dependent level of primary representations – he/she will need the object as they are and will experience substantial difficulties when confronted with change.
5. Absence of prominence 'as if' in the transference requires meta representations, the capacity to entertain a belief whilst at the same time knowing it to be false. Psychotherapy requires such pretence and it's [sic] absence manifests as so called 'acting out' of transference." (Fonagy et al, 1996, p25)

Fonagy suggests that, in the presence of overwhelming affect and in the absence of a containing adult who has the capacity to imagine and sooth the pain of the child, the child is unable to regulate its affective state. Adequate self-soothing relies upon adequate metacognition that is achieved through the carer's capacity in metacognition. Fonagy points out that the dissociated child becomes an adult who avoids mentalising as a defence, and thus is deprived of the very capacity that is required in therapy for satisfactory processing and integration.

Morton (1991, 1994), an influential psychologist at the Medical Research Council Cognitive Development Unit, and Chair of the British Psychological Society Working Party on Recovered Memories, has proposed a non-associationist view of memory, and suggested that this "headed records" approach (Morton, 1985) may explain the splitting or compartmentalising of memory found in MPD. Morton suggests that the self is the essential ingredient in creating the subjective record labels or heads, and that these are then independent of each other. Retrieval only searches headings and not content. He suggests that the different and separate self-structure in MPD gives rise to separate headings to memory records that are unassociated with

one another. This relates to the neuropsychological model of autobiographical memory of Conway and Pleydell-Pearce (2000), discussed below. Examining the criticism of the diagnosis of MPD and the iatrogenic argument, Morton concludes that there may well be such cases but that it should not deter clinicians from distinguishing between developmentally generated MPD and iatrogenic MPD.

Mollon, a clinical psychologist and psychoanalyst, has focused on the fragility of self and has therefore encompassed dissociation and multiple personality, and is one of the few UK professionals to have published on the subject. In his book, *Multiple Selves, Multiple Voices* (1996), he examines the evidence for the existence of MPD/DID and is critical of the "bias" (op cit, p116) of Aldridge-Morris, saying the evidence of the existence of MPD/DID, if rare, is apparent. Mollon outlines the phenomena that are familiar to British professionals;

> "notions of coexistence of sane and psychotic personalities, internal 'gangs and mafias', cohabitees. There are a number of trauma-driven disturbances of development and personality which are varieties of long-term post-traumatic stress disorder – a kind of characterological PTSD, which has much overlap with borderline personality disorder. Some degree of dissociative phenomena is usual in PTSD, along with a range of other symptoms, including mood and arousal disturbances, hypervigilance, anxiety, self-harm, and hallucinatory and flashback imagery." (op cit; 120)

Maddison (1997) argues that many cases of dissociation, including cases of Dissociative Disorder Not Otherwise Specified, or what I would conceive of as disorganised DID, can be misdiagnosed as Learning Difficulties or Autism/ADHD/Aspergers spectrum disorders. Indeed, it may be that a better understanding of dissociative processes and disorders would shed light on these distressing and poorly understood conditions. Given the debate over the past few years about the wisdom of prescribing Ritalin, an amphetamine based drug, to children diagnosed as having ADHD, and the concern about long term effects as well as short term effects of such treatment, and the lack of controlled studies of efficacy, it could be argued that, if only in this regard, adequate investigation of dissociation and a full and adequate public/professional dissemination of data and debate is urgently required.

De Zulueta (1984, 1993) suggests that, rather than developing PTSD to the extent of adults, children may respond to the overwhelming affect of trauma by internal changes such as dissociation and multiple personality disorder, thus compartmentalising this from general consciousness. Although of European parents, de Zulueta had lived in many countries as a child, and even as a professional was not constrained by one discipline, being a psychotherapist, psychiatrist and a biologist. Working in the UK, she came to consider the peculiarity of the British stance on MPD and, whilst acknowledging that the fragile self of the traumatised client could lead to iatrogenic exacerbation of existing splitting, she thought that:

> "in his eagerness to protect 'the good name of psychiatry', Merskey does in fact throw away the baby with the bathwater. He ignores the importance of trauma in producing these dissociative experiences and what this means for our understanding of the human mind." (de Zulueta, op cit, pp189-190)

Sinason (1994) took as her focus the treatment of Satanic Ritual Abuse trauma that inevitably included several references to multiple personality disorder by several of the contributors, not all of whom are from the UK, but Joan Coleman, an Associate Specialist in Psychiatry, reports having treated cases of multiple personality disorder. Sinason (2002) edited a book on multiplicity from the perspective of attachment theory, and included contributions from psychologists, psychiatrists and psychoanalysts Dr Arnon Bentovim, Dr Felicity de Zulueta, Dr Peter Fonagy and Dr Phil Mollon, amongst others. The result is not a synthesis of theory but a collection of perspectives, including those of people with DID.

Spinelli (1997) described working with a case of possible dual personality. Although this case appears to fulfil the DSM-IV criteria for DID, there was no formal Dissociation assessment utilising either the SCID-D or psychometric measures, and the description comes from the phenomenological data gathered during therapy. This is a very rare presentation, possibly the only reported case of double personality, in modern literature, and therefore potentially of great significance.

Although there is a dearth of published material, it is possible that the obstacles to publishing and the dissemination of material do not reflect actual practice; this will be

discussed below in the light of this research, and also does not reflect the number of investigations into dissociation that form part of university theses. The apparent impediments to publishing mean that valuable data is failing to be made available to the professional bodies en masse. For example, Baker (2002, D Clin Psychol Thesis) found that sexual offenders were more likely than non-offenders to have high levels of dissociation, particularly amnesia, in conjunction with disorganised patterns of attachment, and violent offenders also had high levels of dissociation compared to non-offenders. She concludes that sex offenders have multiple internal representations of self in relation to others and that, in line with the suggestion of Liotti (1999), this is a dissociative process. Stirling (1998, Undergraduate Thesis) examined the link between DID and the hysterical narrative in an attempt to respond to Showalter's (1997) *Hystories – Hysterical Epidemics and Modern Culture.* Showalter asserted that mass hysteria explained some new psychological disorders. In a similar vein to Aldridge-Morris, she is of the opinion that the United States is (quoted by Stirling) the "hot zone of psychogenic disease ... [instigating and nurturing] ... new and mutant forms of hysteria" (Showalter, op cit, p4). Stirling (1998) finds Showalter's thesis unproven, and suggests that conclusions rest as much on subjective experience and personal opinion as upon argument.

Finally, implications and applications of our current understanding of dissociation and DID are not solely confined to treatment or intervention for that specifically. McIntee, G (2001) investigated dissociation as a mediator in deliberate self-harm (DSH), and found that significant differences were obtained between a DSH and a non-DSH group of adolescent female A & E patients. This demonstrated the importance of dissociation as a mediating factor in DSH, which affects some 100,000 hospital referrals per year in England and Wales. The SDQ-5, a shortened version of the SDQ-20 (Nijenhuis et al, 1997), developed to measure somatic dissociation, following the historical influence of Janet, is recommended as a very fast screening tool that would permit the identification of people at risk, and potentially indicate a more specific treatment intervention.

4.11 The positive relationship with Posttraumatic Stress Disorder (PTSD)

A further issue to be discussed, salient to a UK context, is that of Posttraumatic Stress Disorder. In the previous literature review, Part 2 (**Chapter 3**), more integrative

accounts of dissociation were examined; similarly the concept of PTSD also offers a framework for some resolution of the widely differing opinions and approaches. The concept of PTSD developed from military psychiatry, prompted by the events of World War One, when 7-10% of officers and 3-4% of other ranks had "mental breakdowns" (Gersons and Carlier, 1992). British and French psychiatry developed differing concepts that were experientially determined. The hand to hand fighting did not reach Britain, and here the concept was *hysteria,* but in France, where clinics were set up behind the trenches, the concept became *shell-shock.* This had implications for treatment; in Britain the phenomenon was often not addressed, but left unspoken about or, following a biological approach, attributed to the fact that micro-sections of exploded bomb had entered the brain, yet many sufferers had not been in explosions. Beyond this orthodoxy, Cannon (1914) proposed a homeostatic model where abnormal or extreme threat destabilises the human equilibrium. Seyle (1975) suggested a heterostatic model emphasising the possible continuum between normal equilibrium and physical and mental breakdown. These theories gave rise to physiological identification of heightened perception, increased muscle tension, and quickening heart beat, that corresponded to the psychological experience of fear, heightened alertness and tension, increased arousal, sleep problems, irritability and concentration problems. Investigators realised that there was a lasting physiological response. Van der Kolk et al (1985, pp222-223) and van der Kolk (1987, pp63-87) suggested the neuro-endocrine axis as responsible. It was proposed that the cerebral cortex receives the experience, then the hypothalamus and hypophysis stimulate or limit production of certain hormones. Kolb (1987) and Briere and Runtz (1987) have suggested that this may create a permanent change. As not everyone develops PTSD, Ross et al (1989) thought sleep disorder was responsible, and this led to antidepressant treatment (Frank et al 1988).

Freud (1917) had initially developed an important link between trauma and depression, and Lindemann (1944) developed the theory of acute grief. Lindemann was responsible for the realisation that these symptoms could occur in anyone, leading to psychosomatic disorders, visions of the trauma or associations, aggressive reactions, behavioural problems, withdrawal, hostility and self-harming behaviours. Gersons and Carlier (1992) suggest this led to an emphasis on process rather than

diagnostic details. There then developed an attention to risk factors and protective factors, a distinctly psychological approach to the issue of PTSD.

The late 1970's and early 1980's saw a rapid expansion of research literature on stress (Horowitz 1976; Kutash et al, 1980; Goldberger and Breznitz, 1982; Neufeld, 1982; Garmezy and Rutter, 1983); for comprehensive reviews of the historical data on stress and its roots in the beginning of the nineteenth century, see Garmezy and Rutter (1985); Gersons and Carlier, (1992). Acute Reaction to Stress was introduced into ICD-9 (1975), and the term Posttraumatic stress disorder into DSM-III (APA 1980). It is perhaps not surprising that the USA provided such an important lead in the modern understanding of PTSD and Dissociation, as services tried to make sense of the impact of the Vietnam War trauma upon American troops, against the background of a highly developed system of psychological research and theory. The ensuing research development widened the topic to include; PTSD in children, war trauma (e.g Northern Ireland), disasters, both human-generated and natural, eg Aberfan, 1966 (Lacey, 1972); Three Mile Island, 1972 (Handford et al, 1986); Buffalo Creek Flood, 1981 (Newman, 1976; Green et al, 1991); Chowchilla Kidnapping, 1979 (Terr, 1979, 1983), and produced a proliferation of physical, social and psychological measures and interventions, including attention to prevention.

By the late 1980's the prevailing view amongst accepters was that DID was an extreme and chronic form of PTSD (Braun, 1984, 1985; Frischolz, 1985; Kluft, 1984, 1985; Putnam, 1985; Spiegel, 1984, 1986a, b, 1988). Amdur and Liberzon (1996) describe various symptoms in PTSD that are dissociative "flashbacks, emotional numbing, and psychogenic amnesia for trauma ... it is not uncommon for PTSD patients to enter trance-like states ... when trauma-relevant affective states or memories begin to enter consciousness" (op cit, p118). DID however remains controversial, whilst PTSD has only met with resistance in the UK on reaching a challenging level of compensation claims. This challenge has not had significant impact upon research and intervention, but perhaps a minor impact on litigation. The body of literature is now too well established for its influence to be reversed. The relative rise in interest in PTSD in the UK may relate to a strong association with its comparative amenability to empirical research, and the dominance of Cognitive and Behavioural interventions. This may function to make the concept both more

acceptable and more accessible to a wide range of professionals and avoids the bio-medical and psychodynamic therapy controversy. A wealth of publications also exist regarding the interface of dissociation and PTSD (eg Speigel et al, 1988), thus we may optimistically conclude that a greater acceptance of the concept of DID may be achieved via this cross-over literature.

4.12 Extant Models and Theories of DID

Further to integrative accounts and frameworks, investigators have also proposed a number of models to account for dissociative phenomena. Braun (1985b) developed the BASK model for understanding MPD/DID. BASK represents Behaviour, Affect, Sensation and Knowledge, that Braun conceptualised as functioning in parallel on a time continuum. He stated "The model permits graphic illustration of dissociative disorders, such as automatism (dissociation in behaviour), hypnosis induced to create anaesthesia (dissociation in affect and sensation), and typical MPD (dissociation of all BASK elements). Consonant with the classic description of multiple personality, the MPD patient is never out of touch with reality because one or another of the personalities is always present with a more or less full range of BASK-encoded memory." (Braun, 1986)

As this review highlights, in its identification and examination of explanatory frameworks, Putnam (1991) made the point that theories of MPD/DID are all rooted in the nineteenth century data. He lists them as:

The trance state or autohypnotic model
The split brain/hemispheric laterality model
The temporal lobe/complex partial seizure/kindling model
The behavioural states of consciousness model
The role playing/malingering model

Putnam concluded that the decade to 1991 had seen the emergence of solid research on MPD and the dissociative disorders, noting that there was now a developing field of study of child and adolescent dissociation and MPD. He stated that "The repeated replication of a core clinical phenomenology demonstrates construct validity equal to, or superior to, that demonstrated for most DSM-III/IIIR disorders." He stresses the importance of future multi-centre studies and cross-cultural studies. Analysing the

evidence for each of the models he examines, Putnam summarises the research on the first model as demonstrating that MPD/DID cases do have higher hypnotisability than others and, although this is insufficient in itself to explain the phenomena, it is an important factor that models must address. He concludes that there is little empirical support for the hemispheric theory, or for the temporal lobe/epilepsy theory, although he identifies the need for further research on both of these models. The behavioural state model is concluded to be consistent with all available empirical data. It is also consistent with the concept of state dependent learning.

Putnam criticises the malingering model, primarily on the grounds that simulators are unable to reproduce the psycho-physiological phenomena found in MPD/DID. Braude (2002), an American philosopher, examined the evidence for the complex nature of dissociated autobiographical states, and proposed that the phenomenon is similar in some aspects to lying and hypnotic illusions, but infinitely more complex. It is similar to hypnotically induced hallucinations in that it requires both positive and negative false constructs, or falsely adapted constructs, and it is similar to lying in that it requires the construction of more or less complex webs of false constructs and hypervigilance for threat and intrusion of incompatible data. The DID phenomenon differs from hypnosis in handling much more salient and potentially threatening data, and in being self-motivated and self-protective. Although the creativity in hypnosis is seen to require active constructs (eg glove anaesthesia matches personal construct not neurological structures), it is passive in that control is passed to the experimenter. It could be said that in this way it is rather similar, except in complexity, to the interaction between a DID person's active use of personal constructs to meet the requirements of an abuser or abusive environment. Lying is self-generated, and defensive in the same way that DID is conceived to be.

By the 1990's there was some consensus of opinion that trauma was the psychogenic cause of dissociation, and that dissociation was initially an adaptive facility, protecting the subject from overwhelming affect (Putnam, 1989; Classen, Koopman and Spiegel, 1993; Van der Kolk and Fisler, 1995). Merckelbach and Muris (2001), Dutch psychologists, are critical of the empirical evidence for this conclusion, arguing that it relies upon cross-sectional and self-reports of traumatic histories. They argue that the association between trauma and dissociation is much more

complex and suggests that family dysfunction may be a more important correlate of dissociation, as demonstrated by Sanders and Giolas (1991) and Nash, Hulsey, Sexton, Harralson and Lambert (1993). High DES scores correlate with both dissociation and relevant and innocuous use of fantasy or absorption (Ross, Joshi and Currie, 1990), as well as the tendency to make false positive errors (Merckelbach et al 2000a) and to yield to authoritative influence (Merckelbach et al 2000b). Tillman, Nash and Lerner (1994) conclude "dissociative symptomatology may predispose some patients to confound fantasy, dream, and mnemonic experience".

In 1992, McIntee proposed a trauma-based information-processing model of DID, based on developmental theories (Mahler, Winnicott, Kohut, and Stern amongst others), and information processing theory (Sternberg), and informed by clinical experience. This was followed by refined versions in chapters within edited books on working with traumatised children. The first (McIntee and Crompton, 1997) was criticised, not without some justification, by Peter Dale of the British Association for Counselling, for failing to acknowledge the controversial nature of DID. The second (Mulholland and McIntee, 1999) apparently received no adverse criticism. In summary, the proposed theoretical basis for understanding multiplicity is that trauma causes altered states of consciousness in which information processing is reduced. Recovery and completion of information processing can be delayed over enormous periods of time. Information processing involves the integrating of separate sensory information and autobiographical data. The model of memory is associationist, and incomplete information processing produces only limited association, or a lack of conscious association, and is known as dissociation. Multiplicity, formerly called Multiple Personality Disorder, and more accurately renamed Dissociative Identity Disorder, is seen as a severe form of dissociation, usually produced through extreme or prolonged trauma during early developmental phases, where dissociative responses become built into the development of personality and self-identity. Although an Information Processing Model, it is an integrated model, with physical mechanisms suggested for reduced processing, and it is also based in the Objects Relations school of psychodynamic theory of child development. The model is consistent with the functionalist models (Hart, 1926), and the BASK model (Braun, 1985). A series of workshops were also devised and presented to assist professional colleagues; these

workshop programmes were written into a booklet and self-published as Trauma: The Psychological Process.

Similarly, McGee et al (1984), in Ireland, published a review of the history of the concept of repressed experience, and presented two contemporary case studies, one of which was a woman with a repressed alter part called "It". His analysis also points to an understanding of delay in information processing, and suggests that the limbic system, particularly the hypothalamus and pituitary gland, and their control of the autonomic nervous system are likely to be implicated in such phenomena as flashbacks and repressed memories.

Nijenhuis et al, (1996, 1997, 1998a, 1998b) proposed the concept of separate somatoform dissociation, as opposed to psychological dissociation. Nijenhuis had revisited Janet's earlier theories and proposed a parallel between animal defensive and recuperative states that are evoked in the face of severe threat. In a study aimed at controlling for prevalence and severity of traumatic experiences, Nijenhuis, Spinhoven et al (1998) found dissociative disordered subjects to have severe and multifaceted traumatisation, and significant scores on the DISQ together with sexual abuse predicted both Somatoform and psychological dissociation. Early onset, intense, chronic and multiple traumatisation predicted greatest degrees of dissociation. Autobiographical data suggested this abuse was also in the context of emotional neglect and abuse. Miti and Chiaia (Italy, 1998) explored the idea that it is disrupted attachment, in particular a lack of emotional availability from the mother in early life, that is the potential cause of dissociative disorders. Spiegel (USA, 1986a) suggested that it is the double bind in paradoxical family communication that provides the psychogenesis for PTSD, and Dissociation in particular.

Kennedy and Waller (1998) developed a cognitive model of dissociation, and hence DID, based on Beck's (1996) theory of modes, personality and psychopathology. Beck conceives of personality as constructed of agglomerates or schemas. Using this information processing model, Kennedy and Waller suggest three types of dissociation; the first at the automatic, preconscious stage; the second functions in unattended consciousness and utilises dissociation or de-coupling to cope with overwhelming data achieved, for example, through flattened affect or conversion

symptoms; the third utilises the poly-psychic mind model to suggest that use of sub-personalities can restrict focus to protect against overwhelming affect and associated data.

With some similarity to Kennedy and Waller, Brenner (2001) conceives of a hierarchy of Dissociative presentations. From a psychoanalytic perspective, Brenner conceives of DID as personifications, characterological splits based on trauma impact management. He describes a hierarchy of Higher Level, where there is minimal disturbance of the unified personality; then Attenuated Multiple Personality with minimal splits; then Dissociative Disorders Not Otherwise Specified (DDNOS); then, at the most severe level, DID. McWilliams (1994) sees DID as spanning a hierarchy from neurotic, as what Kluft (1986) would call Higher Functioning DID, through disturbed, and then borderline, and at the least functioning, the psychotic presentations.

Models of mind tend to have moved firmly from the idea of unity (Cooper, 1996; Spinelli, 1996) to that of the concept of sub-selves. Rowan (1990) argues the case that we are all basically multiple, not in the most extreme manifestations, such as MPD/DID, that he says are favoured by the media, but in the sense that our concept of self unity is merely a functional illusion, and that the data from everyday experience, from psychotherapy, from history and from literature, is that we are, in fact, a system of sub-personalities with more or less consensus as to who we are. Slovenko (1989) believed MPD to be more fundamental than different persona. "A person is one and many at the same time. Everyone, to some degree, hosts a crowd of sub-personalities. Each of these sub-personalities represents a complex of tendencies that, in its drive to be expressed, has developed an identity and character of its own. In the process of successful personality development, the individual attains a sense of harmony and unity within himself. Unity of the personality is not given to the individual as a matter of course, but is realized and achieved through persistent and perhaps life-long efforts". These philosophical theories on the concept of mind are soon to be informed by the fruits of technological advances that permit seeing processes at work in the human brain.

4.13 Technological and neuropsychological advances: A Collaborative research approach

In the last few years, as the polemic has subsided, there has been a return to scientific investigations and synthesis of knowledge, particularly in psychology. Pribram (1993) had suggested that, in circumstances of lesions in the frontolimbic portions of the forebrain, there is dissociation between instrumental consciousness (operantly conditioned learning), and intentional consciousness. Under these circumstances, it is possible for the instrumental responding to occur without becoming part of the patient's narrative consciousness. He suggested that unity is achieved via the central (somato-sensory-motor) systems, and stated "specifically involved is a band of cortex reaching from the parietal to the frontal lobe".

Advances in neuro-imaging techniques have made it possible to see representations of increased brain activity in localised regions of the brain. In order to develop a comprehensive model of dissociation, it is now necessary to take account of data from practically all areas of psychology, for example memory research, neuropsychological research, cognitive research, social construct theory, attachment and personality theories.

Tsai et al (1999) actually attempted to observe switching between different DID personalities using functional magnetic resonance imaging, and found that switching may result from changes in hippocampal and temporal function, but noted that their research could not differentiate between the process of switching personalities and differential use of the brain function in different self-states.

Spinhoven et al (1999) reviewed the evidence coming from memory research and its explanatory power in relationship to trauma. They noted the ethical dilemma that prevents laboratory experiments inducing trauma, but suggest that there is an inverse relationship between stress and memory functions that cannot be found in laboratory conditions. They noted that trauma is personally salient, and autobiographical memory is involved in creating PTSD and dissociation. An extremely thorough review and synthesis of the psychological literature is reported by Conway and Pleydell-Pearce (2000). These authors propose an empirically driven model of autobiographical memory that is consistent with clinical presentations and

conceptions of PTSD and dissociation, including DID. Conway and Pleydell-Pearce's model provides the neuropsychological detail that underpins their concept of how memory works. They examine autobiographical memory, which is central to the controversial topics of DID, CSA, Recovered Memories and FMS. They propose the concept of "event specific knowledge (ESK)", the basic essential component of autobiographical memory, which is related to a "goal oriented working self". These units combine in an emergent process to become the self-memory system, which has an executive modulating function. The process is dialectical and, under traumatic conditions, can be circumvented, creating several ESKs, thus providing the basis for dissociated experience that may be relatively enduring, and developmentally may be incorporated into sophisticated self-organisation.

Conway and Pleydell-Pearce (2000) propose several brain areas to be involved in the complex matter of memory, but they suggest that different aspects of memory function, under normal and traumatic conditions, activate the brain differentially. They state "the goals of the working self are represented in frontal-anterior temporal regions and, more specifically, in networks in the left frontal lobe (after Damsio, 1994). Autobiographical knowledge is assimilated in the right frontal cortex, and represented primarily in networks, mainly in the right hemisphere. They conclude that, whilst infants develop autobiographical memory from before birth, the ability to perform the feat of narrative memory depends upon the development of the cognitive self, and the concepts of the subjective 'I', and the objective 'me'. Under conditions of trauma, especially repeated trauma:

> "trauma knowledge structure will have been created and this may become represented as a distinct part of the autobiographical knowledge base with a direct and powerful connection to the goal structure of the working self ... with like experiences being associated with each other as a gradual accretion of personal schemas ... once autobiographical knowledge is organised into a knowledge structure, this may render that knowledge more amenable to inhibition by executive control process simply because it is a distinct structure to which access can be isolated".

New technology offers the possibility of expanding our knowledge, and some interesting findings have been employed to support convincing and thoughtful models. Such is the integrationist approach adopted by the investigators discussed

above, and, as we shall see below, practical implications or applications of these findings have also been considered.

4.14 Historical Overview

In this review it can be seen that cases of dissociation and case examples of DID have a long, if controversial, history in the UK, from the early sixteenth century through to present day. MPD/DID has been conceived of as possession, somnambulism, resulting from the divided brain and, more recently, as relating to psycho-neurological processes resulting from trauma and its effect upon the development of self and attachment with others. Although early cases were identified as dual, there are also early cases of multiplicity, as well as the isolated modern case of duality (Spinelli, 1997).

Various themes emerge from the literature, such as the predominance of female cases, the relative ascendance of expertise in the USA in modern times, the polarisation between acceptance and even fascination with the phenomenon versus extreme scepticism. In the UK, the political hegemony of the sceptics in the professional press has perhaps distorted the perspective of the main professions, and hindered the publication of facts or the experimental investigation of actual data.

At least historically, dissociation and MPD/DID can be seen to have arisen spontaneously in a range of countries, and indeed it was France and the UK that led the field long before the rise in reported cases in the USA. The concept of the so-called US phenomenon of MPD/DID appears to have developed only in the past two decades. It has been called a cultural artefact (Aldridge-Morris) and indeed there are aspects of the US culture that appear relevant. Psychology has developed into a mature discipline much earlier in the USA than in Britain. The dissemination of information and access to information is greater in the USA, and there is more advanced use of multi-media technology. Together with the greater advancement of feminism and women's health, this has probably had a direct causal effect on the earlier rise in awareness of child sexual abuse. This increased attention and research into childhood trauma also influenced some of the advances in PTSD. Indeed, Gersons and Carlier (1992), state "the most important change in the situation *(of PTSD)* has been brought about by the discovery, or rediscovery of incest".

During the modern period, a great volume of literature ensued, with the inevitable variation in quality that comes with proliferation. At the turn of this decade there was a modest number of letters, articles in the UK professional literature, and the problems extant are a lack of agreement about MPD as a category in psychiatric diagnosis and discussion about belief. What was distinctly lacking was any sound research data

It could be argued that, in the UK, it is the neglect of existing historical data, a preference for biological models in psychiatry and the relative powerlessness of other disciplines that has led to a failure to report DID. Mollon (1996) states that discussion in the *British Journal of Psychiatry* has all been critical and negative, and concludes "The publishing policy of this, the leading British journal in psychiatry, seems curious. Its readers are subjected to a series of papers attacking a concept that is remote from the consciousness of most British psychiatrists." (op cit, p110). These factors could therefore have directly led to the US imbalance in reporting, and even increased its apparently pioneering position into polar opposition. As discussed in the second part of this literature review (**Chapter 3**), the socio-cultural context of the UK debate can sometimes lead to an attitude of splendid isolation and insularity that can provoke defensive attacks and assertions. Interestingly, Canadian psychiatrists and psychologists tend to identify to a greater extent with Britain, and anti-American sentiments and competition may be one influence in the anti-American stance by Merskey.

Finally, as the extremes of polemic appear to have been quelled in favour of low key or integrated scientific endeavour, a synthesis of psychological research and professional collaboration across disciplines and specialities began to establish scientific data and to generate models. Few modern UK case studies have been published, with the notable exceptions of excerpts by Mollon (1996), but perhaps the professional silence masked activity in clinical practice. Therefore this thesis will attempt to contribute data to the consideration of DID in the UK, via the presentation of a single case study and by presentation of a nationwide survey of psychiatrists and psychologists, to test how representative are published accounts of actual professional belief and clinical activity. One of the aims of this current research was

to test the hypothesis that DID is a US phenomenon, and that no-one is identifying and treating cases in the UK, as the prevailing impression would suggest. I knew that, as an initial sceptic, I had certainly not *wanted* to discover or generate MPD/DID in my clients, and yet I faced such a phenomenon. I also knew of other professionals who identified and treated such cases, so it was curious that the professional press offered no guidance other than disbelief. It became obvious that if I were to accept that view I must dissociate from my actual experience in much the same way as an abused child is denied reality. I wondered if it were possible that many clinicians were simply coping with the pressure of disbelief by keeping silent and maintaining a low profile, similar to frightened and disbelieved children, or whether they were being impeded in more purposeful ways from sharing information, such as having papers refused for publication.

4.15 Interim Summary: Tracing Continuity and Contradiction

- Interest and Pressure groups lead to US dominance, and DSM followed by ICD inclusion of Dissociative Disorders, including DID

- Scepticism and claims of malingering and iatrogenesis continue and develop

- Confusion and controversy over differential diagnosis; Ross suggests that ideology and biological psychiatry single out DID for specific attack; is this resistance to a paradigm shift, where mental health problems are recognised as traumagenic, rather than biologically determined

- Aldridge-Morris leads the UK perspective on DID as a North American, culture bound, role-playing, deceptive exercise; Merskey supports and develops this view, but without direct clinical experience of DID, and with selective attention to data, historical and current

- The rise in recognition of trauma, and in particular child sexual abuse, with its links to dissociation and repressed and recovered memories, gives rise to litigation and counter-attack in the False Memory Syndrome Foundation (US) and the British False Memory Society (UK)

- The Royal College of Psychiatry and the British Psychological Society commission reports on recovered memories. Only the BPS report is published, and concludes that there is evidence for recovered and false memories, as well as for confabulated memories

- In the USA, data driven science stems the polemic, and the trauma and dissociation field is said to be "at the point of unprecedented theoretical sophistication and burgeoning research" (Chu and Bowman; 2002, p5); Britain remains silent

- Widespread International data contradicts the claim that DID is a US phenomenon

- In Britain, low key clinical and academic work continues, and begins to highlight the cost implications for human and financial resources, eg McIntee G (2001), and in the US, eg Spiegel (North American Psychiatric Meeting, 1988)

- Dissociation becomes integrated with the extensive research and development in the field of PTSD

- Historical and current models are reviewed, set against the establishment of a poly-psychic model of mind and technological and neuropsychological advances

- The positive outcome of the controversy is that Treatment Guidelines are developed by ISSD, and attention is re-focused on ethics; safety and pacing indicate an eclectic approach to therapeutic intervention

- The status of empirical data is reviewed, and the need for a prevalence study of clinicians' experience of dissociation is highlighted, leading to the current research

4.16 Historical framework

- From religious/possession to biological reductionist and then to psychological/traumagenic

- Early frameworks never relinquished; models are superimposed, one on another; there is no clear paradigm shift and regression can occur

- This is no different from other fields of mental health enquiry, eg addictions

- DID is unique in its particular isolation in modern times regarding the charge of Iatrogenesis. Railway injury claims in the 19th Century produced charges of malingering as a protection against litigation, and this is also the theme in the literature of the FMS organisations and media activity, but this is the first time for the issue of iatrogenesis to be so prominent. There may be anti-American sentiments involved

- Cases are documented for more than 400 years, largely in Britain and France, but throughout Europe, and only in the past 200 years in America

- Scientific Models of mind move from simplistic two brain correlates to emergent models, and from a unitary consciousness to a polypsychic model

- Models move from metaphysical, to physically/psychologically spatial, to psychologically functional with underlying physical process correlates

- Reports move from single case studies to systematic descriptive and experimental data and incidence studies

- Dissociation gains recognition through US leadership, via pressure groups and scientific endeavour, despite vitriolic opposition

- Worldwide and historical case reports contradict the claim of DID as a modern US phenomenon

- Technology and knowledge advance with time, but not in a historically linear manner

- An inter-disciplinary integrated approach develops to explain the phenomenon and inform treatment

- There are cost implications for health services, whether cases are recognised and treated or not

4.17 Constancies

- History has always documented multiple and dual cases

- There have always been cases of differing ages and both genders, although female, child and young adult cases have predominated

- Cross gender alters occur throughout history, though not in every case

- Switching and amnesia are constant themes

- Sleep disorders, eating disorders relating to dissociation and DID are regular reports, though not constant

- The use of hypnosis by clinicians has been fairly constant until modern times, as an investigative/therapeutic tool but is now largely dropped as a defensive strategy by clinicians

- A great power differential between the investigator/treatment provider, such as medical doctors or clergy in relation to poor, highly dependent persons, is a regular theme

- Trauma is often an obvious theme and includes childhood trauma, war trauma and domestic violence

- ❖ Belief/disbelief is a regular but low-key theme, except for particular peaks of controversy

- ❖ Evidence and theory so far suggest that the function of DID is linked to the internal management of trauma, repression and subjugation, and to occur disproportionately in disempowered groups, such as women and children and men under regressive stress conditions

4.18 The Present Research

Discourse regarding dissociative disorders in the UK appears to have become detached from the historical roots, and from scientific endeavour. As the literature review shows, there is a rich history, informed by many bodies of knowledge from many countries throughout the world, but it is unclear what impact this has upon professional opinion and practice. If this history and synthesis of knowledge is not made readily available to professionals, through training and their professional press, they are left to personal research and discovery, incurring maximum effort and impediment. In terms of modern Britain, the question is raised as to whether it is a dearth of cases of DID that explains the lack of publications, or obstacles to publication, such as clinicians failing to write papers or failing to have papers published because of prevailing ideologies, as suggested by Mollon (1996, op cit). Thus it may be that prevailing conceptions or misconceptions remain untested, and possibly unfounded, but nonetheless dominant and influential.

With the dearth of scientific data in the UK press, and there being little point in engaging in polarised polemic, it seemed important to present my own clinical data and to begin to collect data as to the opinion of clinicians in the UK. It also provides the opportunity to test the prevailing opinion as to whether clinicians report any significant number of dissociation or DID cases in Britain, or whether it is true that MPD/DID does not exist in Britain and is a US phenomenon, as Merskey has claimed.

Another possible trend in Britain is that the climate of scepticism versus clinical data results in a discrepancy between what is happening at the clinical level and what is reported in the professional press. This may result in the identification of

dissociation becoming integrated into more mainstream issues that are less controversial, such as PTSD and Attachment. Extant publications would suggest that this is a more acceptable publication route for those who espouse the concept of multiplicity (see Sinason, Mollon ops cit).

The convoluted history of DID in the literature, and the modern climate of opinion in the UK professional press, indicate the need for data rather than rhetoric, and this research aimed to report a single case study of psychotherapy with a young woman assessed as having DID, and also to conduct the first widespread survey ever held in Britain, of clinicians' experiences and beliefs of DID, indeed the first nationwide study in any country. This research survey was conducted before that of Dorahy, and so at the time there was no such study in the UK that was known. Dorahy's regional study is a valuable contribution to developing a body of sound research data; the present study aims to provide a wider context, greater volume of data and a comparison. In addition to the professional survey data reported below, this study aims to present an integrated psychological model for understanding dissociation and multiplicity, and will also examine some of the presenting challenges met in psychotherapeutic intervention, all of which argues the need for improved recognition of dissociation, an accurate representation of the historical context, adequate training and supervision for all relevant professionals and appropriate services for clients.

4.19 Aims of This Research

A. Through the examination of a specific case study, the aim was to examine the development of models of DID in the historical literature and their resonance with specific clinical experience.

B. To investigate parameters relating to clinical practice more widely in relation to DID in the UK.

   1. To conduct a nationwide survey of relevant clinicians reports regarding dissociation and DID in order to ascertain their beliefs and experiences regarding potential clinical cases and to permit comparison with previous reports

2. To obtain data on clinicians' beliefs and attitudes regarding dissociation generally, and DID in particular, and how awareness of these concepts had been acquired

3. To investigate some characteristics of cases reported by clinicians

4. To gather information regarding research activity, teaching, training, supervision and experience of support for clinicians identifying and working with cases of DID, and whether limited publication in this field reflects the abstinence of research effort and interest

Having stated the aims of the research, the next chapter will present a single case study from my psychotherapy practice with a young woman who I assessed as having DID. Details of the assessment of this case, including measures utilised, are provided below in **Chapter 5, (**sections **5.1-5.8**). This clinical work commenced several prior to conducting the survey, to be described and reported in **Chapters 7 and 8**, or the full literature search, already presented in **Chapters 2-4** inclusive.

CHAPTER FIVE

CASE STUDY

5.1 Introduction

The thesis has so far examined the historical and international evidence for the existence of DID as a clinical phenomenon, and demonstrated that, far from being a US phenomenon, the UK has a rich history of case reports, research and theorising. As previously explained in **Chapter 1**, the **Introduction**, I was first presented with a client describing multiplicity when I was still very sceptical. Before reporting the nationwide survey that resulted from curiosity engendered by my subsequent clinical practice in DID, I will exemplify my own clinical experience with this phenomenon, with a report of the work with one particular completed therapeutic case, that I consider to fulfil the DSM-IV criteria. My theoretical understanding of the phenomenon of DID developed over the years of treatment. As with any clinical intervention, this is a dialectical process, with a tension between the scientific curiosity and need to measure, describe and test hypotheses and the ethical need to prevent scientific curiosity from abusive invasion of the therapeutic relationship. As a result, my prioritisation of the client's needs has lead to some scientific questions and proofs remaining outside of my grasp. Set against that is a positive therapeutic outcome, where the once extensively shattered self-construct of a child has evolved into a functional form of self-integration that has provided, amongst other things, safe parenting for the next generation of children, and further development of my concept of DID and the development of mind. I will now present the case study, and then review the evidence for the diagnosis of DID and the case study's implications for models of DID and models of mind. Identifying features of this case have been amended in order to protect and preserve the anonymity of the client.

5.2 Referral

Susie, then aged 15, was first referred to me in 1989, as an anonymous case. A Police Sergeant, who had attended a workshop on Dissociation that I had given for the NSPCC, contacted me and asked if she could send me some poems, stories and drawings that she suspected to be indicative of a young person with DID.

Some of the poems indicated a troubled teenager who was struggling with physical abuse, family secrets and identity problems.

> Things can't get any worse,
> Nothing else can happen
> To make me hurt inside
> I've been through more than kids my age
> So I can understand,
> The whole world's problems from A – Z.

At the age of 11, she had written a story at school about being lonely until, one day, after wishing for someone to come and play with her, a girl came to talk to her and help her with her worst subject, Maths. Despite the obvious loneliness depicted in the story, the teacher had only responded to spelling and punctuation mistakes.

Another poem told of family conflict between her father and grandfather being solved by the grandfather being "at peace". A letter and a poem to Miss X, to whom she also refers as 'mum', but who is not her real mother, suggests she is trying to reach out and share a secret but cannot do so.

> … I can't tell no-one at all,
> This secret it hurts me,
> But that's my problem not yours
> I can only tell you so much.
> Please, Please try to understand …

In a letter to a teacher she talks about school, saying:

> Dear Miss,
> … I can't wait to get back, holidays have been dreadful & mainly because Dad hasn't been working so he's been pissed every night and kicking the shit out of me & … [her sister, two years younger]. I've just had a black eye from him, and a dislocated finger you should have seen me making excuses from that …

In another letter to Miss X, she wrote:

> … I know you don't want me to put on a 'face' and believe me I have many of those. So I don't do that, but as far as I can see when I'm with you, I'm trying so hard not to be everybody that I'm nobody, no personality or anything …
>
> … You're always asking me what do I think cutting my arms is doing for me. Well it might seem stupid but in a way I'm saying to myself or thinking about everything and it's going round and round and I want to scream and scream and cry and never stop but I can't. So I hurt myself because in a way that is a real pain and for a while it takes over the pain that's going round in my head.
>
> I'll do anything to help my family or at least keep things as easy and comfortable as I can and by allowing things to happen to me, Mum's happy because Dad's satisfied and [sister]'s happy because both parents are happy. So the only person unhappy is me, but I can handle it, and if that's what it takes to keep the peace even for one night out of seven that's fine. I still feel awful, dirty, stained and unhappy. But then I don't really think I deserve to be happy or that's what I've always been told …

Her struggle between containing and reaching out for help is exemplified in another poem.

> Do you ever feel completely on your own
> People all around you, Still you feel alone
> All you want is a smile, a hug, a friendly face
> But it's so hard to say
>
> Stop look, I need your help
> I'm crying out inside
> Yea, Okay so I'm smiling
> But that's not me.
> The real me had died.
> The real me must hide
> From you all.
>
> Do you ever feel your life is just an act
> A cover-up, not showing the love you lack
> You always look so happy, smiling through the day.
> You're Bottling up your feelings Look Stop,
> That is not the way …
> Just say …
>
> Stop, Look, I need help
> I'm crying out inside
> Yea, okay so I'm smiling

But that's not me,
The real me has died …
The real me must hide
has died
must hide

The real me must hide from you all.

Another poem describes Susie's identity struggle

When I look in the mirror
I stare at what I see
Two people so different
Staring back at me
The girl on the outside, is the one who's smiling back.
Putting on her makeup, she looks quite relaxed …

People have two sides
Image, Personality

So when you look in the mirror

Take a look at what you see

Is there a girl on the inside? A side,
That no-one knows
Seeking desperately to find herself
Will you let her show?

Do people see you as you really are, or are you hiding too
If you're like me, when you look in the mirror
And you're scared of what you might see
Don't look in the mirror
If you're confused like me!

It appears no contemporaneous action was taken by any professional as a result of these writings. Susie first came to the notice of child protection professionals when her sister had taken a beating and wanted to report her father. Susie stepped in to make a report to protect her sister, but her sister withdrew her allegations and this left Susie isolated and she returned home. These writings only came to light amongst her things much later. In 1989, after a particularly violent sexual assault, Susie hid some evidence of the abuse and, after having a row with her father, she sought refuge at a neighbour's house. She was then accommodated by the Local Authority after attempting to strangle herself with her jumper, fearing she would be returned home.

Once in Care, she began to reveal more about physical and sexual abuse by her father, and her writings received attention. My opinion was that the writings were potentially suggestive of multiplicity, but that a fuller assessment was required (I also held in mind that the writings may simply be the expression of Susie's feeling unable to be unconditionally accepted as who she really was, perhaps due to an abusive family situation).

By the time she was referred to me she had made a police statement and was in a Local Authority Children's Centre. Her father, a professional man, had been arrested and charged with several counts of sexual abuse. I was asked to assess Susie with a view to assessing her psychological state and functioning and, in particular, to determine if she were likely to have DID, and whether there was any psychological evidence to support her claims of sexual abuse. She was jointly referred by the police and Social Services who were concerned about her care and her ability to be a credible witness for the prosecution of her father.

5.3 Self-assessment

Susie completed a self-assessment form as part of the referral process. This form was primarily designed for use by adults, and at this time my service had not yet designed separate assessment forms for younger children and adolescents, so Susie, who was 15, completed the adult form. About school she said:

> At a younger age I liked school and would stay until the caretakers locked up. I liked it because it kept me away from my real home.
>
> More recently School is suffocating me and I feel like I don't fit in, I feel different to all the other kids, I skip loads of lessons and often go for walks on my own.
>
> At the moment I live at the Children's Centre, I like it here, and I liked all the staff in … and I think we get on quite well. One of the staff is called … I get on really well with her. I think an awful lot of her. She sees through me and I can't get away with anything with her. But she's great. She understands.
>
> My mum, she doesn't believe that Dad could do what he did to me, she isn't excepting [sic] it, I haven't spoken to her for what seems like ages. I'm frightened to, I don't know what to say or what she'd

say if I did see her. I haven't seen my sister either I want to but can't unless I speak to mum.

The form then asks whether the person has any children, to which Susie wrote:

> Yes 1 she's just over one year old and she's got blond hair and looks like me.
>
> I miscarried her Christmas '88
>
> Dad's in Prison, because I've told the social worker & Police what he did to me. He won't admit to the charges.
>
> Went to see Dr [Psychiatrist] but refused to speak to him.
>
> Mum and Dad both drink Heavily
> So does my little sister ...
> Dad and Mum used to hit us quite often
> Both parents have been drinkers as long as I remember.
> I can't hate my father, but I want to.

Susie responded "Yes" to a question "Is there anything you would like to say but cannot bring yourself to write down?".

5.4 Initial Assessment

My assessment, completed 2 months after receiving the referral, included psychometrics, clinical assessment and consideration of the data provided by others, as well as Susie's creative writing and self-assessment form. The psychometric assessment was conducted blind by another psychologist so as to keep this separate from the clinical and therapeutic role. Susie was brought to my consulting rooms for assessment, her first trip away from her small rural community.

Regarding the result of psychometric assessment, on the Wechsler Intelligence Scale for Children Revised (1974), despite being towards the upper age for this test and having an overall IQ in the average range, Susie showed an extreme range of functioning from that at the very bottom of the scale to the very top. I would later discover that Putnam (1997) reported a case of child DID showing 'significant scatter'. Susie made interesting responses, eg on the Picture Completion subtest, which asks the child to identify the missing part of a picture, one stimulus is the top

of a screw with the groove missing where the screwdriver would fit for turning the screw. Susie responded to "Tell me what's missing" with "the girl". It transpired she had free associated to the word screw and interpreted it sexually. It had double resonance for her because, in her police statement, she reported that her father had, in addition to his own body, also used metal instruments to sexually abuse her.

When completing the Family Relations Test (Bene & Anthony, 1985), Susie had chosen an adolescent boy picture to represent her father, and had turned it away from her, saying it made her nervous. She perceived her mother as being unable to protect her, her father as being overindulged and herself as powerless and isolated. She had described how she and her sister had been surprised in later childhood to realise that other children's mothers were still up and walking about at 9 o'clock at night, whereas their mother was always unconscious through alcohol. Susie said her younger sister had been the first to articulate this as she had always preferred to think of her mother as sleeping through tiredness. She remembered sitting with her sister on the stairs, listening to their parents fighting.

Analysis of the Locus of Control (Norwicki-Strickland, 1973) demonstrated that Susie's profile was of a child who knew that one's own actions could create influence, but who saw herself as particularly ineffectual and powerless to affect the outcome of things at home, especially with regard to her parents. She was both acutely and chronically anxious (Spielberger, 1983, scores: Acute=69 & Chronic=53) and also highly clinically depressed and potentially suicidal (Beck Depression Inventory, 1979, score=47), with low self-esteem (Rosenberg, 1989, score: 15, range=10-40).

5.5 Dissociation/DID

At the time of this assessment, I had worked with several adult clients who were reporting experiencing DID, but I was still working with poor awareness of what little advance there was in the assessment and treatment of MPD/DID. Ross and Heber (1989) devised the Dissociative Disorders Interview Schedule (DDIS), but I did not become aware of this until several years later. I had attended two workshops in London that had challenged my general scepticism, and had raised my general awareness of the phenomenon of multiplicity, but not of any assessment tools. I

therefore approached this assessment from a similar standpoint to that of any other psychological or psychotherapeutic assessment. This involved gaining some base-line measures of intellectual functioning, emotional and interpersonal functioning and basic mental health functioning, as well as clinical history.

Susie disclosed, at this stage in a very limited way, that there were specific parts of her that related to specific activities. Susie had a middle name, which was that of her maternal grandmother, and she reported that her father had often used that name to address her, when sexually abusing her. The result was that she perceived that a separate part of her, with sexual abuse specific memories, coped with the sexual abuse by her father. Another part of her specifically cared for her mother, emotionally and physically. Susie described a handful of other self-parts with specific functions and disparate ages, eg a child who went to school, and a mother figure who was approaching mid-life. According to her very clear descriptions of these parts, their functions, their functional ages and their relative amnesia between parts, she fulfilled the DSM criteria for MPD/DID. As far as I could tell, Susie's age and rather isolated country upbringing, in a very insular subculture, meant that she was unlikely to have previously been exposed to media portrayals of MPD/DID, and her detailed personal accounts argued against vicarious learning. By this time, I had encountered and worked with a number of such adult cases and had found their commonalities, as would be expected from a common media influence, to be far less striking than their individual differences, in much the same way as any psychotherapy case. I discovered that biblical symbolism was a common influence in naming some self-parts in clients that I had encountered with DID. Susie was the first adolescent I had encountered that fulfilled the criteria for DID. Before this case, I had not even considered the possibility of a child or adolescent case, despite knowing that the adult cases reported the existence of DID from childhood; they also all reported that no professionals had recognised their experience until adulthood. With hindsight, I can see that my lack of experience resulted in a simplistic grasp of the phenomena that were new to me, resulting in a narrow focus and less complex understanding than I developed over the following years. By the time Susie's case went to trial there was corroborating evidence of different self-states by other professionals and also corroborating physical evidence, from a specialist paediatrician, of sexual abuse and of past pregnancies. Thus, although I had not at

this stage read the book by Aldridge-Morris (1989), this case fulfils his advice to 'only diagnose DID where there is corroborative evidence that complex and integrated alter egos, with amnesic barriers, existed prior to therapy and emerge without hypnotic intervention by clinicians' (p109).

In the intervening time between my initial assessment and the case coming to trial, I had been asked to visit the rural community in which Susie lived, accommodated by the Local Authority, but still proximal to her parents' house. I was asked to meet Susie's mother, to assess her potential to support Susie with her allegations and the potential trial. She met with me on Local Authority premises. Susie's mother appeared unkempt and was avoidant of my efforts to obtain a developmental history for Susie. She could not even consider the possibility that Susie's allegations could be true and was resentful that her husband was in custody. She presented as focussed on her own needs and showed no ability to empathise with Susie or consider her needs. Despite the medical evidence of pregnancy, Susie's mother denied this to be a reality. The meeting produced no data to assist my assessment of Susie or to demonstrate that her mother could provide practical or emotional support to Susie in facing the trial.

5.6 The Trial

Susie was unable to enter therapy until after the trial against her father, so this delayed the start of formal and regular therapy for more than another year. I was asked to support her for trial, trying to ensure she could remain sufficiently in control of her switching between self-states to give her evidence coherently without aggressive or child alters undermining her credibility with the jury or the judge. Susie independently decided on how to solve this problem for herself, and reported to me that she had created a specific new self-part to deal with the trial, who would have access to all the necessary data from disparate other parts, but who would handle the presentation of the evidence and who would be sufficiently separate from all the other parts to prevent switching between alter personalities during her evidence, which would have carried the attendant risk that she may become contradictory, unpredictable, overemotional or unable to continue. She proposed that after the trial she would amalgamate this self-part with her main operating part so that she was not proliferating her fragmented self any further than already existed.

For my part, my only previous experience of a client creating new parts, whilst working therapeutically with me, was Marian, discussed in **Chapter 1**, the **Introduction**, and again in the second paragraph of section ***10.6 Transference and Counter-transference***. Marian had created extra self-parts whilst in therapy because she erroneously thought that would please me, though she also dissolved them when she knew I thought their creation to be inappropriate and dysfunctional. I was therefore rather apprehensive about Susie's use of this process but, because I had, as yet, only initial knowledge of Susie, I decided to trust her judgement that this was a technique that had met her needs in the past and would do so on this occasion too. As it was, at that point, I had no better solution; now, with the benefit of hindsight, it is my opinion that Susie chose exactly the right solution to a very demanding situation. The functional part created by Susie for conducting the trial differed from the creations in therapy by Marian. Susie's new part was similar to her other active self-parts, in that it had characteristics specific to the role and function it would serve. Marian's on the other hand had the function of numbers and so were characterless, nameless, functionless and formless in every other way, save for making up numbers.

At the time of the trial, Susie was still a minor; she endured almost three days of solid and very hostile questioning, with serious cues to the abuse, present in the court room, which could easily have triggered the sexually abused child alter(s). For example, Susie later disclosed to me that, in relation to sexually abusing her, her father kept a school exercise book, in which he wrote down random reports of whether he considered she had been good or bad. If he recorded that she had been bad, he then sexually abused her; the more severe the bad recording, the more sadistic the abuse. The defence lawyer used a book that was similar in appearance, when cross examining Susie. After the trial, I went on to work therapeutically with Susie for a further eleven years and, despite various other traumatic life events and huge emotional demands, she never, to my knowledge, created any subsequent parts, and the trial part never played any further part in her life beyond the trial.

Another prelude to the commencement of our psychotherapy was that, not only had I assessed her for forensic purposes but, as a consequence, I also was required to give evidence on behalf of the prosecution. This is a regular aspect of my work in general,

and I was required to give my opinion as to the psychological evidence for traumatic impact and developmental disparity in Susie, and the probability of it being related to child sexual abuse, and also her credibility as a witness. One major defence argument was that she had learned about sexual abuse from a friend at school and was fabricating her allegations. The jury were from the same small community, most of whom would have known Susie's father because of his prominent social position. I assisted them to understand my psychological profile of Susie. To help them understand my opinion that there is a difference in detail between experiential learning and vicarious learning. I had to provide some explanation of the self-splitting and amnesia that can occur in traumatic conditions, without risking straying into the whole contentious area of multiplicity. I needed to provide data on Susie's extremely disparate intellectual functioning, and explain the relevance of the very detailed and personalised data she had provided about the abuse, which, in my professional opinion, were coherent and consistent. The presence of physical evidence of sexual abuse and pregnancies was also of great significance, as well as her father's semen detected on her nightclothes.

The police and social services had found it very difficult to protect Susie, and during the trial there was an attempt by her mother to put Susie under severe pressure to retract her allegations. Susie was tormented by her loyalty to her family and her instinct to protect herself. The outcome of the trial was a resounding conviction on all of the many charges. It later transpired that Susie had been very selective in her disclosures to the professionals. As therapy proceeded, she revealed sexual abuse by her mother, who also prostituted her from the age of about 8 years, as well as abuse by other members of their community, in an organised group. She reported very sadistic abuse occurring sometimes, in all of these situations. Had Susie revealed all of this before the trial, a successful prosecution and her subsequent protection would have probably been severely undermined, because of the difficulty of proving a case against multiple perpetrators and the strain placed on jurors to accommodate and believe extremely unusual evidence. Susie was resolute that she would not file a complaint against her mother or anyone else. She said she would never do anything to hurt her mother and, with regard to her other alleged abusers, she felt unable to contemplate another trial.

At the conclusion of the trial the police and social services felt it was imperative to secrete Susie away from her locality and into a place of safety, since there had been many anonymous threats against her life, assumed to be from her family and family friends. It was also felt necessary to accommodate her close to my locality so that I could begin to provide therapeutic support and intervention for her. It took about 2 weeks to find her a local foster family and social worker.

Once Susie was settled into a family placement and some training and support provided to her carers by a variety of professionals, including the social workers and this author, she commenced therapy. In this safe family environment, Susie began to disclose more about other sexual abusers, some of whom she said belonged to a group who wore masks and robes and conducted meetings with ceremonies. Potentially corroborating evidence came from the fact that another adolescent, who was of Susie's acquaintance and peer group, also began to disclose sadistic sexual abuse but, just as Susie had initially confined her allegations to her father, this other child, Gemma, identified only her own parents as her abusers. She was accommodated by the Local Authority but no prosecution followed, as she was a reluctant witness and the parents did not oppose her accommodation.

5.7 Self-part Revelation

What did quickly become clear, in therapy, was that Susie reported a complex arrangement of internal self-parts that were highly organised into clusters associated with specific functions. She had begun this process of disclosure to her social worker and the police sergeant prior to starting therapy, and the process of disclosure continued with me. Soon after she made the complaint against her father, she had shown her social worker photographs of her father, who she described on different photographs as being her 'different dads'. She would explain this further, later in therapy. At this time she was concentrating on explaining her own experience of her own self-identities. There was one group that coped with her father and one that coped with her mother, in terms of sexual abuse. Other clusters were for other functions, such as the prostitution performed under her mother's management from 8 years of age. As therapy progressed she described the activities of a satanic or paedophile group, and she also revealed that, to cope with this organised abuse, she had other separate internal systems of organised parts that were kept completely

separate from her day to day alter personalities, except for a switching link performed by one self-part, Julie. The number of self-parts she was reporting, even at this initial stage, went far beyond anything I had previously encountered or read about. I had received no training in Dissociation when Marian was referred to me; by the time of seeing Susie, I had become acutely aware of the need to ensure that therapy promoted integration and not separation of self-parts. In general, and not specifically with DID, my therapeutic style is to avoid leading the client and to allow her to pace the work herself. I try to ensure that my reflections and summaries are even-handed, reflecting holistically the client's narrative. The exceptions to this are the need to maintain safety for the client and others in emergencies. I was therefore careful to attend equally to all of Susie's disclosures, and not to show differential interest in her self-presentations unless it was agreed by the whole of her that there was a pressing need to do so. I was aware that my reactions may either close down her engagement in therapy, or potentially reinforce the creation of splits, a lesson I had learned several years earlier when working with Marian. I attempted to remain fully attentive and unconditional, as I always tried to be with clients. As Susie revealed the information from her daily existence in System One, she did so all at once, in one session. This information, potentially overwhelming for me, was offset by the detail of how these parts were highly organised into teams performing specific and highly differentiated functions. Just as this helped me to cope with so much detail, I could see that this was also how she coped with what would otherwise be quite overwhelming external and internal demands.

I witnessed an impressive feat of memory that was suggestive of experience rather than fabrication. In this one session Susie drew, on a piece of A1 flipchart paper, the names of her parts in System One. This was executed swiftly and without any hesitation. She switched hands, sometimes writing with her right hand and sometimes with her left.

The major organisation of her self-parts was in terms of attachment. There were four poles of organisation: liking people versus keeping people away, and her caring side 'worrys [sic] for people will help any-one she can and take anything on board' versus 'tells people to get lost'. At the centre was Mary, the head of the committee, a 15 year old part (Susie's chronological age) who attempted to control which parts

exercised the body and conducted social intercourse. Susie explained that her self-splits had begun at age 3, when she was sexually abused by Sally, the female leader of the organised abusing association of adults to which her parents belonged, and at that time her splits did not have separate names; they were all Susie but split into Susie 1 to Susie 4. It is possible that the name Mary was chosen as a manager, because of its association with the mother concept in the Christian religion. It is also possible that this is the autobiographical data available in explicit memory rather than implicit memory that emerged later in therapy, which suggests serious abuse at a much younger age. Terr (1988) has demonstrated that preverbal children remember abuse. Other clients with DID have reported very early memories.

Susie reported that splits had proliferated with the severity of situations she coped with and she began to name them. Mary had come into existence when the body was 10, but Mary had always been 15. Below her, in authority and control, was Jean, who was 40ish (began when the body was 12), who deputised for Mary as head of the committee and who was a mother to the other internal parts of System One. I had long wondered if Mahler's (1975) theory of separating from a fused mother/baby state to a 'me plus other' state, happened internally for DID clients, as one common denominator, in the clients I had encountered, seemed to be the existence of a maternal or nurturing figure. I conjectured that, if external separation was impeded by a fused mother or parent, perhaps this developmental process occurred anyway but internally, where the child could exert some control. In male clients this had taken the form of a male stereotype strong protector figure, so it may not be universally true that it is a mother figure. Perhaps what is general is the creation of an older figure, to meet the needs of the vulnerable child, who can protect and take care of the abused or traumatised child and, in situations when external fusion cannot be overcome because external adult pressure prevents separation, separation occurs inside and is the first organising principal in the creation of DID. According to Susie's reports, my theory is challenged, since she reported her initial splits to be in the child self identity only, with these adult projections occurring later.

I was unaware at that time that the research literature had previously indicated reports of an average of 13.3 self-parts (Putnam et al, 1986) and 15.7 (Ross, 1989). Bowman (1990) reported the range for adolescent cases to be 2-69 self-parts. Kluft (1985) has

reported isolated cases of up to a hundred self-parts, but my own experience did not prepare me for what Susie was revealing. In System One, consisting of more than 50 self-parts, radiating out from Mary in the centre were the four poles plus a further 9 branches of fine-grained organisation. One example of this was the function of protection, achieved via either psychological barriers or physical fighting. Psychological protection came from Emma, aged 16, who came into existence when the body was 12, 'puts up barriers and closes us in if we slip up'. Also on her team was Valerie, aged 33 (began when the body was 14), who was described as 'fighter, heated temperament, argumentative' and Mark, aged 16 (began when the body was 9), who 'helps out with fists when required'. Whilst I could detect no obvious specific media influence relating to DID portrayals, as later alleged by Merskey (1992, 1994), it was obvious that cultural ideas of male and female roles came to bear on how Susie conceived of her varied self-identities. There had not been any detailed reports of DID cases with complex identity structures in the media. *Three Faces of Eve* had shown a very limited split between good and evil, a traditional theme in films and other literature, eg modern films such as *Star Wars* (Lucas, 1977), and whilst *Sybil* had depicted a more complex personality structure, it had confined itself to only a few personas. Even as a professional providing clinical intervention for DID and trying to read and learn about it, I had found it difficult to locate texts and I had not been exposed to anything that could have served as a model for what Susie was describing about her own functioning. The naming of key self-parts could, however, have been derived from symbolic concepts in the Christian religion and may have been unconsciously chosen to counterbalance what Susie perceived to be satanic experience.

Susie revealed a cluster of parts that coped with her grandfather, another that coped with her father, a group that coped with Sally when she was acting alone, another that coped with her mother, and yet another group that coped with nightmares. In addition, Susie also reported a female part who could change in her external presentation to anything between 8 and 40ish, according to external demands, because her job was prostitution. Such variation in age perception within one part was also something new to me and not something described in the literature. Susie also reported having a 6 year old female part, Julie, who coped with the organised group abuse, but it later transpired that she was actually the link into System Two, the

separate system coping with the organised abuse, that would later be fully revealed. In the bible Julie is not a main character, but is described as a Christian woman. At the time I was given all of this information, I was probably already finding this a high information load, and it did not occur to me that it may seem strange that groups were needed to cope with family and everyday issues, whilst mere individual parts appeared to cope with the extremes of group abuse and prostitution. System Two was also contained self-parts that came to help with the prostitution when it became violent and deviant. She would also eventually disclose a third, deeper System that had no name, and contained hypnotic suggestions of supernatural control that came from the organised abusers.

5.8 Reassessment in Therapy

In late 1990, six months after the trial, Susie was reassessed psychometrically for funding purposes and showed considerable development in IQ, predominantly in Performance IQ. One consideration regarding the interpretation of this data is that it was necessary this time, because of her chronological age, for her to be re-tested using the adult version of the Wechsler test (WAIS-R^{UK}). Measurements at the extremes of scales are subject to greater error than those falling more adequately within the scale but, even allowing for this, the improvement was still remarkable. Her overall IQ had risen by 18 points. The range of difference between subtest scores had originally been 12, compared with a range of 9 at re-testing. Other aspects of her mental health remained constant, but she was less depressed, as measured by the Beck Depression Inventory (Beck, 1978), than at initial assessment (score of 31, compared to 47 previously) and her distress was marginally less somatically expressed as measured by the General Health Questionnaire 60 (1978), (score of 9, reduced from 11). These psychometric results were also consistent with clinical opinion recorded by me and another clinical psychologist before comparison of the psychometric results. Despite these improvements and regular therapy, she was registering extremely highly on the Impact of Event Scale, with a score of 61/75 (Horrowitz, 1979), administered to Susie for the first time. It showed that she often had intrusive experiences, such as flashbacks, and often tried to avoid triggers to the abuse. By this second assessment, I had also begun to use the Dissociative

Experiences Scale II (Carlson and Putnam, 1993) and this formed part of the assessment, the result of 56% indicating MPD/DID (cut off for DID = 30).

Susie was reassessed a number of times in the first few years of therapy, in conjunction with the funding requirements. Once she reached the statutory age limit, the funding arrangements changed; for a while she was funded by a special Social Services fund whilst an application was made for Criminal Injuries Compensation. Once successful, this supported her therapy until completion. Susie declined to continue psychometric reassessment, once this was not necessary for funding purposes, as she experienced it as an enormous ordeal. She reported that it was extremely difficult for her to maintain such protracted and sustained concentration to complete the battery of measures. She reported that she tried to do her best in performance and in reporting accurately on all measures, but this involved a great deal of internal checking. This intellectual challenge felt Herculean to her and it interrupted the flow of psychotherapy. Once it was no longer crucial to funding, the practice was dropped. She also declined to undergo such an assessment at conclusion of therapy, feeling she had moved on and that it was no longer necessary. I felt that it would have been meeting my needs, for service evaluation, and not her needs, and I agreed to dispense with it.

Measures were taken periodically, during the first few years, and tended to show the vicissitudes of the therapeutic process, such as the regression associated with the therapy being undermined by her mother and Sally, to be discussed below (**Managing Internal Conflict and External Safety)**, but additionally there was a gradual increase in the DES score during the first two years. I had noticed a similar pattern in a women's group for sexual abuse survivors. The group scores had increased steadily during the life of the group, a similar period of about two years, and dropped as issues were resolved and people were ready to leave the group. I had hypothesised that the fragmented manner of their functioning at the beginning of the treatment meant they were less aware of the full extent of their dissociated behaviour and therefore potentially underreported. Once in treatment, they seemed increasingly prepared to accept feedback from family members, friends, therapists, group members and work colleagues about their dissociated behaviour, and as their awareness increased their reported scores increased. Their subjective reports and

clinical observations of amnesia decreased whilst their reports of awareness of dissociation increased in the early stages of therapy. The therapeutic process also reduced other avoidance mechanisms, as well as amnesia, and so difficult affect was increased until therapy was in the final stages. As therapy progressed and dissociation was no longer employed as a defence strategy, affect was increasingly tolerated and reduced, and so the reported scores decreased.

5.9 Therapeutic Approach

By the time of seeing Susie, I had experienced a handful of adult cases of MPD. I was interested in this multiplicity phenomenon and engaged in reading widely about the arguments and theories for and against the existence of DID. I attended conferences and workshops to expand my knowledge and skills in working with such clients, whilst trying to hold in mind that professionals on both sides of the debate felt strongly and made passionate arguments. I was keen to maintain a balanced perspective and to focus on the commonalities with non-DID psychotherapy cases, whilst not ignoring the specific differences that DID cases presented. I generally saw DID cases as presenting more extreme examples of the problems that are generally encountered in psychodynamic therapy. The main therapeutic issues of engagement, trust, disclosure, resistance, transference, and counter-transference were all similar to other cases, but more obvious; everything was more extreme potentially because of the lack of integration and the consequential presence of polarised and unmodified affect and behaviour.

The therapeutic model I was using was largely psychodynamic, based on a developmental model, but because of child protection issues it was necessary also to include a more active stance in some emergencies, as well as to utilise cognitive and behavioural interventions for achieving greater functionality and self-protection for Susie. My general approach was to assume that all or any parts of Susie were present in therapy and treat her as a whole person, unless there was some pressing issue of protection or conflict, when a focus on specific self-parts became necessary. However, I was always mindful that all parts of her were present and would be influenced in some way by all that happened. Unless there was an emergency, to be discussed below, I never called upon any specific part, but as therapy progressed I did

suggest to her how she could promote information exchange between self-parts and practice co-consciousness between parts.

5.10 Working with a Co-therapist

During the first year of therapy it became obvious that Susie and her Carers could not sustain her functioning adequately across my absences, such as annual leave. Although I had not discovered a precedent in the literature, with DID and other complex cases, I had worked in tandem with another member of the team, so that absences could be covered and continuity maintained. In this case I began co-working with another female therapist, but after the first two years, she left the practice and another female psychotherapist, of approximately the same age and experience as me, was introduced to cover my annual leave. After several years, she retired and I co-worked this case with a male therapist. I have found this practice to be supportive, to the client and to me, and positive results and therapeutic effort have been maintained in this way. It seems particularly effective for the client to experience the general similarity of two different therapists, and yet small individual differences too. I have found it particularly effective when working with a male/female combination of therapists. It is possible that this mirrors the functional family experience of being cared for by two different but complementary parents, who are consistent on salient issues, but teach good communication and negotiation, flexibility and relativity through their small and less significant differences. The issue of close liaison will be examined further now in relation to wider professional teams and services.

5.11 The Importance of Inter-agency Cohesion

Previous experience had taught me that a lack of integration in the approach of professionals resulted in the professional service reflecting the lack of integration in the client, causing mixed messages to the client, confusion, poor progress and impeded trust development. This had been the case with clients generally, but with DID clients I found that it exacerbated both external splitting behaviour and, more importantly, internal conflict. I deliberately tried to set up multidisciplinary systems that promoted integration and modelled this for the clients, but in some cases there were times when the teams did not manage to be as integrated as was desired, and it was not always possible to control or influence the behaviour of other professionals

outside of the teams who had contact or influence with the client. In this way, through being a member, even a leading member, of an un-integrated team, one experienced something that was similar to the reports of the lack of cohesion in DID internal self-systems. Thus it was possible to gain some small understanding of the internal conflicts and dilemmas reported by DID clients, where self-parts were convinced they were acting for the general good, but sometimes with disastrous consequences, that they were unwilling or unable to evaluate with hindsight and learn from. Even when experiential learning was possible through trial and error, it made for a slow trajectory of progress. With complex cases there is already a huge mismatch between funding pressures and the time needed for therapeutic change and development, so professional methods of working that fail to promote expedience are very regrettable. For example, in another complex dissociated but not DID case, the therapeutic team unity was hampered by poor social work liaison and a lack of modelling of pro-social behaviour. This was a client who had an extensive abuse history and poor emotional development, and was hypersensitive to rejection. This sometimes resulted in verbal aggression and abusive language. The therapeutic professionals and their support staff had managed to moderate this behaviour considerably by not taking the behaviour personally, by using calming techniques and by overtly modelling an alternative way of being heard, so as to avoid the perception of rejection that fuels the unwanted behaviour. No amount of liaison enabled the social work service to adopt a more functional and unified approach, and instead they modelled inappropriate behaviour, such as taking things personally and putting the phone down on the client, the very thing that therapeutically the client was being asked to change in his own behaviour. In another case, a semi-retired GP was the weakest link; despite advice from a hospital consultant and the clinical psychologist involved, the GP over-prescribed medication because he could not resist the temptation of the rescuer role. This resulted in the client overdosing several times. His semi-retired status meant that opportunity to liaise and influence him was limited, and it was also impeded by the general perception of medical supremacy in opinion and prescribing practice.

In Susie's case, this integrated professional team approach, where professional unity was very successful, contrasted with the difficulties I had encountered in some previous DID cases in which, for example, a client was refused admission to hospital,

with her new baby, after becoming overwhelmed and confused emotionally. She reported that she was told she could only access this admission to hospital if she dispense with the diagnosis of DID, and accept a different diagnosis of Borderline Personality Disorder. This undermined the therapeutic alliance as she interpreted that the doctor had greater status and was saying that her therapist was wrong. It also made it very difficult to support and inform hospital staff of the best ways of interacting with her to reduce problems and maintain safety. The failure of hospital staff to acknowledge DID resulted in their lack of awareness of the client's switching behaviour. To achieve internal safety and maintain child protection in relation to her new baby, the client and I had agreed an internal co-operative of self-parts. The client's ability to maintain control at times of particular stress relied on her ability to engage staff help. Their lack of understanding, of the vicissitudes of her behaviour and switching of self-parts, led to her becoming labelled as manipulative. This further distanced her from the support that she needed, thus reducing internal safety, as well as the child protection control that was one major feature of the psychological and psychotherapeutic intervention. With Susie's case, the professional cohesion was exemplary in the main. Regular meetings and telephone liaison were held with Susie's original social worker, her current social worker, her foster carer and me, as her therapist. Susie stated that she 'hated' us meeting but, at the same time, it was possible to detect relief in her when we made decisions in her best interest, such as helping her to access GP care with multi-disciplinary liaison, and procuring funds to continue her therapy.

This successful team integrated approach was, in my opinion, an important ingredient in the eventual success of Susie's therapy and personal progress. We modelled positive team working and good communication, mirroring the aim of co-consciousness and open communication also being promoted between Susie's self-parts. Eventually Susie came to describe how this team approach contrasted with her own experience of being parented, when the only time her parents acted in concert was during the organised abuse; at all other times, they warred violently and Susie tried to keep the peace by putting herself between them, usually at great personal and physical cost. This close and unified inter-agency liaison would become even more vital in the later stages of therapy, when Susie left foster care, began independent living and became a parent of three children.

As is evidenced by the experience reported above, the professional climate, in which the concept of DID was disputed, made the usual problems of interagency and inter-professional agreement more problematic than usual. Where professionals had experienced very dissociated clients, even if they did not have DID, an open minded attitude was experienced but, where the professional had no direct experience of dissociation, there seemed to be a polarisation of response. People either became fascinated and over-focussed on novelty and separateness, often allowing their own curiosity to override the needs of the client, which was a problem occasionally encountered with Susie's foster mother; alternatively they were very dismissive, attributing malevolence to the client, especially assuming either malingering or manipulation. In Susie's case the core professional team took the decision to limit the amount of information made available to peripheral professionals, in an attempt to achieve the best treatment for Susie, whilst preventing her from becoming the object of people's curiosity, and consequently decisions were made on a need to know basis.

It proved very difficult to get an accurate eye test for Susie, as the optician was confused as to why no constant reading of the physical parameters of her eyes and vision, such as pressure or reading ability, could be obtained. This was tentatively interpreted by Susie and other professionals as varying according to which self-part was being tested. Although I had heard the suggestion that the physical parameters of DID clients could vary according to the executive control of alter self-parts, this was the first time I had experience of it being specifically measured. Miller (1989) and Miller et al (1991) have reported similar differences. This was again a situation where my own professional curiosity caused me to wonder about researching this with the optician, but I did not think that was in Susie's best interest so I did not have direct contact with the optician, leaving that to the social worker and Susie. The problem of the eye test was solved by Susie ensuring that her committee manager part, Mary, remained co-conscious for the eye test and for all of her daily existence as far as was possible, perhaps suggesting support for the hypothesis of Susie and the professionals that the previous variation had been due to switching of self-parts. This co-consciousness was the concurrent objective of the therapy in any event but, as with my assessments, specific psychometric examinations caused extra stress for

Susie, and at those times she found it took a great deal of extra concentration to maintain a cohesive consciousness.

5.12 Better the Devil You Know: Fear of the Unknown and Destructive Envy

One of Susie's first problems in the new foster family was that she found it uncomfortably clean and it did not feel like her own family home. Even though she had an obsessional part of herself, that loved cleaning to excess, her prevailing orientation was adapted to living in squalor and this became her focus for being an outsider in this new family. She could not relate to the two birth children of the foster family, who she saw as very babyish and spoilt. There was a lot of destructive envy to manage and a real fear that Susie may sabotage her new situation. She had made the abuse stop, but at great personal cost and loss. She was strongly attached to her family of origin, even to her father. She desperately missed her mother and sister, and felt alienated in this new environment. She expressed her feelings in this poem:

Too Different

Am I only dreaming
Can all this be true?
Will I ever wake up
To the life I was accustomed to?

This house is too different,
There isn't any dirt at all
Everything seems to have a place
But I miss the damp on my wall

The mother is too different
She's kind and always sober
Her kids are her pride and joy
But I miss my own mother.

The kids are too different
They just don't have any fears
They feel safe inside this house
Bur I miss my childhood tears

The father is too different
He makes sure his kids are never sad
You never see him in the dark of night
But I miss my own dad.

Am I only dreaming
Can all this be true?
Will I ever wake up
To the life I was accustomed to?

The protector self-parts acted to prevent Susie from perceived emotional harm by attempting to prevent her from forming attachments. For some self-parts, attachment to new people, especially her foster family, was experienced as betrayal of her mother. Others reasoned that she was not going to stay so there was no point in attaching and then losing those attachments. It was often the child-parts who sought attachment. In order to protect these parts of her that, for example, sought attachment to the children in the family, her distancing parts emphasised differences and, as the

lesser of evils, allowed Susie to build alternative and more distant alliances with other foster children who came and went in the foster home, with whom she could more easily identify, and with whom there was less chance of permanent relationship. She also differed markedly from these other foster children, in intellect and developmental potential, so she could exercise more control in these relationships. There were times when I was concerned that she may sabotage the placement and the therapy, in order to go back home, regardless of the cost to herself. Generally, I assessed that there was more internal weight towards staying than returning home, but that she needed to express to me her resistance to both the therapy and the placement. I expressed empathy with her feelings, whilst also reflecting accurately all of the shades of opinion and behaviour she was displaying. I think that allowing her to dissipate this resistance and frustration in the presence of empathy enabled her to integrate and moderate the more prominent of her contradictory feelings and to begin to settle.

This was also made possible because, in terms of interpersonal relationships, Susie was beginning to perceive her parents in a more rounded way, talking of their abuse of her as well as her love and attachment to them. Even though she had written in the past and at assessment of their abusive behaviour, she repeatedly dissociated from it, and some self-parts, such as Sarah, her mother's carer, denied the abusive behaviour. Therapy was focussed on reflecting the whole of what Susie reported, and this often meant repeated reflections. In the bible, Sarah is 'a woman of obedience' (Capoccia, 2000). As Susie's integration of information and affect progressed, she was also beginning to demonstrate attachment in her foster family and perceiving herself less negatively than before, but this was a slow process. Susie struggled with adults who allowed children to be free of responsibilities, and mother-daughter relationships that were close and loving, such as her Carer had with her own daughters and with her own mother. Susie complained that these kinds of relationships and the way she was cared for in her therapy were the 'wrong way round'. Her experience had been that children care for adults, not the other way round. Therapy aimed to raise her awareness of normal childhood, where children could be free of adult responsibility and could play. This was achieved by a combination of psycho-social education about positive childhood experience, and helping her to assess her current experience of the foster family and compare and contrast with her own childhood experience, as

it was being revealed in therapy. It also involved responsible adults, consulting Susie, but ultimately taking responsibility for decisions about her care. This was complemented in therapy by helping her to integrate her experiences and opinions, and to become aware of the negative effects upon her own development, of acts of commission and omission in her parents' management of her childhood. Examples that Susie provided were of burning herself when making her mother's meals at the age of six, being unable to concentrate on schoolwork because of being anxious about her mother's welfare, or tired and sometimes physically hurt following childhood prostitution.

5.13 Managing Internal Conflict and External Safety

5.13.1 Self-harm

Destructive envy did not just operate between Susie and other people, but also internally between different self-parts. Susie's committee managers reported that, if child-parts tried to attach themselves to her new foster carers, the protector parts interfered and often punished her with self-harm, such as cutting. One of the early tasks of therapy was to encourage internal communication that was more functional, such as discussion, and to raise internal awareness as to the functional purpose of some of her behaviours, so that objectives could be more consensual and less extremely actioned. Although self-cutting behaviour was reduced, it would be several years before it was entirely eliminated. As the behaviour changed and cutting became less frequent, Susie showed more ambivalence about it. She had significant scarring along the length of both of her arms and all over her stomach. As she became a mother, she began to be conscious of the model she was setting for her children, buying plasters that had ingredients to lessen or prevent scarring.

Self-harm is a difficult issue for the therapist. Some schools of thought involve asking the client to contract not to self-harm, but with DID, this carries the risk of the self-harming alters losing therapeutic alliance with the therapist and becoming engaged in a power contest, though perhaps acting in a more secretive manner. Another client wondered why I did not contract with her about self-harm as she reported that she had been coerced to contract by a previous therapist. I explained that I wished to leave the control to her and I felt that internal contracting was more important than contracting with the therapist. She also explained that she had

superficially complied with the previous therapist's contract so that no new cutting was visible or reported, but that she had been cutting her labia with a razor blade to obtain the emotional and physical relief, but had done so in a way that no-one could see. In another case that I was asked to evaluate, reviewing the therapy notes made it obvious to me that the therapeutic alliance had been lost by such a contract, and the main protector alter then systematically worked against the therapy until it eventually failed some eighteen months later. The unfortunate therapist had been untrained in working with DID, and supervision was not frequent and also lacked awareness of DID. My experience is that this is not a problem unique to DID and that, in the case of self-harm and suicidal behaviour, contracting can serve the emotional needs of the therapist rather than those of the client, who can experience the contracting as a form of control to be resisted, with the danger that ultimate control may come in the form of suicide. Therefore there is a risk that contracting about behaviour rather than looking to intercede at the causal level may even potentiate the undesired behaviour rather than reduce it (Drew, 2001).

Being a witness to the therapeutic and developmental journey of someone who self-cuts is very uncomfortable, sometimes in the extreme. My approach was to try to raise the client's awareness of the function of the cutting and find an alternative way of meeting this need. It is my experience that, as a client can become more articulate and feel understood about the affect that builds into the pressure for expression, that pressure is manageable and eventually reduces and even stops producing cutting altogether. This is what happened with Susie. It pained me to see the results of her cutting, every time it happened, and it was easy to engage in self-searching as to why I had not completely succeeded in helping her to stop this damaging behaviour. I had to remind myself that this was a process and therefore takes time, and console myself with the evident progress in that process. Each time cutting was either obvious or reported, I tried not to reinforce it by attending to the damage, but helped Susie to examine the underlying pressure and acute process that led to such a consequence. At the same time, I thought it important to acknowledge any new cutting I could see, if she did not spontaneously talk about it. In this way I felt she tested me in the unseeing and uncaring mother transference in the early stages of therapy. When we first met, cutting would happen whenever she felt high stress but, once therapy started, cutting became less frequent, averaging about once per month. After about

the first year it reduced to peak occurrences, such as her self-blame following the death of her mother. There were self-parts that were active in promoting the protection of the body; as co-consciousness and internal communication improved, these parts came to play a key role in helping to reduce the self-harm.

5.13.2 Contact with Abusers

Only a few months after the trial, after some initial success in therapy and increased functioning by Susie, it became obvious that she was independently writing to her mother and, although it was possible to monitor the letters sent by her mother and others, via Social Services, to Susie, it was not possible to monitor the communication in the other direction. On one occasion, Susie declared a letter to her mother, prior to posting it, and it became clear from the content that, in addition to the letters being sent via the official Social Services route, Susie was receiving other mail, though it never became clear how this was achieved.

I had become aware, from clinical discussion at a DID conference, that correspondence and seemingly innocuous objects could act as triggers to alter personalities who were attached to abusers, and the early stages of therapy were dominated by the dilemma of whether to pass on to Susie, letters, cards and presents from family and friends, since her community was so close knit and there was no way to know if any of these people had been her abusers or not. Susie's mother and sister remained aligned with the convicted father, and Susie revealed that her mother had been one of her sexual abusers, but that she would not press charges against her mother. She revealed that there were many other abusers in the community, some of whom she could identify and some of whom she could not, as they had been disguised by clothes and masks, or she herself had been blindfolded. It became difficult for the Local Authority to know which items were from innocuous sources and which may be potentially life threatening to Susie. There was a general fear by the Police Authority and Social Services that, if Susie were triggered to leave her current security or to reveal her whereabouts, she may be kidnapped, physically harmed or even killed. This meant that therapy was sometimes overshadowed with the child-protection issues, and Susie was in the situation of having jumped ship, from the people who controlled her life before her disclosure and the trial, to a team of professionals, about whom she was uncertain. She was unsure they had the power

to protect her. Her previous authority figures had, in her experience, demonstrated that they had supernatural power, so she was out on a limb, putting her safety in the hands of people who did not. She reported experiencing sophisticated mind games at the hands of her parents and others, and that her protector parts saw therapy as another form of mind game. I always encouraged Susie to learn to trust herself and her own sense of whether things were right or wrong, based on improving her internal communication, when weighing up what I was saying or doing. I was encouraging critical analysis by her and helping her to make decisions based on complex data rather than on over-focus. In this respect, it was helpful that Susie had good intellectual capacity, when her emotional issues did not restrict her application of it to situations. It has been suggested that intellect is a prerequisite to the development of DID (Kluft, 1985) and certainly it seemed to me that the extremely complex organisation of self-parts reported by Susie could not have been accomplished by poor intellect.

I had heard reports that some therapists had encountered active interference and hostile behaviour from family and associates of clients in therapy. This challenged my confidence and was a distracting variable when trying to establish therapy as a safe and steady context. I tried to keep my anxieties outside of the therapy sessions and to manage them in discussion with professional colleagues. It never became possible for Susie to identify more than a handful of key alleged abusers, some of whom were pillars of the community and associated with authorities; other than the conviction against Susie's father, no prosecutions have resulted. The Social Services Department kept Susie's records in restricted access.

5.13.3 Promoting Internal Communication and Co-consciousness

Susie often reported day to day difficulties because of switching and amnesia between self-parts, such as have been described in the historic case studies, for example Mary Reynolds (Plumer, 1860). Having arranged a job interview, Susie dressed appropriately and left the house; the next thing she remembered was being on the bus and looking down and realising she had on an exceptionally short skirt and 'was dressed to go out for the kill'. She realised her prostitute part had taken over, gone home and changed, and had no intention of attending the job interview. Encouraging her to promote communication between self-parts began to reduce these

occurrences. This was done by a number of different techniques. She practiced co-consciousness in safe settings such as when colouring pictures or watching a television programme. She initially reported difficulty with this, saying that perception was different for the different self-parts and, if co-conscious, it was difficult to focus the eyes properly; different parts had different colour perception and they were used to handing over to each other, not staying co-present. With encouragement, Susie practiced and eventually this became her dominant way of functioning. Meanwhile, she also used other techniques, such as setting up internal conversations between self-parts in relation to both past and current experience. She adopted the use of an internal virtual notice board where important events were written, and all relevant self-parts agreed to take notice of it. Previously they had used cutting on the stomach to transmit some urgent information. The prostitute part proved the most difficult during the first few years of therapy, mainly because of how isolated she was from the others and how resistant they were to accepting her, being abhorrent of her activities, but she became a key player in trying to maintain the protection of the body from cutting, and specific issues arose for her when it came to pregnancy.

Sarah, experienced as 14 years old (came when the body was 8), was described as 'quiet, loves mum, used to help mum, domesticated'. She was linked to Matthew, aged 11 (came when the body was 8), whose job was to 'cope with mum's sexual needs'. I would later see the connection between Susie's need for a male alter for sex with a female, and Bernadetta's use of a male alter for a similar purpose (Brown, 1896). Matthew in turn was linked to Jane, aged 18 (came when the body was 10), who 'coped with mum's drinking'. Sarah was the part who looked after (mothered) Susie's mother practically, and she had gradually begun to expand her reports from the idealised picture of her mother, to include reports of being used as a human dart board 'when mum got mad', or being locked in the dog house, sometimes with the dog. This gradual rounding of the picture of Susie's mother happened incrementally over a period of about two and a half years.

As Sarah recounted her experience of caring for her mother, she did so in a very dissociated manner. She told of learning to cook by trial and error from at least the age of six, of trying to be perfect because that was what her mother wanted. She

stepped in between her parents when her father hit her mother, mopped up her mother's vomit, dragged her upstairs and undressed her and put her to bed, and cooked for her little sister and her father, who was angry if his dinner was not ready when he came in. The Sarah part continued to say how wonderful her mother was and how stupid her foster carer was for 'the way she lets her children walk all over her'. As Sarah told her story, she sometimes acted out her dissociated affect in conjunction with other self-parts. One night out in a public house, a man had made amorous advances 'to one of the little ones' and Sarah took aversive action, with Mark then hitting the man in the face and breaking a glass to prepare for the man's anticipated retaliation. She was thrown out of the bar, and fortunately the man did not follow her.

5.13.4 Shoplifting

Twelve months into therapy it became necessary to concentrate some attention on Chrissie, a teenage alter who was experienced as 13 (began when the body was 9), and was described as 'cheeky, uses cans gas (used to), shoplifts etc'. She was up to her old tricks of shoplifting, having now found her feet in her new neighbourhood in concert with other teens in care. This part also related to three other teen self-parts, one whose role was to be secretive, another described as the 'main cover girl, keep the image together' and yet another who 'copes with other peoples opinions of us, puts a face on'. By specifically asking these teen parts to practice being co-conscious with Mary, the committee chief, for sustained periods each day, they increasingly became aware of the fact that they were not alone. Mary helped them to become aware of the consequences of their actions, previously managed by non-offending parts, one of whom was apprehended putting something back after it had been stolen. Jean helped out in her deputising controller role so that Mary could spend time educating and monitoring the shoplifter and her cover girls. This shoplifting problem was soon solved over a matter of weeks and never resurfaced over the remaining years of therapy.

5.13.5 Pacing Integration

The development of co-consciousness was proving very successful, in terms of everyday life in the present, but there were also strong protective reasons against the sharing of past experience inside the systems. For example, as Mary learned about

the existence of System Two and some of the experience contained there, she became very depressed and the risk of suicide became an issue to be managed. This also depleted her ability to maintain her role as internal committee leader and practical controller of System One, and Jean increasingly played a substitute role. The therapeutic dilemma was whether to continue increasing Mary's overall knowledge of past experience, or whether to desist and promote Mary's original dissociated manner of functioning. We agreed to continue to try to reduce the dissociation but to try to pace the work so that, although Mary felt emotionally stretched, she did not become totally overwhelmed. This required regular external communication as well as internal communication, and times of rest for Susie, and especially for her internal manager, Mary. It required internal co-operation from Jean, who was working a lot harder than previously, and also from Julie, who was sharing information about System Two, where previously it had been her role to restrict information.

On another occasion, Susie asked her social worker to accompany her to a session. The previous night she had been found digging up gardens and it transpired that Eve, the mother figure in System Two, had been trying to find her baby. Other members of System Two said that this baby was dead, but that Eve did not know. It transpired that Eve was constantly searching for her baby and kept thinking that other babies were her baby. I was aware that this was the sort of pressure that led some women to take babies that did not belong to them, and so this added to the number of ways in which protection of Susie was always an issue. Solving the internal pressure seemed to be the best way to prevent dysfunctional behaviour. Through encouraging the sharing of information and memories between others in System Two and Eve, a slow process, paced according to her ability to tolerate the associated affect; she was able to accept the death, grieve for the loss of her baby and stop her searching behaviour.

5.13.6 Dissolution of Amnesic Barriers

The literature I had found at the time had tended to emphasise separateness of personalities. My clinical experience was beginning to teach me that underlying unity was always obvious, as I was later to realise from reading Gurney (1884b) and Binet (1896). Firstly, amnesic barriers are not absolute, I had noticed with other DID clients that there was always some leakage of affect, no matter how slight. In therapy this gave the opportunity for the sharing of information. For example, a self-part may

have no memory to explain a feeling of great sadness or fear. Therapeutic dissolution of amnesic barriers could utilise a current event to encourage self-parts to share information. An early example of this was a child part feeling very angry but not knowing why. Mary, the carer/manager part explained that the child part was jealous because Mary had played with the foster carer's daughter. This not only produced amelioration of the anger, but also led to the child part coming to appreciate what had been missing in her experience of being parented.

This sharing of information was not a one-way process. On the one hand, it permitted Eve to learn from others about the death of her baby, but in so doing, information was also shared about her parents' role in this, and so Sarah began to resist knowing that they were capable of such serious harm. As Susie told her therapist about these experiences, she was also telling herself. I had, in the past, naively thought that amnesic barriers in DID would dissolve in an orderly fashion, but I had realised from experience that any disclosure of information and affect in therapy was accompanied by some form of deterioration in the internal amnesic barriers that occurred in a very gradual way. This seems to be an exaggerated form of the memory modification described by Siegel (1999, p42). Sometimes affect would leak from one self-part to another, sometimes an undefined sense of information would find its way to a related self-part. This eventually led to Susie narrating a scene from when she was 13. This memory was triggered by her current boss and her husband having a row in Susie's presence. She reminisced that, in the school library one evening, she had a strong feeling that something was wrong at home and that she had to go there. She ran most of the way, and saw her father leaving the house. Inside her sister was at the top of the stairs, crying and screaming. Susie realised there was something missing, her first thought was that her father had done something to her sister. She went in search of her mother, who she found in the living room, lying on the floor with a pool of blood at her head and blood on the skirting board. She thought that her mother was dead and she felt guilty that she was not there to calm things down. She made connections between feelings in the present, as well as the past, of feeling lonely and lost.

This led on to the reporting of another incident. Susie, her mother and her sister had been watching television and, tired of the arguments between the other two, Susie had

gone to feed the rabbit and have a cigarette. She heard her sister scream but decided not to go in, as she was fed up with sorting these things out. After a second scream, she went in to find that her mother was holding her sister by the hair and was banging her head on the cabinet. Unable to break it up, Susie had gone to get her father from the pub, but he had refused to come home. Now in therapy, unable to tolerate this integration and the associated feelings further, there was an abrupt switch to a coping part that was to take her home from the session. I suspected it had been Sarah, who was struggling with accommodating this negative image of her mother, and that the self-part that ended the session may have been Chrissie, who has the pseudo-confidence, but equally it could have been Sophie, who 'keeps the image together' or Patricia who 'puts a face on'. I never enquired, always expecting Susie to take responsibility for coping, unless she was unable to do so, which only happened in extreme circumstances.

Therapeutic work aimed at reducing amnesia was focused on specific dyads or groups of self-parts, and later on more general co-consciousness for present-day living. Parts were often associated in pairs, such as the two little girls who related to Sally, the one who adored and idealised her and the other who knew how Sally had hurt her. Another pairing was Damian and Sarah II. Damian could well have been named after a general association between the name and a violent and unfeeling male child character, especially given the role of alienated self-part, after the film *The Omen* (1976, Twentieth Century Fox), again showing general media influence rather than specific DID media influence. In both of these examples, one part had exported unwanted affect or knowledge or both into the other part. In some cases this prevented protection, as cause and effect could not be reconciled. Therapy encouraged the giving back of feelings so they became associated with the actions that gave rise to them. In this way, the amnesic barriers dissolved in a permanent but uneven manner. Naturally the parts that had been protected in this way were reluctant to own such unpleasant affect, and in some cases responsibility, but gradually they did. It took a considerable time to desensitise Damian to accepting feelings such as fear and powerlessness, feelings he associated with girls and not himself, the main macho man, but gradually his tolerance was increased through processing both past and current events holistically.

Therapeutic processing did not follow the orderly path that I had originally expected when beginning to work with DID. For example, with Susie, during the period when she was the mother of an infant, and her father had been released from prison, her therapy consisted of working on several topics with different sections of her internal structure. All during the same phase of therapy, she worked on the following issues: the abuse by and attachment to Sally, who was continuing to manage to contact Susie, through her sister and via phone calls; Eve's processing of the first birth, when the body was 10 years old, when she had not even known she was pregnant, her mother having explained the baby's movements as 'the evil moving around' inside of her, and telling her that if she was not good it would explode. She also worked on Damian's owning of his own feelings and experience, instead of doing the actions but relying on Sarah II to hold the feelings for him, as well as the normal psychological developmental tasks that he lacked, and development of relationships with other self-parts and me. At the same time, current events such as parenting, visits back home, contact with Sally, her own health issues and those of her son, all had to be accommodated, as did the co-therapist's returning to work after almost a year's absence, and then soon afterwards announcing her retirement. In some ways, the switching of therapy space between these issues brought directly into therapy Susie's DID way of functioning and coping with overload. Progress and development nonetheless continued.

5.13.7 Managing Negative Affect

Susie attended one session expecting to see my colleague, but saw me instead, through unforeseen absence. She was cross because she had done her hair and makeup and said she need not have bothered for me. I wondered, without saying so, if she had less need of a mask with me as her main therapist. She was able to disclose her thoughts that she was going to die and there was no point in going on, as there was nothing to live for. We managed to reframe this, as the avoidance of the pain of her integrated learning about the past. We talked extensively about how the pain could be reduced, as it was shared and expressed, but that there was no quick solution to this overwhelming pain and distress. She felt worn out and did not think she had the energy to cope with this. As the session progressed she began to talk about planning a trip home, having her own home when her foster placement ended, and having a baby in the hope that this would fill the hole from the babies she had lost.

Privately I took solace in any mention of the future, as it helped to balance her despair, but I also remembered another DID client, who had been so physically damaged, by sexual abuse and miscarriage in the past, that she never managed to have the babies she desired. This was one of the occasions where I judged that it was appropriate and necessary to introduce some psycho-educational aspects to the work, which took us outside of a purely psychodynamic framework. I talked with Susie about her needing to get herself into the right circumstances before having a baby, and the need for her to be able to meet her baby's needs and not for the baby to meet her needs. I suggested that, while she had so much internal conflict, a baby would be at risk, and that her first priority needed to be to nurture herself so that she could attain enough emotional stability and integration to parent safely. This led to her talking negatively about her parents' lack of care for her and her sister. She also began to make links between her mother's involvement in the loss of Eve's baby, discussed further below in ***Pregnancy and Motherhood.***

5.14 Therapeutic Boundaries

The arrangement I had always had with clients was that I saw them for their regular therapy session and had a boundary that they would not contact me in between sessions, except in an emergency. Contacts outside of therapy were generally rare, and would usually relate to non-therapeutic matters, which would be handled by my admin team, so as not to reinforce contact with the therapist outside of the therapeutic hour. With Susie's situation, her carer managed to obtain my personal telephone number from the social worker, and on one or two, out of hours, occasions I was asked to intervene when Susie was out of control. For example, on one occasion, Susie's prostituting part had become active and had got into a deal with a client. A male member of the internal protection team had tried to fight their way out of the situation. She had returned to her foster home but could not regain control enough to explain what had happened. On this occasion, by telephone, I asked to speak to Mary, who was then able to regain control and could explain what had happened and could then manage a recovery plan. In deciding to intervene directly in this way, by way of an out of hours request, I had to weigh up the loss of appropriate boundaries and the impact this may have on the therapeutic process, against the distress Susie was in and her foster carer's inability to manage the situation. I could not risk empowering the foster mother to talk specifically to named parts as, not being a

clinician or trained professional, I felt she may not restrict such use to this one occasion or to emergencies. She had on occasion behaved in ways that had not been very helpful. Despite being provided with some background information to support her role, but being asked not to ask Susie specific questions about her past or her condition, the foster mother had sometimes said things that were therapeutically unhelpful, such as criticising Susie's mother. On other occasions she had unnecessarily, and purely out of curiosity, asked Susie specific questions about being DID. The professional team was aware that she was the weakest link in an otherwise very tight team. I felt that her lay appreciation of DID may make a little learning a dangerous thing, but also the team emphasis had always been on asking the carer to avoid using any of Susie's alternate names and to treat her as a whole and integrated person, as that was what she was aiming to become. I therefore decided that a brief intervention, by me on the telephone, aimed only at enhancing Susie's own ability to regain her normal equilibrium, together with the agreement that we would talk about it in her next and imminent therapy session, was the action with the maximum benefit and least costs attached.

5.15 Undermining of Therapy

By the end of 1994 another psychometric assessment was conducted for funding purposes, and it was evident that some of the developmental ground gained had been reversed. It became apparent that this followed some few occasions of unsupervised contact via telephone with both Susie's mother and Sally, the female leader of the abuse organisation. Susie originally had no memory for these telephone calls and her increasingly poor functioning was puzzling. It was not long before Mary, now benefiting from decreased dissociation, was able to do an internal audit of information and reported that these telephone calls had been conducted with self-parts in System Two. I was then informed of this second complex system of parts that were linked to System One by only one key part, Julie, in order that System One, coping with everyday existence, was not undermined in abilities by the terrible knowledge of the extreme abuse experience of System Two. I was then informed that a part in System Two had been conducting telephone calls to Susie's mother and Sally. I was told that, through hypnotic suggestion, in which Susie had been trained from infancy by Sally, resistance to therapy had been promoted, and it was about this time that the shoplifting and prostituting had recommenced. Julie reported that Sally

had said that Eve's baby was still alive, but would be killed if Susie did not stop therapy and return home. Julie reported that a tape had been played down the phone of a child being hurt. Susie was also being urged to get pregnant and then return home to be cared for. Although these were powerful messages to some parts of System Two, they were being struggled against by other parts in both System One and System Two. Once I was provided with this information, I tried to make sure that the developing co-consciousness, which I had been encouraging to counteract the amnesia, particularly included Julie, the link between the two systems. It also became obvious that a birthday card, from her mother, which I had unwittingly passed on to Susie, had been the initial trigger to her making these telephone calls. The card had a fluffy sheep on it and inside was a piece of real sheep's wool. Julie disclosed that the sheep's wool had acted as a trigger to the organised abuse, which took place mainly on Sally's farm. As already stated, although I knew that objects could act as triggers to deep memories, and in some cases automated behaviour, I had no way of knowing what the triggers were.

It became obvious that the shoplifting and prostituting problems had resurfaced around the time of these reported telephone calls. It was quite a task to help the prostitute part to understand that she could transfer her skills to something more functional. She was the one who was good with clothes, make-up and, surprisingly, knitting. Though her resistance was problematic, the resistance of the other parts in System One towards her was exponentially worse. They distanced themselves so strongly from the role she had played that they could not distinguish between her and the role. I encouraged internal explanation and raised internal understanding that, if she had not performed for Susie's mother in this way, perhaps one or more of the other self-parts would have had to do so. Reluctantly there developed acceptance of this logic, and this permitted the inclusion in day to day activities of the prostitute self-part. It was similar to trying to develop an understanding in parents within a dysfunctional family to distinguish between the child and the behaviour. In addition to these difficulties, she grieved for the loss of her role, which had given her a sense of control, power and skill. Once persuaded that continuing with this role was not a good idea, she went to the opposite extreme and wanted to be a nonentity. She took some persuading, especially in the face of the continuing rejection by the other parts, that a skill transfer was even possible. Gradually all came to accept her in this new

role, and she learned to accept a less dominant and, as she saw it, less starring role. Part of the success of this was to have her feel the feelings associated with her experiences, which she normally exported (dissociated) to another self-part, so she could be emotionally untouched. She accepted this very reluctantly and only gradually; taking on board both the physical and emotional damage of her trade helped her to give it up, but not before several further incidents and the imminent birth of her baby. On one occasion, when she was being rebellious and thinking she was helping to prepare financially for the baby, she plied her trade by getting into a man's car. When he realised she was pregnant, he threw her out while the car was moving. Susie was very badly bruised and feared for her baby. This set back the acceptance process for a while, but did finally end her prostitution.

As the first anniversary of her mother's death approached, and the incidents of acting out increased, including self-harm and a suicide attempt, Susie again revealed that she was in receipt of things from Sally. She told my colleague that she was not going to show me the letter from Sally as I would only pull it to pieces. My colleague asked her which would be the bits that I would pull to pieces, and Susie talked spontaneously about the various hidden messages and triggers, in particular the suicide message 'take care of yourself'. It was shortly after this that she required me to rescue her when drunk. She reluctantly accepted my colleague's interpretation that she may have unconsciously needed to secure my full re-engagement as her main therapist.

5.16 Psychological Shutting Down and the use of Symbolism

It has been my experience that most, if not all, DID clients have, at times, shut down part or all of their conscious self, either voluntarily or from sheer exhaustion. Sometimes it is necessary for clients to develop control over mechanisms they use unconsciously, so they can use them more functionally, until greater co-consciousness and integration is achieved. It seems to me that dividing up one's sense of self and maintaining amnesic barriers is very energy consuming and that, while total shutting down of consciousness may conserve energy, as may be the case in depression, the shutting down of part of the self whilst keeping other parts functioning is very energy consuming and can only be maintained for relatively short periods of time. One such example, when Susie was encouraged consciously to shut

down parts of herself, was on a trip back to her home community, after her father was released from prison, and whilst Damian was in the early stages of developing new perspectives on his experience and Susie's life in general. Under these circumstances, to promote safety, Susie shut down Damian and Sarah II for the duration of the trip. This was done during our last session before the break, and undone in our first session afterwards. Upon return, Damian professed not to want to exist anymore. Susie and I had to evaluate this feeling and realised that, since he was a part of her, he could not cease to exist, and he was in fact feeling rejected, sulking at having been shut down. He was soon back on track with his development, tolerating me and the self-parts that had been specifically chosen to aid his development, and soon was back working on feelings.

Another technique that I have used, with general clients as well as with DID clients, is the idea of putting feelings into a box until the next therapy session, symbolic of containing them until help is available for processing difficult affect. Such an example occurred at this time with Damian. He had been learning to tolerate his own feelings in the present and to stop automatically passing the feelings to Sarah II. Additionally, he was working on receiving back from her feelings from the past. When training him, via desensitisation, to tolerate these feelings, I had agreed with him that he could hold the feeling for a limited amount of time and then give it back to Sarah II. As we gradually extended the time he held the feeling, on one occasion he panicked and automatically passed it back. I persuaded him to take the feeling back, hold for a moment and pass it back under control, as previously agreed. He did so. Once this process was more established, and he was processing extremely difficult feelings from the past, he wanted to pass them back to Sarah II at the end of the session, but I suggested that instead he put them into a box until the next session and continue to work on them then. He agreed to this and this increased his ability to own the feelings as relating to his experience, and to complete the processing, as well as decreasing his dumping on Sarah II. In aid of this, other internal parts and I also reinforced his protective feelings towards Sarah II. Another device that was used in the later stages of amnesic reduction, as tolerance was reaching a higher level, was to have Julie arrange for the unconscious transfer of information and affect.

In one session Damian reported how he was beginning to put together his feelings of fear and the bodily sensations with Sarah II's knowledge of a ceremony in a church. He had used a picture of a 'lady in the window' to help him focus during the ceremony. He drew this picture, which was a stained glass window of the Madonna and Child. He reported that the window was the only thing that was coloured. He went on to reveal that the window made him feel safe and was comfortable. He tolerated my reflection that what he was saying was that what was happening at the father's behest in the church (with funny dressed up people) was scary, and in black and white, whereas the safety was up in the window with the colour and the lady.

Another technique I employed, as therapeutic processing was more advanced and integration more established, was the use of virtual video processing of memories. Whereas in the early stages of therapy, memories had been processed in therapy as and when they surfaced, usually because of external triggers, this involved making the conscious decision to see if deliberate processing could speed up the time required and help Susie complete her therapy more quickly. The technique was to have a part or parts view an internal video screen during a therapy session, where memories could be played at a fast speed. This is an adaptation of the yoga technique of processing events and affect in an objective manner. An example of this was when Damian agreed to process some of his memories as Julie said his memory processing could not be held up much longer with the advent of a second child coming. Damian was less than thrilled at the idea of this rapid processing, but he did it. Through this, Damian learned how Sarah felt when hurt by dad, and understood his part in things, especially that on this occasion he fought with dad to protect Sarah. We ended the session with a debriefing task of an on-going jigsaw. On leaving, Damian said he was going to be with Sarah. I privately wondered if this processing had brought him into greater sympathy with Sarah and integrated them more.

Through the processing of Damian's memories via internal video imaging, there was one time when he could not understand what he was supposed to be learning from one scene. We used left-handed automatic writing to see if the unconscious mind could assist. The answer came, 'no special powers, no magic'. Damian described a scene of a child standing on a chair with a rope around her neck and he having to kick the chair away. He thought the child had died and that, through his own magic, he

had been able to bring her back to life. This led to discussing tricks and illusions, such as trick knives which use something that looks like blood, to simulate stabbing and killing.

5.17 Abuse Dynamics

Through working with Damian and Sarah, it was also possible to help raise awareness of the harm that abuse creates, not just in the victim, but also in the perpetrator. As Damian came to understand how he and Sarah came to be split and separated from each other as a result of the terrible things dad forced them to do, he recognised that the split between them hurt him. Through this he came to see that the harm he was forced to do not only hurt the animal or child involved, but also hurt him and Sarah. I ventured to suggest that it also hurt and damaged the other internal self-parts, and even Susie's father.

5.18 Bearing Devastating News

After two years of therapy, another extreme impediment to progress occurred. Susie's mother was still drinking heavily, and one night she choked on her own vomit and died. I was notified by Susie's local social worker and she proposed a meeting between us, together with the original social worker and Susie, to be held the following morning. My notes record the following about how this situation was not smoothly handled. Everyone arrived at once, and the receptionist inexplicably put everyone in Susie's therapy room. The service had conventions that visitors were met with in alternate rooms, to protect the boundary of the therapy room, but in the confusion, this had not been effected. The error was corrected and they were moved to another, larger room, on the basis that it would afford greater comfort. I joined them there. Paraphrasing my notes:

> The atmosphere was very tense. I found it difficult to start. We all seemed to be expecting a miracle from each other. [Social worker] referred to [Susie's] control, as if she felt the need to reinforce it. I asked what they had done that morning, there was an awkward response from [Susie] as if she found my enquiry frivolous, and it felt that way to me as I struggled to find a foothold. Eventually things started to ease after [social worker] asked [Susie] to tell me who inside knew about mum's death. She identified the internal managers, the link between the systems and the one who coped with her father's sexual abuse. I reflected that it was the mature manager self-parts but wondered if it was difficult to keep

the feelings from leaking inside to other self-parts. I wondered how I could help. After a silence I asked when it might be safe for the other self-parts to know, and she immediately said 'with you'. It became clear she was just waiting for me to get on track so I asked if she were ready to go to her therapy room, just me and her. She was keen to do so.

Once in the room she was actually a bit more relaxed and normal although obviously distraught. She began to sob. I sat with her for a while on the settee and suggested that it would be best for me to spend some time with the ones who knew before telling the others. I asked them to let me know how they were all reacting. Julie was coping, Mary was the most shocked, somebody was very angry and Eve was feeling the loss. She played with the knitted doll that Marian [DID client referred to in Chapter 1] had made to represent me, that [Susie] had always thought was like her mum. She got very angry with it.

I prepared them by asking Julie if she would tell the others and she agreed. I said that I wanted everyone to listen as we had to discuss some very bad news that was going to be difficult to deal with and we needed all to be one big team to help each other and to cope. Julie anticipated that Sarah and the prostitute would take it the worst. I then checked they were ready and willing and asked Julie to tell them. She did this internally and there was slow surprise and shock permeating through her inside. She reported that Sarah was particularly unable to take it in, the prostitute was mad with mum and threw the mum doll across the room. We spent a lot of time repeatedly going over the fact that this and similar accidents did not happen because [Susie] wasn't there or had not been in touch, that it could have happened at any time, it had always been a disaster waiting to happen. This found a root in [Susie's] own experience, she could hear her dad saying 'you've left the grill on again'. At one point she felt that she would have her dad hung in his cell next. She was really mad with her sister for not saving her mum. She repeatedly wished it had been her sister or her dad who had died instead of her mum.

We returned to the other professionals and I reiterated the need for all self-parts to pull together to help with this. As they were leaving Sarah came out and threatened to go back home with her original social worker, who was only here on a day visit. I emphasised that there was nothing to do there at present and we made an appointment for 9.30 am the following morning which she said she might come to. Actually I think it was Sarah so I hoped that was a good sign. I am concerned how she will be tonight when her social worker goes back to the community without her and she is left relatively alone.

The return to the community of origin, the thing the professionals had most sought to defer, was now inevitable. Susie had fainted in the doctor's waiting room, and again at the airport. She had been to see her mother's body. She had a need to know and to

see everything. Her mother's appearance had been awful. At one point the door had banged and the sheet had moved. It had been alarming for both her and her social worker, and did nothing to assist my attempts to help her reality test her belief that her abusers had supernatural power. There was to be a significant delay before the funeral could be arranged.

She was upset that her father was preventing her from having any say in the funeral arrangements. She felt she would know what her mother wanted, not he. She found this lack of control and waiting very difficult. She was afraid of how her father and sister and others would view her being at the funeral. She reported that she had been able to have all self-parts present when she saw her mother. She said the child parts were initially very frightened but were now coping better than the adult parts. She talked of there being no point in continuing therapy now, as its purpose was to be strong enough to go home and look after her mother. She was helped to think about the way in which she wanted to fulfil her mother's wishes about the funeral, and to consider that her mother may have had aspirations for Susie beyond her mother's death. She reported feelings of guilt, anger and loss. All were available emotions and not dissociated. She reported having shouted at her mother's body for being so stupid and careless. We looked at her parenting of her mother and she likened the loss to that of losing a child, and realised this was why Eve was one of the main mourners. She said she felt left again. Her only area of control about the funeral was what she would wear, and how she would cope with any negativity she encountered. She declined an extra session. She left saying that seeing her mother's body would have been worse if she had not already seen much worse sights in childhood.

Shortly afterwards Susie asked her social worker to inform me that she was finishing therapy and returning all the things she had borrowed, such as a teddy, from my clinic. Susie felt it was all my fault that her mother had died, and the cause of death was that she had not been there to protect, and that was all my fault. She said she was aware that Sally would use Susie's sister to try to engage her with the abusing group again but she could handle it. She thought she had to keep in touch with Sally or her sister would die. She thought she could manage all of this. Her omnipotence had never really been allowed to recede in childhood, because of the many quasi-parental and adult roles she reported playing. The death of her mother brought this

grandiosity to the fore again. I privately reflected on where that placed me, as it seemed Susie conferred on me even greater power that she must resist, and yet was drawn towards. I reminded her that, even if she were to end therapy, we would need to meet to talk about and process the ending. She agreed to come for the next session.

Handling Susie's wish to attend her mother's funeral was an extremely challenging time in therapy. This was the first time she had gone back to her community and there was no way to ensure her protection from abusers, both those identified and those unknown. Although Social Services continued to keep supporting her, she was no longer a child in their care, having reached adult status. Having already had the experience of Susie receiving triggers via telephone calls, it was extremely concerning for all the professionals to have her visit and stay with people during this time. Susie herself was highly anxious that the new control and co-operation she was experiencing within System One may unravel, and she was particularly concerned about losing control of certain key parts of herself. Once Susie had attended the funeral, she continued to be adamant that she would end therapy. It was the Sarah part who attended the funeral, and was dominating Susie's existence at the time. She claimed to be integrated but her manner of delivering this information showed that she did not believe it herself and did not expect me to believe it either. We examined the possibility that she (Sarah) was angry with the people who were trying to care for her, but not with her mother, from whom she had wanted care. She reported having hit a colleague at work who had said bad things about her mother; I wondered if she were feeling like that in the therapy session, and felt she was unable to handle much reality testing and integration of her own experience at this time.

As Susie struggled with the pull back to her own community, feeling that it was only there, where people knew her mother, that she could mourn, she also showed evidence of a counter pull to her new location, with a photograph of her friend's new baby, to whom she was going to be godmother. On the one hand she argued that she was now a 'stroppy cow', and not the malleable child she was previously; on the other hand, she talked about needing to make a new life in her new locality. As Susie worked her way through her ambivalence about life and therapy, she continued to attend, but she refused to see me unaccompanied any more and would only see either

my colleague, or me together with my colleague. This remained the case for the next few months of therapy and, although Susie sometimes refused to see me, she talked about me repeatedly in her sessions with the other therapist. She blamed me for her mother's death, the logic being that her mother had stayed alive all the years that she was there to ensure her safety, and now she was dead, because I had made Susie live in my locality for therapy. There had been many near misses in the past, due to her mother's drinking, and sometimes Susie was able to acknowledge this but at other times she kept a narrow focus on the specific incident that killed her mother.

Parts of her, mainly Sarah, were angry and refusing to see me, whilst other parts were telling my colleague that they needed to see me. They were afraid to let Sarah out as they felt they could not control her because of her grief and anger, and they were afraid for their own safety if she got control of the body. As much internal co-operation was established as possible, and internal control exerted over Sarah. Although Susie and all of the professionals were very anxious, she returned safely after the funeral and overnight stay with friends. She continued therapy with me and my colleague, and processed her anger and mixed feelings about me.

Interestingly, during this time, several emergencies arose in which she requested my help. One occurred when she herself got drunk and incapable, in the centre of town, and I was requested to find her. Mary had telephoned the foster carers and requested they ask me to find her and help her to regain control. I did so and brought her to my clinic, whilst we awaited her social worker to transport her home. She sat on the floor in the garden at my clinic, having a cigarette, and said 'why don't you give up on me'. It was as if these crises were testing my constancy and ability to withstand her rejection and anger. A little after this, and as the first anniversary of her mother's death approached, she requested to start seeing me again, and disclosed that, for the period she had attended without seeing me, she had always brought a knife to therapy with her, with the intention of killing me, in revenge for her mother's death. In refusing to see me, or to see me only with a chaperone, Susie also sought to protect me from her fury. In presenting herself in crisis as a helpless, vulnerable child, she put in me the power to keep her safe, thus counterbalancing the role she had played in her relationship with her mother. We were able to examine her destructive anger, as well as the way in which she kept me involved via rescuing her from crises and

testing my ability to stay with her through thick and thin. I privately wondered if she carried the knife to protect herself as well, since I hypothesised that, if she felt I had killed her mother, she may also experience me as magical and supremely powerful, and perhaps she needed to conceive of me in this way in order to put her trust in me to help her overthrow the influence of abusive past and the people who had controlled her. I was acutely aware of my limited human power, but felt that perhaps Susie needed to give up this idea of my omnipotence slowly as I continued to encourage her to weigh things up for herself, training her in a dialectical analysis of all of her own experience.

Susie appeared to show a similar loyalty to me and the co-therapist, as she had in the past to her parents; she refused to choose between us, and wanted to continue seeing us both. Since her difficulties following her mother's awful death, it was considered appropriate for her to increase her appointments to two per week, and so it was arranged that she would have one with my colleague and one with me. That arrangement continued until a year or so later when my colleague went on long-term sick leave and I became Susie's sole therapist again. The joint arrangement had proved very fruitful in that Susie acted out a lot of splitting behaviour between us, but she always experienced us as united. She was often heard saying, in both exasperation and relief, 'Oh, that's what Jeanie says'. In this way, it seems she experienced us as being like a good parental team, in contrast to the conflict she had experienced with her parents.

5.19 Internal Nurturing

The mother figures in System One and System Two had already been instigated for the purpose of protection, control and nurturing, though with so many internal parts and external demands, their role was akin to trying to stop the tide coming in. Still this was a good basis from which to promote internal development. Gradually, psycho-educational input was provided to help Susie to understand that her self-parts were developmentally delayed relative to her chronological age, because of traumatic impact, lack of nurturing, and the child roles required of them, for example, Wendy (experienced as 8, began when the body was 10) 'coped with Dad if drink made him like me if I was little'. Therapy promoted sharing of information and affect, as appropriate, but also provided for the lack of nurturance. Various self-parts were

encouraged to play constructively with smaller parts to promote their growth and development. As Eve recovered from grieving for her baby, it proved mutually beneficial for her to play with some of the younger self-parts.

Sometimes unfair practices in the present would trigger her expression of feelings about past injustice. On one occasion, the fact that she was not being paid extra for working Bank Holidays, in the Care Home at which she was employed, triggered discussion of the way mum made her work as a prostitute but she got only pocket money from what the men paid, and if they paid more to be rough with her, she still did not get any extra pocket money.

Through the process of internal nurturing, utilising all the forms of nurturing usual to child-rearing, listening, empathising, explaining, playing, teaching, loving and cuddling, Susie was able to bring her separated self-parts into co-operation and greater harmony. As a result of this, all of the less developed parts gained development and she perceived them as growing in age as well. For example, at six years into therapy, she reported that the part who was attached to Sally, who had by then been involved directly in the therapy for about one year, had gained in age from 18 months to 3 years. The one who had been abused by Sally had gained from three years of age to about six.

As Susie's son grew and developed, her internal child parts experienced a whole range of emotional reactions. They found it difficult to see the attention that he received. Just as Susie had been negatively affected by seeing the easy life her foster carer's children had, so the internal child parts sometimes resented but mainly were educated by seeing this outside child having a different experience than the one they remembered. For example, the infant who was attached to Sally, and who had been potty trained by her with sweets for getting it right, and smacks when not, compared her experience to what she observed as explanations and the little boy's ability to ask questions. This led first of all to some acceptance that Sally had hurt her and was not quite the idealised figure she had thought, and secondly she began to ask questions, of her therapist, but mainly of the adult and caring/controlling internal parts. Through this her own growth and development was accomplished, but not as quickly as the outside child was developing, and this posed some difficulty. Some of her growth

was achieved by allowing her to play with the little boy with toys, but with the co-presence of an adult carer part. As the development of Susie's son overtook that of the internal child part, he remarked, 'play little again mummy'. Because of concerns for his normal development, an increasing adult part presence was required, and other means of creating internal development, such as internal playing and external playing when the son was not present, were employed. When Susie had her second child, new opportunities for external play became available. The internal child parts also observed that Susie's son overtook them in development, because he was receiving more developmental time than they were, their time being shared with adult duties and therapeutic processing, but by the time Susie's daughter developed, they were beginning to keep up.

5.20 Body Memories

As Susie toilet trained her son, three blisters came up on the palm of her left hand. At first she was completely baffled by this, but she began to report a memory of being the same age as her son, and her father teaching her not to touch matches. As she reported the gradual remembering of this, she said that her father had deliberately burned her to teach her that matches were dangerous. As we discussed this, the blisters disappeared in front of me, during the therapy session.

5.21 Dependence and Independence

Susie was already approaching a move to independent living when her mother died. She used therapy to examine being alone. She found it difficult to sleep, and she found it difficult that her father would never admit what he had done. I think this may have been about the wish to return to the family they could have been, instead of moving to live alone, something she was really not ready for, despite her chronological age. She reported that there were self-parts that were no longer out, but she was unsure if that was because they were not coping with her mother's death or giving way to the main mourners. She talked of there being no place for her. She anticipated leaving foster care and her place ceasing to exist, or becoming someone else's place, her father taking over the control of the family house even though he was still in prison, and her original home also not being a place for her. She felt in a place that was no-where, between cultures. Therapy alone did not contain or fulfil her. Within a few months of her mother's death, and at about the same time as her

planned move to independent living, Susie began a relationship with a young man. She was keen to show off her pride in this relationship, but often showed her ambivalence by describing how she used him to meet her needs whilst keeping him distant by her repeated rejection. It was clear she needed someone to bridge the loss of her mother and family of origin, as well as leaving her foster family, and all this came at a time when she was keeping me at a greater distance than usual. She solved the problem of her new isolation by having a partner who she did not allow to live with her, but by whom she became pregnant. She acted out her approach-avoidance behaviour with me, by refusing to see me but engineering crises from which I was expected to rescue her. She never said so, but I privately wondered if she also fantasised that I might rescue her and take her to live with me. Once in her own flat, she was nervous, full of bravado that her abusers would not get her, but calling the police when she had a wrong number phone call on her ex-directory number. She talked of how she longed to have her mother to phone when she was anxious, and we examined how a geographically distant mother could provide comforting words, like she had from me at times of crisis. I encouraged her to think of what she would have wanted to hear from her mother and whether she could say those words to herself.

The impact of her mother's death, revisiting her community, seeing her father at the funeral and coming into contact with other previous abusers, particularly Sally, and now moving to independent living, were all overwhelming Susie at a time when she was keeping me and her boyfriend at a distance. Her previous high level of co-consciousness had regressed and she was now reporting an increase in her loss of control of some of the self-parts. She reported that, whilst she was asleep, some part or parts of her had trashed her flat, breaking wine-glasses and cutting her back, although she thought that had been done with a knife as she could not find any bloodstained glass but the knife had blood on it. In a session with my colleague, she examined the way in which these bodily cuts deflected from greater hurt, and how her anger with herself and with me deflected her anger away from her mother. She also realised that her grieving was causing her to punish herself by not allowing her to attach herself to anyone. She was cutting herself off from those who cared for her and then she would be on her own, which was what she felt she deserved. She shook and silent tears dripped. She came to consider her mother, less as vengeful and more as incompetent, but wanting to promote good things for her daughter if she had been

able. In this way she came to feel that her mother would not have wanted her to be all alone and without people to care for her. Julie began to report that Sarah was so stuck in her grieving process that she was holding up other urgent therapy work, and that was why there was an increase in acting out behaviour and loss of control. Julie though it urgent that Susie engaged fully with me again, and regain her former more integrated functioning. With hindsight I can see there was some awareness in her management self-parts that it was urgent to get greater integration in advance of an inevitable pregnancy.

5.22 Pregnancy and Motherhood

Before the issue of pregnancy became an actuality, Julie reported the need to process memories of previous pregnancies, stored in System Two. She produced a handwritten account of a previous traumatic experience:

> I arrived at 12.40am. Julie said she was 12, and was having contractions, she was very distressed. At 1.20am she delivered a boy, his toes and fingers were deformed, half his forehead was missing and his elbow was deformed. Everyone was annoyed with her. The baby was taken from her ... [mum] was very cross with me told me I had let her down and she beat me with a stick very hard and shouting at me ... A few weeks later she was taken by Dad to a small church ... There was a large tank of water at the bottom. She was held under the water several times ... They told her she must get pregnant again soon ... she was in a lot of pain and very tearful. I put her to bed she was fast asleep very soon and I left at ¼ to 4. I visited her next morning, she couldn't remember much about the night before. She could hardly walk. (POOR KID WHAT A LIFE)

This account was two full pages and the narrative moved effortlessly between first person and third person grammar. These kind of traumatic issues were being reported against a backdrop of Sarah still grieving for her mother, and being unable to demonstrate any ability to integrate the good memories with the bad memories that she had reported prior to her mother's death. The processing of these trauma memories by those in System Two leaked into parts of System One, including Sarah, whose hostility repeatedly increased and receded as the processing continued. Sarah was reluctantly learning how the self-splits tried to contain these opposing data and affect.

Having a DID client with no experience of good parenting in her childhood, previous lost pregnancies and past extreme destructive behaviours, was indeed a challenge. She was ambivalent about the pregnancy. Sarah, the carer of Susie's mother, was the one with the intent to get pregnant; she wanted to replace the mother-child relationship and fill the void left by her mother's death. She had utilised her power over Chrissie, the teenage cheeky part, to effect this plan. Chrissie was a pseudo-confident part, who flirted with males and engaged them for sex. At the time she reported this pregnancy, she said that various of her self-parts did not know about it and some of them would be angry. I was aware of the potential for self-harm that could be invasive and threatening to the foetus. Whilst pregnancy was triggering similarities with past pregnancies, there were also huge differences. One of the most important was that, this time, she had to go through it without her parents, in a hospital, and she had never previously carried a baby to term. She was unused to waiting so long for the baby to arrive and had an urgent impulse to be in control of things for herself. The child protection issues, which had initially been about protecting Susie as a child, were now taking on a new dimension of concern for her unborn child. In one session, I had been trying to reinforce her patience to wait for the baby to know when to be born, and not to be forced, as she had told of her parents having forced and traumatised her in different ways. 'So knitting needles are out then' she quipped. Knowing her well by this time, I also knew there was a concern that she was expressing here, and I took the issue back to the professional team so that the social worker could monitor through her home visits.

Being pregnant also brought up copious amounts of unresolved feelings about past pregnancies that Susie reported. She recognised some of her current experience as being similar to past pregnancy, and this led her to think that the last one had been a boy, and she hoped this current pregnancy would be a boy, as 'bad things happen to girls'. This, despite reporting having self-parts that she conceived of as male, to whom bad things had also happened, and previous foetuses that had been of either gender. I found myself also thinking that, if it were a boy, it may be easier for Susie to care for the child appropriately and permit some separation, compared to a female child who would be at increased risk of unhelpful self-projections.

In discussing how Sarah wanted someone to love, Susie was helped to see that sometimes people have babies so the babies can love them, and she came to appreciate the need to avoid repeating parental patterns she experienced in her own childhood.

One of the major themes of therapy so far had been the development of increasing co-consciousness between self-parts, and through this means she had also begun to reduce her bodily anaesthesia. When first in therapy, she often attended in cold weather, inadequately dressed though not feeling the cold, not feeling her self-cutting behaviour, immune to her impact upon others. A lot of emphasis was placed on tuning into her body to enhance her ability to know what her bodily sensations were. This was a role the prostitute could play and, after the baby was born, she was the only part that could tell if the bathwater was the correct temperature.

An associated theme was of promoting her ability to be aware of the various emotions held in the different self-parts. Not only was she sometimes generally unaware of the variety of feelings inside her, but even sometimes felt disconnected from some of the ones she was aware of, so that she conceived of them as not hers.

This was even more important during the pregnancy, and the progress with Damian's emotional thawing was a crucial ingredient. Fortunately she carried the baby to term without problems, but handling her ante-natal appointments once she was required to attend hospital was more problematic. It had been possible to provide her GP with edited information to assist in meeting her needs for general care in the first few months of pregnancy, but influencing the machinery of a maternity hospital was more than any of the professionals could manage adequately. We limited the information to her past child abuse and difficulty in managing intimate examination. We prepared Susie regarding which parts of her would be co-conscious to achieve the birth, and we tried to guard against memories being triggered. As she approached her due date, I was worried about her impatience to get the baby out. Although this is not uncommon, Susie's previous experience with knitting needles and other instruments of abortion increased my anxiety. She managed to tolerate going over her date, and also having to have the baby turned, since he was breech, and eventually he was born successfully.

The prostitute, or ex-prostitute as I now should call her, having given up plying her trade as the birth became imminent, was reluctant to own the pregnancy, creating a problem for herself as one of the key self-parts with a role in relation to caring for the body. Her attitude was that it was nothing to do with her; it had prevented her working; she would not have been so stupid as to get pregnant. She announced that she was having nothing to do with this baby, saying 'it's not my baby'. It seemed that being heard and understood eventually led to the thawing of her disposition towards the baby, and I noticed that, when I incidentally referred to it as 'your baby', she had nodded. I took this as a sign that the resistance was reducing. It was this part that was in urgent need of a return to therapeutic processing when the baby was a few months old. Susie had turned up with the baby and herself, both with a cough and cold. The ex-prostitute was complaining of not being able to do business, and being bored and tired as they were not getting enough sleep because of 'nasty', as she termed the baby. This led to our examining her addiction to the physical highs of trauma, and the victim abuser dynamic that she felt she had turned the tables on but, as I reflected, not solved, merely moved to a different position in the dynamic. We talked of the need not just to swap roles, but to move beyond the abusive dynamic. At the end of the session she switched back to a baby carer part, and I noticed that the ex-prostitute had not shown any sign of having the cold, cough or sore throat that was troubling Susie more generally.

I was also told at this point in the therapy that, when the prostituting had required a victim stance, this being quite beneath her perceived dignity and pseudo-control, it had been Mary who played this role. As this victim role had not generally been required since leaving her original community, Mary had not performed in this way for several years, and had adopted an over-corrected Madonna self-perception. It appeared that, just as ex-smokers are often the greatest protesters, having the greatest need to distance themselves from their past habit, so Mary was developing her new unsullied self-identity by projecting onto the prostitute self-part.

Susie had another child a few years later, and some of the same issues resurfaced, but to a greatly diminished extent. I reminded her of the care that had been taken to ensure that Damien did not feel destructively envious, and helped her to prepare her

son for this new baby arriving. My concern that this baby may be a girl had lessened, as I felt that having a boy first had shielded him from too many self-projections, though I was now conscious of the potential for different risks. In the event, such problems were within normal proportions and, if anything, her protectiveness was even greater with her daughter; this helped her to resist the temptation to return to her original locality and the risk of contact with people like Sally. She had reported that, on one of her trips back home after her mother's death, Sally had sexually abused her.

With each birth, Susie mourned for the grandparents her parents might have been and, just as she had kept me at a distance when her mother died and was not available, she kept her partner's mother at a distance from being a grandmother, as the maternal grandmother was unavailable through death. Although these issues were addressed with her, they were never really resolved towards the ideal, merely moderated away from an excess.

5.23 Loss and Separation

Mourning for her dead mother had become a prominent issue fairly early in therapy, but it was a recurring theme throughout. Susie contrasted her foster mother's mourning for her father with her own grieving for her mother. She mourned the loss of her past babies, and the temporary, then permanent, loss of her co-therapist through retirement. At this point she became very concerned that I would not be able to continue seeing her, and I would become ill, have a nervous breakdown or retire before she had finished her therapy.

It was also necessary when dealing with the mourning for Susie's first born, when she was age 10, to help her to recognise the relationship she had with this baby, even though it had died, and the need for a goodbye ceremony of some kind to mark his loss and separation. Susie, as Eve, had been very stuck with the loss of this baby and had been unable to grieve fully until she had allowed herself to relate and then lose him. She found this difficult as she had not known she was pregnant. She had been told she had evil inside her. He had been born dead, but had then been drowned in a ceremony, so she was unclear as to whether he was really dead or not. She utilised her recent successful pregnancy to make connections to this early experience, to recognise that he had been dead when born, but first he had been alive and growing

inside her, and subsequently she was able to say her farewell. The place where a lot of the organised abuse and ceremonies had taken place was sold, and Susie wondered if any of her babies that she suspected to be buried there would be found. She wondered if the contractor may be part of the group and would be keen to keep evidence well hidden.

Past and present, real and fantasy losses sometimes coincided. At one point Susie and her partner decided to live together. It did not last long, and around the time of the anniversary of her mother's death, she was also processing the loss of her partner, the fantasy of a perfect family, her perception that she would now not have the additional child she desired, self-parts who were processing loss of childhood, loss of roles and loss of co-therapists, and Damian processing the feelings of fear, all at the same time. My therapy notes record my concern that almost all of her, child and adult parts, need TLC at this time and there was no-one to give it. She had arrived freezing cold one day, and it was easy for her to make the links that her cold feeling was not just physical. As she thought of how she could begin to be her own carer, something that could not be taken away from her, she thought she could begin by wearing much warmer clothes. Her partner's moving in, and then moving out, also affected their son, who became afraid of losing his mother. As always, therapy was not short of demanding issues, and the past and the present were intermingled, at least promoting integration.

5.24 Counter-transference

Quite often the feelings in the sessions were very hard to witness, and it was of great benefit to be able to share this in working with a co-therapist. On one occasion Susie's carer had telephoned prior to the session to say that Susie had been ill the night before with body pains. In the session, Eve revealed body memories of an induced labour at six months pregnant, when the body was 10, performed by Susie's mother. This memory was swiftly followed by an attempt to get pregnant, changing her mind, getting raped, finding another man who telephoned her foster mother, and returning to safety, but having to take the morning after pill.

Engagement with aggressive alters was also very challenging. Towards the end of therapy, and before the second pregnancy, there was a very lengthy challenge. This

was brought about by the release from prison of her father. Julie became aware of the danger of this triggering activation of dangerous alters in System Two and, now that she had a baby to look after, her protectiveness enabled her to bring these very difficult issues to therapy. One night when her son was teething and would not stop crying, she lost control and a part of her threatened to harm him. She had called her foster mother, who had not been able to hear the need for her to be a grandmother figure and take the baby for a while, but instead panicked about child-protection, and at the same time did not follow through on this and communicated with me instead. I consulted with the professional team and we agreed to try to control things through therapeutic intervention and social work monitoring.

Susie, as Julie, reported that in System Two there were two parts that were opposite sides of a coin, created by Susie's father's forcing them to hurt animals and other children. One was a female stereotype; she was another Sarah, and was perceived as weak, holding the feelings, caring, promoting growth. The other was a male stereotype, called Damian; he was emotionally numb, physically and emotionally strong, capable of anything. He came into existence when Sarah (System Two) could no longer cope with the increasing horror or the violence she was forced to perform, so he took over and did the deeds and exported the feelings to her, his twin part. He was reluctant to take part in therapy as he might harm me; in fact, with hindsight, I think he was probably terrified of me. He gradually surfaced in therapy. He could not eat or drink, could not see colours, only black and white, except for when I introduced crayons for drawing, then he could see the colour in those. Damian had been secluded in dark places by Susie's father Eve had previously kept them both in an internal, dark, secluded place, far away from all of the other parts, as they were perceived as extremely dangerous. To begin with, communication with Damian was achieved through Sarah II. Firstly, Eve put them into a secluded garden, as a counterbalance to the dark and cold in which they had been kept, firstly by Susie's father and then internally by Eve. When Susie was locked in a bare room, without heating, by Susie's father, Damian had drawn pictures in the soot of the fireplace and Sarah II had to guess what they were. They used this to pass the endless time they were imprisoned there. In the internal garden Damian proved antagonistic to Sarah II. She grew virtual flowers, and he ripped them up and trampled on them. Despite his excessive cruelty and destruction, he loved Sarah II and this was the base I used to

educate and influence him. At first his polarised thinking meant he saw Sarah II's attachment to me as a threat to her attachment to him. It took months of painstaking work, mainly through the medium of drawing, to help him to relate to me as well as Sarah II, and to become constructive in his actions. I then encouraged his relating to other internal parts, and they to him. It was a similar dilemma to the prostitute part; he had committed acts that the rest disowned and they were reluctant to relate to him. We began with the nurturing Eve. It took months of patience by Eve to get him to take food and drink, symbolic in promoting his emotional nurturance. It was necessary for him to develop an understanding that he did not have to give up being powerful, but to exercise power in new ways that he could learn. He had to learn to apply critical analysis of the father's actions and, just as Sarah I had been very reluctant to see anything wrong in her mother's behaviour, Damian had difficulty accepting that the father's actions had been wrong. Eventually his progress became urgent as Susie became pregnant again, and his previous harm of children was an enormous cause for concern. He and Sarah II were eventually able to be co-conscious with other members of System Two, thus ensuring greater balance, positive development and safety, in time before the baby arrived.

Damien's connectedness with Sarah II was the key to Damien's rehabilitation into the total self-systems of Susie. Damien was always kept peripheral but I advised that he should be co-conscious as much as possible to prevent his polarisation and the attendant risk of his acting out in a polarised manner. No further problems were reported with Damien. He had been neutralised by increasing his integration with Sarah II, and increasing his acceptance into the general personality structure, but his role had always been a very restricted if highly destructive one and, in the absence of Susie's father, his usefulness had diminished. He was eventually able to learn to help Sarah II with her virtual gardening, symbolic of his move from destruction to creation, isolation to attachment, and he ended his direct presence in the therapy by making flower pictures and cards for Sarah II. Despite Susie's trepidation, he was allowed to be peripherally co-present when all self-parts were shown the new baby. I had to help Susie think about how he may otherwise feel resentful, and she needed to ensure that his previous destructiveness was not reactivated with the consequence that his integration would be undone as the other self-parts would jump to the self-fulfilling conclusion that he was still a risk and needed to be isolated further. In the

event, all went well as Susie was helped to anticipate these problems and prevent them from being problematic.

She continued a part-time relationship with the same partner, who she had always kept at a distance, probably through selective appreciation of her own experience, not daring to let her own children have too much exposure to a father, since her experience had been that fathers were dangerous. She then had the second baby, this time a girl. With her son, I had been concerned at times as to how close she came to what may edge over into emotional abuse. He often spent more time tidying toys away into the toy box than getting them out to play. She spoke sharply to him on occasion, and her handling of both children was not as gentle as mine would have been. I have often had to keep double checking myself when assessing parenting as there are only principles about what is and what is not acceptable, and there is variation in all manner of things within normal limits, which requires objective judgement and not subjective comparisons to one's own idealised rather than actual parental practices. Again the benefit of a professional team gave a forum for support and reality checking, but it still required an effort and constant self-awareness in observational skills and in therapeutic skills. Susie sometimes brought her children with her when she attended for therapy. Whenever possible we tried to leave them to play in the playroom with someone to look after them, but Susie was initially overprotective with both children and so, both in therapy sessions and in incidental observation when she left and collected them from the playroom, I had opportunities to observe her parenting and the children's behaviour. Although it was never felt necessary to allocate a social worker for Susie's children, the social worker who had been allocated to Susie continued to visit her weekly, despite having no continuing professional role. As Susie had her third child during the course of her therapy, the risks appeared to lessen even further. After her first child was born, however, a social worker was provided in the locality of her independent living, in order to support her attendance at therapy and to provide her with a Local Authority Nursery place for the children.

During each of the pregnancies, there had been the necessity to pace the processing of traumatic memories and, following each birth, Susie's reluctance to leave her children also restricted the discourse of therapy to current functioning, but it was clear that she

had not yet finished the necessary work and, though she had co-consciousness for most of the time, it was not for all of the time and she certainly did not have integration as I conceived of it.

5.25 Male Self-parts

No matter how multiplicity is conceived of, if it is accepted that this is the client's self-perception, it is clear that there is a complexity of internal contradiction and conflict over how to see the world and the self. A commonality I have found in DID clients is that male alters are generally built on male stereotypes, and used to fulfil roles that are extremely difficult. The literature review also suggests that, in historical case studies, male alters provided woman with access to power or otherwise restricted roles. From my own clinical experience, there is not always uniformity, even within one person, about how they develop. In Susie's case, she reported her first sexual abuse to be by Sally, and the self-part that coped with that was a little girl, who became split into two, one who attached to Sally and had no memories of the abuse, and the other who suffered all forms of abuse and held the memories of it. Her father began to abuse her in multiple ways at around this age too, firstly with physical abuse to gain her compliance to Sally, and then later she was sexually abused by him and also by her grandfather. She was a little older and more socially aware when she was sexually abused by her mother, and she created a male alter to cope with this. Her first male alter had been created to be tough and to fight physically, but she later employed this device to create another male alter to meet her mother's sexual needs.

Ameliorating the male identities and functions was a delicate task. They had to come to terms with being in a female body. At first they were too dissociated from this or in too much denial to accept it. Gradually their increasing co-consciousness with other self-parts that knew, or came to know, together with the increasing acceptance that they all shared the same body, began to emerge. This was still in process when Susie became pregnant and, they were very challenged in their separate self-identity under those circumstances. My notes at that time record:

> Damian had benefited from having Mark in the garden with him all week again. Sarah is becoming aware of changes in the body and thinks it is ill. I have said it is not ill but is changing. I have to be careful how ready Damian is to hear the body is pregnant. He is having enough trouble

> coping with it being adult and female, but we are slowly getting there. We continue to talk of integration. He asked if they will have to change their names, I said they had a name for them collectively and he searched and found it was [Susie]. I always have him and Sarah co-conscious for the jig-saw now and there seem to be no problems with that. I feel a little pressure to work towards integration because of the time-scale and wonder if this will backfire. I need to discuss this in my meeting on Monday with [the professional team].

The work on bringing Damian, the dangerous and destructive alter, to the knowledge, not only of inhabiting a female body, but that Susie had a son and was now pregnant again, was handled delicately and slowly against the backdrop of a pressured time-scale of pregnancy, cessation of funding and Susie planning to return to her community of origin and potential abusers. Having accepted that he inhabited a female body that was also adult, he was then helped to acknowledge that adult female bodies are designed for having babies, and through the unconscious links with the memories of other self-parts, organised by Julie, he began to be aware that there had been past pregnancies, and was then introduced to the idea that Susie had a son. Obviously Susie wished to ensure that Damian did not conceive of this as a potential father/son relationship, with the risk that Damian may bring behavioural patterns from the past to bear.

Even as they came to accept the inevitable, their own specific identity did not cease to exist but adapted. In my opinion they came to accept that their identity was based on psychological factors and not physical ones. With another female client of mine, there were male self-parts who insisted that they were also physically male, until the later stages of the therapeutic process permitted greater reality. Perhaps with Susie, there was such an overwhelming female identity when her self was viewed in its entirety, that the resistance in male identity was less strong.

The work on inhabiting a female body was often intertwined with other topics. In one session Damian had asked why it was that when dad had hurt Sarah, and she was bruised and could not stand, he took over and was not bruised and could stand. We discussed the way in which the mind could control some parameters of the body, and also how the mind can create the illusion of some things. We talked of how dissociation can affect the presentation and symptoms of the body, but could not

make the body male or female, bigger or smaller, or have short hair or long hair; that could only change mentally in perception.

At times I encouraged dialogue and co-consciousness between male self-parts, including the co-consciousness between Mark from System One with Damian from System Two. Thus, whilst focussing on the male/female body/identity issue, integration was also being achieved more generally and between systems.

In retrospect, it is my opinion that these self-perceptions are not, in essence, different from those of general psychotherapy clients who, in the face of evidence to the contrary, see themselves as bad, useless or weak and ineffectual. They are often based on defensive functions or roles engendered by the outside world relationships and interpersonal attachments. In domestic violence, women come to see themselves as unattractive, powerless, unlovable and without options. Therapy aims to reality test these self-perceptions and reinforce more healthy ones. Dealing with DID alters is similar, but more extreme and exaggerated. In both non-DID and in DID cases, dissociation and narrowing of focus make these distorted self-perceptions possible.

5.26 Distorted Perceptions

The very existence of split selves meant that all had distorted perceptions of themselves. Lots of the self-parts had restricted roles and were polar opposites of other parts, so moderation did not occur much before therapy. Some parts were more rounded than others, according to their utility and life experience. Damian was probably the most restricted self-part. His achievement of developmental stages was extremely limited. He had been taught to think of himself as devoid of feelings, only able to comprehend opposites, with no shades of complexity. He had been taught to think of himself as an animal, tough strong and invulnerable. Through the therapeutic processing he was learning that this was an illusion. He noted that other children had an affinity with each other that he did not have. We talked of how it met the father's needs to have him feel this way and to avoid any affinity with the other children as it would have undermined his ability to harm them in order to obey the father. He had been told that if he touched another human he would be burned by the touch. He said this had happened in the past. I wondered if this could be another trick to make him believe what dad said. In a later session it transpired that someone

had touched him on the shoulder once whilst they were wearing a glove and he had been burned. We again discussed abusers' use of tricks in controlling children. It was not until much later that he was brave enough to put to the test this theory of touch burning.

As Damian progressed with owning his own experience and feelings and understanding how the harmful events of the past had separated him from his beloved Sarah, he began to recover the ability to see colours other than just in the crayons. The first colour recovered was red

5.27 Guilt

Susie's guilt, as expressed by several of her self-parts, was a protracted issue. The child-part that was sexually abused by Sally was scrubbed by her in the bath and told she was dirty and bad. Her father beat her with a belt into accepting Sally's actions, and so she was also told by him that she was bad. The common denominator for her was that she was bad and dirty. Her self-perception was improved by helping her to see the power of the adults and their manipulation of her behaviour and her self-perception. She was helped to see that abusers act as if they are not responsible, and often specifically tell their victims that they are themselves responsible, and that children who are at ego-centric stages of development are especially vulnerable to taking in these projections as self-introjects. She was assisted by learning that she was not the only self-part to have these kinds of experiences and distorted self-perceptions.

One of the hardest things Susie had to cope with was the memories of her own destructiveness. This had been so deeply buried but, eventually, despite her concerns that all professionals were out to take her children from her because of child protection issues, she found the courage to disclose them and process them. Sarah II and Damian had extensively harmed animals and children, including her own sister. All of this had been under her father's control and direction.

She had been even more disturbed to remember her own violence at home. She had flashbacks about her father tipping her drunken mother out of a chair and she kicking 'hell out of her' as she lay on the floor. She remembered setting fire to her bedroom.

She agonised over she and her sister's torturing of the dog. She remembered that her sister had been even worse than she was.

There also came a time when she owned that she had hit her son. At the time she had a broken wrist, but it had only a support and had not been plastered. He had run towards her and, having slipped, had grabbed at her for support, grabbing her broken wrist. She had reacted automatically and hit him. She was devastated. The backdrop to this was an active NSPCC campaign that was also sparking off memories for Sarah I about her mother deliberately scaring her by rocking her highchair dangerously. Sarah had other flashbacks about other incidents that were hard for her to integrate with her idealised picture of her mother. Now, as the carer of her infant son, Sarah I was mortified that she had also hurt a child, even though it had been another self-part that had automatically reacted; this sense of responsibility and guilt in Sarah was evidence of the increasing integration between the self-parts.

Guilt took many forms, one of which was projection. Sarah I, who had studiously avoided me ever since her mother's death, but would work with the co-therapist and talk about me, forced herself in this way to examine the way in which she projected her sense of guilt onto me. This came to a head when the co-therapist retired and Sarah I had to agree to have therapy with me or be left out of the therapeutic progress that was generally acknowledged to be urgently required.

5.28 Funding Crises

Throughout the eleven years it took for Susie to achieve complete co-consciousness and integration, there were many times when it seemed the funding would cease and she would end therapy. The professional team had grave concerns as to Susie's vulnerability to returning to her community, having contact with her father and other alleged abusers whilst still being unable to protect herself fully. Such a crisis occurred as she was expecting her second baby during the therapeutic period. My notes record a meeting in this regard:

> I said I was concerned that [Susie's] therapy would not be finished by the time she goes home and that [Susie] is resistant to integration. We all expressed concerns that [Sally] is to be [Susie's] only means of getting housing. [Susie] is returning to … late summer and will come back for

> check up sessions (her idea). She thinks every 6 weeks and then every 6 months, totalling 2 years. [Susie's] idea is that [her social worker] will take the day off work, bring her to [my clinic] and also spend time with her (preserving the relationships with us both and tailing them off gradually).
>
> [The two social workers] feel [Susie's son] is doing well and [Susie] has done a good job. I wondered how [social worker from Susie's home community] would keep an eye on [Susie] when she returns to .... She said it would be unofficial (Susie now beyond statutory age for Social Services).
>
> [The two social workers] confirmed the need for integration before returning to ... I think this is an impossible target and that [Susie] will either not do it or will pretend it is done and there will be no consolidation phase. There will however be no more money so this seems inevitable. [social worker] will speak to [solicitor] and see if there can be money for the check up phase.

These were the external pressures on the therapeutic process, in addition to those discussed about the undermining of therapy by alleged abusers.

5.29 Extending and Testing Integration

As Susie prepared to return to her original community, and the cessation of funding loomed, we tried to speed up and test her ability to stay co-conscious. She had previously engaged in only spontaneous and partial co-consciousness with people other than me, and her only experience of full co-consciousness was for very brief periods of time, usually alone and with me, only when an important message needed to be shared for safety reasons. On these occasions she found the process of full co-consciousness so debilitating of her energy levels that she could not sustain it. We agreed she would practice having significant numbers of self-parts co-conscious when talking with another member of the clinic staff, with whom she was not very familiar and who was male. Susie found this extremely tiring, but the more she practiced it, the less tiring it became.

As Susie progressed with co-consciousness, she reported problems with physical integration, and more accidents were occurring. In an extreme example, she cut her hand badly on a broken glass in the washing up bowl and had to have stitches. I was concerned that the outside pressures were causing us to lose the appropriate pacing of therapy. Susie reported that some internal parts were confident of achieving

integration quickly, whilst others were definitely opposed to the pace of therapy and others were just scared.

It was very noticeable that, when Susie reported being co-conscious to any significant degree, her skills, such as dealing with her children, or doing the jigsaw, were vastly slower and less accomplished. She engaged in a great deal of swapping of handedness, some of her alters having differing dominance. As she developed greater experience with co-consciousness, her speed and skill increased, but this took years to develop to normal levels.

5.30 Integration

Susie continued to move between discussing current life problems and disclosing past trauma memories. As co-consciousness and integration progressed, the number of topics that were interwoven into our therapy sessions also became very complex. Susie reported that some self-parts were growing and developing but were not together and though some groups and pairs were less antagonistic to each other they would never be together.

As her children began to be more independent, Susie returned to having therapy sessions without her, whilst she was at nursery. She now felt that she was as integrated as she would ever be, that she no longer had any loss of time or memory for current experiences, and that her care of her children was adequate. I was unsure as to whether her decision that co-consciousness, rather than integration as I had conceived of it, was adequate, but I felt reassured that she no longer planned to return to her community of origin and was maintaining the stability for her son who was now in school. Against this background we agreed to begin the closure of therapy. Susie tried to reproduce her mind map, to review the relationships of her self-parts, and found she could not really do this in the same way as previously. She could not remember how it used to be. She drew a schematic diagram, naming the parts, but she could only manage a proportion, about half of those she had identified previously. This time the handwriting was all uniform and using the right hand. The arrangement showed one system in which all parts were connected, although those that were original System Two parts were in one section.

In the final analysis, funding did continue, and the therapy reached a good enough stage when funding finally ran out. Susie settled in her new location with her two children and did not return to her original community. The social worker continued to keep weekly contact with her and to monitor her safety and further development. At that stage Susie reported that she was no longer hypervigilant for significant cult dates in the calendar, Christmas having become overlaid with new associations such as her children's nativity play at school and their presents at home. She also no longer switched under stress but could scan around her internal parts to gain information and insight into the source of problems. Therapy did not end in the ideal way that I had envisaged because funding did not permit, and after eleven years Susie was weary of the process. I also felt that her developmental need to leave home and live independently, without returning to be dependent upon alleged abusers in her original locality, was taking precedence, and so, for a combination of reasons, I supported her leaving therapy. I think an important part of her adolescent/emerging adult development, experienced in her late twenties toward the close of therapy, meant she needed to leave me in stages and have control over that process herself. I was the only person with whom she had been able to do this; her own parents were unavailable, her foster mother had ceased to be her carer when she reached the statutory leaving age, and she was keen to leave me before I retired. We continued to meet monthly for a further six months, and then for a final review three months later. She continued to demonstrate that her issues were not fully resolved, and perhaps never would be, but she had strategies for coping that were perhaps at an acceptable level. For example, my notes on her review session record an incident:

> [Susie] reported seeing one of [ex-prostitute self-part]'s old customers in the supermarket when he bent down to talk to [one of her daughters]. She suddenly abandoned her shopping and removed herself and both children. She was able to settle the children and when they were in bed to review what had happened and piece things together. This seems to have been less of a blank than an automatic reaction to a crisis situation.

The social worker continued to visit her weekly on an informal basis, and every Christmas I receive a card providing an update of her progress. She later moved on to a new relationship, was engaged to be married, and seemed really happy with her life. She is now several years post-integration without reporting any significant difficulties, and without amnesia or loss of control.

Having provided a synopsis of the therapeutic process with Susie, that for the most part was undertaken in the absence of knowledge of most of the data contained in the literature review, I will now turn in the next chapter to an analysis of the case study, my reasons for considering Susie to have DID, and to integrate my clinical experience with intellectual learning and the historical literature, particularly implications for models of mind and the concept of how DID manifests and is generated.

CHAPTER SIX

REVIEW OF CASE STUDY

6.1 Review of Case Study in Relation to DSM-IV Criteria

Having now presented the case study of one therapeutic intervention that I categorised as a case of DID, I will now examine the case in relation to the DSM-IV criteria.

Predicated upon the thesis of Boyle (1990) and Newnes (1999) that psychiatric diagnosis is an unscientific approach to the description of phenomena attracting psychological intervention, it is nonetheless, as Davey (2003) has pointed out, the system commonly used, in the form of DSM-IV, as a means of professional communication in research, and therefore I will consider this case study against this system of labelling.

The diagnostic features of Dissociative Identity Disorder, as defined by DSM-IV, are comprised of four criteria, A to D, discussed in more detail below.

6.1.1 Criterion A:

The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

Susie demonstrated that she experienced herself and was observed by others, both lay and professional, to have two or more distinct identities, relating differentially to specific people or events. All of the self-parts described by Susie were reported to have different and unique personal histories. For example, in addition to the ones outlined above, within the system designed to cope with the organised abuse, there was a tomboy whose job it was to fight back. She was experienced by many other parts to be a huge problem, and to put the rest or the whole at risk when silence and submission were felt to be the best means of survival. She was reported to have developed when the body was about 8 years old. Her resistance appeared to function to motivate continuing existence of the system when other self-parts were

submissive, overwhelmed and hopeless. She functioned like a counterweight to the danger of giving up, but needed to be prevented from escaping to the outside, unless needed, since her emergence may invite worse abuse and the risk of annihilation, the very thing to which her feistiness was the counterweight. Until it was deliberately encouraged in therapy, there was no reported evidence of co-consciousness between self-parts, although it was later revealed in therapy that some limited aspects of internal co-consciousness existed, such as between Sarah II and Damian, and there was evidence of one-way amnesia, such as the written note by a caring part after giving birth. Again one-way access to information was clearly evident in Susie's production of a witness part to handle the trial

The tomboy never shared experience with other parts but just 'came out' at times, to resist the abuse, and other parts vied to suppress her for fear of her behaviour inviting worse abuse, demonstrating at least awareness of some aspects of her actions or their results. Her personal history to her had the appearance of a continuous narrative, but to an objective observer it had breaks of which she became aware, but could not explain. She always maintained her own autobiographical memory, based on her own experience of 'being out', and did not experience conscious awareness when not 'out' or active in the outside world. In this way her reports were similar to historical case examples such as Mary Reynolds (Plumer, 1860) or Miss Beauchamps (Prince, 1905). Other manager self-parts did have some continuing awareness of the interaction with the outside world, even when they were not themselves 'out'. Thus it can be seen that self-parts, such as the tomboy, held a distinct self-image, separately self-identified from other parts. Not all self-parts had equally extensive personal histories. Their narratives were largely confined to the times at which each had been interacting with the outside world. Susie had described a highly complicated pattern of self-parts, each one's interaction with outside experience was necessarily limited. Not all were 'out' to the same degree. As previously described, there were hierarchies of utility, and some parts had limited and highly prescribed experience and responsibility. The tomboy was not extensively employed but was regularly utilised in small bursts of resistance. The functional nature of Susie's self-architecture is in line with Hart's (1926) idea that self-parts develop in response to a functional need.

Additionally, there were limits of awareness between self-parts. When introduction of increased awareness was achieved during therapy, there were a mixture of reactions and manifestations of resistance to acknowledging their own limited status and area of influence in the overall personality structure of Susie. This often initially caused resistance to learning of the shared or integrated personal narrative and the handovers or takeovers that had functioned to manage their overwhelming experience and its impact. Similar resistance to full reality is also reported in many of the historical case studies.

6.1.2 Criterion B:

At least two of these identities or personality states recurrently take control of the person's behaviour.

Susie reported that, when she lived at home with her parents, there was frequent switching of control between various self-parts, according to the demands of her life. As previously discussed, there was a group of parts that dealt with her mother, another that dealt with her father, another that dealt with school, and others that dealt with prostituting, organised abuse and self-nurturing. Though not all parts took control or were given control in equal measure, many parts were repeatedly active in everyday life.

Once Susie was living independently from her family, and under the regular supervision of professional carers, the different self-presentations were regularly observed. Professionals who did not know Susie well, and who were unaware of any diagnostic label, experienced her as extremely changeable and sometimes volatile or emotionally labile. She was sometimes described as a Jekyll and Hyde. With greater acquaintance, and in the same way that one would gradually achieve the ability to distinguish the fine detail between identical twins, Susie's different identities were relatively and increasingly easy to recognise as cohesive entities. Continuity of presentation in any one self-part was observed over sometimes extensive periods of time, particularly by Susie's carers. Switches, from one identity to another, were apparent, demonstrated sometimes by discrete and sometimes by obvious changes in the characteristics of personality, memory and use of the body.

At the beginning of therapy, switches of identity were usually instantaneous and coincided with environmental triggers, such as association to past abuse or an alleged abuser, or in order to fulfil a particular function. Examples of triggered associations could be a card or letter from her mother or from the female group leader. On one occasion, the presence of sheep's wool in a card caused extreme fear and distress to specific child alters, and temporarily overwhelmed the usual continuity of control, by manager parts, that had increasingly been developed during therapy. On other occasions, Susie had little idea why a particular switch had taken place, for example, when going to a job interview, she had switched to a teen part who dressed in a sexually explicit manner. As therapy progressed, Susie learned to achieve both co-consciousness between specific parts and deliberate switching for specific purposes, in a proactive way, rather than the reactive manner usually utilised. The deliberate switching was slower, though still took only a moment, but it was distinctly slower than the panicked switching brought about by high levels of negative impact. When working with Damian, he sometimes, suddenly handed back control to Sarah when he found affect intolerable, but he could be encouraged to increase his tolerance and negotiate handovers, rather than make panic switches at the expense of shock to Sarah II.

According to the DSM-IV description, the primary personality that carries the person's name is often 'passive, dependent, guilty and depressed', but Susie was always conceived of as the overall collective identity of the self-parts, at least by the one person who had sufficient overview to ***know*** this. Even the other parts, that lacked this overview, also talked in terms of a sense of what Susie represented, once they began to raise their awareness beyond their immediate experience. This may be another reason why Susie chose to become a co-conscious collective, rather than collapsing her other self-parts into a primary personality called Susie. She did conceive of Susie as beginning as a unified personality, and becoming split in infancy, but she seemed not to perceive her organisation as having a host or primary personality, as is often described in other case studies in the literature.

As has been illustrated by examples in the case presentation, and consistent with historical case reports, Susie described self-parts that differed in perceived age, as well as chronological engenderment and development. She reported several child

alters at different stages of development, according to the roles and functions they served. Several male alters were reported, always based on perceived social stereotypes, such as the need for a male alter to engage in sexual activity with her mother, and when male traits such as strength and fighting were required. Although the tomboy, female part fulfilled this function, her role was more one of psychological and verbal fighting, and less physical action, and her underlying function was fighting for survival; she became the embodiment of the life force of the whole system, as external pressure became increasingly life-threatening and intolerable. The male parts who fought used more physical action than words. Different parts had different aspects of skill and knowledge. The prostitute was very astute at working out the characteristics and predilections of her customers, whereas one of the teenage parts was apparently sexual, but in fact had little ability to recognise when she was in danger. The carer parts fervently disapproved of both the teenage acting out and the solicitation, and all parts who became aware of the prostitute tried to disown her.

Certainly knowledge of one part about another seemed to be determined by their affinity or the management or supervisory relationship. Some relationships were unconsciously co-operative or complementary, others were consciously so, whilst yet others were oppositional or conflictual. The part who idealised Susie's father was loath to accept the memories of Susie's father abusing another part. Damian was aggressively defensive to all other self-parts, and to the therapist, wishing to protect the status quo and his perceived exclusive relationship with Sarah II. Even before therapy commenced, the overall manager of the system that coped with the organised abuse made decisions about which parts were needed to achieve recovery in certain situations, and so could put alters to perform certain tasks both internally and externally. This, however, did not mean that she could control who was out all of the time, especially at times of extreme stress and crises. Hostile alters can sometimes purposefully try to disrupt the activity of others. Damian was very aggressive and rejecting of Eve's nurturing, at the time when his idea of intimacy was centred solely on control, and was so dyadic as to exclude anyone except Sarah II.

6.1.3 Criterion C:

Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

Susie demonstrated amnesia for personal information, beyond that which would be considered normal forgetfulness. There was no single conscious part of Susie that held a full and continuous memory for her life, but instead her personal narrative was broken up into autobiographical episodes arranged according to the function of the alter and its relationship to other alters of similar or complementary function. Until the later stages of therapy, this was the case for both contemporaneous memory and for distal memory. As therapy progressed, contemporaneous memory became more continuous and normal as distal memory was also integrated. Once memories were made available to different alters, they never returned to the previous amnesia, and the newly acquired knowledge was accompanied by psychological development, as it is with normal development.

Before therapy the amnesia was largely asymmetrical, with the supervising alters having awareness of the function and some aspects of the memory of alters whose functions they directed or monitored. According to the DSM-IV manual, more passive personalities tend to have more constricted memories, whereas more hostile or controlling personalities have more complete memories; it also notes that an identity that is not in control may nevertheless gain access to consciousness by producing auditory or visual hallucinations, such as a voice giving instructions. In the case of Susie, the variable that seemed to determine the complexity of memory was complexity of role and amount of time spent 'out' relating with the outside world, particularly with other human beings. Damian was one of the most destructive and aggressive alters, but had the narrowest of experience, development and memories. The alters who had the widest memory spread were the ones with supervisory and management duties, and who did not necessarily have the greatest active time out but did have the greatest active monitoring of the time out by others. Susie did not report hallucinations in the conventional sense, but Damian did report a lack of ability to see in colour, and several alters perceived themselves as physically different from how the body actually was, such as being male or having different coloured hair. These trends were less obvious in Susie than in some other DID clients of my experience. For example, none of Susie's male parts insisted that they

had a penis, rather they were reluctant to admit that they shared a female body, whereas another client was less realistic and more self-delusional about this. One client saw herself in the mirror as having long hair when in fact her hair was short. These physical properties were of less import to Susie, and never featured strongly in the therapy. There were times when voices disrupted the consciousness of others. At times, alters complained of being disturbed by others arguing or crying internally.

Amnesia was discovered by reports from alters, such as one suddenly looking down and finding she was wearing flirting clothes instead of interview clothes. To my knowledge, there were never times when external people reported behaviour that Susie, as the collective person, was completely unaware of, though it may be that the part of her that was told about the behaviour was not the part that held the awareness. For example, a part of her could regain consciousness at the end of a therapy session and become responsible for going home, without having memory for the content of the session that may have been experienced by one or more of the other self-parts. It is the case that, when entering therapy, Susie did not have extensive periods of childhood amnesia, as can be found with many traumatised but non-DID clients. On entering therapy, a moderately normal amount of childhood narrative was related but, as therapy progressed, the details of a more extensive history unfolded via the many alters. This extended narrative did not contradict her original narrative, but highlighted the polarisation of the differing views held by specific alters in relation to other people, especially her parents, and provided a wealth of greater detail. It may be that, for the purpose of handling the trial and therapy assessment process, it was one of the managing alters who provided the narrative. They certainly had access to a greater pool of autobiographical data than the parts that emerged in therapy. It may be wondered why this capacity did not enable the managing parts to achieve self-integration without therapy. In my opinion, this is explained by their ability to deal with information rather than affect, indeed perhaps their objectivity, detached from affect, was what enabled them to fulfil their management function and especially to endure the trial. It also seems that more normal interpersonal relating with the outside world was also necessary for the release and processing of disturbing affect, and developmental growth that formed part of the integrative process.

Amnesia, however technically achieved by the client, was rationally explained throughout the therapeutic process, as an emotionally defensive strategy that helped to compartmentalise affect into manageable chunks, and delayed integrative processing until external help and containment were available; gradual desensitisation and empathy were successful in therapeutic intervention, which produced apparent change in personality structure and interpersonal presentation, on a permanent basis.

6.1.4 Criterion D:

***The disturbance is not due to the direct physiological effects of a substance (eg blackouts or chaotic behaviour during Alcohol Intoxication), or a general medical condition (eg complex partial seizures*).**

The influence of substance abuse was adequately excluded as a significant variable since Susie was not a regular alcohol user and did not use street drugs, although she had times when she used alcohol regularly as an anaesthetic. Her switches in identity were observed under circumstances that excluded both intoxicants and any identified medical conditions. She was checked regularly by her GP, she attended hospital and ante-natal clinics during two pregnancies, was subsequently attended by a health visitor over a period of some 10 years, and there was never any suggestion of a complicating medical condition.

The DSM-IV manual cites the possibility that certain identities may experience conversion symptoms (eg Pseudoseizures) or have unusual abilities to control pain or other physical symptoms. There was never any evidence of seizures either before or during the period of therapy. DSM-IV also states that there are reports of variation in physiological function across identity states (eg differences in visual acuity, pain tolerance, symptoms of asthma, sensitivity to allergens, and response of blood glucose to insulin) and individuals with DID may have migraine and other types of headaches, irritable bowel syndrome, and asthma. As reported previously, eye tests undertaken by Susie specifically reported variable eye pressure and visual acuity that had no medical explanation, but was thought to relate to the physical examination of differing alters on separate attendances. Whilst there were no significant health problems reported by Susie, there were on occasion abuse wounds that coincided with memory work, and were better or worse in presentation during sessions,

according to which parts were out. Additionally, there were self-parts who reported no sense of physical pain at times and also no sense of painful affect. One such is Damian, whose role was to withstand physical pain and knowledge that Sarah II found too much to bear. In his conscious state, no pain was experienced, but it was still bourn by Sarah II in a passive state. Therefore this does not so much describe physical anaesthesia, but a separation between the conscious action demanded of Damian by his father and others, and the tolerance of, or submission to pain without action was invested in Sarah. She was aided in this tolerance by conceiving of it as not hers but Damian's pain that she was holding for him in an unprocessed, somewhat encapsulated, but still highly demanding state. Similarly, when Susie was inclined to cut herself, at times of great psychological stress, the part doing the cutting dissociated from the pain, whilst other, but not all, parts were feeling physically hurt. In the early stages of therapy, such a large part of her self-organisation was tuned out from the bodily sensations that she failed to feel the cold weather and dress appropriately. Specific internal safety arrangements had to be made when her babies arrived to ensure that their bathwater was not too hot or too cold for their well-being. She presented with cold symptoms in some self-parts but not in another.

It is my overall conclusion that Susie's presentation is best aligned with the diagnosis of DID, as has been argued above, but it is necessary to consider also alternative diagnoses, as discussed below.

6.1.5 Differential Diagnoses

According to DSM-IV, the diagnosis of DID takes precedence over Dissociative Amnesia, Dissociative Fugue, Depersonalisation Disorder and DDNOS. DSM-IV also recommends differentiating from cases of other psychotic disorders, Bipolar Disorder, With Rapid Cycling, Anxiety Disorders, and Personality Disorders. Overlapping with the DSM-IV guidance, the historical challenges to the DID diagnosis were typically Conversion Disorder (Hysteria – Merskey, 1994), Fugue (Fahy, 1988, p599; Hodgson, 1891), Borderline Personality Disorder (Hofmann and Rost, 1995), and Schizophrenia (Ross, 1989). Additionally one might consider Factitious Disorder or Malingering (Merskey, 1992, 1994), and I will discuss these possibilities in turn.

It has been suggested by Brenner (2001) that the DSM-IV criteria describe DID, but that it may be a complex overarching condition that includes a number of other descriptive conditions, such as Amnesia, Anxiety and Depression, to name only a few. In the case of Susie, there was no doubt that at various times, and perhaps recurrently for a lot of the therapy, she would have fulfilled the criteria for a number of these more discrete categorisations, but none of them would have accounted for her complex self-structure and lack of integration and control of executive functioning. Amnesia as a diagnostic entity is much more confined and restricted than the way in which it interacted with Susie's multiplicity, therefore I consider it an insufficient diagnosis for the phenomena presented. Similarly there were aspects of Susie's self-structure that would meet some of the criteria for Depersonalisation Disorder, but her self as a whole did not meet these criteria. Many of her parts had very strong self-identity and none of her self-parts forgot their own autobiographical information; it just was not integrated across the personality structure as a whole. The DDNOS label is a category where clear self-differentiation is lacking and where the criteria for DID are not met; this was not the case with Susie, who fulfilled every aspect of the DID criteria.

Dissociative Fugue can be excluded as describing a much more narrow range of experience of amnesia than was found in Susie. Although Susie did suddenly find herself in places without knowing how she got there, or who had dressed her, reacting to such situations with shock and dismay, other parts of her self-organisation could be accessed who did have this knowledge. It is therefore my opinion that the diagnosis of DID is a much better categorisation of her presenting phenomena, than Dissociative Fugue.

Bipolar Disorder is an inadequate diagnosis for the phenomena presented by Susie. Her presentation was far more complex and her affect far more varied than the polarised presentation observed in BD. Although there was variable high and low affect in some of her self-parts, this was not so extreme as in BD, and rationally related to specific external or internal events, such as the processing of negative affect, or in response to information and affect overload in the processing.

It is my opinion that this client does not meet the criteria for Conversion Disorder, since it does not account for the systematic self-part organisation of her memory and functioning; more importantly, Criterion A for Conversion Disorder, voluntary motor or sensory deficit, is not a defining feature of this client's presentation, as had been the case with some of the early cases in the literature, though, as has been described, there is evidence of some limited sensory deficit in specific self-parts under specific circumstances. This is insufficient to warrant this diagnosis, which in turn lacks the complexity to match and describe the phenomena presented in this case study.

I am also of the opinion that the diagnosis of Borderline Personality Disorder is an inadequate categorisation of the client's presentation compared to that of DID, since the client's presentation does not meet the necessary minimum five criteria. The main feature in common between DID and BPD is that of identity disturbance, but the BPD criteria describe a more labile and chaotic style of regular presentation and interpersonal functioning than is found in this client and in DID. DSM-IV does discuss the overlap that is found with some patients who have both DID and BPD but, in the case of Susie, order rather than chaos was the overarching factor; emotional lability was not found within self-parts and changes in affect were explained by rational switching of parts in response to external or internal circumstances rather than internal whim or apparent irrationality. Therapy generally had a sense of accumulative progress that, although not clearly linear, was on an overall trajectory of increasingly normal functioning. Even before therapy, Susie had not appeared abnormal to neighbours, friends and professionals who met her; she had not attracted mental health concerns. Brenner (2001) reviews some of the professional opinions about the overlap of phenomena between BPD and DID. He concludes that BPD patients have intensely chaotic and insecure attachment styles and polarised perceptions of others. In contrast he sees DID patients as having an avoidant attachment style, and being internally organised, even if not integrated, despite the possible presence of chaotic switching. In my opinion one of the differences may be that, in DID, there appears to be an internalisation of self-nurturing, consistency and complexity of self-structure that is largely absent in BPD or in DDNOS.

Schizophrenia is an inadequate diagnosis, given the lucidity and functional activity of the client's behaviour in the majority of her self-parts that were, nonetheless, experienced by herself and others as separate from each other and to have problems of relative amnesia. Within self-parts, there was no evidence of thought disorder or disorganised speech, in the manner of schizophrenia presentations, merely a lack of reality testing in the face of partial information.

As regards Factitious Disorder, there was no convincing evidence to support any of the criteria for this disorder. The client did not present in a sick role. I believe that the client had very few short term gains to being in therapy, from her own perspective; given a free choice, she would probably have returned to her abusive home situation out of habit, familiarity and a misguided sense of responsibility, particularly for the welfare of her mother.

I can identify no evidence for the existence of false presentation or malingering. I found her separate presentations to be coherent, though developing, throughout the twelve years of her therapy. Her self-organisation was found to be rational and far too complex to have been imagined in the absence of supporting experience. I am of the opinion that the client did not possess the wealth of psychological knowledge necessary to present such coherent developmental scenarios and characterisations, except from real experience. That is not to say that I think her self-narrative is all objectively accurate. It is likely to be subject to the same idiosyncratic distortions and confabulations as any other personal narrative. It is my opinion that, despite her insecure attachment and loyalty to her family, and her avoidance of alternative attachment, she responded positively to the nurturance she received in foster care and in therapy. From the point of view of the necessity for her to be safe, live independently and live a normal family life as an adult, therapy needed to achieve sufficiently normal self-structure, reduce amnesia to a minimum, stop self-harm and prevent harm to others, and to create sufficient change in her self-narrative for the past not to intrude upon her present existence. All in all, this seemed to be achieved and, as it was accumulated during therapy, it has remained stable over the years and has remained so since therapy was completed.

6.2 Media Influence

No doubt sceptics will argue, quite rightly, that I have no way to be absolutely sure that Susie was not exposed to any media influence, and such a hypothesis is, in Popper's terms, completely scientifically unfalsifiable and can never be disproved. My twelve years of clinical experience of Susie's case provided no indication that contradicted her report that her multiplicity began, in the absence of external knowledge of DID, as a result of an increase in repeated physical, sexual and emotional trauma from about the age of 3 years, although her memories of being toilet trained suggest it may even have been earlier than her explicit autobiographical memory reports. It was only several years later, after more complex self-splitting, that she retrospectively began naming these parts. Even then, a prototype process of naming had been suggested by her father's use of her middle name during extreme sexual abuse, and its significance as her grandmother's name. The fine detail of separated memory and functional ability, as exemplified by Damian's visual perception lacking colour, made therapeutic and psychological sense in terms of his need to avoid any form of integration and remain loyal to the absolute and polarised perceptions modelled by the father, and this was unlikely to have had its aetiology from media influence. During the middle phase of therapy, long after she disclosed her full self-architecture, Susie's foster mother chose to read the account of DID by Chase (1990). It is not clear if this had any influence upon Susie, though she made no alteration to her self-structure, during or after therapy, which seemed in any way related to the content of this book, other than the fact that Chase gives the only documented account of the outcome of therapy being full co-consciousness and not full integration into one self. This was of course the final outcome chosen by Susie for her therapy. It certainly did not match my expectation or desires for the outcome of therapy, and therefore does not reflect my influence, but does reflect Susie's own attachment to her self-parts and perhaps reflects the influence of Chase's account. It is also just as likely that this co-conscious form of integration was the logical outcome of the fact that there was never any sense of a core self or main personality as has been described in many case studies. The name Susie always designated the whole self before splitting at age three and, although there was a hierarchy of managed control of the self-parts, there was never a core that was protected from the abuse by all of the other self-parts. Instead, knowledge, affect and sensation was limited to specific parts and they were organised, sometimes in pairs and sometimes

in groups, but always around the function they were to serve, and in relation to the outside world. As regards external verification of the childhood abuse, although no-one accepted responsibility for the variety of abuse reported by Susie, some of her narrative of early sexual experience, probable abuse and early multiple pregnancy was verified by a gynaecologist, and her case of sexual abuse by her father was accepted as proven by the court. It may be that, as well as being a lack of a designated core self for alters to integrate into, the norm as described historically in case presentations, the number of self-parts involved, in both the account by Chase and by Susie, lead to a completely different form of integration, that of co-consciousness and a shared autobiographical memory, under the given and socially used name. Thinking forward in this thesis to my discussion of the new psychoneurological theories, perhaps so much neural investment has been laid down in the brain that undoing it makes no sense, but overriding it with new integrated connections is a more economical and practical outcome.

6.3 Iatrogenesis

As with every case of DID that I have encountered, evidence of the presentation pre-dated therapy and was independently observed, if not interpreted as DID, by several different professionals. Referring professionals, who suspected DID, reported that they were careful not to discuss their opinions with the client until after a full psychological assessment had been conducted. Even then, discussion with Susie was limited to the more general diagnosis of Dissociation, until after she entered therapy and had disclosed her self-structure spontaneously. Additionally, she was not witness to my testimony at the trial. Throughout therapy I was careful to remain as client centred as possible but, since interpersonal relating is a complex and dialectical relationship, even in psychodynamic psychotherapy, I will not have been free from influencing the client, though there was no evidence that any of her self-parts were created during or after therapy. I did not use hypnosis, although some critics may rightly say that therapy might have proceeded more quickly if I had, but because of the controversy surrounding the diagnosis and treatment of DID, I chose not to do so. Susie produced a mind-map very early in the process, and repeating the process towards the end of therapy demonstrated a reduced number of self-parts and it took a lot longer to produce, as though she were producing it from memory rather than current experience. She failed to complete the task, reporting it to be too difficult.

This was in stark contrast to the rapidity that had characterised the production of the first mind-map.

6.4 Amnesia and Traumatic Memory

Critics may also challenge Susie's report of amnesia. Certainly Kihlstrom (2006) has demonstrated that there is no sound experimental evidence that proves the link between trauma and amnesia. He is, however, referring to the disruption of normal memory functions and the fact that no experimentally based theory has been able to account for the types of amnesia or forgetting found in trauma cases and in DID. It is acknowledged that experimental demonstration of the amnesic phenomena observed with DID clients is lacking, and some critics would be led to conclude that the clinical phenomena are not what they seem. Kihlstrom is more inclined to the view that there is a gap between the theory and the practice.

A simplistic understanding of the DSM-IV criteria may lead to the concept that there is complete amnesia between self-parts. Indeed this was my expectation at first, but experience has taught me that amnesia, which of course is underpinned by at least unconscious unity, is relative. There is indeed almost complete amnesia, particularly for information, between many self-parts, but complete separation of affect is less successful. This may be because of the visceral nature of emotions and that, although cognitive shifts may be rapid, visceral changes are less so. Usually DID clients report affect remaining after a switch of identity. Leakage of affect between parts usually seems to happen when alters are in active use of the body rather than in a more limited internal state. This situation appears to change with the development of partial integration, where internal leakage is also reported. Once clients extend their awareness of self-parts and their function and characteristics, they make guesses about which part had handed over control to them; each time they do so, they appear to achieve greater degrees of integration with such parts. It may be that the amnesic barriers are psychogenically, not consciously, but preconsciously or unconsciously, generated encapsulations that limit the affective and therefore visceral impact of the experience. Cognitive recognition between self-parts and acknowledgment of, and thereby some processing of, the affect each contains is only a small aspect of the whole desensitisation process that is necessary. Deeper desensitisation accompanies the information and affect processing, which leads to affect modulation and

accommodation within a newly integrated memory system. It may be that executive control of the body is initially required for affect to be shared between parts, but that once the amnesic barriers begin to weaken, through the desensitisation process, then internal leakage can also occur. Once this is possible, integration appears to increase in pace and can be consciously as well as unconsciously produced.

Additionally, some self-parts have access to the knowledge and memory of other parts, even though this is usually not a mutual arrangement. As is documented in previously published case studies, there is usually a hierarchy or control in the organisation of self-parts, as was explained in the case of Susie. It is through this process that Susie was able to create a part to handle her court case, providing access to knowledge and memory of abused parts but not to other knowledge that would have endangered the trial process, such as the systems of self-parts responsible for handling the organised abuse. The ability to create self-parts at will was not always available to Susie, and she reported never having consciously pre-planned such a creation before. She never reported any spontaneous or pre-planned creations during or after the twelve years of therapy, despite experiencing several traumatic events during that time, though with the support and opportunity for contemporaneous processing and recovery. Another, male, DID client had explained to me that his alters came about in childhood, through the necessity to protect himself from bullying, but they later got beyond his control, whereas other clients have reported having no control over alters that develop to meet functional needs, but that later their awareness had increased and they found they could control the process of creation, but not the behaviour of these additional self-parts. Other people describe an increasing control over self-parts as information processing progresses. It is usual for DID clients to report variable levels of control rather than no control over switching between parts. As therapy progressed, Susie increased her control over the switching behaviour and operated with a mixture of control and lack of control. Her control increased with therapeutic progress, though, as previously reported, this was not linear. At the close of therapy she only experienced brief loss of control, at times of crisis, but could still maintain sufficient control to take protective action and, upon reviewing memories, she was also able to access all autobiographical knowledge and repair any damage.

6.5 Comparison to Historical Case Reports

If the reader is of the opinion that I have now made my case for considering Susie to have DID, I will now examine how this case study compares to those reported in the literature review. Susie's case is relatively unique, according to published data in modern Britain, in that she was still in her teens when she entered therapy, her self-fragmentation was already witnessed by other professionals and supported by writings from early childhood. There have been few detailed reports of child or adolescent cases and few reports of completed therapy with DID cases. There are fundamental differences with early case studies where exorcism or hypnosis was used. In Susie's case, neither of these techniques were employed, but instead an eclectic form of psychotherapy, developmentally and psychodynamically based but with cognitive and behavioural adjuncts, was employed. It can be seen how these techniques overlap in the case study. Systematic desensitisation is a CBT technique but is nonetheless the process that is being implicitly employed when one self-part is learning to tolerate the autobiographical details and affect of another self-part.

Several of the early case studies in the literature were merely descriptive or investigative, rather than specifically treatment orientated. Susie differs from these early examples in her facility for switching without the pain reported in Mary Reynolds (Plumer 1860) and many others. Susie had no concurrent or precipitating physical illness and no epilepsy or pseudo-epilepsy as reported, for example, in relation to Mary Parker (Ward, 1849). It will be seen, in section **2.9** of the literature review, that common features in historical cases reviewed by Crabtree (1993) were sudden changes in self, amnesia between self-parts, continuity between self-states, relative functionality in life, and skill and knowledge development within states, but differing between states. The case study of Susie has demonstrated that, before therapy, she conducted a relatively functional life at school, so that the dysfunctional nature of her home life was a well-kept secret. Professionals witnessed sudden changes in Susie's presentation of self, both before and during the period of her therapy. Amnesia between her self-parts has been described, and includes both forms of amnesia, mutual and one-way, as investigated by Myers (1903), discussed in the literature review. Susie's case also clearly demonstrates the underlying unity that permits switching and overall survival, as claimed by Gurney (1884b) and Ribot (1885) among others.

Compatible with reports by Ross et al (1989) that 86% of cases have child alters and 62.6% have opposite gender alters, so too, although only 15 years old at assessment, Susie reported many self-parts at a variety of ages, ranging from infancy to middle age, including several male parts. One unique aspect was that her prostitute part could present at a very wide range of ages according to the sex roles she was required to play, although it became clear that she regarded this as role playing, and distinct from a core and stable sense of self in that part.

All of these facets of self-presentation, not dissimilar to other documented cases, were described by Susie in great detail and with much more extensive self-architecture than is normally described. Though in modern times there have been reports of complex self-architecture, such as Chase (1990), it is still rare and often consists of a combination between well-formed alters and fragments, whereas Susie appeared to have no fragments. This author has experienced other clients with DID or dissociation who had self-fragments, but this was not the case with Susie. In common with some but not all case reports, Susie had both male and female self-parts, such as was reported in the case of Bernadetta (Brown, 1986). Susie's experience of amnesia and switching is consistent with earlier reports, as is her use of self-harming behaviours, but she was not prone to eating disorders as has been reported by Elliotson (1846) for example. Whereas Hart (1912) had described his client's $1/5^{th}$ man as the crystallisation of resistance and, in modern times, negative alters are also seen in this vein. In Susie's case, resistance was experienced in varying degrees and guises throughout her self-system; the greater the degree of self-alienation, the greater the resistance to processing and integration. It is also interesting to consider resistance not just in the therapeutic sense, but in terms of the genesis of DID per se. In the historical reports, alters have often appeared following a scolding or in resistance to a compliant or constrained role. A consequence of the theory of Forrest (2001), to be discussed further below, in considering models of mind, would be to suggest that severely and repetitively abused children must inhibit their resistance to the demands of adults, in order to be able to perform to meet those demands. Perhaps it is not surprising that it is in adolescence that many historical demonstrations of this resistance to authority or confinement are found. Adolescence is a time of restructuring of the mind and sense of self to facilitate a major change

between childhood and adulthood. It is more likely, in adolescence, that resistance may erupt beyond self-control; in later life, maturity and greater empowerment may produce a reduction or integration of DID, as is suggested by the Mary Reynolds case.

Elizabeth Bowman (1990) specifically reviewed adolescent cases of MPD/DID in the historical literature (n=6), and in modern times (n=37), concluding that modern cases are younger on average (mean age of 15 compared to 17.5 for the historical studies), contain more female cases (73% compared to 50%), and report a higher number of self-parts. However, a more comprehensive analysis of historical cases, including those quoted by Bowman, but also adding cases from this literature review, show the mean age to be 15.6, and female reports at 64%, comparable to Bowman's analysis of modern cases. In her historical analysis she excluded cases that did not supply data across wide parameters, and this led to a distortion of the mean age. Bowman also concluded, in common with the findings in this thesis, that modern cases have more complex self-structure, and are less likely to be seen as the result of neurological or physical illness, and more likely to be understood in psychodynamic terms as resulting from trauma and abuse. For other reviews of adolescent cases the reader is referred to Dell and Eisenhower (1990), and Kluft (1985). In **Tables 6-1 & 6-2** below, I present a comparison of historical adolescent cases, incorporating Bowman's data that overlaps with data from this literature review.

No	Date	Author	M/F	Opp Gender	Case	Age	No of states	Diagnosis	Inc in Bowman Analysis
1	1602	Jorden	F	No	Mary Glover	14	2	Witchcraft vs medicine	No
2	1816	Alden	F	No	Mary Reynolds	20	2	Epilepsy	No
3	1823	Dewar	F	Yes	Not known	16	2	Uterine dysfunction	Yes
4	1831 reported 1845	Mayo	F	No	Elizabeth Moffat	18	2	Trans state dysfunction	Yes
5	1840	Despine	F	Yes	Estelle	11	2 grps	Religious Ecstasy	No
6	1843	Wilson J	M	No	Not known	14	2	Dual	No
7	1849	Ward	F	No	Mary Parker	13	2	Dual	No
8	1882	Camuset	M	Yes	Louis V	17	6	Hystero-epilepsy	No
9	1887	Azam	F	No	Felida	13	2	Dual	No
10	1887	Barrett	M	No	Not known	17	2	Cataleptic hysteria	Yes
11	1896 1904	Wilson A	F	No	Mary Barnes	12	11	Hystero-epilepsy/ MPD	No
12	1906	Burnett	M	No	Not known	16	3	Not known	Yes
13	1906	Gordon	M	No	Not known	19	2	Epilepsy	Yes
14	1926	Goddard	F	No	Not known	19	3	Loss	Yes
Analysis:			F=9, M=5			Age Range: 11-20 (mean age = 15.6)			

Table 6-1: Early adolescent cases of MPD/DID after Bowman 1990

Detail	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Total
Dramatic behaviour	*	*	*	*	*	*	*	*	-	*	*	*	*	*	13
Trauma/Abuse	*	?	*	*	*	-	-	*	?	?	-	-	-	*	6 ?3
Physical illness/problems	-	-	*	*	*	-	*	-	-	-	*	-	-	-	5
Somatic problems	*	*	*	*	*	*	*	*	*	*	*	*	-	-	12
Amnesia	*	*	*	*	*	*	*	*	*	*	*	*	*	*	14
Depersonalisaton	*	*	*	*	-	-	-	-	-	*	*	*	*	-	8
Affective problems	-	*	-	-	-	-	*	-	-	-	*	*	-	-	4
Conversion symptoms	*	-	*	-	*	-	*	*	*	-	*	*	-	*	9
Drowsiness & switching	*	-	*	*	-	-	-	-	-	*	-	*	-	-	5
Sleep to switching	-	*	*	-	-	*	-	*	*	-	-	*	*	*	8
Eating problems	*	-	-	-	*	*	-	-	-	-	-	-	-	-	3
Passive/Active states	*	*	*	*	*	-	*	*	*	*	*	*	*	*	13

Table 6-2: Details pertaining to the 14 cases of Table 6-1, after Bowman 1990

Bowman (1990) also made the case that earlier reports may have been limited to the perception of two states because of the influence of the two-brain theory, which incidentally seems to have had a dominant influence in discussion of even early multiple cases. She also notes the restricted role of women and the lack of openness in the medical profession in Britain, at that point in history, to recognise or discuss sexual trauma. Early cases could only be written down by coming to the attention of professional men, such as doctors, lawyers and clergy. This may colour the presentation of cases identified in this way. Perhaps more subtly powerful females could find less dramatic or obvious ways of resisting authority. It will be remembered that Susie's internal management system often struggled to control one particular part that resisted the organised abuse.

In comparing Susie to the early adolescent cases, or the modern cases reviewed by Bowman, she did not present with mental health symptoms, despite having a very complex self-architecture. She did not present with dramatic symptoms or behaviours, and did not have headaches or sleep on switching. She was of average age for referral when first identified and assessed, but she reported a much higher than average number of self-parts. Self-harming behaviour, which was a feature of Susie's case in the early stages of therapy, is not mentioned in these early cases. In common with the case of Susie, Paul Dell (1990), in his analysis of 11 modern adolescent cases, found variable school performance, amnesia, mood swings, sharp changes in personality, and a history of sexual, physical and emotional abuse. He also found that 73% had parents with a diagnosable dissociative disorder and 36% had mothers with DID. Susie had herself suggested that her father, in particular, had

several selves, and Susie's own DID status and integration progress was a great concern once she became a parent, though this situation was managed satisfactorily and tended to promote integrative progress. Dell's subjects all had angry, protector, depressed, scared and child self-parts. As was seen in **Table 6-2**, the historic cases also had parts that projected them out of passivity, some even to violence or wild behaviour, some requiring male alters to achieve this. Susie described the genesis of her male parts as being to achieve physical aggression, sex with her mother and unemotional cruelty. Bowman reports that, in keeping with the changing trends of history, all modern cases are understood in psychodynamic terms.

When I began the therapy with Susie, I based it on my own somewhat crude model of DID, an integration of Object Relations Theory and Information Processing Theory. Although many aspects of that model are still relevant, I have learned that even the more complex integrated neuropsychological models at the beginning of the twenty first century are still not able to do full justice to such a complex phenomenon as DID. I had originally conceived of trauma reducing blood supply to the brain and thus complex processing being delayed. Whilst this may still be one aspect of how the brain and body function under extreme stress, people with DID report adaptation and complex brain and body functioning under extreme circumstances, which is not accounted for in my simplistic model and may not be the same as how normally integrated adults perform under less repetitive or more circumscribed stress. It may eventually be understood that even what is currently thought of as DID may in fact mask differences in how children adapt. Certainly, although Fonagy's (1996) description of the lack of mentalising capacity of parents describes Susie's report of her parents' behaviour, it does not describe how Susie's mind functioned even as a small child. Perhaps DID is the exception where, despite a lack of mentalising in the parent, the child, though lacking parental modelling in this respect, develops the ability to mentalise, understand the bizarre machinations of the parental mind in service of its own survival and attach to its parents. This is what is suggested by Susie's account of how she experienced childhood, and her reactions to it both behaviourally and emotionally. Susie did have mental constructs of how her parents functioned and what responses she needed to make to manage risk. Thus in considering this case study, and in particular Fonagy's concept of mentalising, it is

necessary to consider the implications of Susie's case presentation for how personality is structured and how mind is developed.

6.6 Personality Structure and Models of DID & of Mind

Because DSM is a categorisation system, it is concerned with phenomenology. The rigorous recording and comprehending of phenomenological data is hugely important. As well as aiding communication, it is also important as the basis on which to try to integrate this phenomenological data into models of development and function of mind. To fail to do so leaves the data encapsulated in a similar way to the DID separated self-parts, in need of being integrated to avoid polarised and extreme functioning, as may be occasionally seen in professional opinion on the subject of DID. An attempt will be made to examine the data available in this thesis, from the historical literature, clinical practice and the presented case study, to develop as integrated a perspective as possible, given how vast the field of psychological research now is.

In the early stages of the study of any subject, data description is the only facility. It is only when sufficient quality data has been gathered that realistic models may be proposed. Early attempts were made at the synthesis of data into rudimentary models, especially by both Janet and Ribot in France, and Myers and Hart in the UK, not forgetting Prince in the USA. These models were fledgling models in terms of DID, but have cumulatively contributed to modern models that are still only just beginning to be integrationist and sophisticated enough to attempt to explain such a complex phenomenon as DID, which involves so many psychological, physiological and psycho-neurological systems. The problem is that there are no fully proven models of any complex psychological systems, upon which to base the model of DID. Churchland and Sejenowski (1994) demonstrate the complexity of the problem of fully explaining even relatively simple brain systems, such as the lobster's feeding ability. Despite these severe limitations, there are some interesting partially proven models that are now being considered, and help in our understanding of what might be behind the phenomena found in clients diagnosed as having DID.

Currently there is no accepted analysis of competing models of DID. Different authors have tried to summarise them (Putnam, 1997; Brenner, 2001). I have tried to

summarise the historical models in **Table 6-3** and found it too difficult to continue the summary to group these historical models together with modern models, illustrated separately in **Table 6-4**, as it is impossible to consider models of DID without consideration of Models of Mind; because the complexity of the subject means that models are not necessarily competing, but each investigator is using his or her own framework of reference in which to view the subject, thus authors are approaching the same phenomenon from different frameworks.

It is the complexity of mechanisms involved in DID, and its implication for Models of Mind, that makes DID so fascinating. Just as Piaget (1924) revolutionised the investigation of the development of intelligence, by investigating children's errors, and just as brain injuries and deficits have contributed to the understanding of brain and mind functioning, so DID offers a very informative window into the functioning and modelling of mind, including, memory, personality, sense of self, attachment and many other aspects of psychological functioning, including mind/body integration.

Referring to the key historical investigators in **Table 6-3**, and considering Susie's case, I will take each in turn. Gurney, as early as 1884, emphasised the underlying unity in MPD/DID, and this was clearly the case for Susie. Although at a conscious and perhaps pre-conscious level, her self-parts did not share the same experiences; her manager parts had the potential to identify the source of such experience within the self-structure, although this was not generally realised, prior to therapy. This may raise a different question about the therapy's provision of attachment, psychological holding and appropriate relating that seemed to facilitate and make possible the integrating of experience, through desensitisation and emotional and other psychological development, especially the development of emotional regulation. Another important factor, given the role of the right hemisphere in reflecting, temporal self-representation of an integrated kind, and activated by a positive experience of the mothering voice or 'motheres' (Seigel, 1999), may be the ability of the therapist vocally to soothe and reflect the whole self-narrative that has been presented in dissociated chunks. The ability to switch self-parts, does still attest to some underlying unified structure that, prior to the trial and therapy, was apparently not a conscious process.

MESMER 1779				
UK	**FRANCE**			**USA**
GURNEY 1884 Experimentor underlying psychology unity	FREUD 1886 deductive reasoning cons/preconsc/ unconsc hierarchical division of mind	JANET 1886 Experimentor somnambulism weakness/narrowing of consc	RIBOT 1885 experimentor clusters of consc somatic & psychological dissociation laws of memory phys explanation of bypass conscious	
BARKWORTH 1889 active consc linear passive consc holistic			BINET 1896 Multiple consciousness emergent philos	PRINCE 1890 2nd consc = brain & volition not reflex Multiplicity
MYERS 1903 iceberg/specifically of amnesia				
HART 1926 functional vs special dev of alters via experience				

Table 6-3: Early Models of Dissociation and DID

As discussed above, Freud conceived of a horizontal split of the mind between conscious, pre-conscious and unconscious, and Janet described vertical splitting within consciousness. The discussion of these, as opposing models, does not do full justice to the fact that Breuer (Freud, 1893-95, with J Breuer) acknowledged that other authors were reporting vertical splits (Mollon, 1996) and, as Hart (1910) has suggested, Freud and Janet differ less on model than on the phenomena on which they chose to concentrate. Susie's case suggests that it is possible that both Freud's and Janet's ideas may be true, so that they are in fact complementary rather than competing concepts. Repeatedly, during the middle and final phases of therapy, Susie employed information processing techniques between self-parts that were previously vertically split, not sharing conscious information, affect or sensation, but she also began to speed up the integration process later, by the use of a technique, extrapolated from Ericksonian psychotherapy (Milton Erickson, Collected Papers, 1992), of engaging the unconscious mind to transfer data from the unconscious mind of one self-part to the unconscious mind of another self-part. Of course there is no way to verify what was actually taking place in Susie's mind or brain, and at what level, and bearing in mind that there was clear evidence of underlying unity existing

prior to therapy, though operating in an automatic and involuntary manner, perhaps this action of unconscious transfer took place, not in Freud's concept of the unconscious but, in the pre-conscious. Modern theories of intellectual development also suggest the presence of both horizontal and vertical faculties (Anderson 1999). The study of intellect produced theorists, both horizontalists and verticalists, but modern integrationist models suggest that intellect functions in both of these ways and that, rather than intelligence being a complex but unitary facility, it is likely to consist of inter-related multiple intelligences. This issue will be examined further after reviewing the historical and modern models of mind and DID.

Ribot (1885) concluded that the MPD/DID mind has clusters of consciousness and that each has its own somatic and psychological experience. He made the important contribution of the laws of memory and the mechanism by which the physical can bypass consciousness. Susie certainly exemplified Ribot's conclusions. Not only did each of her self-parts represent a cluster of relatively rounded experience, but each was subsequently organised into clusters, either complementary pairs or small groups, sometimes with less important offshoots. Susie's self-harming behaviour evidenced the way in which physical pain bypassed the consciousness of parts that were out and controlling the active life of the body, though it was consciously experienced in some other self-part.

Barkworth (1889) proposed that active consciousness is linear, and passive consciousness is holistic. Modern integration of psychobioneurological data is compatible with this view, although now much greater complexity is available as a result of new instruments. It is now understood that a simplification of the brain's functions shows a tendency for the left hemisphere to be top-down in choosing its focus, based on personal salience, and its analysis to be linear and fine grained. The right hemisphere tends to be dominant for holistic implicit and bottom-up (data driven) analysis.

Both Binet (1896) and Prince (1890) concluded that DID consciousness was multiple, and Susie's case exemplifies this view. For someone who was still in her mid teens when I met her, Susie had an extremely complex self-structure of many tens of parts, organised into sections that she had labelled 'systems'. There were

three systems, one for normal daily life, including parental abuse, prostitution and abuse by family associates. The second, underground system dealt with organised abuse, which she conceived of as religious, Satanist abuse, and the third, that was buried so deeply that only one of her manager parts detected it, was concerned with deeply imbedded hypnotic injunctions, such as the introjection of 'demons'. Again there was evidence of underlying unity because, although all self-parts initially had no conscious knowledge of this system, Susie as a whole was differentially affected by the power of it. Only the one self-part that could bridge systems could identify the third system and its contents, when trying to detect impediments to progress. This third system contained only a handful of parts and none were conceived of as self-parts, but as implants that she felt powerless to eject. Therapy enabled such ejection, eventually, and more significant progress was made afterwards. This specific therapeutic stage was in many ways as if the adult confidence and perceived strength of the therapist enabled the childlike and young client to be accompanied to know about and face her fears and to banish them. I saw system three as being like monsters under the bed; in order to make them go away, they had to be faced and their imaginary power challenged and diminished.

Myers (1903) had described in detail the various forms of amnesia to be found in DID, which are consistent with Susie's case. She had self-parts that had no access to the minds of other parts, and some who had partial access and sometimes shared experience or partial experience, perhaps knowledge, sensation or emotion, but not the whole experience, in this limited way exemplifying the BASK model (Braun, 1998b).

Hart's (1926) idea that DID is based on functional organisation fits perfectly with Susie's explanation of her own self-architecture as well as reflecting modern knowledge of the way the brain develops and is organised (Taylor, 2005, p22). Susie's complete self-structure was organised around function, not only in the way she separated herself into systems, but also in the way that self-parts were grouped within System One and System Two. Functions in System One were, for example, caring for and relating to her mother, father or family friend (group leader) or prostituting. Functions in System Two were, for example, giving birth (in group activity, prior to therapy), the mothering and healing of parts physically and

emotionally hurt in group activity, dealing with specific people or demands, such as the harming of animals or children, dealing with rituals and the inflicting of harm by others.

Another of Hart's findings was that self-parts can develop with exposure, such as in therapy. Normally self-parts in DID are relatively consistent and stable, prior to therapy, though responding to development through experience, in line with Hart's conclusion. This appears consistent with the manner in which the average personality achieves normal development, consistent with Object Relations Theory. An extreme example of the flexibility of a human child to adapt to environmental influence and demand is seen in the various wild child reports, such as the boy in India who was captured by and raised with a wolf pack, behaving in very similar ways to wolves and never acquiring much human language after recapture (Cohen, 2002, p23). Even prior to therapy, Susie reported growth and development in some, but by no means all, of her self-parts. Again it seemed to relate to the intensity and quantity of their employment, in dealing with the impact of the outside world. Susie also demonstrated that there can be exceptions to the normal stability of personification within one self-part, as exemplified by Susie's prostitute part, which functionally needed to be extremely flexible in age-presentation and activity, in order to meet the needs of her clients. She also shared her duties with one or two other parts, for example a prim, Madonna part who performed sexual acts against her will and in a passive manner, whereas the prostitute thought she was the one in control and abusing the men, by taking their money and laughing at them. This worked especially well for men who wished to be humiliated, and she left this sense of power unintegrated from the fact that several of her customers were violent, sometimes to extremely alarming degrees. In working with this part in therapy, it was clear that the flexibility of her presentation was superficial and involved routine pretence or acting, and underneath she had stable characteristics that were quite resistant to change of function and skill transfer and, as stated, she enlisted what she perceived to be outside assistance (handing over to other self-parts). Susie's explanation of her prostitute part suggests interesting differences in her perception between what she saw as variability in this character's presentation and 'presenting' herself in a role, and what she conceived of as separate self-parts, even when they were involved in turn-taking behaviour with the prostitute. Perhaps this suggests that there is in fact

some qualitative difference between acting/pretending/simulating and DID development. Braude (1995) suggests that there are both similarities and huge differences between falsifying and dissociating. In some unpublished research I conducted with Joy Silberg in 1997, we found that children clearly differentiated between DID self-parts and imaginary friends. Although Myers had the beginnings of an emergent philosophy, necessary for modern integrationist models, it did not come to fruition, at that time, being distracted by the two-brain theory. That clearly has little relevance for multiple cases of DID, as with Susie, although differential brain functioning and mapping, a more sophisticated development from the two brain model, made possible by technological advances, does, and will be discussed later. The differential influence of the separate hemispheres has already been alluded to above.

In conclusion, the early theorists had important contributions, much of which is still valid, in considering modern cases. What characterises the discrepancies between them is also similar to the differences between the modern theorists; it is a matter of emphasis and framework of reference. No-one was able to investigate the whole picture because of its complexity. The legacy of their findings is still highly valuable to modern investigation, especially both Janet and Binet in France, and both Myers and Hart in the UK

In relation to the various historical and contemporary models of DID, it is obvious that a comprehensive model that can account for the complexity of data at the phenomenological, psychological and neurological levels is still not completed. Modern models are consistent with many aspects of some of the earlier models, but the development of these has not been linear and, in particular, Janet's eclipse by Freud's greater professional and public acceptance, as well as his very extensive publication in English, has long deprived the dissociation field of important study, until recent times. Though, as the historical literature review has demonstrated, clinical and sometimes theoretical activity has continued out of the public gaze, especially in Britain, where our own historical heritage has become almost entirely forgotten. The problem in reaching a comprehensive model of DID is that DID seems to be a complex personal development structure, which encompasses a wide range of both developmental and other psychological functions. Therefore theorists

have approached it from different perspectives and it is a bit like the story of several blindfolded people each examining a different part of an elephant, they each arrive at different conclusions derived from partial data.

Whatever the reasons for the differences and differential historical influence of Janet and Freud, it seems they too were largely separated by perspective; Janet the scientific experimentalist, observer of external data and holistic thinker; Freud, concerned with introspection, deductive reasoning and a different client group, and a prolific communicator, though having a narrower disciplinary focus than Janet.

I would agree with Myers in finding Janet's concept of weakness in personality structure or consciousness to be misleading in relation to DID; at least, it represents unfortunate terminology. It is likely that Janet merely hoped to convey the inability of the conscious system to remain integrated in the face of overwhelming trauma, and certainly, in this sense, Susie's case is consistent with that view. Such extensive self-organisation, as has been described in this case study, argues for strength of personality structure rather than weakness, and an adaptability that ensures survival in extreme circumstances.

Cognitive Theorists				**Neurological Models**		**Psychoanalytic**
MEMORY	COG SCHEMA	INFO PROCESS	ATTACHMENT	EPILEPSY	HEMISPHERIC	POST FREUD OBJECT RELATIONS
Morton 1991,1994	Kennedy &Waller 1998	Hilgard 1977, 1986 Overton 1964 - State dep learning	Fonagy 1996	Persinger 1993	Ahern et al 1993	De Silva & Ward 1993 Brenner 2001

Integrative Models						
BRAUN 1988b	NIJENHAUS Et al 1998	McINTEE 1992, 1997	PUTNAM 1997	CONWAY et al 2000	SCHORE 2001a&b	TRAUMA
BASK	Ψ/Somatoform/ Animal Studies	Info process & neuro/biolog process + object rel	BDS	ESK	psychoneurobiological	as overarching paradigm. DID as special PTSD. HERMAN,1992 de ZULUETA,1984

Table 6-4: Modern Models of Dissociation & DID

Let us now consider the contributions of the modern models. Morton's headed records model is non-associationist, in contrast to all of the other models. Susie's

report of how her sense of self was organised was associationist, and I would suggest that it is only through multiple associations that such swift switching of parts, in the service of survival, would be possible. It is my contention that Morton is in part right, but that association is required as the main mechanism of organisation and access in memory, where a headed records system of access may be a sub factor in the process, thus allowing the same data to be accessed but through many headings, and not just one as suggested by Morton. Martin and Caramazza (2003) have shown that it is still proving difficult in cognitive neuroscience to specify the mechanisms of semantic organisation, and debate continues over categorisation or function as the organising principal. Perhaps this too will turn out to show that the mind is so complex that it accommodates both, and it is the limitations of investigation that lead to these competing ideas, that may in fact turn out to be complementary.

The models based on cognitive schema, such as that by Kennedy & Waller (1998), are also valid as an explanation at a cognitive level, and this level of explanation is incorporated into the more complex integrative models. State Dependent Learning and Information processing models (Hilgard, 1986; Overton, 1964) are quite consistent with Susie's case and are incorporated into the neuropsychological models proposed by Putnam 1997, Schore 2001a&b and Conway et al 2000.

Although the explanations of DID related to Attachment Theory (Fonagy, 1996) make a valuable contribution, they are of even greater utility when incorporated into a more integrationist model, as proposed by Schore (2001a&b), though even in Schore's very elaborate model and explanation there is a suggestion of permanent brain organisation damage that is belied by clinical examples, such as Susie's therapeutic development demonstrates. It may also be supposed that Susie's young age and stage of development was particularly helpful in promoting her eventual integration, and this is undoubtedly true, but I have also witnessed integration achieved in much older DID clients with extreme trauma histories extending throughout their childhood and well into adulthood, demonstrating the reversibility or plasticity that is possible in DID that may be the exception to the damage or atrophy pictured by PET scan research (Van der Kolk et al, 1997). Also, Fonagy's idea, that disorganised attachment leads to a lack of mentalising or metacognition, may also be quite accurate as an explanation for the difficulties experienced in the

general class of Disorganised Attachment Style, perhaps particularly in the extremely neglected unattached forms, but in DID it is evident that some metacognitive capacity is clearly not a description of how the mind is organised in DID. In this case some metacognition or theory of mind, even if it is at a preconscious level, is required for the managing and organising principal that underpins the self-architecture and the switching. Susie described insight into the working of the minds of her abusers, and she had, albeit unconsciously or preconsciously, organised her own self to manage their behaviour and its impact upon her. Other DID clients have also described similar insight into the minds of their abusers. As Prince (1890) demonstrated, dissociative behaviour associated with a lack of primary consciousness is not a reflex but is a combination of the brain and volition, so it is more likely that it is managed by the right holistic hemisphere of the brain, and conscious control of the switching between self-states may be a matter of degree. It may also be that DID is the exception to the rule, regarding the model as described by Fonagy, and indeed as regarding the neurological damage reviewed and reported by Schore. Perhaps DID is the result of some exceptional plasticity and resilience in the organisation and functioning of the brain and organisation of the mind.

Putnam (1997) has summarised five basic models gleaned from the historical literature. To recap, these are the autohypnotic model, neurological models such as epilepsy and temporal lobe dysfunction, hemispheric laterality, social role/simulation/malingering and animal models. Consideration of their limitations led him to suggest a new Discrete Behavioural States (DBS) model that incorporates the idea of State Dependent Learning (SDL) and suggests that the modern theory of non-linear dynamics helps to conceptualise the way in which internal DID architecture functions. Interestingly, SDL was initially described in 1830 by George Combe, an English phrenologist, and later rediscovered by Donald Overton (1964). Putnam's DBS model is consistent with available data, and attempts to integrate data from the different levels of description, the behavioural, the cognitive and the biological/neuropsychological, but emphasises the conceptual. More recently a neuronal analogue of SDL has been described by Shulz et al (2000). Conway and Plydell-Pearce's (2000) neurological model, discussed in section **4.10**, is not inconsistent with Putnam's concept, or indeed with the gist of Schore's contribution and it also begins to suggest the neurological mechanisms in more detail. Recent

psychoneurological theories also expand on Albert Wilson's 1904 suggestion that the prefrontal area of the brain was responsible for MPD. Conway et al's model provides a less permanent structural mechanism that is able to account for the therapeutic changes observed in DID clients of all ages. Forrest (2001) has also proposed a neurodevelopmental theory, extending the work of Putnam, and also of Attachment Theory, and suggests that the orbitalfrontal cortex manages DID. Her thesis is that, in normal development, the infant's integration of different experiences of self, represented by differing neural networks, is achieved by consistency in the nurturing caregiver. In the seriously abused child, traumatic experiences prioritise behavioural responses demanded by the immediate situation, over the integration of contradictory self-states resulting from contradictory demands by the adult. She suggests that the orbitalfrontal cortex (OFC), responsible for inhibitory control of information, and also, through the mechanism of dopaminergic innervation, controls emotion, attention, movement, visceral functioning, movement towards emotionally significant stimuli, attachment and social interaction. Under normal circumstances of development, the child would act upon the synthesis between immediately temporal information and stored and relatively integrated data but, for the DID child, survival demands that contradictory information be strongly inhibited. Forrest proposes, in common with Schore, that this is achieved in the OFC by protective inhibition because, in the absence of such inhibition, the contradictory information would seriously disrupt immediate goal-oriented behaviour. She proposes that the OFC is unable to bias towards either the sympathetic nervous system high arousal or the parasympathetic nervous system low arousal since the adult's unpredictability requires the child to remain hypervigilant and capable of complex behavioural actions, and so adopts context specific inhibitory processes, resulting in amnesia between self-states. Forrest also suggests that fusion and integration of self-parts in therapy is achieved by the therapist providing 'sufficient contiguity of dyadic input'.

Consistent with the theories above, imaging studies have demonstrated that trauma specific memories activate different areas of the brain in different self-parts of DID subjects, and that DID subjects have different access to affective memories in different self-states (Tsai et al, 1999 and Reinders et al, 2003).

The phenomena from Susie's case is consistent with these information processing models and leads me to conclude that, whilst my information processing model, which was arrived at in an ad hoc manner and served to support my psychotherapeutic intervention, was in many respects simplistic, in the light of my current experience and in light of current published opinion and data, it is substantially valid. I had initially conceived of processing backlog in terms similar to Braun's BASK model (1988b), but Susie's case and other DID cases have taught me that, whilst this is probably one aspect of some of the processing delay, in the majority of experience for Susie, relative integration of the components of the BASK model were achieved within each self-part and her lack of holistic integration could not be explained by Braun's model. Those of Putnam, and also of Conway et al, also help to explain some of the mechanisms that may have been involved in the way Susie organised herself to manage overwhelming experience.

In agreement with Putnam's dismissal of the autohypnotic model of DID, Susie's case presented no direct evidence of this as a process, although it may have formed some aspect of a much more complex set of processes that served to manage her situation and development. In support of the idea that it may play some part, another client described in great detail how she held her breath for incredibly long periods of time in order to balance between existence and almost total internal and external passivity, in the face of overwhelming abuse and abject helplessness and despair. This was not my only client to describe something of this kind; as mentioned earlier, another example was found in the client who used to revisit this experience compulsively through exhaustive running. Again in agreement with Putnam's evaluation of the research evidence, the simplistic hemispheric model of DID is woefully inadequate to account for the relatively rounded existence of such a multitude of self-parts as described by Susie, though the new PET scan techniques and increased knowledge of brain development, organisation and functioning are beginning to describe specific brain site involvement in emotional and other cognitive experience. The relative independence of brain functions, both between and within hemispheres, attest to the enormous flexibility and plasticity of mind organisation.

6.7 Conclusion re evaluation of this case study

The presentation of Susie, though largely unique, appeared consistent with other cases of which I had experience and appeared to fulfil the criteria for DID according to DSM-IV. As far as I could ascertain, although subject to normal cultural influences such as Christianity, gender stereotyping and possibly films, I could detect no specific cultural knowledge of DID as depicted in films, literature or specific accounts of DID, at least until therapy was well under way and Susie had delineated her self-architecture. She reported an organisation of self-parts, that was hierarchical and functionally based. She experienced both mutual amnesia and partial amnesia between self-parts, with her organising parts increasingly able to access information at will as therapy progressed, though there was evidence of some volition in this regard even prior to therapy.

All of her parts developed in proportion to their experience of the external world, both before and during therapy, consistent with the experience of Hart and the '1/5th man' and with Prince and 'Miss Beauchamp', and in reflection of the world's degree of control over Susie, consistent with Object Relations Theory, combined with the inverted nurturing dynamic between Susie and her parents. Susie had, from a very early age, learned to reflect her parents in the absence of their reflecting of her, a recognised abuse dynamic. All of her self-parts seemed to have both conscious and unconscious or perhaps pre-conscious systems, and all were underpinned by an unconscious unity, as suggested by the historical writers, Gurney (1884b) and Ribot (1885). Because the objective of psychotherapy is to place the increasing functionality of the client as paramount, and scientific investigation has to be relegated, it was not possible to test this hypothesis, but merely to report it as an interesting therapeutic phenomenon that is suggestive of a complex theory of mind. Therapeutically, she could make progress via systematic desensitisation and the sharing and processing of difficult knowledge and affect, through the utilisation of both conscious and unconscious/preconscious links between self-parts.

A specific comparison of historic adolescent case reports, shows Susie to have consistencies, such as age, variable visual acuity, different gender and age alters, as well as distinct differences such as an absence of headaches associated with switching of self-parts, a lack of physical illness or neurological dysfunction and a

significantly increased number of self-parts, placing it at the complex end of cases, even in comparison to modern cases.

The study of the literature and this case have inevitably involved a consideration of models of mind and of psychoneurological and developmental explanations for DID, suggesting that complex state specific experiences are inhibited from integration as a functional necessity is achieved automatically by infancy, in the face of overwhelming and life threatening repetitive trauma, in the interest of self-survival and conformity with adult demands. Modern models of mind suggest this is achieved primarily in the working memory/orbitofrontal system through selective inhibition of stored information in long term memory, and that this is largely controlled in the right hemisphere implicit processing system.

6.8 Susie: An Isolated Case in Britain?

As already stated, when I began therapy with Susie, I had already encountered other adult cases of DID and become aware of other professionals who were also providing such clinical intervention, but this provided only anecdotal data. A pilot survey had been conducted earlier by this author, of conference participants at the first three ISSD(UK) conferences, but again this was likely to be a biased and self-selected audience and curiosity remained as to the position of professional awareness, belief and clinical activity throughout the UK. This lead to the conducting of a nationwide survey of psychiatrists and clinical and counselling psychologists, via their professional bodies. In the next chapter the method for conducting this survey will be detailed and results provided in **Chapter 8** and analysed in **Chapter 9**. The survey was conducted prior to the author's current awareness of the literature and during the course of the therapeutic process with Susie, but long before its conclusion.

CHAPTER SEVEN

METHOD

7.1 Design

A cross-sectional design was employed in the administration of a self-report questionnaire to a sample of professionals working in psychology and psychiatry in Britain.

7.2 Participants

Participants comprised 972 professionals, from the fields of psychology and psychiatry working in Britain (482 male, 485 female, 5 unspecified; mean age 42.1 years, s.d. 11.4) who responded to the administered questionnaire (See *Sampling procedure* and *Psychometric Instruments*). An overall response rate of 9.3% was achieved; further participant characteristics and differentials within this response rate are detailed in the body of **Chapter 8, Tabulated Results**.

7.3 Sampling procedure

As the primary aim of the research was to investigate clinicians' own reports of the awareness and experience of dissociative disorders in Britain, and practical constraints prevented surveying the entirety of this population, a sample had to be selected from all possible professional and non-professional groups who could be identifying relevant cases. Originally the target sample was defined as all psychiatrists registered with the Royal College of Psychiatry (RCP) and all clinical and counselling psychologists registered with the British Psychological Society (BPS), a total potential sample of 10414, comprising 7500 RCP registered psychiatrists and 2914 BPS registered clinical and counselling psychologists, including trainees. Counsellors and psychotherapists out with the target groups are also likely to have valuable data but could not be included in this study. As noted in the literature review charting the historical development of the concept of DID, psychologists and psychiatrists have dominated the professional literature. In

addition, to reach target individuals outwith the BPS, and at different career stages, batches of questionnaires were also mailed to all clinical psychology training courses for distribution to their trainees.

Within the target sample, respondents were self-selecting on the basis of the return or non-return of the distributed questionnaire (see *Administration procedure* and *Psychometric Instruments*). Non-returns were not subject to follow-up procedures, as a single-sweep administration to a large sample was considered a better use of resources in maximising data collection, rather than targeting a smaller sample and allowing for reminder or re-administration procedures.

7.4 Administration procedure

The initially preferred administration strategy, to address each questionnaire personally to all recipients in order to attempt to maximise the return rate, could not be implemented in practice.

Additionally, the large number of registered psychiatrists was prohibitive to conducting individual mail shots, due to the practical constraint of cost. In order to preclude the use of further sampling criteria, and achieve the study aim of contacting all registered psychiatrists, the questionnaire was included as an insert in the *British Journal of Psychiatry*. This procedure thus balanced the loss of personalisation against the potential of data gain via contacting all potential respondents, whilst professional affiliation was maintained via the journal. Moreover, this option was chosen, over a personal mailing to selected psychiatrists, in order to make the sample size as large as possible.

A similar procedure was considered for contacting psychologists, however, the British Psychological Society's Division of Clinical Psychology have a policy of not allowing questionnaires as inserts in their journal, thereby barring this equivalent procedure. The purchase of a BPS mailing list was also precluded due to the expense of the option. Thus the most cost-effective option to reach the largest number of people within the target sample was selected: Questionnaires were placed in envelopes and sent to the BPS for onward personalised mailing to a list of all registered clinical and counselling psychologists. As reported all clinical psychology

training courses were requested to distribute questionnaires to their trainees. This action was especially relevant to accessing details of contemporary training (see *Measures*).

In both instances, and in line with response rate maximising procedures as established by previous research (Robson, 1993, p251), a stamped addressed envelope was provided, for the return of the questionnaire, to minimise required participant investment, and eliminate potential time, effort and cost-related barriers to responding. On the outside of the envelope, above the return address, in capital letters and in bold, was the request **"PLEASE HELP WITH THIS IMPORTANT RESEARCH"**.

7.5 Psychometric Instruments

The questionnaire constituted a computer-designed, professionally printed, four-sided A4 booklet (see **Appendix 1**).

Considerable effort was invested in considering general presentation issues. Firstly, commentators, such as Robson (1993, p250), have suggested that the appearance of questionnaires is a vital factor in securing a good response rate from postal surveys. Moreover, as the target population was considered likely to be frequently requested to participate in research, a well-presented design was considered to be of increased importance. The computer design and professional printing of the instrument addressed these considerations.

Furthermore, ease of response, in terms of time and expended effort, was considered an important factor in reducing attrition rates and non-response rates in a potentially 'research fatigued' sample of busy professionals. Such considerations necessitated careful balancing of the somewhat conflicting aims of maximising data collection, and presenting items in a user-friendly format, which ensured the questionnaire was simple and quick to complete. To meet these aims, the booklet format reduced the volume of the questionnaire, increased its ease of handling and appearance, and a tick-box response format was used wherever possible. In addition, except for items in the first section of the questionnaire (see *Measures*), the tick-box response sections

of the questionnaire were highlighted to focus the reader's attention, thus minimising data loss.

Further steps were undertaken to encourage completion and return of the instrument. Page one, the front cover of the A4 booklet, constituted a covering letter bearing the Regent's College logo. It was intended that this logo would make it immediately obvious to the recipient that the research was supported by an academic institute, so encouraging recipients to reflect on their own experiences of academic research and the need for co-operation between professionals in such endeavours, hopefully improving return rates. The letter was addressed, **"Dear Colleague"** for similar reasons. In addition, the incorporation of the academic crest clarified that the purpose of the research was to achieve an academic qualification, rather than to meet the needs of a professional organisation or body (see **Chapter 9, Research Evaluation & Discussion of Results**, for further consideration of this issue).

A capitalised heading in bold type followed the addressee line, reading

"NATION-WIDE SURVEY REGARDING FMS AND DISSOCIATION",

thus clearly orienting the reader to the central topic of the research. Below this heading, the aim of the research, to inform future training needs, was highlighted, thus conveying to potential respondents that completion of the questionnaire constituted a forum in which professionals could make a valuable contribution to the mental health professions by identifying ways in which to improve services to clients/patients. Since my own experience (see **Chapter 1, Introduction**) had been that my work with DID clients had begun in the context of a dearth of specific training, this was a particular focus in the body of the letter.

The main body of the letter acknowledged time constraints and requested completion of the questionnaire, briefly explaining that the research was for the purpose of a PhD project. It was specified in bold type that the questionnaire was addressed to

"all psychiatrists and clinical/counselling psychologists in Britain"

in order to make the scope of the research explicit, and to avoid the impression of a single profession survey, as might have been intimated by circulation via the professional bodies. Circulation via the BJP may otherwise have given the impression that psychiatrists were the target profession in research conducted by a

psychologist, thus reducing the professional identification required to maximise results. It was hoped that making explicit the comparison between psychiatrists and psychologists in this contentious area of research, would maximise respondents' tendency to express an opinion. The researcher, whose status and affiliation as a PhD student was again reiterated at the bottom of the letter, personally signed the questionnaire.

7.6 Development procedures

Advice on early versions of the instrument was obtained from a number of sources: the thesis supervisor who, as a counselling psychologist, constituted a member of the target sample, and from various colleagues from diverse professional backgrounds. Additionally, as well as the questionnaire being subject to approval by Regent's College, as the presiding academic body, the adopted administration procedures (see below) necessitated that the questionnaire be approved by the Royal College of Psychiatry and the British Psychological Society.

Not only could the educational and ability level of recipients be assumed, the target sample was also assumed to be "survey literate", and it was therefore felt unnecessary to conduct a full pilot study to test the usability of the questionnaire. This again freed resources to permit administering the instrument to the greatest number of target professionals. The questionnaire was, however, tested on a number of colleagues in a small-scale pilot study, to assess comprehensibility and completion time, which was found to be approximately 15 minutes.

Feedback was handled via discussion sessions, and improvements were suggested, designed, and implemented in an interactive process. In result, the shaded areas to draw the eye to the tick boxes were added, more clearly defined tick box areas were designed, a simplified numbering system was adopted, and a smaller font was used - all contributing to the cleaner appearance of the questionnaire. Via the consultation process it was also suggested that, despite the assumption that professionals would be familiar with DSM criteria, consideration be given to including definitions. Although space did not permit their inclusion, it was thought useful to include the categories as a key to box ticking, thus acting as a reminder for the categories themselves.

7.7 Measures

The questionnaire was designed to obtain both qualitative and quantitative data about Dissociation, and consisted of both closed and open questions, the latter being kept to a minimum in order to meet the aims discussed above (see *Psychometric Instruments*), and in line with the suggestions of Robson (1993, p243). As no comparable survey of this kind regarding Dissociation had previously been undertaken, all of the items were originally developed, though "standard formats" were drawn upon where possible, for example in the presentation of demographic items. Measures were grouped under section headings outlining the content of the items following. The section headings used in the following summary replicate the questionnaire wording.

Professional Details. Items1-6 comprised requests for demographic details, namely open-response items concerning profession, professional and academic qualifications, current role (including specialism) and current service, with designated space for participants' responses and response boxes in which participants were requested to indicate age, gender, and years of post-qualification experience (or alternatively years until qualification). These demographic items were presented first to comply with convention, thus constituting a familiar format and, as prioritising the demographic variables also prioritises the personal details of the respondent, thus conveying a sense of the importance of the individual's contribution.

In order to assist participants in responding to the subsequent sections, a key to abbreviations was located below this Professional Details Section, and repeated on each of the subsequent pages of the questionnaire. As discussed above (*Development procedures*), in responding to the following items it is assumed that the respondent is familiar with DSM-IV criteria, but this key acts as an economical and orienting reminder.

Dissociative and FMS Awareness. Items 7-14 requested that participants indicate in highlighted tick-boxes, offering "Yes" or "No" responses, in relation to both Dissociation and FMS, whether they had heard of the concepts, whether they agreed the concepts existed, whether they had encountered such in a client, and whether they

agreed that such were consequences of iatrogenesis. Open response items also asked participants how they became aware of FMS and Dissociation, and to provide their own definitions of FMS and Dissociation. In this initial section, participants were only required to supply their beliefs regarding FMS and Dissociation, in contrast to later items that question participants regarding further sub-categories (see *Details of your clients*).

These items, regarding participant awareness, were presented next, as this again continued the collection of personal data in the form of personal understanding and opinion. On a further terminological point, although the term FMS has been justifiably criticised, by authors such as Stephen Braude (1995), as inaccurate nomenclature, it was used in this survey since, during the 1990's, it seemed to have become common parlance amongst professionals and the media. Another reason for its use was that the Royal College of Psychiatry had conducted a UK survey of its members regarding recovered memories and had received a poor response rate. It was therefore felt that using the more widely publicised term FMS might elicit a broader set of data and opinions by encouraging a greater number of responses.

Therapeutic Intervention. Item 15 asked participants whether they were providing treatment for 'Dissociative' clients; following this item the respondent was provided with a shortcut to the final section (*Teaching and Training*) if the answer to both sections of question 15 was "No", thus saving time and maintaining the relevance of the questions. If a "Yes" response was given, participants were then asked, with reference to Dissociation, in what year they first supplied treatment, and were asked to state (i.e. openly respond) in what capacity it was supplied. Participants were also asked to indicate what form the treatment took, by ticking "yes" or "no" with regard to the supplied options; individual therapy, group therapy, supervision, drug therapy, or assessment only. The final item in this section asked for the number of hours per week working with these conditions, in order to gain an idea of the proportion of time spent with these cases.

Details of your clients. Items 20-27, concerned both demographic client information and information in regard to treatment and treatment outcomes. In this section the items relating to dissociation were sub-divided into the three possible categories

relating to DSM-IV (for definitions see Appendix 5), eg Dissociative Disorders, Dissociative Identity Disorder. The DSM-IV category of Dissociative Disorders Not Otherwise Specified is a non-specific category, so it was located slightly apart from the other boxes, but included for completeness.

Question 20 had 14 sub-sections corresponding to age ranges for males and females separately across the four possible conditions. These categories were as follows: less than ten years, less than 18 years, 19-25 years, 26-35 years, 36-50 years, 51-65 years and over 65 years. Response boxes were supplied for respondents to record numbers of male and female cases separately for all age ranges.

Teaching & Training. Items 28-33. In this, and the remaining three sections, the sub-division for dissociative conditions was deemed unnecessary and the response format condensed in the interest of economy. Items 28-30 comprised "Yes/No" tick boxes – this replicated the response format utilised on page two of the questionnaire (as detailed above, see *Dissociative and FMS awareness*). Questions 28 and 29 asked about training received, and question 30 asked about training provided. Questions 31 and 33 comprised open-ended questions regarding the audience trained and the course content, and question 32 asked for the number of hours training, on Dissociation, provided to other professionals who are at different levels of experience and training.

Supervision/Research/Resources. Items 34-36. This section contained one "Yes/No" response format item asking whether respondents had provided supervision for professionals working with Dissociation. A further two, open-ended, items required respondents to provide details of the professions to which this supervision was supplied, and the number of hours of supervision provided

Item 37. This section contained Yes/No tick boxes only, and aimed to consider the issue of why there is such a dearth of published data and articles, by asking respondents whether they had started and/or completed research, and the number of publications achieved and rejected.

Item 38. This section asked for a rating of professional support received from colleagues, on a scale of 1 (non-existent) to 5 (excellent), for each of the following groups; own work group, own profession, other professions.

Given the need to be economical, and remain within a simple four-page format, this section was somewhat condensed, however, in view of the lack of existing research in this area, the included questions were deemed sufficient to supply preliminary data.

A reminder was located following the final item, reading; **"PLEASE POST IN THE ENVELOPE PROVIDED"**, and a statement thanking the respondents for their help.

7.8 Summary

- A postal survey methodology was selected
- The target sample of psychologists was defined as all clinical and counselling psychologists registered with the British Psychological Society (BPS), and all clinical psychology trainees enrolled on accredited courses
- The target sample of psychiatrists was defined as all professionals registered with the Royal College of Psychiatry (RCP)
- BPS registered clinical and counselling psychologists were contacted via a personalised mailing, and clinical psychology trainees were contacted via questionnaire batches sent to accredited courses
- The target sample of psychiatrists was contacted via an insert in the *British Journal of Psychiatry*
- With regard to questionnaire design, consideration was given to presentation and ease of response, with the aim of maximising response rate

- ❖ Feedback from fellow professionals was sought, and acted upon, in refining questionnaire design

7.9 Hypotheses Relating to the Survey

1. The majority of clinicians will be aware of the concepts of dissociation and DID due to media exposure (Dorahy later reported that 55.8% of practitioners in Northern Ireland 'believed' in DID)

2. Clinicians will report limited training provision

3. Clinicians will report low levels of professional support

4. Psychiatrists will be less likely than Psychologists to report cases of DID (Mersky, 1992, 1994)

5. Clinicians will believe DID is iatrogenic (Mersky, 1992, 1994)

CHAPTER EIGHT

TABULATED RESULTS

8.1 Sample Characteristics

The mean age of respondents was found to be 42.1 years (s.d. 11.4, n=954), with a range of 24-83 years. More specifically, where gender could be identified, mean age was 44.4 years (s.d. 12.64, n=473) for the male respondents supplying data, and 39.8 years (s.d. 9.58, n=480) for the female respondents.

Participants reported a mean 15.3 years in practice (s.d. 10.6, n=883), a mean of 17.9 years for male respondents (s.d. 11.4, n=454), and 12.6 years for female respondents (s.d. 8.8, n=429). A median split of participants was effected to allow comparison between relatively less and more professionally experienced groups.

The demographic information supplied by participants provided a detailed picture of respondents' professional background and current role. On the basis of the information supplied regarding profession, respondents were classified into the professional category of psychologists (including BPS respondents, clinical psychology trainees and psychology assistants) and psychiatrists (consisting of RCP respondents). For ease of reference, these two groups will hereafter be referred to broadly as psychologists and psychiatrists. Where several qualifications were held, the respondent's own dominant classification was used, or where this was not possible, respondents were classified according to their current role. By this classification of the 972 respondents, 454 were categorised as psychologists, 506 respondents were classified within the psychiatrists category, a further 10 respondents were unclassifiable by this binary professional categorisation, by virtue of their qualifications and professional roles, and two respondents gave null data.

A further classification was effected for comparison, based on the cited qualifications, experience, and role of the respondents, to differentiate between those reporting therapeutic training and those not reporting such. By this classification, of the 965 respondents who supplied this data, 157 reported therapeutic qualifications or experience, whilst 808 did not. Data for psychologists and psychiatrists, excluding other professions, was further analysed, as illustrated below.

Coded Profession/Training Category	Gender of Respondents (Frequency, Percentage of Coded Category)		Mean Age (s.d.) in Years	Mean Years (s.d.) in Practice
	Male	Female		
Psychologists	144 (31.9%)	307 (68.1%)	40.2 (10.0)	11.7 (8.27)
Psychiatrists	333 (65.7%)	173 (34.3%)	43.5 (12.4)	18.1 (11.3)
Therapeutic training	63 (40.4%)	93 (59.6%)	46.7 (11.0)	15.7 (10.6)
No therapeutic training	417 (51.7%)	389 (48.3%)	41.2 (11.3)	15.2 (10.6)

Table 8-1: Gender Distribution, Mean Age & Mean Years in Practice of Respondents, by Professional Category

	Number	Percentage
Therapeutic Training	157	16.15
No therapeutic training	808	83.13
No response re training	7	0.72
Total	**972**	**100**

Table 8-2: Therapeutic Training of All Respondents

Coded Profession Category	Number of Respondents Indicating Trainee Status	Percentage of Professional Category
Psychologists	60	11.8% (n=506)
Psychiatrists	11	2.42% (n=454)
Total	**71**	**7.4% (n=960)** (of all category coded respondents)

Table 8-3: Respondents Indicating That They Are Still in Training, by Coded Profession Category

8.2 Geographical Distribution of Responses

As the survey was anonymous, it was not originally intended to classify the responses by region, but in some cases demographic information was supplied by respondents. Also, although not originally a planned variable, curiosity about postal marks gave rise to interest in this data, and it was possible to classify 87% of

respondents according to geographical regions, grouped according to a division of the UK into the following areas: North West, North East, Midlands, South West, South East, East Anglia, London, Wales, Scotland, Northern Ireland, and Eire. One reply was received bearing an Australian postmark. The number of responses received from the categorised regions is displayed below in Table 8-4.

Coded Region Category	Respondents			Total Number of Responses	% of Responses Coded by Region (n=848)	% of Total Responses (n=972)
	Psychology	Psychiatry	Others			
North West	41	44	0	85	10.0	8.7
North East	49	71	0	120	14.2	12.4
Midlands	47	51	2	100	11.8	10.3
East Anglia	33	15	1	49	5.8	5.0
South West	39	39	0	78	9.2	8.0
South East	65	52	1	118	13.9	12.1
London	66	94	4	164	19.3	16.9
Wales	14	21	3	38	4.5	3.9
Scotland	31	38	0	69	8.2	7.1
Northern Ireland	11	12	1	24	2.8	2.5
Eire/Ireland	2	0	0	2	0.2	0.2
Australia	0	1	0	1	0.1	0.1
Total	**398**	**438**	**12**	**848**	**100**	**87.2**

Table 8-4: Responses from Professional Categories, Presented by Region

8.3 Knowledge and Beliefs

Data were analysed to investigate salient differences in knowledge, beliefs and attitudes between the professional groupings. Of those who responded to questions regarding knowledge, beliefs, and attitudes, 94.5% reported that they had heard of dissociation. Of these participants, 97.9% endorsed "Yes", dissociation does exist. Notably, many participants qualified their answers to the former question, or indicated their difficulty/reservations in responding.

Response	Professional Category			
	Overall (n=855)	Psychiatrists (n=475)	Psychologists (n=369)	Others (n=11)
Yes	837 (97.9%)	466 (98.1%)	361 (97.8%)	10 (90.9%)
No	18 (2.1%)	9 (1.9%)	8 (2.2%)	1 (9.1%)

Table 8-5: No. of Respondents who had Heard of Dissociation, Agreeing that Dissociation Exists

73.1%, or 645 (n=882) respondents reported having encountered dissociation.

Profession	Number & Percentage of Respondents Reporting Having Encountered Dissociation
Psychologists	239 (n=395) 60.5%
Psychiatrists	399 (n=477) 83.6%
Others	7 (n=10) 70%

Table 8-6: No. of Respondents Reporting Having Encountered Dissociation, by Professional Category

A notably low number of responses were received in answer to the items asking respondents whether they considered dissociation to be a consequence of iatrogenesis (n=666). Indeed, some participants added a note indicating they were unfamiliar with the term iatrogenesis. Overall 21.3% of respondents providing an answer attributed dissociation to iatrogenic causes. Further indicating that respondents had difficulty with this item, 50 respondents (7.5%) added "don't know" and 30 respondents (4.5%) wrote "possibly" or "sometimes", alongside the provided yes/no tick boxes. Typically, qualifying comments accompanied these amendments.

	Dissociation Attributed to Iatrogenesis?		
	Number of Respondents	% of Valid Responses	% of Total Respondents
Yes	142	21.3	14.6
No	444	66.7	45.7
Don't Know	50	7.5	5.1
Possibly/ Sometimes	30	4.5	3.1
Total Valid Responses	**666**	--	**68.5**
Missing Responses	**306**	--	**31.5**

Table 8-7: No. of Respondents Attributing Dissociation to Iatrogenesis

8.4 Case Reports

Overall, 73.1%, or 645 (n=882) respondents reported having encountered dissociation. Following this introductory question, more detailed information was gathered regarding client numbers, and this data is presented in Table 8-8, below.

Condition	No. of Cases Reported by Respondents	Percentage of Total No. of Reported Cases
Dissociative Disorders	2651	81.3
Dissociative Identity Disorder	394	12.1
Dissociative Disorder Not Otherwise Specified	216	6.6
Total	**3261**	--

Table 8-8: No. of Cases Reported, Presented by Condition

Profession	Number of Respondents Reporting Having Treated DID
Psychologists (n=454)	52 (11.5%)
Psychiatrists (n=506)	51 (10.1%)
Others (n=12)	2 (16.7 %)
Total Sample (n=972)	**105 (10.8%)**

Table 8-9: Number of Respondents Reporting Ever Having Treated DID

Those respondents reporting ever having treated DID had a mean age of 45.1 years; Of the 105 respondents, 51 were male and 54 female. Only 1 was yet to qualify fully. It was possible to classify 93 of these respondents according to geographical region, as detailed below:

Coded Region Category	Number of Respondents	Percentage of Responses Coded by Region (n=93)
North West	13	14.0
North East	12	12.9
Midlands	14	15.0
East Anglia	9	9.7
South West	9	9.7
South East	10	10.7
London	14	15.1
Wales	3	3.2
Scotland	9	9.7
Northern Ireland	--	--
Eire/Ireland	--	--
Australia	--	--
Total	**93**	**100**

Table 8-10: Geographical Distribution of Respondents Reporting Ever Having Treated DID

Condition	Total No. of Cases Reported by Respondents Categorised by Profession	Professional Category (Frequency, Percentage of Total No. of Cases Reported by Respondents Categorised by Profession)		
		Psychiatrists	Psychologists	Others
DD	2651	2014 (76.5%)	617 (23.5%)	20 (0.7%)
DID	394	288 (73.1%)	106 (26.9%)	0 (0%)
DDNOS	216	128 (59.3%)	88 (40.7%)	0 (0%)
Total	**3261**	**2430**	**811**	**20**

Table 8-11: No. of Classifiable Cases Reported by Respondents, by Professional Categories, by Condition

Professional Category	Mean No. of Cases	No. of Respondents
Psychologists	2.47	43
Psychiatrists	7.02	41
Overall (Total Sample)	**4.69**	**84**

Table 8-12: Mean No. of DID Cases Reported by Respondents, Specifying DID Case Details, Coded by Professional Category

The number of DID cases reported by individual respondents ranged from 0 to 70.

Profession	Number of Respondents	Percentage of Total No. of Respondents Reporting Ever Having Treated DID (n=105)
Psychiatrist	45	42.86
Clinical Psychologist	44	41.91
Counselling Psychologist	6	5.71
Doctor	4	3.81
Psychotherapist	3	2.86
Clinical Psychologist & Counsellor	1	0.95
Clinical & Forensic Psychologist	1	0.95
Unclassified	1	0.95
Total	**105**	

Table 8-13: Professions of Respondents Reporting Ever Having Treated DID

Chi-squared analysis revealed no association between the groups defined by the median split of years of experience with regard to whether respondents had heard of dissociation, believed in the existence of dissociation, or attributed dissociation to iatrogenic causes.

Experience Classification	Not Encountered DID	Encountered DID	Treated DID
More Experienced	91	321	58
Less Experienced	102	292	45
Total	**193**	**613**	**103**

Table 8-14: No. of Respondents Classified as More/Less Experienced (Variable Defined by Median Split) Reporting Ever Having Encountered/Treated DID Clients

8.5 Age and Gender Distribution of Case Reports

Client Gender	Number of Clients Reported Within Age Classifications						
	<10	<18	19-25	26-35	36-50	51-65	>65
Male	18 (0.7%)	124 (4.7%)	263 (9.9%)	195 (7.4%)	114 (4.30%)	18 (0.68%)	23 (0.87%)
Female	38 (1.4%)	327 (12.3%)	653 (24.6%)	533 (20.1%)	232 (8.75%)	58 (2.19%)	55 (2.07%)
Total	**56 (2.1%)**	**451 (17.0%)**	**916 (34.6%)**	**728 (27.5%)**	**346 (13.1%)**	**76 (2.9%)**	**78 (2.9%)**

Table 8-15: Age and Gender Distribution of Reported Dissociative Disorder (DD) Clients (n=2651)

Client Gender	Number of Clients Reported Within Age Classifications						
	<10	<18	19-25	26-35	36-50	51-65	>65
Male	2 (0.5%)	14 (3.6%)	52 (13.2%)	28 (7.1%)	13 (3.3%)	0 (0.0%)	9 (2.3%)
Female	12 (3.0%)	38 (9.6%)	91 (23.1%)	74 (18.8%)	32 (8.1%)	6 (1.5%)	23 (5.8%)
Total	**14 (3.6%)**	**52 (13.2%)**	**143 (36.2%)**	**102 (25.9%)**	**45 (11.4%)**	**6 (1.5%)**	**32 (8.1%)**

Table 8-16: Age and Gender Distribution of Reported Dissociative Identity Disorder (DID) Clients (n=394)

Client Gender	Number of Clients Reported Within Age Classifications						
	<10	<18	19-25	26-35	36-50	51-65	>65
Male	0 (0.0%)	7 (3.2%)	21 (9.7%)	22 (10.1%)	10 (4.6%)	0 (0.0%)	0 (0.0%)
Female	0 (0.0%)	13 (6.0%)	55 (25.5%)	53 (24.5%)	27 (12.5%)	7 (3.2%)	1 (0.46%)
Total	**0 (0.0%)**	**20 (9.3%)**	**76 (35.2%)**	**75 (34.7%)**	**37 (17.1%)**	**7 (3.2%)**	**1 (0.46%)**

Table 8-17: Age and Gender Distribution of Reported Dissociative Disorder Not Otherwise Specified (DDNOS) Clients (n=216)

8.6 Teaching, Training and Research

Training Received in Treating Dissociation (n=877)	
Yes	500 (57.0)
No	377 (43.0)

Table 8-18: Number of Respondents Reporting whether Training Received in Dissociation

Research/Publication Activity	Number of Respondents	n	%
Research Started	28	769	3.64
Research Completed	19	765	2.48
Publications Achieved	11	762	1.44
Publications Rejected	7	752	0.93

Table 8-19: Number of Respondents Reporting Research & Publication Activity in the Area of Dissociation

Research/Publication Activity	Mean Rating (s.d)	Likert Scale Interpretation
Support From Own Workgroup	2.80 (1.38)	Basic/Average
Support Within Profession	2.83 (1.23)	Basic/Average
Support From Other Professions	2.31 (1.24)	Basic/Average

Table 8-20: Mean No. of Respondents Reporting Support in Treating Dissociation, & Categorisation of Level of Support

8.7 Summary

- A low response rate of 9.3% was achieved yielding 972 respondents
- Hypothesis 1 is confirmed. Almost all respondents report being aware of Dissociation with 73.1% having encountered cases
- Hypothesis 2 is not confirmed, with more than half of respondents reporting having received training in dissociation. The question was unfortunately not specific to DID
- Hypothesis 3 is partially confirmed, with reports of Basic/Average support from colleagues

- Hypothesis 4 is not confirmed, with the return rate of psychologists (15.5%) being higher than that of psychiatrists (6.7%), but psychiatrists reported two and a half times the number of DID cases

- Hypothesis 5 is not clearly confirmed. 14.6% of respondents thought that dissociation is iatrogenic, 45.7% thought not, but some respondents did not understand the term

- Clinicians' reporting of identifying and treating cases of Dissociation produced a distribution amongst sub-categories that was in expected proportions, apparently matching a normal distribution

- Data generated by open-ended questions are reserved for future analysis

- The core issues are selected on the basis of gaps identified by the literature review

- Particularly, other available UK prevalence/incidence data are restricted to Northern Ireland and localised regions of England.

- Therefore this survey data, representing a nationwide study, made analysis of the geographical location of responders and clinicians' beliefs in and reports of 'DID' cases of importance.

- These results are organised in the same order as they appear on the questionnaire, to aid reference to the questionnaire (see **Appendix 1**).

- Areas reported and examined are sample characteristics, geographical distribution of survey responders, and their knowledge and beliefs regarding Dissociation. Next, identified cases of Dissociation, including DID, are reported and analysed according to age and gender.

- Finally, data on teaching and training in the field of Dissociation will be examined in **Chapter 9.**

CHAPTER NINE

SURVEY EVALUATION & DISCUSSION OF RESULTS

9.1 Evaluation of the Planned Research and its Results

The present study brings to awareness the clinical provision of service in the UK, to a small but meaningful number of people, spread throughout the whole of Britain, who are reportedly identified as having Dissociative Identity Disorder. This stands in contrast to the dearth of British DID case reports in the professional press, and exposes published sceptical opinion as unsubstantiated, but also contradicts the notion that a few professionals report large numbers of subject. The results are compatible with the probability of DID being a small but significant subsection of Dissociative Disorders, and prevalence being very small, possibly though in a similar proportion to Schizophrenia .

This study aimed to survey the majority of psychiatrists and clinical psychologists in Britain. A questionnaire was sent to 10,414 clinicians, including trainees, from the psychiatric and psychological professions (7500 Psychiatrists, registered with the Royal College of Psychiatry, 2600 Clinical and Counselling Psychologists, registered with the British Psychological Society, and 314 Trainee Clinical Psychologists, accessed via university training courses). Despite a low response rate of 9.3%, to be explored further below, returns yielded almost a thousand responses (972), with similar numbers of returns from both of the professions, and roughly equal numbers of male and female respondents.

The implication of the results will be discussed in more depth below. To summarise, in total, participants reported 3261 particular cases from their clinical practice, classified by respondents as 2651 Dissociative Disorders, 394 DID, and 216 DDNOS. The majority of responses (87%) could be identified by postal region, and those respondents were spread geographically throughout all regions of the UK, not

from specific localised regions of the country. 10.8% of respondents reported ever having treated DID. Respondents appeared to be demographically representative of the target population. All of these issues will be discussed in more detail below.

There is a possibility that there may have been duplication in the reporting of cases known to more than one professional in the same service, though as the survey was nationwide and responses were geographically spread, it is reasonable to conclude that the likelihood of the same cases being reported by more than one professional (false positives) is small, and probably outweighed by the number of cases that have not been reported (false negatives).

Even in local geographical areas, such a survey relies upon personal contact between researcher and respondents, and this precludes the provision of anonymous data. In the current survey this would have meant a lack of anonymity for respondents regarding their belief and practice relating to contentious areas of clinical practice. Given the controversial topic under investigation, and the lack of published accounts, it may be that the anonymous nature of this survey permitted expression and reporting that may otherwise not have been available.

9.2 Postal Survey

The methodology employed, namely a postal survey, was appropriate to such a widespread survey. It is a commonly used research tool (Robson, 1993, p243). Face to face researcher controlled data was completely impractical in both time and financial resources. One disadvantage of utilising a postal survey is that data is necessarily superficial and responses are unverified.

The response rate is low, but comparison to other published postal surveys is difficult as they are not so wide reaching and target more localised communities. The low return rate may be a feature of national postal surveys of clinical subjects.

Interventions used to boost responses, such as follow up letters, were financially prohibitive and therefore not employed. Results tend to suggest that respondents were generally interested in the subject matter and had opinions and clinical

experience to report. Therefore the sample is likely to be self-selected, as is often the case with postal surveys.

9.3 Respondents

The target population of Psychiatrists and Psychologists is linked to my own professional experience as a clinical psychologist and psychotherapist, as well as the fact that these have been the dominant professions in the history of dissociation and the controversy regarding DID.

One hypothesis, based on anecdotal data, was that psychiatrists were more sceptical, and even negative, towards the diagnosis of DID, than psychologists. This view was influenced by the dominant, though not exclusive, published views in the professional press; in the later study of Dorahy, this hypothesis was confirmed. In the present study the results allowed for exploration of a more complex picture.

Responses demonstrated that the two groups reached through the RCP's British Journal of Psychiatry (BJP) and the BPS were not completely homogeneous groups. Of the 506 psychiatry respondents, 11 were still in training, and 22 described themselves in an undifferentiated way as doctors or medical profession. Of the 454 psychologists, 377 were in or working towards the clinical psychology profession (including 51 clinical psychology trainees) and 3 were psychology assistants. The remaining 74 were counselling and other psychologists, including 6 counselling psychology trainees.

A sufficient number of respondents provided information that permitted analysis of their gender, age, qualifications and length of service. Mean ages and standard deviations were comparable for both groups, psychologists and psychiatrists, and appeared to demonstrate a representative distribution across the age range expected in the professions (see Table 8-1). Respondents appeared to be representative of their professional populations, and were remarkably similar in age to Dorahy's respondents. Of the 506 psychiatry respondents, there were 333 males and 173 females, representing 65.7% and 34.3% respectively. Of the 454 psychology respondents, 451 indicated gender, 144 males and 307 females, representing 31.9% and 68.1% respectively. This is consistent with the gender distribution in the two

professions. In Britain, psychiatry is a male dominated profession, and clinical and counselling psychology is a female dominated profession. This also has implications for the relationship of the two professions, to be discussed below. Although respondents appeared to be representative of their professional groups, and this enhances the utility of their data, nothing can be assumed about the 90.7% who did not respond to this survey (or the 15 who did not specify their gender).

9.4 Response Rates

The response rate of 9.3% was disappointingly low. Dorahy's later regional study achieved a 51.5% return rate, with responses from twice as many psychiatrists as psychologists, resulting in 86 responses compared with 972 responses in the present survey. Dorahy's study was conducted in May 2000, almost three years after this study, and therefore the current survey may have acted as a primer for Dorahy's study and thus increased his response rate. Robson (op cit) has suggested that follow-up contact increases response rates, and there may have been some interaction between the two surveys to act to increase the threshold for response to the second survey. It may be that local surveys permit greater responder identification with the task than a nationwide survey. The latter may invite a diffusion of responsibility, such as is found in group decision making and bystander apathy. In the current survey, geographical location was identified for 87% of respondents, which included 24 responses identified as being from Northern Ireland (12 psychiatrists, 11 psychologists and 1 not specified), compared to Dorahy's total of 86 (58 psychiatrists and 28 psychologists). In the current survey, proportionally there was a greater response from psychologists than psychiatrists, with a rate of 15.6% compared to 6.7% for psychiatrists. Dorahy had twice as many psychiatrist responders as psychologists, surveying clinical and forensic psychologists, whereas the current research surveyed clinical and counselling psychologists. Dorahy's more prominent published profile and post-doctoral staff position at an academic institute may have assisted the perception of the relevance of his research, and the regional identification with a relatively more local survey may also have been an influence.

Despite the number of psychologist responses in the current survey, and the anecdotal opinion, later confirmed by Dorahy in Northern Ireland, that psychiatrists are more sceptical than psychologists, for all identified clients/patients in the current

research there was a 3:1 chance of being diagnosed as having DID by a psychiatrist, rather than by a psychologist in the UK. Despite Dorahy's higher proportional response rate, his 86 respondents reported only 5 current cases of DID, and he found his psychiatry responders much more sceptical than psychologists, though a significant number of total responders (55.8%) believed in the reality of DID. As the response rate of Dorahy's research indicated that 51.5% of the target population supplied data, this is quite a significant statistic in Dorahy's research, meaning by extrapolation that at least 25% of the target professionals he surveyed in Northern Ireland believed in the existence of DID, despite UK published opinion to the contrary, and almost no published opinion to support such belief, and in the absence of a high number of actual case reports or published responses to Merskey and the discussion in the British Journal of Psychiatry in 1993.

With psychologists being comparatively fewer in number (approximately a quarter of the target population) it was within the financial budget of this research to purchase the service of a personally addressed mailing by the BPS that would reach all Clinical and Counselling Psychologists. This may also be a factor to account for the better response rate from psychologists (15.6%) compared with the psychiatrists (6.7%). Interestingly, though a smaller proportion of psychiatrists responded, those who did gave the larger numbers of case reports.

Another factor affecting response rates is competing demands on professional time. Most professionals are extremely busy and, unless one has a particular interest in supporting research, or in the particular area under study, it is an imposition on one's time that has no immediate personal or professional rewards. This survey was targeted at clinicians who are generally more orientated to direct client work than paperwork of any kind, never mind unsolicited questionnaires. Generally, clinicians experience administration as an intrusion into their *real* work (Thomas et al, op cit).

Although the questionnaire was quick to complete if all data was easily available, it presented a problem for people who had a lot of data to report. Isolated comments from responders were that it was impossible or very difficult to remember how many cases had been diagnosed over a long service history, and often records were either time-consuming to access or were not available.

It is likely that, in order for a questionnaire to trigger a response, there will need to be an identification of some kind in the responder. It may be that psychiatrists place higher value on medical and possibly biochemical research, than on psychological research, since that is the prevailing approach in British Adult Psychiatry, thus it may be that the majority of psychiatrists had little or no identification with the subject matter of this survey, although Dorahy's respondents were predominantly psychiatrists, in contrast to mine.

9.5 Clinicians' Reported Beliefs and Clinical Experience

In refutation of the fourth hypothesis in this study, the psychiatric respondents to this survey reported the majority of the total case numbers, i.e. 76% of the DD cases, 59.3% of the DDNOS cases, 73.1% of the DID cases. Additionally, as reported in Table 8-12, psychiatric respondents who specified client numbers reported a mean of 7.02 cases of DID per respondent, compared with the mean of 2.47 cases of DID per respondent of the psychologists specifying client numbers. The overall response rates for the two groups, psychiatrists and psychologists, compared with reports of treatment and actual case numbers, suggest that a greater proportion of the psychologists responded to the survey whether they had actual Dissociation case data to report or not, but psychiatrists more frequently responded with relevant case data to report. This was not the case with Dorahy's returns, where a higher response rate resulted in reports of only a handful of cases of DID. Since there was such a high level of belief in the existence of Dissociation, it may be that psychiatrists who responded to this survey did so because they were demonstrating a strong opinion about the subject matter. So too, research is an important emphasis in the discipline of psychology, and the need for psychological research in particular forms part of the academic qualifications of psychologists, and is a key requirement in Chartership. Research may therefore be valued and supported more by psychologists than by psychiatrists, thus resulting in survey returns regardless of case data.

There is a chicken and egg situation in the case of psychiatric conditions that are not mainstream areas of study and intervention. Clinicians already aware of dissociation are more likely to be triggered to respond. Any professional who is unaware of the area of study may fail to identify in any way with the topic, or may feel they have

nothing to offer in a response, and simply dispense with the questionnaire. It was certainly the case that responders to this survey demonstrated a high level of awareness, so there may have been a self-selecting influence on results. Responses showed that a few people returned their questionnaire stating that this was not an area they knew anything about, or that they did not have such clients. It is reasonable to assume that the majority of busy professionals for whom this was the situation may not take the trouble to return their questionnaire and provide any feedback by way of comments.

The data at least supports the notion that those who did respond were almost all aware of the topics and believed in their existence, compared with Dorahy's study, where respondents demonstrated more diverse opinions. In his study, psychologists had a higher level of belief in the reality of DID than did psychiatrists.

Awareness and training may be associated, and in this study, despite a high level of awareness in respondents, there was a moderate level of training, compared with Dorahy's report of a low level of training.

The disciplines of Psychiatry and Psychology employ different methods of categorising or describing the presenting problems of the clients under their care. In particular, the Clinical Psychology profession has often sought to challenge the categorisation system largely used in Psychiatry. Critics (Boyle, 1999; Newnes, 1999; Bentall, 2003) have challenged the Social Construct basis of this approach, and its lack of scientific descriptive power and operational value. This may have led some psychologists to fail to engage with this project, which explicitly relied upon the use of DSM-IV criteria to describe the area of investigation. One psychology respondent specifically expressed this view. Additionally, even amongst advocates of the categorical approach, many British Psychiatrists do not favour the use of DSM as a categorisation system, preferring the World Health Organisation alternative system of the International Classification of Diseases (ICD-10, 1992). Given this divergence of terminology and theoretical approaches to assessing clients between and amongst these two professions, it would not have been possible to utilise a uniformly acceptable and easily coded categorical system. It was therefore necessary to choose a system that was most likely to be relevant to the topic investigated, and at

least potentially known and accessible to those surveyed. The choice of DSM-IV was based on the fact that it is the more comprehensively developed categorisation system in the field of Dissociation, and the most widely used in the Dissociation literature and amongst known DID practitioners. DSM is also widely used in published research in Britain (Davey, 2003, p413).

This divergence of labelling method may lead to a lack of uniformity as to how professionals record their cases, making the collection of prevalence data per se very difficult. Prevalence data is crucial to the development of research, professional development of concepts and interventions, and training and awareness. Prevalence, or a lack of it, has in fact been a central tenet of the dominant discussion regarding DID in Britain, where it has been asserted that cases do not exist. Categorical labelling should be a scientific enterprise so that descriptive data is organised into mutually exclusive groupings that are reliable and repeatable. In reality, data is often collected subjectively, and in a hypothesis confirming manner, and patients can earn different diagnoses according to the views of different assessors. This problem is particularly relevant to DID cases, given the complex nature of such client histories. There is a strong possibility of co-occurring and more easily recognisable conditions, such as depression, anxiety, self-harm, and disorganised and perceptually disordered behaviour. Research in the USA suggests the co-existence of several other conditions in most cases of DID (Ross et al 1989; Braun, 1986; Kluft, 1985). Critics have not only challenged the general scientific construct and utility of the categorisation system in psychiatry, but also its application (Boyle, op cit), demonstrating a poor level of inter-rater reliability.

Professionals may record their cases under the major or preferred category, and the same case may be differentially labelled, as was demonstrated in the disagreement amongst medics across historical cases. Some respondents indicated that they did not know how many of the clients they had treated had dissociative conditions, if they were treating the clients for other presenting problems.

Respondents would also be unable to identify cases retrospectively, i.e. those that they may have encountered prior to becoming aware of Dissociation. It is my clinical experience that this is true of the development of clinical experience in

general. I can look back on my own clinical practice and now recognise aspects of earlier cases, about which I was unaware at the time of intervention. I can recall a few clients that, with hindsight, may have been at least dissociative, and one that may possibly have had DID. Similarly, a potential respondent may not have known that their client had a dissociative disorder if they were not trained in this field, and they may have confined their treatment to a co-morbid condition or reframed the presenting problems in terms of their own professional paradigm. This is necessarily the case for practitioners who are sceptical, or even definitely rejecting, of a diagnosis.

Some responses were excluded from the analysis, where clear data could not be determined. It is important to consider reasons for which respondents may have been unable to give exact figures. An important consideration is that, if they had treated a large number of clients, respondents may not have been able to remember the exact numbers, and such an example is given below. Such answers were treated as "don't know" for the purpose of coding responses, so this is another reason for assuming that the reported and estimated data in this survey is conservative.

Two respondents claimed to have treated "over a hundred" DID clients, and this unspecified amount, as an outlier in the data, was excluded from analysis. The results are therefore moderate; one respondent reported 70 DID cases, two reported 45 DID cases, with the remainder at 20 or less. This research would lead to the conclusion that the prevalence of DID is small but meaningful, and worthy of further research and appropriate training and service provision, particularly in view of the human and financial resource implications, to be discussed below.

Some other reports were excluded from analysis on a similar basis; one case was excluded because the responses were given as a block response. That is, exactly the same figures were given in a particular section for all four diagnostic categories, creating the impression that this was a block answer rather than accurate data. In this particular example, the figures were not especially large and, whether included or excluded, the block nature of the responding would have affected all four diagnostic categories equally.

Psychiatrists reported treating more than twice as many clients for DID than psychologists. Psychologists generally see fewer clients for longer appointment duration, and less often act as the named clinician, the client actually being seen by a more junior member of staff. Psychiatrists, with the possible exception of those employed in the capacity of psychotherapists, often use very short session times for assessment or follow up, and little application of direct psychological therapeutic intervention, with supportive therapy or occasional intervention often being provided by a Community Psychiatric Nurse. So this may represent a difference in working practice between the different professions. It does therefore seem that at least some psychiatrists, geographically spread throughout Britain, are more likely than psychologists to identify both Dissociative Disorders and DID cases. This is despite the fact that in this survey the response rate for the targeted psychologists was 2.3 times greater than that of the targeted psychiatrists.

It is likely that, as with any survey, the respondents were self-selected for a number of reasons, and the number of identified clients is likely to be conservative. For the purpose of identifying the significant presence of cases, this is not a problem, but the ideal position would be to have a national audit of clients presenting to all known services, with appropriate screening using standardised instruments, thus providing a national incidence study, that is the number of cases in presentation to identified services in any one period of time. This is not data that is extant for other, more prevalent and recognised conditions, so it is unlikely to be feasible to collect such data in this particular subject area. This current survey then is probably the best available UK data to date.

Despite the limitations of the data collection method, the results confirm that both psychiatrists and psychologists, throughout the United Kingdom, have identified and provided treatment for a range of dissociative cases, including Dissociative Identity Disorder.

Since this survey demonstrates a small but still meaningful number of DID cases, it thus disconfirms the claims by Merskey that DID either does not exist in the UK, or is being over-diagnosed. It also cannot be claimed that the number of cases are being reported by only a handful of respondents, perhaps a few ardent advocates

exaggerating or over-diagnosing because of their enthusiasm for the subject. The results show that, considering only respondents who indicated having provided services for DID clients and specified client numbers, 84 respondents (41 psychiatrists and 43 psychologists) reported an average of 7.02 cases per psychiatrist and 2.47 cases per psychologist. The overall mean for all positive responders was 4.69, with a range of 1 – 70 cases per respondent.

In discussing the results of this survey and interpreting their meaning, I have addressed general data first, such as envelope post-marks, and have then addressed data in the order that it appears on the questionnaire. This is to assist with any reference the reader may wish to make to either the Tabulated Results section (**Chapter 8**) or the questionnaire itself (**Appendix 1**).

9.6 Nationally Representative Data

Although this current research was conducted via an anonymous survey, and respondents were not asked to identify where they came from, it was possible to record the post mark of most of the return envelopes (87%) to give an impression of the geographical spread of professionals responding. At the time of conducting the survey this had not been a central or planned variable, and became an afterthought as responses arrived and excited a curiosity as to their geographical origin. A systematic categorisation of the postal region was undertaken. In retrospect this variable had greater value than was realised at the time. This information was categorised into regions, and the results are produced in **Table 8-4**, which shows that respondents came from all over the British Isles. The data indicates that there is not an obvious area of the country that did not produce a respondent. A reasonable comparison can be made with DID reports, where 82.8% of respondents reporting DID cases could be identified by geographical location. DID reports came from all regions except Northern Ireland. Dorahy later identified 5 cases, and it is tantalising to wonder if there was any influence upon the second piece of research, by this study.

9.7 Demographics: Length of Professional Experience and DID reporting

In the context of the neglected UK history of DID, and the fact that professional training does not routinely include DID, it may have been expected that more recently trained clinicians may have been more open to new ideas, or apparently US

influence. Alternatively, it may also be hypothesised that clinicians in practice longer would have greater exposure to the possibility of encountering DID cases. In fact, the study found that experienced and less experienced respondents were equally likely to report having ever treated DID, if the median age is taken as the cut off point (see **Table 8-14**). Comparison of mean numbers of cases reported would provide less meaningful data on this point, as increases in client numbers reflect the experienced group's longer time in practice, thus inference regarding professional openness to ideas is better examined via this variable.

Anecdotal difficulties of providing treatment for DID clients within NHS services, and clients' reported difficulties in obtaining appropriate services, still current, may have suggested that a disproportionate number of DID cases would be found in private practice. Data on this point was difficult to examine, as many respondents indicated that they worked across NHS and private services, with only 7.6% of respondents identifying themselves as working exclusively privately. A further confounding factor is that respondents classifying themselves as working solely within private practice were also a more experienced group, with a mean 20.8 years in practice, compared to 13.9 years for the NHS group. It is acknowledged that counsellors and psychotherapists, who may be more likely to work outside of the NHS, have not so far been surveyed, and so comprehensive data on this subject is not yet to hand.

9.8 DID Reports

Amongst the subject area of this research, the topic that had received the most exposure in both the professional press and the mass media was that of repressed or recovered memories and False Memory Syndrome (FMS), rather than Dissociation or DID. Results showed that most respondents were aware of Dissociation. Despite this media influence, only a quarter of respondents (26.9%) reported not encountering dissociation.

Ross (1989, p159) has suggested that DID may be roughly as common as schizophrenia. Clinicians in the current study identified cases (3261 in total), across all diagnostic categories investigated. This is small expressed as a percentage of the general population, 0.005%. Reported cases of DID (394), are therefore even lower

in number, insignificant in terms of the general population. This may be seen to support the contention (Merskey, op cit; Aldridge-Morris, op cit) that dissociative phenomena are rare. In terms of human suffering, even these reported numbers mean that people throughout the UK require a service that can recognise their specific condition and experience, and provide the appropriate treatment. Considering the lack of training regarding dissociation, and DID in particular, it is interesting to compare these reported cases with the rise in awareness of schizophrenia. Between 1914 and 1926, there were only 100 case reports in *Index Medicus,* compared with 3,500 between 1927 and 1939. Interestingly, such a rapid rise in reported cases, which is an argument that has been contended against the veracity of DID reports, has not led to any such failure in the acceptance of schizophrenia. As was seen in the literature review, Rosenbaum has suggested that the rise in the acceptance of schizophrenia may have adumbrated the recognition of DID. Given the poor scientific basis for the diagnosis of schizophrenia (Boyle, 1999; Bentall, 2003), the acceptance and popularity of psychiatric labels is clearly dependent upon factors other than the issue of flawed theories (Ross, 1989, p28). The comparison and confusion between DID and schizophrenia makes explicit the nature of psychiatric diagnosis as social construct. Indeed Ross (1989) has suggested that schizophrenia may be a diagnostic fad, driven by biological reductionism. Ross et al (1989) showed that 40.8% of a sample of 236 cases of DID had previously received a diagnosis of schizophrenia. Schizophrenia is found in approximately 1% of the general population, and so unless both of these concepts, schizophrenia and DID, are more clearly delineated and prevalence researched, there remains the conjecture that cases of DID may be misdiagnosed as schizophrenia. In arguing the case for better identification, Ross (1989, p40) states "there is much better evidence in favour of the posttraumatic nature of MPD, than in favour of organic etiology [sic] of schizophrenia". So with relatively low rates of reported cases in both Dorahy's later study and in this research, an almost complete absence of published cases in Britain, and a lack of specific training on DID incorporated into general psychiatric and psychological training, the question of clinicians' awareness of DID was investigated by this study.

9.9 Awareness of Dissociation

A high percentage of the total number of respondents said they had heard of Dissociation (94.5%). A significant number of these said that Dissociation exists (97.9%). Although this question was phrased somewhat simplistically, so that the responses lacked definition, it matches the equally simplistic published opinion in the professional press that DID does not exist. In order to augment these yes/no answers, a supplementary question invited respondents to provide their own definitions of dissociation. These respondents were not asked specifically about the existence of DID. Dorahy asked specifically about belief in DID, and found that 55.8% believed in its existence. It may be that this lower rate of belief, in Dorahy's sample, relates to his higher response rate, especially by psychiatrists, and may also relate to the priming by my earlier survey. If it is the case that there is widespread resistance to the diagnosis of DID, the appearance of a second survey may have prompted more disbelievers to respond to Dorahy.

73.1% of all respondents reported having encountered dissociation. 83.6% of Psychiatrists and 60.5% of Psychologists said they had encountered Dissociative cases. At this stage of the questionnaire, about having encountered dissociation, the condition was not subdivided into the three categories, so the question was not asked specifically about DID. However, from the identified and reported cases section of the questionnaire, it is apparent that 10.1% of psychiatrists and 11.5% of psychologists have diagnosed DID cases.

Since the strong views expressed in the professional literature, particularly by Aldridge-Morris (op cit) and Merskey (op cit), have apparently promoted the concept of dissociation being attributed to dissembling or iatrogenesis, it was surprising to find that this did not appear to have promoted a clear view amongst responders. 31.5% did not provide an answer to this question. 14.6% thought that dissociation was iatrogenic, 5.1% did not know whether dissociation was iatrogenic, and 3.1% responded 'possibly' or 'sometimes'. 45.7% thought dissociation was not iatrogenic. Direct comparison with Dorahy's results is not possible because the current respondents were not asked this question specifically about DID. This is a shortcoming in the questionnaire and research design. What is clear from these results is that these respondents are quite divided on the issue of iatrogenesis. This

clearly argues for a need for appropriate training, at least amongst responders to this survey; rather than the polemic having appropriately informed clinicians, there remains considerable need for good quality information. Despite the responders to this survey having a high level of awareness of dissociation, and reporting a relatively high level of having encountered actual cases of dissociation, there is a lack of consensus as to the aetiology.

With the benefit of retrospection, the question of faking or dissembling was not at all investigated by this survey, although it may be assumed that clinicians would not report cases as dissociative if they thought them to be faked, but would be likely to offer an alternative diagnosis or comment further. Respondents frequently added comments to their returned questionnaires, and such comments about faking were noticeably lacking.

The length of time that clinicians had been aware of dissociation showed that awareness was not recently acquired. The way in which awareness was gained was asked as an open question, analysis of which is deferred, but a common response was that awareness was gained through the general course of working practice, or provided by a senior clinician.

Definitions of Dissociation were fairly uniform across responders, and approximated DSM-IV definitions, therefore confidence can be expressed that the subject matter under investigation is adequately understood and defined, so that results are uniform and meaningful, even though some issues remain unresolved about aetiology.

The data from this survey suggested that, despite the obvious hiatus between the historical literature of DID in the UK and the dearth of published UK cases in modern times, together with relative silence of UK clinicians at the time of the heated debate in the British Journal of Psychiatry (1993), clinicians from all over the UK reported awareness, knowledge of, and belief in, DID and reported treatment of cases of all forms of dissociative disorders, including significant numbers of cases of DID.

The historical literature had led from metaphysical theories of possession, to reductionist, mechanical theories, with the advent of anatomy in the nineteenth century, and then to emergent materialist theories. As the review reached the twenty-first century, new scientific equipment was beginning to bridge the mind-body intersection. The survey showed that respondents espoused a psychological model of DID and almost exclusively perceived DID to be a loss of information from consciousness, as a result of trauma, in line with both Janet's concept of dissociation and the DSM-IV criteria, and consistent with Bowman's (1990) conclusions regarding changing medical perspectives throughout history regarding DID. A significant number of survey respondents were able to distinguish between the DSM-IV general dissociative disorders and DID.

As was seen in the case study, presented in **Chapter 5**, the clinical work, which took place before the results of the survey were known, was at first conducted, in the absence of positive UK publications in the professional press. Therefore therapy proceeded without the knowledge that so many clinicians, throughout the UK, were similarly identifying and treating cases of DID, as results have shown, and are discussed, by returning now to the details of the survey.

9.10 Therapeutic Intervention

Although this section of the questionnaire yielded notable results, retrospective scrutiny has revealed some potential problems with wording. Use of the word clients, rather than patients, may also have hindered returns from some respondents. This terminology was used in various places throughout the questionnaire. Even the heading "Therapeutic Intervention" may have reduced identification for clinicians who only provide assessment or very brief intervention, or do not label what they do as therapeutic, possibly reducing the responses to other questions in this section.

Question 15 is also expressed in the present tense, and therefore may have failed to capture clinicians who had identified cases in the past, but were not involved with such clients at the time of the survey. This section also makes a leap from the question of ever having "encountered" cases, to "Therapeutic Interventions", and may therefore have obscured the issue of identification of cases without treatment. All of these issues tend, if anything, to reduce the number of cases possibly

identified, thus suggesting that, if there is a bias in this research, it is likely to be in the direction of false negatives rather than false positives, making the research findings reliable, if conservative.

Of the psychiatrists providing responses to the relevant survey items, 83.6% *had* encountered dissociation. 51 psychiatrists, or 10.1% of the respondents in this group, reported ever having treated actual DID cases. 60.5% of psychologists had encountered dissociation, with 52, or 11.5%, reporting cases of DID.

These results now beg the tantalising question as to the approach to therapy and goals of therapy. No data is available, from this survey, as to whether the goal of therapy was to alleviate other associated conditions, such as depression, anxiety or self-harm; to achieve increased functionality, with or without continuing amnesia; to achieve elimination of alter personalities, as was the approach of one modern UK practitioner (Phillips, personal communication, 2002), or to achieve psychological integration, which is the recommended approach and the goal I have held with my own DID clients.

9.11 Identified Cases

In 1990, Ross et al suggested that, if screening for Dissociation were routine in British Psychiatric Hospitals, a prevalence of 5% MPD and 5% other Dissociative Disorders would be found, however, his figures represent an estimate based on professional opinion, not directed research efforts. Davis and Davis, in an unpublished paper presented to the 3rd ISSD(UK) Conference in 1997, found a similar incidence rate to that in other countries, for dissociation. The study examined 109 outpatients attending clinical psychology, psychotherapy and psychiatry services in a UK urban area, and found 15.2% with Dissociative Disorders and 6.7% with MPD/DID.

Acquarone's electronically published incidence study (1997), reviewing the files of 120 acute psychiatric inpatients, found 5% indicative of DID and 22% indicative of dissociative disorders. He also noted that almost a third of the repeat admissions patients had positive dissociation scores. This raises further questions about the

financial as well as personal costs of the failure to recognise dissociation in clients/patients.

Dorahy (2002) conducted a similar postal survey to the one conducted for this study. His subjects were psychologists and psychiatrists in Northeren Ireland. He obtained a response rate of 51.5%, finding that 55.8% believed in the existence of DID, 9 clinicians had previous personal experience of DID and 5 current cases were in treatment, none of which appear to have been published as case studies. Psychiatrists showed more scepticism than psychologists. Believers thought the condition was uncommon, and lower in prevalence than schizophrenia and depression. As discussed earlier, Bliss estimates that DID is more prevalent than schizophrenia. Awareness of DSM-IV and ICD-10 criteria did not relate to scepticism. Only 10.8% of responders believed accurate diagnosis accounted for the recent increase in reports of DID, other explanations were iatrogenesis, factitious disorder and misdiagnosis. Dorahy found psychiatrists to be divided about DID, but psychologists largely found DID legitimate. Dorahy noted the lack of training and support for professionals regarding dissociation. Although a comprehensive regional survey of both attitude and prevalence, Dorahy's paper was refused for consideration by the *British Journal of Psychiatry* but later published elsewhere.

The distribution of reported cases of dissociation in the current survey is in line with the low proportion that would be expected. Incidence rates had indicated that the ratio of DID to Dissociation case reports are expected in the proportion 1:2.3 (Davis and Davis; op cit) and 1:4.4 (Acquarone, op cit), see Table 9.1 below for incidence data.

	Ross	**Davis & Davis**	**Acquarone**
DID	1% (estimated incidence)	6.7% (incidence)	5% (incidence)
Diss.	5%	15.2%	22%

Table 9-1: Available Incidence Data

In the current prevalence study the proportion was 1:7.3. Proportions would be expected to be higher in incidence studies, as screening instruments were used, rather than just clinical judgement that also relies upon the clients' voluntary disclosure of

information. This suggests that the conditions are not being over-diagnosed or over-identified, as Merskey had claimed with DID. Both psychiatrists and psychologists report clients in all categories. If DID is a more extreme form of dissociation, it would be expected that the number specifically with DID would be small compared to those with more general Dissociative Disorders, and this was demonstrated by these results (see **Table 8-8**). The distribution of these statistics is quite comparable between the psychiatric group and the psychologist group. In the Others group, i.e. responders who could not be classified in either the psychiatric group or the psychology group, there are few reports in the DDNOS category, which may indicate lower awareness or may be an artefact (is artefact the correct word to use?) of the low number or responders in this category making case reports.

Missing data were excluded. A slightly skewed distribution was found across all categories, with most falling in the 19-25 age group, despite that being a relatively small age span compared to some other categories. The 19-25 category alone accounted for around 35% of cases, and the 19-25 and 26-35 ranges combined accounted for more than 60% of cases in all categories.

The only age group with no reports was the DDNOS category for those under 10 years of age. This is a particularly problematic category of Dissociative Disorders anyway, that would be especially criticised by psychologists of a radical or pro-scientific orientation, because it is merely a category to contain those cases that will not fit into one of the other categories. My own clinical experience, and that of colleagues, has led me to conclude that the kind of dissociative cases that are not covered by the other categories, and therefore may be classified as DDNOS, tend to be chaotic forms of DID. The functioning of these clients is usually too complex for their condition to be classed as Dissociative Disorders, and they lack the internal self-organisation and functionality found in DID. Their disorganised presentation is highly likely to earn the label of Borderline Personality Disorder (BPD). The problem of differential diagnosis was discussed above, and considered in terms of the adumbration of DID diagnosis, and that of other dissociative disorders. BPD is reported to have a prevalence rate of double that of schizophrenia, so the two labels, schizophrenia and BPD, could mask potential DID cases.

Returning to the actual reported cases, it was only upon analysis of results that it was noticed that there was a potential overlap between the first two age groups on the questionnaire. Instead of the first category saying <10 years and the second saying 11-18 years they said <10 and <18. It is therefore theoretically possible that responders may have entered the same cases in both columns. As the rest of the questionnaire utilised mutually exclusive categories, it is unlikely that respondents would have interpreted this literally, rather than in the spirit and mode of the questionnaire as a whole, but it is still a possibility. If so, this would mean that the child cases are somewhat over-reported, though the <10 category makes up only a small percentage of the data in any event (2.1% of the DD cases and 3.6% of the DID Cases reported).

9.12 Teaching and Training

My own clinical experience had indicated a lack of general training in the area of dissociation, as discussed in the Introduction to this thesis. I had provided training and supervision for clinicians and other professionals, and lay people, such as foster carers, all over the country, and had encountered reports of similar experiences to my own. As national Chairperson of ISSD(UK) for five years, and Conference Organiser of the annual International Conferences, I had the opportunity to meet people from all over the UK who attended the conferences, and who invited me to provide workshops, training and supervision. Dorahy states that professional education regarding DID is scant in Northern Ireland, and the current study echoes that finding throughout the UK as a whole. 57% of respondents to this survey reported having received some training concerning dissociation. Training with specific regard to DID was not investigated. As significant numbers of DID cases were shown in this study as being identified and treated, there are several specific areas of concern for the clinicians working with DID cases. The present situation for most professionals, but certainly for Clinical and Counselling Psychologists, is that there is a requirement to demonstrate current, adequate and relevant training in order to qualify for registration and, perhaps even more importantly in this era of increased litigation, there is a strong possibility that, without adequate training, clinicians may be in breach of a duty of care to their clients, and employers may be in breach of a duty of care if they do not provide or purchase adequate training and supervision for their employees. Mayo's (1845) comments about the clinician's duty to treat their

clients with the respect they deserve, to investigate their complaints seriously, and to provide appropriate treatment, still needs to be echoed today. His opinion is compatible with that of Elliotson (1846, p160) also arguing for appropriate recognition and treatment of patients with DID.

I know from my own clinical experience, and that of others I have supervised, that it can be very surprising, perhaps even quite shocking or frightening to have a client display or report multiplicity. Perhaps disbelief is one manifestation of professional defence in these circumstances, demonstrated by the psychiatrist who wanted one of my DID clients to accept a change of diagnosis, discussed further below in the Research and Support section. This could be understood as reframing the problem into a known, accepted and less threatening paradigm. Though this can serve the needs of the clinician, it may not serve the needs of the client, who might be required to mould their presenting problem into a recognised and accepted format, such as schizophrenia, and in so doing echoes the way the client may have developed DID, to produce roles or functions to meet the needs of people in authority at the expense of their own needs and development.

If a clinician has not been adequately prepared for the presentation of a DID client, the literature is confusing, and discussion in the professional press is hostile and unsupportive. Not all clinicians work in closely knit, supportive teams and not all clinicians are equipped or prepared to be pioneers in reporting something unusual, or even to admit to difficulties in treating clients. When faced with this novel situation, those inexperienced professionals, who have not dismissed or disbelieved the clients, could be in danger of falling into one of the two extreme positions of either over-fascination or panic. The client's situation can appear so terrible from the point of view of an integrated person, and indeed they can sometimes present to services in extremes of crisis, that there can be the temptation to rush in where angels fear to tread (Pope, 1711). Even when a climate of recognition and support is available for both client and clinician, the strength of the counter-transference and transference can be quite formidable. If the client is also in crisis or not stabilised, and given to acting out their distress, this can create alarming and even dangerous situations for both client and therapist. This issue will be discussed further below, in treatment issues.

9.13 Supervision

A limitation of this section is that it asked about the respondent having provided supervision to others, but failed to enquire about the respondent's own receipt of supervision. Thus, it is not possible to determine how many practitioners may have been providing supervised intervention to clients, and how many may have been working without supervision and support. There is no data as to the level of expertise or skill of the supervisors who may have provided for these respondents.

My own experience had been quite mixed. I had initially had the benefit of a supervisor with some level of awareness and training in the area of DID, who had introduced me to the occasional US training event, but this supervisory relationship was short-lived and, in retrospect, I now feel that, in the early years of practice, the lack of regular and skilled supervision resulted in a less than optimal level of clinical practice on my part. I was subject to occasional good and bad influences, largely from US professionals, but I mainly muddled along with the support of even more inexperienced colleagues. It is always possible to reflect on one's clinical practice from the benefit of experienced hindsight and see mistakes, both large and small, but with such a complexity of clinical material, a complete lack of professional training in the particular subject area and a climate of disbelief and ridicule, it seems miraculous that I survived and that any of my clients progressed, but we all did.

What this survey does identify is the proportion of the sample of responders who are potentially able to provide supervision in these areas, but who remain anonymous as a result of the method of enquiry of this survey.

9.14 Survey Data on Research Activity

One of the main problems that I encountered throughout this research project was the constraint placed upon me as a scientist-practitioner clinical psychologist, running an independent team practice, where there were so many competing demands. Thomas et al (2002) charts a recent decline in clinical psychology research, and suggests that the employment burdens of unfilled places, and "ever increasing organisational and service demands" placed on clinical psychologists, are responsible. In independent team practice this is an even greater pressure. It is only direct client work that pays

the overheads, and income is on a case-by-case basis, with no guarantees of funding. Performance pressure experienced in the NHS, linked to evidence-based practice, is even more pronounced in independent practice, where evaluation of performance is more immediately effective and apparent, since ineffective practice would result in a loss of income. As the leader of the team practice with key skills, my direct client work contributed to the salaries of other team members, and had to be prioritised to ensure the continuation and development of the service. The involvement of the service in forensic work meant that there were externally imposed deadlines for work that must also be prioritised, and court appearances that can be ordered by the court in the case of unwilling professionals.

Thomas et al (op cit) note "producing research of a national and international standard is exceptionally demanding, and will not be achieved in the evenings or on occasional research afternoons, by overworked staff whose energies and attention are mostly taken up with other professional concerns." All of this competing pressure, in my case, generally meant that efforts to progress the thesis in all its forms, from questionnaire design to literature review to write up, have not been in regular time slots, but in bursts of frenzied activity followed by periods of relative and sometimes complete inactivity. This has made it difficult to keep in complete control of the process, and indeed some of the material connected with the enterprise. Although the level of organisation was quite good, it would have been enhanced by regular diary keeping. Moving offices and home a number of times, over such a long period of time, has added to the difficulty and undermined the organisation of the project. It has also been difficult to maintain enthusiasm and focus at a physical distance from the academic institution to which I was affiliated; that in itself was confusing since, at the beginning of the process, this also meant relating to two different institutes. Distant study, despite the current technological possibilities, in this case had limited availability; this meant that I have not had regular, free and full access to literature searches, general library facilities and peer group activities. Given these obstacles, and the benefit of e-mail and telephone, it has been possible finally to report these findings, though it has also affected the immediate availability of the results, both to respondents and the professional community at large, since little time has been available to prioritise the publication of results, or to introduce a wider audience to the benefits of the literature review.

In the present research, 28 respondents indicated having started research in dissociation, with 11 reporting having achieved publication and 7 having received rejections. Although invited to supply details of publications, none did so.

A specific finding in the literature review, as well as my own anecdotal experience and that of colleagues, was the paucity of published research or case studies in the UK. This led me to speculate as to the reasons for this. I had found the task of providing intervention to DID clients very taxing and time consuming, leaving little time for reporting findings. Reflecting honestly on the situation, I think I was also feeling very insecure about the whole situation. Publishing of any kind is a daunting situation for most clinicians, who are more comfortable in clinical work than in writing and publishing. Thomas et al (2002) state that "Having to split their time between provision of clinical services and research means that clinical psychologists often do research as an afterthought". The great demand of clinical work means it is always easier to prioritise this area of work, and it is difficult to create the time and space to write and publish. The process of high levels of rejection in publishing is aversive, and most clinicians do not work in an environment where colleagues pursue or support non-clinical work, especially as a priority. Thomas et al (op cit) suggest that "even where research output has been achieved, it is often rigorously – and often critically – evaluated through peer review. Consequently, it is quite likely that a research novice will experience evaluation stress and disappointment". In the NHS the ever present spectre of waiting lists is a constant pressure, especially with the current financial implications of service ratings; most of this leads to research that is not directly related to psychological processes (Thomas et al., op cit), therefore publishing unusual cases in a hostile climate is even more aversive.

My natural inclination was to seek safety in numbers, in a less hostile and more supportive context. The nature of the work made it necessary to obtain as much positive experience as possible, and avoid negative experience. I therefore sought to network rather than publish, and that was done very successfully, whilst at the same time undertaking my psychotherapy training. Publication may then have become the next logical step, but the demands of running a team practice; leading a national network involving organising international conferences each year; being part of an

international committee on Dissociation in children; being the International Director of the world-wide organisation of ISSD; and completing supervisory qualifications in counselling and psychotherapy, took all available time. Hostilities increased in the professional press at around this time, and I managed only to self-publish a booklet based on the workshops I had conducted, as well as providing separate chapters in two published books. The booklet was as much a summary of my own thoughts, as it was for consumption by others, and consisted of my discovery to date gleaned from my training as a clinical psychologist, and psychotherapist, as well as from my own clinical experience, occasional US training and supervision, and reading, largely non-UK sources. The first of the two chapters (McIntee and Crompton, op cit) refined and summarised my thought process and theoretical model, as I gained further experience and information. The second chapter (Mulholland and McIntee, op cit) applied my theoretical model to a specific case that I had supervised.

My own trepidation, in publishing the fact that I was working with several cases of DID, made me wonder whether I was one of only a small number of clinicians who were working in this subject area, most of whom I had met at ISSD(UK) conferences, or whether there may in fact be other people working with DID clients, but who were not part of the ISSD(UK) network, and who were not publishing anything about their work. I wondered if the latter were indeed the case, and whether their reasons for not publishing were similar to mine, or whether their papers were meeting rejection, as later reported by Dorahy, or in some way connected with publication policy of journals, such as the opinion expressed by Mollen (in Ross et al, op cit) regarding the *British Journal of Psychiatry.*

9.15 Survey Data on Resources and Support

My own experience had been a dearth of informed managers and supervisory support, save for my very fortunate introduction, a relationship that was sadly short-lived. I had also encountered hostility from some professionals, including one psychiatrist who told one of my DID clients that he would withdraw medical cover from her unless she accepted a change of diagnosis to that of personality disorder. In my immediate group of colleagues, I was amply supported, but these people were less qualified and experienced and, in management hierarchy, more junior, so did not sufficiently relieve me of a great weight of responsibility, try as they might.

Endeavouring to support clients without a context of interagency support is very undermining for both client and clinician. It is difficult to convey a satisfactory level of therapeutic holding for a client when the therapist is not only inadequately held and supported, but even sometimes attacked.

The position of the clinician as an isolated, and sometimes belittled and abused, person comes to mirror the situation of the client, or at least the client's historical issues that are the subject of the therapy. The difficulty of achieving cohesion in a professional team or inter-agency group can result in mixed messages, fragmentation, hostility, abusive attitudes and behaviours, de-motivation, isolation and dangerous, extreme polarisation. All of this means that the professional service, comes to mirror the internal fragmentation and conflict of the DID client. What is actually needed is a cohesive professional service with few face to face professionals involved, with consistent and reliable messages, clear and consistent boundaries, and a clear unity that is mature and attractive, to act as a model for the DID client to emulate and work towards.

For most DID clients, their family background or early environment is replete with such contradictions and conflict, and if they are to understand the traumagenic nature of these dynamics, they need to see and experience an attractive and wholesome alternative. Otherwise they would be sorely tempted to stick to what they know best. DID clients report this world view, and it is true that, despite the negative consequences of having DID, which has brought them into contact with services, their system of coping has kept them alive and functioning at a certain level so far, and the inherent challenges and aversive aspects of being in therapy, e.g. facing excruciating affect, offer little incentive to undertake the rigours of therapy, if they do not detect a definite silver lining.

Many DID clients, and other clients traumatised by other human beings, come to believe in a dichotomous world peopled only by abusers and victims. This produces difficult transference and counter-transference, as the therapist is cast in these alternate roles. Resistance of the impact of such transference and counter-transference whilst offering a move towards a paradigm shift for the client, that the

world has other non-abusive possibilities, is undermined if a service is unable to model this potential positive world view. In those circumstances, the therapist appears to lack credibility compared to past abusers, who appear to be proved correct.

In this survey, results showed that, with regard to dissociation, respondents reported a basic to average mean level of support, within their own work groups and from colleagues both within their discipline and from other professions.

9.16 Summary

- Use of postal survey has been critically examined and found to be valid in method
- Target population, success of method and response rates were critically examined
- Low response rate still provided data on cases, geographically spread
- Reports found good awareness (97.9%), and clinicians providing details of cases of DID (8.6%)
- DID is reported in expected proportion to other dissociative disorders
- A potential pool of unidentified trainers and supervisors are reported
- A small number of publications were reported on dissociation
- Basic to average professional support was reported in dissociation
- Treatment issues will be examined in more depth in the next chapter informed by both the literature review and the author's clinical experience of providing psychotherapy for people experiencing DID, as well as the author's experience of supervising other professionals dealing with such cases.

CHAPTER TEN

TREATING DID

10.1 Treatment Implications for Working with DID

Having discussed the current theoretical perspectives in the literature, and presented both a case study and survey results demonstrating clinical activity in this area throughout the UK, the further issue of treatment must also be discussed – especially as the author has stressed the importance of informed treatment approaches, lamented the lack of guidance available in the UK, on the basis of personal experience, and discussed research (McIntee G, op cit), indicating the financial and moral implications in failing to recognise dissociation.

Chu and Bowman (2000) describe three generations in the development of the modern treatment model. The first, up to the mid 1980's, based in the recognition of childhood trauma, was first discussed in the scientific literature in *Psychiatric Annals* (1984). This abreaction model was found to be successful in treating other PTSD conditions, and was an extension of psychoanalytic principles of bringing unconscious conflict or affect into conscious awareness. It was believed that working through these abreactions permitted split-off parts of the self to be integrated. Results were not universally positive. From the mid 1980's there began to be an integration of a wider range of techniques, from cognitive-behavioural and psychodynamic, to hypnosis. Sodium Amytal and abreactive restraints were beginning to be less valued. From the late 1980's, until the 1990's, there developed a more sophisticated and safety conscious approach, utilising an eclectic array of techniques. This was a staged treatment, with ego-support, stabilisation, impulse control, establishment of safety and containment, affect tolerance, and skill development being the primary goals before trauma work could be undertaken. Although this approach had its roots in nineteenth and early twentieth century models (Herman, 1992), this developed approach was only published in the early 1990's (Chu, 1992; Herman, 1992). Although Scheflin and Brown (1996) have shown that amnesia for childhood abuse

was found in virtually all cases of amnesia in traumatised patients, the third generation of trauma treatment (Curtois, 1998) has benefited from the controversy of the FMS era. There has been a particularly important contribution by psychological research into memory, and therapists have had to acquaint themselves with at least some rudimentary aspects of psychological theory, and in particular to adopt or re-acquaint themselves with appropriate guidelines and ethics.

In 1994, Guidelines for Treating Dissociative Identity Disorder (Revised 1997) were produced by the ISSD, for working with adults (see **Appendix 3**). Separate guidelines for working with children and adolescents were developed in the late 1990's, and finally published in 2003 (see **Appendix 4**). In summary, comprehensive treatment planning is recommended to help achieve the overall treatment goal of integration. Psychodynamic psychotherapy is the primary approach, but cognitive and behavioural interventions are recommended for symptom and behavioural management. Appropriate informed consent and fee agreement is required, and group therapy is not recommended as a primary intervention. Outpatient appointments are the treatment of choice, and prolonged sessions are advised to be used only rarely, and to be structured. Safety and functionality is a pre-requisite to trauma work, and may need to be re-established from time to time; progression and independence should be promoted.

Extreme positions by the therapist, for or against the veracity of abuse memories, are considered a handicap to progress. Pacing of trauma is advised, and providing time for clients to re-orient themselves before the end of a session is vital. Non-verbal adjuncts to therapy are often helpful. Irregular telephone contact, physical contact, and physical restraint are not recommended. The scheduling of extra sessions, and of hypnotherapy, should be cautious. There is sometimes a need to consider the safety of children and non-abusing partners, and utilise family or couples therapy as an adjunct. Appropriate boundary management is a major issue, and needs to be very clear. Therapists are advised to follow relevant legal and ethical codes of practice. Opinions as to the length of treatment vary, but the guidelines suggest a range from 2-3 years to in excess of 6 years. Hospital stays should be used judiciously, and psychopharmacology, electro-convulsive therapy, and psychosurgery are not recommended in the treatment of DID. Exorcism is not helpful, and objectivity by

the therapist is required in spiritual matters. In essence, what these guidelines convey is not only what is unique, and of heightened importance in the case of clients presenting with DID, but what is effectively a reiteration of sound clinical practice in general.

Accounts exist in the literature, of the therapeutic approaches undertaken by practitioners working with DID clients. Marmer (1980), from the USA, presented a case of DID treated with psychoanalysis. His thesis was that DID is explained by Freud's notion of the splitting of the ego as a defence, and the use of the self as transitional object. He explicitly claims to be "removing multiple personality from the realm of the arcane and bizarre ... into the mainstream of other psychoanalytically treatable and understandable disorders" (op cit, p458).

In line with the ISSD Treatment Guidelines, there is a growing consensus, amongst those working with DID, that an eclectic approach is probably required in order to undertake the deep therapeutic work, to manage behaviours and affect and to create safety.

Szabo (1995) UK, published an article examining therapy with DID clients from an eclectic but predominantly psychodynamic perspective, drawing on the Object Relations, Psychoanalytical and Jungian schools. Scott (2000), a UKCP registered psychotherapist, published an emotive account of the difficulty of working with highly traumatised and dissociated clients, and argued that the phenomenological approach to psychotherapy, whilst not reducing the counter-transference, protects the therapist against some of the iatrogenic errors that could be made.

Demonstrating how established treatment methods, from cognitive behavioural to psychoanalytic, can be successfully applied if therapists are alerted to the potential pitfalls when working with DID clients, Fine (1991), USA, outlines clear cognitive and behavioural interventions aimed at stabilising the DID client. Kennerley (1996) reported the use of Cognitive Behavioural Therapy with four cases, each with different aspects of dissociation, one of whom had DID. She stated that cognitive therapists are well equipped to help, and outlined "practical ways in which the cognitive therapist can use standard schema-focused cognitive therapy to help clients

to better deal with the distressing aspects of dissociation". Brenner (2001, op cit) describes several case studies with applied theory and historical review, and examines the variation in technique that may be beneficial in working with DID.

Evidence from diverse specialisms is also beginning to filter into treatment perspectives. Conway and Pleydell-Pearce, discussed above, not only describe a most elegant model of mind and the effects of trauma, but their model generates suggestions for treatment via "intervention directed at changing working-self goals ... as this should reduce the accessibility of trauma ESK". This has great similarity with the eclectic but primarily psychodynamic approach to therapy with DID clients/patients.

From personal experience, and a number of these accounts, transference, and especially counter-transference, issues emerge as important factors in therapy with DID clients. Given the high reporting of childhood abuse in MPD/DID cases, Spiegel (1988) examined the effect of scepticism upon transference in psychotherapy, and suggested that it could re-inflict aspects of the former trauma. He contrasts this problem with that of the therapist who fails to distinguish between reality and fantasy in clients. Spiegel also notes the danger of strong counter-transference, and its exacerbation by the extreme nature of the phenomena and the polarisation of the professional debate.

Further, some authors have empirically studied treatment outcome, and considered the issue of counter-transference. Coons (1986b) attempted a cross-sectional treatment study of 20 patients over a period of 39 months. Clinical, neurological and psychometric data were compiled. Psychodynamic therapy and hypnotherapy were mostly used. Progress in therapy was hindered, mostly by the overuse of the mental mechanisms of repression and denial, the continued use of secrecy, and crises. The most common counter-transference problems were anger, exasperation and emotional exhaustion. Almost half of those studied achieved partial or full integration, but only a quarter maintained full integration. The intervening variable was that emotional trauma was experienced at approximately twice the rate in the unintegrated group.

In presenting the case study of a young woman describing herself as having multiple self-parts, most of whom she had clearly and differentially named and organised according to their function, I have tried to exemplify some of the therapeutic dilemmas and issues that are commonly faced by the therapist. It is not the purpose of this discussion to provide a full treatise on the treatment of dissociation, and in particular DID, but my route into this research project was related to the referral of a series of clients with DID presentations, my lack of training in this specific area, as well as a dearth of published UK literature. Therefore it is important to consider some of the main challenges in this work in order to permit some comprehension of the need for specific training in awareness and treatment of this client group, as well as the need for skilled and experienced supervision as part of the regular package of care for DID clients, and consideration of the negative consequences for clients and services if this is not routinely provided.

In facing the presentation of multiplicity, I would have found most beneficial some synthesis of the available psychological literature to enable me to have some insight into how clients had developed a multiple sense of themselves. I felt I needed to know how this phenomenon fitted into established psychological theories, and also to have some treatment issues addressed such as some discussion on the relationship between psychotherapeutic issues, eg transference and counter-transference, with DID. A few papers have more recently been published on these topics, but at the time of my initial investigation I had been unable to trace any UK sources.

There is still no agreed central model for understanding DID, but there is some general consensus, amongst those investigating and treating DID, that it is traumagenic and developed in childhood. I have attempted to form a synthesis of my clinical experience, psychotherapy training and psychological research, both general and specific to the field of Dissociation and PTSD. This has led me to utilise an information-processing model as the basic concept, combined with a developmental model (McIntee, op cit; McIntee and Crompton, op cit, Mulholland and McIntee, op cit). Object Relations Theory suggests that a child forms internal representation of the outside world they experience. The study of DID can be fascinating in that it appears to be compatible with Object Relations Theory, but also suggests the strong

influence of function and role on development, such as is suggested in Rowan's theory of sub-selves (Rowan,1990) and also exemplified in the presented case study.

A recent interest has developed in the concept of Emotional Intelligence or emotional development, and developmental theory suggests that, in normal development, the initial extremes of emotion are gradually integrated through parental containment, empathy and labelling. Schore (2001a&b) has posited psychobioneurological mechanisms by which the right hemisphere to right hemisphere attunement between infant and carer achieves both attachment and this emotional modulation and containment, facilitating growth and development both psychologically and neurologically. Through this mechanism, a child comes to tolerate and manage a wide spectrum of emotions, and to achieve emotional maturation. In the case of DID, such external containment is unavailable; information and therefore affect processing is interrupted by the constantly returning physical impact of the peri-traumatic state, where organic processing; including neo-cortex functioning, is substantially reduced. Integration is achieved only partially around the more pressing survival needs based on function. A normally developing child achieves a sense of self through the mirroring of adult carers; for traumatised children, their self-organisation comes to be a mirror or reflection of a chaotic, unpredictable or predictably hostile and life threatening external world. It seems that, when intellect permits, a self-organisation of contained sub-entities is achieved, but it is one based on a lack of full integration, of extreme, unattenuated functioning capability, where rapid switching of presentation and conscious awareness and memory are functionally determined in the interest of immediate survival. The system is never perfect, and leakage of emotion or memory does occur. In the interests of functionality, this can lead to confabulation. In order to appear socially normal, an incomplete but necessary attempt at autobiographical memory can lead to a mixture of real autobiographical memory and confabulation. It is my contention that, when intellect does not permit the intricate organisation that is required to create DID, a confused and disorganised state of highly dissociated functioning results that is similar to DID in some respects, in that the person may experience themselves as multiple, and have amnesia for events, but their functioning is primarily chaotic, and their ability to progress in therapy is very poor. Such clients would not clearly fulfil the criteria for DID, and would often be thought of as having Borderline Personality

Disorder, but it is my opinion that there may need to be consideration of a separate category for this chaotic form of DID, that currently might be alternatively placed by default under the DDNOS label or might typically be labelled as BPD.

When faced with a client who presents with a novel situation, the therapist may react in a variety of ways. A confident therapist will be able to stay grounded in their knowledge and skill base but, if that is not possible, responses at either extreme may be found. Either the therapist is fascinated and intrigued by the curiosity of new things, and may become over-involved or over-focussed or, if they lack such curiosity and exploration, they may take refuge in disbelief or become over-focussed on what they do know, and misapply known diagnostic labels and treatment applications. As with any presenting problem, there will never be a textbook that describes any particular client; textbooks can only deal in generalities, and the real fascination for a clinician is the uniqueness of each individual client and their situation. It is my experience that this is equally true of the tens of DID clients I have worked with, either directly or indirectly. Whilst it is essential that a clinician stay grounded in their own skill and knowledge base, and that is by far the greater consideration in the treatment of DID, it is useful to consider the additional and particular features of therapy with DID, and the consequent need for training.

10.2 Transference and Counter-transference

Working with DID clients, in my own experience and that of other professionals I have supervised or consulted, produces qualitatively more difficult and extreme transference, and particularly counter-transference, than in other kinds of clients. Scott (2000) discussed management difficulties with DID counter-transference. The US literature has many examples of the secondary trauma that can result in professionals working with PTSD and DID (Zimering et al, 2003). Wilson et al (2001, p133) examined the extremes of counter-transference upon therapists in groups treating trauma victims. Comstock (1991) describes the extreme counter-transference in working with MPD/DID patients. Spiegel (1988) has argued that it is equally dangerous for a clinician's scepticism to affect the transference of the client, as it is for the professional to become confused over reality and fantasy. He warns that sceptical clinicians may re-traumatise their clients through these attitudes.

One DID client reported to me that in previous treatment, with a cognitive behavioural therapist, she had agreed to collapse her alters into one to effect a positive treatment outcome, as she liked the therapist and wanted to please him, but that this had really been an illusion or a pretence to please the therapist, and the parts still secretly operated independently of each other, thus necessitating further treatment.

The "as if" quality of relationships and experiences are very concentrated in DID clients, because of the lack of balance created by integration. Simple information can have dramatic results, and this issue of pleasing therapists, or performing and moulding the self to please significant others, permeates the work with DID cases. As discussed in **Chapter 5**, a client once asked me for information about the literature on DID; in particular, she asked if she were abnormal. In trying naively to reassure her, I told her that, despite the fact that she was reporting tens of alters, she was not the most extreme in terms of the reported cases. She asked what range existed in terms of number of alters in the literature. As she was an academic with a PhD, and could have obtained this information for herself in any event, I provided the information she requested, advising that there were reports of several hundred alters in some rare cases. It later came to my notice that she was suddenly reporting a greatly increased number of alters, which she said had previously been at hidden levels. It was only when I asked about how and when these alters came into existence that it became obvious that she had created them during therapy, mistakenly 'to please me'. She had erroneously thought that, if she had the most alters, it would make me famous and that would please me. Needless to say, I disenchanted her of such a view, and she was able to uncreate these unnecessary separations. Such conscious production of personalities or personifications seems to differ quite considerably from those that are unconsciously created at times of trauma, or specifically created to perform a particularly demanding role, such as Susie's court appearances. Generally, consciously created alters that are non-essential are under conscious control and can be uncreated at will. This can sometimes be functional, as in Susie's need to create a consciously made alter who had the composure to synthesise information, but not the affect from abused alters, for the purpose of giving evidence in a court case to prosecute her abusing father. Immediately after the trial this alter was no longer needed, and so was integrated

without effort. It does appear that it is experience, particularly external demand experience, that develops alters into stable personifications. Another male client consciously created an alter part, when he was a child, to deal with bullying. This alter was fierce and tough and had the role of protecting the frightened child, which was the core identity of this client. As he grew into adulthood he came for therapy because he had lost control of this protector part that had become unhelpfully aggressive and unpredictable. Study of DID gives rise to the suggestion that this may be the way that any personification, character building, or self-development is achieved, through practice, utility, role model and reinforcement. It is also likely to be the case that, even with relatively integrated consciousness, full control of affect and behaviour is not possible, but the lack of integration makes the variation in psychological operating more extreme and problematic in the case of DID.

The whole issue of the strong counter-transference produced can cause danger to both professional and client, and Spiegel suggests that the unscientific polemic merely exaggerates that danger. Thus, there is a strong need for the employment of scientific method in collecting data, both in individual cases and in group studies. There is also a strong need for skilled, regular supervision of such cases, so that it is easier to keep an objective perspective on the counter-transference being produced, to safeguard against either traumatising the therapist, or the reactive behaviour of the therapist caused as a defence against overwhelming affect. In supervising the work of a very experienced and skilled psychotherapist and clinical psychologist, it was noted that she was sometimes finding difficulty in maintaining the necessary objectivity or overview of the client's narrative data because of the strength of the counter-transference. In this case, supervision was extremely important in balancing this strong affect and helping the supervisee to maintain focus on the main themes and issues.

Although many aspects of the transference and counter-transference are similar to those in regular psychotherapy, the intensity can have particular problems when working with DID clients. Aggression and the death instinct will be discussed further below. First we may consider the therapist's need for safety and defence, and the general issue of whether the internal and external resources of the therapist will cope with such intensity. Intervention is often extremely long-term, and that can also

reduce the therapist's objectivity and protective capabilities. Progress can appear to oscillate dramatically, and it can be hard for both client and therapist to sustain such long-term work. Interpersonal boundaries between therapist and client can become diffuse and difficult to maintain over such a long period, and there is an increasing tendency for the therapist to become subject to experiencing dissociative counter-transference. Brenner (op cit) describes some of these problems in his case studies. An inexperienced or untrained therapist will be unable to foresee the complexity of DID therapy, the length of intervention, the strength and other difficulties of transference and counter-transference, the risk of secondary trauma, the highly demanding boundary testing and violation, the level of confidence required to contain abuse dynamics, and the vision that is required to handle what often amounts to group dynamics within the same individual. Often in group work it is beneficial to have a co-therapist, because of the complexity of the task. With DID therapy it is essential to have a supervisor at the very least, and I have often found it beneficial to have a co-worker who is also known to the client and familiar with the client's issues, to cover times of dependency and need for continuity over therapist absences and emergencies. I have found it particularly beneficial to have a male/female co-working therapy arrangement and have found this to raise differential issues and to have positive benefits, as one would expect from having two parents.

It is my opinion that the crucial factor is to have a well-informed, well-trained, experienced and confident therapist, rather than specific DID training; without both, the therapist is left with even greater challenge to their capacity to hold and promote appropriate change. I emphasise the central therapy skills because it is these that are core to successful DID therapy. The therapist, in making appropriate adjustments, needs to be wary of falling into the trap of specialising the client and loosening too much the therapeutic framework. This happens if the therapist is not fully grounded and, through counter-transference impact, is drawn into the world-view of the client. An experienced therapist, who is diverted by the novelty of DID intervention, is apt to lose their grounding and become over-focussed on the differences from other clients, rather than the similarities. There is no other client group for whom such fundamental and comprehensive self-restructuring is required, and if this is matched by a period of vast personal development in the therapist, it is likely that solid therapeutic grounding will be difficult to find. DID clients require a therapist with a

stable identity, to act as a model, containing, consistent other, whose internal change is kept to a minimum. When physical and psychological survival have been at a premium, on a regular basis from early childhood, it makes most DID clients exquisitely sensitive to the minutiae of other people's behaviour, especially with significant others. Therefore it can be surprising for the therapist, and sometimes alarming, what clients will detect. A counsellor presented a client who came and reported a dream that her therapist was about to marry and move away. It was not possible to identify any way in which the client could have learned this information, but this dream was reported just three weeks before the counsellor was indeed to marry. Although banns had been posted, the client lived in another city and would have been highly unlikely to have seen them, unless specifically visiting the registry office and checking. Any non-verbal concern displayed by the therapist is likely to be registered by the client, and utilised in the abuse dynamic that runs throughout most of the therapeutic liaison. Further, there are many examples of extreme sensory perception. An acquaintance of mine reported that, when her adult daughter was a small child, she always had advance warning of a train going by, as her daughter's hair would stand on end. Animals are also reported to be sensitive to the imminence of storms and earthquakes. DID clients usually display such highly developed sensory skills, making the non-disclosure of non-verbal information by the therapist even more problematic than usual. A client will interpret such lack of composure as weakness and inexperience, and will abandon new learning and regress into greater dependence on the old abusive defence mechanisms.

10.3 Functional but Non-integrated Organisation of Self

The phenomenon of multiplicity appears to leave clients with a non-unitary, arrangement of self-parts, sometimes known in the literature as alters, each existing in order to perform specific and sometimes exacting functions. They are often arranged in oppositional pairs that represent complicated and creative developments, going far beyond the Jungian traumatic split of regressed self and pseudo-mature self (Kalshed, 1996), which is often only the initial response to trauma. Multiplicity appears to be a very creative solution (Ross, 1989, 28) to the managing of over-whelming traumatic affect as well as the need for high levels of diverse skill development where, in some cases, errors may be life threatening. The extreme circumstances of the abuse of some clients has trained them to extreme performance,

necessitating the development of extremely functioning alters. General integration is put on hold, whilst survival is paramount. A simple example was reported by one of my clients who was severely sexually abused during childhood, but had also had her nose broken around age four, resulting in breathing difficulties. During sexual abuse, her whole concentration went into trying to breathe and, in order to do that, to maintain specific physical posture with her head, to avoid suffocation. This was made particularly difficult during oral abuse, or anal abuse where her face was pressed against a surface. Sole concentration on breathing, to the exclusion of all else, is a specific meditation technique aimed at developing extreme concentration of the mind and dissociation from all other distracters. This client appeared to discover the utility of this technique for herself as a small child, in instinctual survival.

The opposite dimension to the creative presentation in multiplicity is that of destructive feelings and behaviours. Difficulties managing self-destructive alters can be very exacting for the therapist. McIntee, G (2001, Doctoral Thesis) demonstrated that dissociation was a major factor in facilitating attempted suicide and other self-harming behaviour. The function of an internally aggressive alter is complex. It can cover the range of reasons why people self-harm, such as tension reduction, externalisation of pain and distress, need display and self-hatred or internalised anger. With DID alters, it can have other functions, such as compulsion-repetition of previous trauma or associated aspects of the trauma, or internal self-control and pseudo-protection. For example, the client with breathing difficulties, discussed above, engaged in excessive jogging behaviour, pushing herself to the extremes of exhaustion, reminiscent of her earlier breathing-related, edge of death experience.

Another example is the way in which there are often parts who will seek nurturance or intimacy with external others and, because past experience has shown that this can be dangerous and self-management may operate through a negative cognitive set, danger or disillusionment is construed as inevitable; an aggressive alter will punish internal parts, often child parts, for seeking this interpersonal contact. The rationale may be that self-harm is familiar and predictable, and that this will be less damaging than unpredictable and unknown harm that is perceived to be guaranteed. It can function to attempt to destroy or deprive the client of good things, since they have learned to perceive themselves as undeserving; there is also fear of the unknown, and

if good things are not familiar they can seem threatening. Susie took several years not to feel very uncomfortable in a clean house (the foster home) since this was unfamiliar and did not feel right to her.

Aggressive defence also protects the client from coming to depend upon good things that may either weaken their hard exterior protection, opening up their vulnerable parts, or may create dependence, with subsequently greater harm and rejection when good things are taken away again. This is a pattern many DID clients have experienced in the past. Therapy is thus a relationship where intimacy and trust are necessary to progress, and such behaviour is therefore likely to be triggered and needs to be managed appropriately. These are issues that are familiar in psychodynamic psychotherapy, but with DID clients the intensity and potential for extreme behaviour and affect is much more pronounced, and difficult for the therapist and the client to manage.

10.4 Aggressive alters

Counter-transference with DID clients can be so powerful and so dissociating as to require the active assistance of a supervisor in debriefing. Containment and safety are obviously very important issues in establishing a therapeutic relationship. With multiple clients this is again more taxing than usual. Many and continuing challenges and boundary violations can leave the therapist reeling, in a similar way as a constantly abused child may feel.

Another particular problem for the therapist is the handling of externally aggressive alters. As discussed in the literature review, Coons (1986b) empirically studied treatment outcome and considered the issue of counter-transference. The most common counter-transference problems were anger, exasperation and emotional exhaustion. The function of an externally aggressive alter is often to preserve a safe distance in interpersonal relationships, so as to prevent dependency and intimacy developing. Aggression is sometimes a conversion from a desire for intimacy, and yet a fear of intimacy, that can produce dysfunctional relating. One of my DID clients compulsively told her non-abusing husband to 'f... off', and explored in therapy how, whenever she did so, what she really wanted was for him to just cuddle her and make it feel better. Such behaviour is reminiscent of the toddler stage of

development, when parental containment of distressing and extreme emotions is required to develop integration. Therapist confidence is associated with appropriate training and supervision, and is essential to avoid the client viewing the therapist as victim. The modelling of a confident and mature integrated, middle way, that is an alternative to the abuser/victim dichotomy, is essential.

Regardless of whether alters are internally or externally aggressive, or both, the main therapeutic objective in mediating aggressive behaviour is to avoid the marginalisation of these destructive parts. This is Ross's (op cit, p28) criticism of Prince, that he tried to get rid of negative alters, instead of integrating them. Engaging with these aggressive aspects of the client can be quite formidable and challenging, above what is generally found in the client population, and is more akin to the sometimes unpredictable and dangerous behaviour that can be associated with psychotic clients. This is another reason why adequate training is so essential, and another contributing factor affecting diagnosis. It is only by sensitively and confidently engaging with the aggressive alters, that the aggression can be neutralised and alternative ways found to employ the skills and serve the desired function. It needs to be recognised that the client's self-protection is appropriate, and this aggressive method may have contributed to survival in the past. Courage is needed by the client in order to relinquish a tried and tested survival strategy, and to place trust in the therapist's novel idea of the need to achieve skill transfer. For the aggressive protector part, it is akin to someone suddenly finding themselves forcibly redundant, and feeling insecure about their future continuance. Alter identity is so narrow and fused with function, that loss of function is perceived as lack of existence. Abuse experience has resulted in learning that trust will always be broken, that nothing is as it seems, and that tricks are the stock in trade of adults, and therefore to be expected of therapists as well.

10.5 Stages of Therapy

One of the problems with assessment is that as Brenner (op cit) notes it is difficult to get a cogent history at the beginning of the relationship. This is partly due to how complex the history is, and usually because the client is self-protective enough to take the time to assess the therapist's ability to hear their complexity. A lot of clients fear being thought mad, and being medicated or sectioned. Many fear being

disbelieved. They have been strongly conditioned to perform to meet the expectations of those in authority, and so will provide a presentation that is built on any cues they can detect as to what the therapist is looking for. This is particularly likely at the assessment stage, when the therapist is likely to be more interventionist than once psychodynamic therapy is underway. It is so easy to reveal one's framework of reference as a therapist. For example, asking "When did you first become interested in members of the opposite sex?" tells the client that the therapist has heterosexual assumptions and expectation.

The first stage of therapy is likely to be characterised by a honeymoon period, and then the risk of premature closure, and the client wanting to leave therapy. The client will have high suspicion, high defensive avoidance, minimisation and high hostility, even if that is not obvious. At this stage, the client is likely to perceive the therapist as a potential abuser and repository for bad things. Unconsciously or intellectually, the client will hold the idea of the therapist as a potentially good object, but this will need to be rigorously tested. Success will bring the second stage of therapy, where the client will never want to leave therapy and will be constantly plagued by fear of abandonment by the therapist. Trust and attachment are beginning to develop, and the client will feel unworthy of the positive regard that they experience but are unable to internalise. Predominantly, negatives can be internalised and focussed upon, and positives are projected onto the therapist. The third stage is a continuation of the fear of abandonment by the therapist. At this stage it is rationalised by the length of intervention, and a disbelief that the therapist will continue to be available. There can be regression in the form of self-punishment, "I should have been finished by now". More testing of the therapist's need to escape is undertaken "This is taking forever, it's never going to work, perhaps I have done enough", "Perhaps integration is not necessary" (death-throes of the old order). If client and therapist can sustain the work, then this stage is characterised by a great deal of integration, and a paradigm shift so that positive and negative are consciously recognised in both client and therapist. The final stage is, as expected, a return to deeper levels of all the issues and, in particular, the relinquishing of the original family mother/child relationship that has, until this point, remained in the form of "I know she cannot meet my needs but perhaps IF ... ". During all parts of therapy, and especially at

crucial testing out points when the client is about to move through a paradigm shift, these issues are acted out and acted in by various alters.

10.6 Interpretation Timing

Another benefit of being an experienced therapist in such complex work is the need to be delicate in the timing of interventions and interpretations. For example, one of my clients regularly experienced me as being like her sexually abusive father, because she could detect little about me as a person. My apparently passive, quiet, waiting stance was experienced as trying to catch her out. If she told me anything about sexual abuse incidents, my stance was experienced as voyeuristic. Allowing this transference into the therapeutic relationship is one of the main tenets of therapy, but deciding when to break the "as if", and introduce some reality testing, is very difficult. Intervening too soon is usually associated with the therapist's difficulty of tolerating negative transference. Waiting too long will collude with the client's avoidance. It is difficult to balance the need to be a witness to the client's trauma, and not be experienced as voyeuristic, especially if the client has been abused in groups with observers. Waiting too long can also prolong the transference on the therapist, as the parent who failed to stop the abuse. It is a fine line that is difficult to maintain. A high quality of DID therapy work requires a high level of theoretical expertise and interpersonal skill and delicacy.

10.7 Pressures on the Therapy

Clients often present a pressure of a conscious need to know exactly what happened to them, and why they are as they are. This is often accompanied by a defensive unwillingness to experience the affect associated with knowing. Because repeated violation of personal boundaries makes these clients confused about internal and external issues, pressure can be put on the therapist to tell the client 'the facts'. The therapeutic alliance is threatened by the functional and factual response that the therapist can not know what happened in the client's childhood. The client is assisted by coming to trust themselves, and to understand that the evidence is inside, and not necessarily outside. Another example of this confusion between internal and external, private and public, was experienced when I discovered that some people with DID, who were not directly known to me but came to my notice through a self-help magazine, were publishing internal maps of their personifications, to use

Brenner's term. They were confusing the need to tell (about their trauma) and the need for them and their therapist to know about their personifications in order to conduct therapy, with putting private information into the public domain. I was dismayed that their therapists had apparently failed to interpret this behaviour in time to prevent such a fundamental lack of personal boundary.

Funding can be another major pressure, whether private or public, as can the status of the therapist, either working for a statutory organisation (NHS, Social Services) or independent. If a client is self-funding, it is an enormous financial commitment to undertake weekly therapy over a period of up to ten or twelve years, and the issue of funding has a constant interplay with resistance and boundary testing, as well as acting out. Of particular note is the way in which the financial cost of therapy becomes confused with the cost of the abuse, and acts as grist to the mill of defences, with the therapist being experienced as an abusing authority figure who is taking all of the client's resources. This is often exacerbated by other people, who tell the client that their therapy is going on too long, and their therapist is just out to make money out of them, especially other people whose own agendas are threatened, whether by the financial drain on resources or by the client's progress. If the client is publicly funded but being seen by an independent therapist, there are the constant issues of funding being threatened and therapy being evaluated. There is often the need for the client to be separately evaluated by an independent assessor, and this can raise all sorts of transference and counter-transference issues for the client and the therapist. Client's attachment, confidence and trust in their therapist can be undermined by external agencies calling methods or timeframes into question, but even positive external validation can interrupt the therapeutic process and flow. Deadlines for funding can often cause clients to fail to deepen their work, for fear of exposure if funding is cut. The client's tendency to see themselves as unworthy, and to go into premature closure, interacts strongly with this issue. If the client is seen without charge in the NHS or similar, the emphasis on evidence based practice, procedural rules and short-term interventions is incompatible with DID therapy. Good and skilled supervision would be a way to meet all of these problems about funding, and evaluation would be more evidence based than in the current arrangements.

In the current climate of litigation, it can be very difficult to contain and work with the level of behavioural and affect disturbance that can accompany DID therapy. Acting in behaviours can result in recurring self-harm that is difficult to manage. Overt contracts merely send the issue underground or threaten therapy for a range of complex reasons. Intense transference can lead to complaints about the therapist. One service has recently instructed their staff to furnish clients with the complaints procedure the moment a complaint is raised in therapy. This is with severe end clients, many of whom are DID, though not formally recognised as such. This prevents the therapist from containing and working through the "as if" issue, and using clinical judgment to distinguish between legitimate complaints and transference issues. It is of course recognised that this leaves clinicians with power that can be misused, but that is another reason for close supervision of such cases.

10.8 Confronting Abusers

There are no hard and fast rules about the actual external confrontation of abusers, but the issue needs to be carefully explored in therapy. Sometimes clients confuse this issue because of the confusion between internal and external representations and power. If internal resolution is achieved, then external confrontation may only be needed as a testing to the client's resolve, or in order to effect protection of others. Sometimes it becomes a focus in order to avoid the internal work, and can result in the client becoming re-abused.

It can be difficult for clients to detoxify from being adrenaline junkies. Having learned to tolerate living life on the edge, it can be difficult to tolerate a lower level of stimulation. Imagine being a racing driver for decades, and then being asked to give it up and live within a thirty-mile an hour speed limit for the rest of your life. Such adjustment is very difficult to achieve, and is not possible in a short time frame, but it may relate to the reduction in DID symptoms in older age. This is another thing that can lead clients into re-enactments of abuse via abusive interpersonal relationships; attachment to abusers, and wishing to confront abusers, can also function as a rationalisation for danger-seeking activity, as well as being utilised by protector and punishing alters to resist therapy.

10.9 Skill Transfer in Negative Alters

When working with negative alters, who fear destruction and annihilation, it is necessary to assist them to understand how their skills can be put to new and more adaptive uses. They need to be educated gently to accept that, whilst their habitual ways of behaving served a useful purpose when they had no alternatives, there are now more adaptive behaviours available. The therapist has to offer this as a choice, assisting the client to weigh the costs and benefits of both old and new ways, avoiding any idea of imposition, as this replays the abusive power dynamic of the past. As discussed, Susie, who had one particular prostituting alter, came to learn that her interpersonal skills, ability to assess people, liking for colour, and interest in clothes and make-up could be used to help other personifications. For their part, they had to be helped to accept that the prostitute had protected them by undertaking tasks (childhood prostitution) that they were unable or unwilling to do. Originally, they detested her and were disgusted by her; they had to learn to accept and appreciate her protection, saving their disgust for what she had to do, rather than for who she was. She learned to moderate her excessive use of make-up and to learn about more socially appropriate ways of dressing.

Poor therapeutic handling of this skill transfer can result in an increase of the old tried and tested methods of aggression that have served the client so far, representing an increase in the therapeutic resistance. Coons (op cit) found that progress in therapy was most hindered by the over-use of the mental mechanisms of repression and denial, the continued use of secrecy and crisis, but the most intervening problem was emotional trauma. Negative alters that are ignored, or who feel too threatened by the therapy or therapist, will interrupt the therapy with absences, threats to the therapist or ancillary staff, or may actively engage in high risk-taking behaviours or other harm. Less than skilled handling by one supervisee led to a client suddenly disappearing from home, returning to report renewed amnesia; she had pronounced amnesia for a weekend in between attendances. Later, alters reported that an angry alter had taken them on a binge in another city, to empty their head of "all this therapy nonsense". It is important to respect the protective function of the aggressive alter, and avoid confrontation or power battles. The greatest of skills in negotiation are called for to permit aggressive alters to learn new, and therefore perceivably risky, alternative methods of protection by their own volition. It is not at all unusual

for aggressive alters to use telephone, letters or other indirect methods of expressing extreme aggression. Sometimes this is directed against the main source of help, as in biting the hand that feeds, but it can also be directed at ancillary staff. Thus training needs are not just for clinicians who may be directly involved with DID clients, but all staff who may be in contact with them for a range of services. In one supervised case, this has included diabetic services, disability services, housing and police liaison staff.

This destructive behaviour is very complex. Sometimes this aggression towards others is also a form of self-destructive behaviour, it can sometimes be the expression of anger towards a soft or a safe target, as in always hurting the one you love. It can sometimes be a genuine, if dysfunctional, attempt at relating, in the manner of adolescent aggressive banter, and physical play-fighting that often also has an aggressive edge. It may reflect the interpersonal style learned from past significant relationships. As previously discussed, it can represent conversion to its opposite in a dysfunctional attempt at intimacy. It tests the therapist to see if they will be a victim or an abuser; often the only perceived possibilities. It can function to test out possible rejection by the therapist or service. This is similar to the way adopted children or children in care will test out the safety of a new home, expecting to be rejected, and wishing to get it over and done with to avoid the anticipatory anxiety, and to be in control of what is perceived to be inevitable. I have discussed this issue in examining self-harming behaviour and its influences (McIntee and Crompton, op cit).

Sometimes the indirect expression through letters etc is a safe way of showing the therapist the affective struggle inside the client, and unconsciously seeking to have this affect made safe and to gain help with affect and conflict management. This is a similar stage of development to that of the integrative stage of the "terrible twos" in toddler-hood. Healthy parenting is not overwhelmed by these excesses of emotion, and affect is ameliorated and integrated, thus permitting more complex shades of affect to produce a continuum between the polar opposites displayed earlier in life. For the therapist treating a DID client, this can be a very daunting task, and a situation where skilled and experienced supervision is essential. A therapist can easily become overwhelmed and caught in the conflict between alters; it is essential

to remain in neutral territory, but this is no mean feat, and is often only possible via anchoring in the supervisory relationship. Full grounding is often necessarily placed in the only closely involved therapist who does not have direct contact with the client, the supervisor. Uncontained clients will be even more likely to act out the transference to administrative and other staff, resulting in a wide spreading of counter-transference problems.

As has been indicated, clients experiencing multiplicity may also act out aggression towards other people besides the therapist; often this is on non-aggressive others, some of whom are vulnerable. Clients who have been abused will often view the world as composed only of abusers and victims, having experienced no other possibilities. This means they will sometimes choose partners who are abusers, and their victim experience will continue. Sometimes relationships are mutually abusive, and at other times there is over-correction so as to avoid abusers, but they will then find themselves becoming abusive towards these more passive partners, or towards their children. This is clearly a state of affairs that requires clear professional guidelines, and experience in developing practical solutions and handling the general issue of safety and duty of care to both clients and their families. This not only requires a high level of training and supervision in the treatment of DID, but also knowledge and experience in dealing with the ethical and legal requirements involved with interpersonal violence and child abuse.

10.10 Integration or Unity of Alters

Integration of alters and the relinquishing of amnesia is not a serial activity, beginning with one alter and moving to another, as I had naively imagined. Integration happens in a very complex and sometimes opaque way, although there may be specific emphasis on information processing with specific alters at specific times. Particular problems can arise. Child alters need to discharge inhibiting affect and fully process information that is impeded, but they also need positive experiences, including affection and play, in order to grow and develop. The client will naturally turn to the therapist to have this need met, and there are appropriate aspects of therapy that fulfil this need, but clients, and especially child alters, are quite concrete in their thinking, and will expect the therapist to parent them in reality. This can lead to problems such as the use of touch in therapy, or clear evaluation as

to when play therapy is serving a positive function and when it is maintaining or promoting regression. Integrating opposite gender alters is particularly problematic in terms of self-identity and reality testing. Brenner (op cit) describes a client whose male alter is so unhappy to discover he is living in a female body, that he self-mutilates the breast and vagina in a very severe way. My own experience with this task was very difficult, but my female clients safely achieved integration or co-conscious co-operation with their male alters.

10.11 Therapeutic Parameters

The need for skilled containment has been discussed, and this relates to many aspects of the therapeutic space and intervention. There is not complete agreement about the length of sessions. It is my opinion that regularity is extremely important, so that should be the primary factor in deciding the length of session. Changing from single to double sessions at the request of clients for special occasions has to be carefully weighed in view of potential boundary violations, security testing, testing the authority, skill and knowledge of the therapist, versus genuine need and necessity regarding the processing of particularly difficult affect. Group sessions and couples sessions are usually longer than individual sessions because of the complexity of issues and dynamics; this can be true of DID. Similarly, the frequency of sessions may need careful consideration. When containment is fragile it usually argues against frequent sessions that serve to keep traumatic affect near the surface. This method was generally designed for a different kind of client group, with less fragmentation. I have generally found that weekly, single sessions suffice, with occasional exceptions. The question of flexibility, versus rigidity, versus loose boundaries, must also be carefully monitored. I have found that poor boundaries always results in impediment to the therapy, but so too does rigidity. Regularity and firm boundaries are required, with occasional appropriate flexibility. This flexibility is more easily judged and managed when the client is known well by the therapist. Therefore, in the early stages of therapy, and at times of moving to deeper levels of work, tighter boundaries are required. Still the essential elements of warmth, empathy and genuineness (Truax and Mitchell, 1971) need focus, and boundary establishment and maintenance need to be kindly imposed.

It is always beneficial to utilise the client's own language, in having the therapist's interjection well received, but in the case of DID the client's use of language is exceptionally varied. It is important to think of the fact that, potentially, all parts are listening and will need to hear the message, so language needs to be simple, with no redundant or ambiguous words. The possibility that autohypnosis is involved in DID argues against the use of some words, and words with more than one meaning. It can be dangerous to say to clients "you must be angry about that" because this can act as a hypnotic injunction, telling the client to become angry. It is unhelpful for the therapist generally to act as a go-between in communicating amongst alters. Internal communication has to be promoted, via internal dialogue, an internal notice board or audio recording. A go-between therapist will soon find themselves shot as the messenger. Service dynamics need to be considered, as a divisive external service environment does not provide the modelling and containment for the desisting of internal divisiveness in the client. When and how to reflect the dissociated expressions of the client's alters is also about considering all the issues. Failing to integrate information received when talking to the client, in any presentation, is to fail to reality test; it is collaborating with the dissociative amnesia of the client and it is keeping secrets. Always feeding back information from alters forces the therapist into the messenger. It is a really seductive activity for the novice therapist who, greatly affected by the counter-transference and unable to contain that, is happy to help and to be doing something useful. There is also a seduction for the therapist to be drawn into the internal world of alters, and become to the client like another alter, but on the outside. Being the messenger can also seduce the therapist into a position of information power, and thus similar to the abuser.

10.12 DID Client Parameters

A great deal of diversity is found amongst alters in most clients with DID, and Brenner (op cit, p33) advises paying close attention to the differences between alters. It is not universal, but neither is it uncommon, for there to be opposite gender personifications, both left and right handedness, perceptual distortions of time and space and even physiological differences between alters. PET scans have shown differential brain functioning. Psychometric testing has shown similar variations and ocular refractions have been shown to vary. It is quite astounding to a relatively integrated therapist to see a client rapidly changing hands and handwriting in a

spontaneous and uninhibited manner. The same client astounded her optician, who found it quite unbelievable that her eye test could vary so much. I have witnessed a client apparently physically shrink, so that her feet stopped touching the ground, and she appeared more child-like in size when a child alter was controlling her body. All this impresses upon the observer that the body is not a stable entity, but its parameters can differ widely, according to functional use and presentation. I suppose this will come as no surprise to skilled actors, but there is a difference between the skill development and rehearsal needed to put on a good rounded performance for the theatre, and that developed and rehearsed on a daily basis from childhood onwards in the case of DID. One main difference is the conscious control of the actor, and the extreme difficulty of playing multiple parts. Amnesia seems to be largely a result of partially unprocessed information, together with suppression to protect the client from disturbing affect, but it can also function as loyalty to the abuser or parent. It is sometimes only as the reduction of significant but dysfunctional attachments is achieved that all amnesia can be relinquished too. Alters can also take the form of people, animals and even objects, and present as pseudo-mature figures well in advance of the client's age, or regressed to various stages of development. Alters can present as therapy collaborators, as well as the embodiment of resistance, all in the same client. All these complexities need to be contained, responded to sensitively, valued and understood in the service of promoting unity. Not all clients see this as a desirable goal. As reported in the case study, Susie was content to keep her multiplicity, now that she no longer has any amnesia, and has full co-operation between her alters. Preference for co-consciousness rather than full integration is described by a writer with DID (Chase, 1990).

10.13 The Functional Development of Alters

Maintaining and promoting the safe functioning of the client is a pre-requisite to tackling the processing of trauma and associated affect, because of the way in which it is likely to cause regression, and the use of well-learned defences, such as aggression. It argues for an eclectic approach to therapeutic intervention, where cognitive and behavioural techniques can be applied to the management of short-term problems, alongside a more psychodynamic approach to the longer-term issues of development and possible integration of self-parts. In working with DID and other seriously traumatised clients, it is very important to know how to stem the flow

of traumatic affect. Past mistakes in therapeutic intervention have often arisen from the false belief that therapy is all about processing traumatic affect, and that the role of the therapist is to facilitate that process. It was this error that led some to the excesses of the past (abreaction). Affect processing is an important part of therapy, but it needs to be done in a paced and controlled way that is managed so that functioning is maximised at all times. Often the first stage of therapy is about stopping and managing the flow of traumatic affect, to stop it leaking out in an uncontrolled and debilitating fashion that interferes with everyday life. It is often such a situation that brings clients into therapy. Once stability and some ego development has been achieved, attention can be focused on trauma processing, but this first stabilisation phase can take several months. It also will need to be re-established from time to time if processing becomes too dominant and uncontrollable, or in the face of new crises. As therapy deepens, clients will access deeper levels of trauma. At each stage of deepening therapy, more boundary testing will be encountered and there is greater need for stabilisation. All of this demonstrates to the client that the therapist is sufficiently able to maintain safety at these deeper and more vulnerable levels of exposure and risk. In promoting stabilisation, the therapist is promoting the strengthening of the stable parts of the client, and reducing the strength of acting out and uncontrolled elements of the client.

Hart's concept that fragments of personality, or fully developed alter personalities, grow, to fulfil a function, matches everything I have discovered in clinical practice with all of the DID clients with whom I have worked. As already discussed in the case study, Susie had been subjected to prostitution by her mother from pre-puberty, and customers ranged in deviation and use of violence. She developed different alters to cope with the different types of activity, according to severity of violence and deviance. Many DID clients, in the absence of a caring mother, develop an alter whose function is to be a maternal carer of child parts. This is often a pseudo-mature projection, an alter created in childhood but experienced as being an appropriate mother age. Sometimes this is another protection strategy, as it may be one of the mother figure's roles to keep child parts quiet whilst being abused, or dissociated whilst a particular child part is being abused, or to nurse better an injured child part following abuse. Sometimes such a mother figure is disabled from fulfilling the

desired function, for example, one client had a mother figure that did not have arms and so could not cuddle child parts.

In the literature review, Hart's $^{1}/_{5}$ Man was discussed in terms of the development of this alter through interaction with the therapist. It has encouraged critics to ignore the integrated final outcome of therapy, and find support for the concept of iatrogenesis. An alternative reading of Hart's data would be that this illustrates the process by which alters develop, according to functional need and external activity, leading some to remain mere fragments and others to become highly developed. In my own experience, Marian, discussed in my introduction, had what some modern authors would call an inner helper, a part who assists the therapeutic process, almost as a co-therapist. In Marian's case, she referred to this part by a god-like name that reflected something of its function. This being (gender was undifferentiated in a metaphysical way) began increasingly to inform me of the inner workings of the collective mind, and provided reality-testing integrity of information. This communication began in writing, but eventually became verbal. This part reported becoming changed and developed through this interaction with me, an outside person, and at one point became very worried that he/she was moving away from their original hidden observer function, and was becoming too external. I understood this to mean that they were worried about moving from some kind of metaphysical detached state (probably the kind of transcendental state aimed for in meditation), towards some kind of worldly corporal state that was considered inappropriate, less pure and less objective and all-knowing. As with Hart's client, this did not lead to further splitting, but to integration and loss of amnesia, thus increasing overall functioning. The case study presentation did not demonstrate such a higher internal being, but instead alters whose job was the organisation, supervision and management of the rest of the self-parts in sub-groups and systems.

10.14 From the Parts to the Whole and the Function of DID

The more recent shift in emphasis, from the label Multiple Personality to Dissociative Identity, is symbolic of a shift in focus on separation to integration. Braude (2002) echoes my own clinical experience, saying that clients do not behave as if states are completely separate. That is only a modern equivalent of the nineteenth century focus on duality. It also reflects a need to separate and compartmentalise complex

data for both client and clinician. There is always leakage between states, of emotion, perception or sometimes memory. Also there has to be a mechanism for switching between alters. There has to be inhibition of one state as well as facilitation or triggering of an alternate state. Clients refer to this as *going inside, couldn't stay, x had to take over*. There is use of *we* instead of *I*. Clients will talk of having to block out all memories associated with a period of time, good and bad, in order to ensure encapsulation and inhibition. DID offers the clinician and researcher a fascinating opportunity to consider whether the development of self under traumatic conditions, resulting in DID, is a completely abnormal state of development, or whether it is merely an exaggerated, delayed and unintegrated form of how normal development takes place. The question is raised as to whether the usual sense of self develops largely in response to functional demands, albeit in a moderated and more integrated way, in the absence of trauma interruption. DID is fascinating for the psychotherapist in that it provides an exaggerated presentation of resistance, introjections and projections, transference and counter-transference. Resistance and introjections become personifications in DID clients, and can be studied more easily; the client will often be able to articulate a great deal of information about their development. All of this would perhaps be thought to be of little relevance to the understanding of normal development, were it not for the fact that what DID clients report is so consistent with many aspects of psychodynamic theory. This similarity also provides a great grounding for students of Dissociation training, and helps to ensure effective and safe practice.

DID appears to function to accommodate an encapsulated form of development, in a climate that does not permit integration, the mechanisms for which are suggested in various ways in modern models, with Conway and Pleydell-Pearce (2000) describing neurological underpinnings for these clinical presentations. The historical literature has shown DID to be traumagenic, and to encapsulate unacceptable affect, and behaviour that is not ego-syntonic or that may threaten continuing existence. This seems the common denominator between Forsyth's soldier case, and the intelligent and assertive alters displayed by a large number of the female cases. My own clinical cases have tended to suggest that alters develop to accommodate functional necessity, and encapsulate difficult affect and behaviour. What appears to start out

as a survival mechanism in childhood, eventually becomes unwieldy in adulthood, and it is that which often brings clients into therapy.

This discussion has sought to place my research study and survey findings in an historical and international context, and to highlight some of the training issues associated with the identification and treatment of DID. The human and financial cost of misdiagnosis, and neglect of the diagnosis, has been touched upon. McIntee G (2001) has demonstrated that, for very little cost and effort, a quick screening tool, the SDQ-5 (Nijenhuis et al, 1997), could identify adolescents at the greatest risk of self-harm, and is suggestive of a potentially fruitful therapeutic approach. She demonstrated the statistical impact of this finding on the high numbers of deliberate self-harm referrals presenting to hospitals in England and Wales. El-Hage et al (2002) found similarly that somatoform dissociation sufferers are "high users of health services but rarely receive relevant treatment". Spiegel (op cit) has emphasised that neglect of this research area leads to treatment that re-abuses clients. I have attempted to demonstrate that DID provides a fascinating and rewarding insight into dynamic psychotherapy theory and practice, and that it would not be too great a cost to clinicians and services to widen the perception of psychological disturbance to include the veracity of DID and provide appropriate treatment. On the contrary, it could be highly beneficial in terms of both human and financial resources, and it would be scandalous for personal and political agendas to be permitted to derail clinicians and researchers from accurate scientific endeavour and evidence based practice.

Dissociative Identity Disorder in the UK:

Competing Ideologies in an Historical and International Context

CHAPTER ELEVEN

DISCUSSION

General Summary Discussion and Conclusions

11.1 The Historical Literature Review

The literature review had demonstrated a progression, from issues of belief to scientific investigation, and in particular to integration between psychological and physical process modelling. Earlier modes have not been relinquished, and continue as dormant themes that still emerge periodically, especially as hybrid models of confused philosophical thinking, particularly under regressive conditions of professional threat or failure. A full reading of the literature leads to the conclusion that modern polemic lost sight of the historical legacy of dissociation studies internationally, and in Britain in particular. In reading the modern professional literature in Britain, instead of being assisted to be proud of the pioneering contributions of the UK, the uninformed reader is left with the impression that the only reports are sceptical, that no cases exist, and that it is a US phenomenon, from which any self-respecting Briton would distance rapidly. It is therefore concluded that this polemic has returned to the issue of belief versus science, and the discussion has not been data driven. The current survey shows that the professional press does not reflect all clinical opinion and activity regarding DID. Indeed recent reviews of clinical psychology have concluded that professional journals have lost touch with clinical activity, causing difficulties for the scientist-practitioner model.

The late nineteenth century in Britain had seen the rise of anatomy, from its inauspicious roots in barbering, to promote a move from metaphysical to biological reductionist perspectives. Models of mind move from the concept of a separate soul, to simplistic two-brain theories, and then to emergent and functional models, from the unitary concept of mind to the polypsychic conception. These developments have not only been embedded in the development of medicine, psychiatry and psychology, but in the struggle between the religious and secular aspects of society,

and the developing role of women. Despite the fact that Britain had experienced strong and intelligent female leaders throughout history, from Queen Boadicea (30–62AD), through Queen Elizabeth I (1533-1603) and Queen Victoria (1819-1901), to the present day, the subjugation of women and the constriction of their role to irrational dependents has only recently seen a pronounced challenge. Even now there is talk of a glass ceiling that prevents women from equality in many professional and business areas. Women are still the greater help-seekers, and therefore are diagnosed with any mental health conditions in greater numbers than men. This is still the context to the interpretation of the current statistic produced by this survey. Historically, female cases of DID have outnumbered male cases. Estimates vary, but have been thought to be approximately 9:1 (Ross et al 1989); in this current survey the proportion was 3:1, which is not particularly discrepant from other mental health or health help-seeking statistics. The role of women is tightly bound up with the role of procreator, in a way that is distinctly different from the role of men. It has been the norm that English Kings and political leaders have engaged in extra-marital sexual relationships whereas, in order to be taken seriously as a leader, women must be seen as much more highly principled. In the past this may even have extended to the need to be seen as celibate. The celibacy of Queen Elizabeth I has taxed many investigators and gives rise to an impression that, in that historical period, in order for a woman to be seen as strong and intelligent, she must also be celibate. It is as if the issue of madness and hysteria being rooted in the womb renders her incapable of having both faculties. It may be thought that, with Queen Victoria, who was the mother of a very large family, celibacy was not required to be a successful leader and the issue was therefore solved, but it appeared in other guises. At the same period, women were beginning to ride bicycles and to ride astride horses rather than side-saddle, the issue of such activities posing a threat to the vital issues of virginity and procreation was raised again. The question may be raised as to why, in the modern era when female emancipation has never been so well-established, we should find not only an increasing number of DID cases, but cases that have increasing numbers of alters. There is no direct evidence to inform this discussion, but hypotheses can be explored. Although women have now entered the workplace in greater numbers, they are also still largely responsible for housework and childcare. The range of roles a woman can now face is developing exponentially. For both men and women, the world is becoming more complex and

multimedia. Television screens now present split images, displaying simultaneous news processing about different and disparate subjects. As has been explored in the move from old models and philosophies to new ones; new ones get layered on top of old ones, old ones do not disappear; so it is in this fast multi-media world of women. The female role has expanded into many new areas, but has not relinquished the old ones. The prevalence of child abuse and domestic violence towards females suggests that the subjugation of women has not been solved, only ameliorated. It may be suggested that it is this complex modern context that is likely to produce the kind of DID cases that are reported in the modern literature, together with a more comprehensive perspective, by the identifying clinicians, no longer encumbered by the two-brain model of the past.

In the nineteenth century the issue of malingering became prominent, at that time in response to increasing levels of compensation for railway accidents. Whilst there will always be false positives and negatives in any situation, promotion of a diagnosis of malingering met the agenda of the railway companies to minimise their liability, as they sought to defend themselves from financial losses. It was again against a background of litigation, this time about past child abuse, that the False Memory societies were formed and the concept of FMS gained prominence. This became implicated in the criticism of DID, and led to claims of malingering, but also of iatrogenesis, where the clinician is alleged to have created the condition in the client. This allegation claimed that the clinician caused the otherwise integral client to split into experiencing themselves as separate people; the creation of alters is also associated with the idea that memories for past trauma cannot be repressed, and then later remembered. FMS society academics, such as Elizabeth Loftus (Loftus et al, 1993, 1994a, 1994b), have conducted experiments aimed at proving that false memories can be developed, as indeed they can (*BPS Report on Recovered Memories,* 1995), but this is also taken to prove that memories recovered in therapy are caused by the therapist having implanted them, and that true trauma memories are not recovered. It will be remembered that Forsyth's (1939) case involved traumatic or unacceptable memories that remained repressed for twenty years, eventually returning and being resolved in therapy, and Kirshner (1973) concluded that the memory repudiates the unacceptable. Williams (1994) has amply demonstrated that, in known child abuse cases, repressed memories are found,

although Kihlstrom (2006) suggests that this may be difficult to distinguish from normal forgetting. Such claims of iatrogenesis, and many implications, ignore the data that exist before the client undertakes therapy. In all of the cases I have dealt with, either directly or via supervision, there has been ample data indicative of multiplicity and amnesia prior to therapy. It is my experience that, as with all categorisation of clients' presenting issues, although there are some commonalities, there are many more differences in the reports of self-organisation of DID clients. I have noted for example that it is not uncommon to find that DID clients have internal carers, or mother figures, and it is very common for them to have aggressive protector alters, but I have never yet discovered anything but unique patterns of internal organisation that reflect the idiosyncratic experiences and needs of the individual client, developed over time. Indeed, as Canter (1994) has shown, behavioural shadows are always left behind when human beings conduct serial activities, so it would be reasonable to expect iatrogenesis to be evidenced by repeated patterns of internal organisation in DID clients treated by the same therapist, but I have never discovered such a thing so far. It would make an interesting research project. Similarly, in arguing against the imagination of presenting symptoms by DID enthusiastic clinicians, Spiegel (1988) found that DID clients assessed by two groups of psychiatrists, one familiar with DID and the other not, still found common symptoms in the clients. Since the claim of iatrogenesis does not match the available evidence, the question is raised about its perseverance as a concept.

At least in the short term, this strategy of blaming the therapist appeared to have been very successful in stemming the litigation against accused parents, but appeared to be a case of shooting the messenger. Litigation against a handful of prominent therapists, in the USA, sent the therapeutic community, in the West, into extreme caution and defence. Objectively, it appeared that there had been some overenthusiastic diagnosis, and overenthusiastic use of abreactive techniques. There was not a great deal of evidence for this in Britain, but clinicians became defensively cautious for a while. The positive outcome from this was that professional bodies sought to devise clearer ethical guidelines for their members, and some ad-hoc training occurred. None of this actually settled the belief versus science debate, but the debate lost its prominence and things settled back down to a normal routine. This

leads to the question of whether British professionals would remain ignorant of their important heritage in dissociation, and whether work continued in Britain to this day, my anecdotal experience being only the tip of something hidden or indeed a rarity that no-one was speaking about in the professional press.

This thesis has sought to re-assert the historical British contribution, particularly of the Society for Psychical Research; important concepts were contributed by people like Hart, as was field research such as that conducted by Myers on War Trauma. More recent inter-disciplinary research has benefited from using modern technology such as PET scans to investigate physiological correlates of cognitive processing, including studies using DID subjects. This has assisted in the development of complex and integrated theories of memory, and in particular autobiographical memory, and dissociated perceptions and functioning, such as that proposed by Conway et al, (2000), Schore (2001a&b) and Forrest (2001). Despite contention, DSM and ICD still have DID as a category. The polemic, though successful in the short term in reining in overenthusiastic therapists and stemming litigation, appears to have gone into recession, largely ignored by professionals who are, according to the results of this survey, actually working with cases that they identify as DID. In the public sphere, it seems to have been a short-lived attack "full of sound and fury, signifying nothing" (Shakespeare – Macbeth, Act V, Sc 5).

11.2 A US Phenomenon

So, in considering both the full British history of DID, and the current need for better identification and treatment that also requires specific training and skilled supervision, it can be seen that the problem is not unique to the USA. Not only has this case study and survey provided data that challenges Merskey and Aldridge-Morris, and exposes their selective attention to the full history of DID, but the literature review has suggested a number of influences that have been responsible for uncritical acceptance of their view.

Access to information is considerably greater in the USA than in Britain. Often, even today, searches and actual papers are more easily available through American websites than British ones. Access to the full historical facts about DID is not easily available, especially in the UK. In conducting my literature searches, I was often told

by libraries, including the British Library, that sources were not available. Personal contacts in the USA and elsewhere provided some materials and helpful searches that revealed greater data than those in Britain, even for papers originally published in Britain. Some early sources are not available in modern English; again original sources were obtained through personal contact. An active scientific community promotes research and development. This is present with respect to the study of DID in the USA, and less so in Britain.

The rise of psychology, especially clinical psychology, as an independent discipline has been more prominent in the USA than in Britain, and the relationship between clinical psychology and other mental health professions, particularly psychiatry, has been more egalitarian and has lacked the extreme class-base of British medicine, where 75% of students still come from professional backgrounds. Clinical psychology was a doctoral qualification in the USA, long before it was in Britain. In Britain, clinical psychology has struggled, from being the handmaiden of psychiatry to establishing its own credentials. This process has also had its convolutions, and was interrupted and regressed by the introduction of largely medical clinical directors, during modern NHS restructuring and budget holding arrangements towards the end of the twentieth century, again the result of medical political power.

The Vietnam War was a particular catalyst for the development of the related area of PTSD research in the USA. This more general area of study has found better congruence with short-term, easily evaluated, cognitive behavioural interventions and research, even in Britain. UK involvement in modern warfare in Europe and the Middle East will also promote greater understanding of dissociation and PTSD.

The emancipation of women was lead by the USA, possibly a result of both the pioneering spirit of émigrés, and the benefit of a constitution, instead of a class bound culture and legal system based on custom and practice. Another potential link with the US hegemony is Bird's data (op cit) showing that immigrants are susceptible to an increased rate of mental health problems. Perhaps in emigrating and settling in a new country, there are even greater contradictory pressures on women's roles. One of the first US cases, Mary Reynolds, was a recent immigrant, and one of Jackson's cases was said to be cured by a family holiday back in England.

America has seen a few particularly high profile cases of DID. Whenever there is a need to investigate something because it has political significance, it can greatly alter the balance and focus of issues in mental health. The Michael Stone murder case in Britain in 1996 resulted in strong criticism of the psychiatric approach to the diagnosis of personality disorder, with financial and resource implications for services in the UK, and a relative rise in the profile of clinical psychology.

It is likely to be the combination of all of these factors, and probably several other more minor ones, that have promoted a body of DID study in the USA, and the neglect in Britain, where personal dominance, cultural reticence and perhaps some anti-American attitudes have contributed. In education generally, Britain has a much poorer rate of completed PhDs than in the USA and, in clinical psychology, it has proved difficult to promote general publication by practitioners. This survey may therefore demonstrate that British practitioners are more inclined to get on with the job, rather than tell others about what they are doing. This low key approach is likely to lead to continually re-inventing the wheel, and great impediment to the development of the study of DID in Britain. There is a recurring pattern in the literature that, after a period of data collection and then conflict over its interpretation, often from professionals with no direct knowledge of DID clients, those with clients just seem to get on with the job in hand of providing treatment; this seems to be what happened in the USA, and more recently in Britain. As was discussed in consideration of this survey, practitioners are generally centred on clinical practice rather than administrative tasks, and client demands are generally prioritised over publication. The treatment of DID is a very demanding, long-term undertaking that perhaps depletes the clinician's energy to research, write and publish data.

Perhaps in Britain there have been particular obstacles to progress, such as a hostile attitude in the professional press, where particular unfounded opinions were allowed to dominate, but where, in addition, clinical psychology is more conservative and equivocal in its opinions and public profile than in the USA.

As has been demonstrated, DID is reported worldwide, including Britain. It is not merely a US phenomenon, indeed, the US dominance is a relatively modern

phenomenon. In Britain, this survey highlights the need for a climate that encourages more representative publication of existing clinical opinion, case reports and research, and the need for a high level of training and supervision.

11.3 The Concept of Dissociative Identity Disorder

Although a diagnostic entity in both ICD-10 (1992) and DSM-IV (1994), Dissociative Identity Disorder remains a contentious subject. It has been criticised as a Cultural artefact (Merskey, 1992; Aldridge-Morris, 1989), though despite cultural differences, core concepts remain remarkably similar across international reports and across historical periods (Coons, 1994; Boon & Draijer, 1993; Martinez-Taboas, 1986; Taylor et al, 1944).

Another criticism is that it is a media-produced phenomenon, and that the rapid rise in reported cases, especially in the USA, proves this to be the case (Merskey, 1992; Piper, 1994). Newnes (1999) has argued that all diagnostic systems result from a social constructionist rather than scientific premise, and Ellenberger (1970) has demonstrated that clinicians understand and label the phenomena they study according to a historical context and state of knowledge and awareness. Ross (1989) argues that many diagnoses change over time, such as Dementia Praecox becoming labelled schizophrenia, and he argues that cases can become misdiagnosed by these professional trends. Under such circumstances, both over and under diagnosis could occur, but careful recording of cases does assist in scientific identification of valid cases.

Lauer et al (1993) has suggested that DID is a misattribution of Borderline Personality Disorder symptoms. Steinberg (1994) has produced structured clinical schedules to aid differential diagnosis. Boyle (1999) has argued that differential diagnosis is, in any event, an unscientific enterprise, so it seems difficult to do other than collect detailed and carefully recorded phenomena observed by clinicians or reported by clients and utilise structured interviews and psychometric tools to reduce discrepancies between clinicians, though it seems it is difficult to get away from subjectivity, even in attempts at strict scientific endeavour. In this respect,

protagonists from both sides of the belief debate agree that the diagnostic criteria for DID need to be reviewed and more tightly specified (Piper, 1994; Putnam, 1995).

Ross (1995) also concludes that the validity and reliability of DID must be based on an understanding that insufficient data exists to establish definitively or refute the scientific reality of the disorder. It is important to grasp the fact that the claim that DID is not valid requires data, and cannot be accomplished by anecdotal case arguments or at an ideological level (Ross, 1995, p66).

11.4 Beliefs and Attitudes versus Science

As the historical literature has shown, although there have been several periods of progress in terms of rigorous description of clinical data and attempts at scientific study, beliefs and attitudes are still strongly influential in this modern 'scientific' era. Clinical services are delivered by psychiatrists and psychologists who are required to base their clinical practice in scientific research but, in practice, human failings mean that personal and cultural beliefs and attitudes have a direct influence upon perceptions of clients and their conditions, and on the delivery of treatment. Levine (2003) has asserted that:

> 'Although usually not volitionally deceitful, the self-deceptions of some psychiatrists, psychologists and other mental health professionals might well enable these "providers" to espouse attitudes, behave therapeutically or promulgate expert opinions in ways that are less than justified or not substantiated by empirical research.'

Shapiro (2003) demonstrated the impact of clinicians' belief systems on the delivery of services:

> 'that those who had stronger beliefs in a just world had stronger negative attitudes toward the poor and poverty. In addition the clinicians' beliefs and attitudes were associated with their beliefs about whether psychotherapy can help the poor and about whether they were prepared to provide psychotherapeutic services to the poor.'

The problem of specificity and subjective bias in diagnosis is also brought to bear in a further criticism of dissociation, that the large number of cases are being diagnosed by a relatively small number of clinicians (Orne & Bauer-Manley, 1991), so that

clinician's belief would be a major factor in determining obtained diagnoses, as has been seen in the field of both domestic violence and child sexual abuse. Finnila-Tuohimaa et al (2005) concluded, in regard to child sexual abuse, that clinicians relied more on their clinical experience than on scientific knowledge. It has not been the experience of this survey that proportionally few clinicians accounted for the majority of reports.

This survey, despite a proportionally low response rate, has demonstrated that almost a thousand clinicians were willing to express opinions about dissociation, most of whom believed in it as a clinical entity, and a significant number of whom reported cases they identified as DID. Therefore some few hundred cases are believed by some clinicians to exist in Britain, challenging the concept that the phenomenon is a culture bound, US issue. As the review has demonstrated, cases are reported all over the world, and culture clearly does have a significant role to play in many aspects of the phenomenon, as it does with any other mental health concept. Firstly, the research and awareness in Britain and France were promoted by the First and Second World Wars, and in the USA by the Vietnam War. Cultural or even sub-cultural experience is seen to affect psychiatric awareness and labelling. In the World War I situation, PTSD came to be conceived of in Britain as hysteria, whereas in France, nearer the Front Line of war, the traumagenic aspects were more obvious, and it was labelled 'shell shock'. In Norway, DID service provision was boosted by oilrig disasters, as well as concentration camp experience. DID in Israel was predicated upon theories of possession rather than traumagenic psychological models. Reporting in Turkey and Japan was influenced by particular high profile cases that set a trend. Mai (1995), in Canada, reported that both the media and the psychiatric belief system affected the identification of the prevalence of DID cases. Conway and Haque (1999) have shown that there are cross-cultural differences in autobiographical memory. McKeller (1989) provided a summary of these cultural influences.

The social constructionist model of psychiatric diagnostic labelling is clearly demonstrated through this investigation of DID and, as has been discussed by Leudar and Sharrock (1999), the question of the existence of DID cannot be settled by recourse to wrangling over one label versus another. There does remain however a

need to provide a climate for free and constructive reporting and dialogue. What this research has demonstrated is that at least a few hundred cases, labelled as DID, have been identified by clinicians, yet very few have been reported or in any way discussed in the professional literature. At the time of strong opinion being published to the contrary, professionals did not offer this data in rebuttal. Although this number of reported DID cases is small, it is four times as large as the early reports of schizophrenia and, even if this is the sum total of cases in Britain, this author would have found it greatly beneficial, when I encountered my first case, to have had access to such information and possible network support. Although the issue of labelling does not assist in establishing the veracity of DID, it is an important factor in considering prevalence. It has been seen that schizophrenia (estimated as 1-2% of the general population) and DID are often confused, not only by the general public, but also by professional diagnosis. Indeed, the term schizophrenia means split-mind (schizo = split, phren = mind, Greek), and unless the differential diagnostic criteria, such as in the SCID-D-R (Steinberg, op cit), are appropriately and stringently employed, it is highly likely that these two labels may be used in a confused way. It has also been suggested that BPD, thought to be twice as prevalent as schizophrenia (BPD estimated as 2-3% of gen pop), may also mask the identification of cases of DID. This survey has also demonstrated that some respondents are utilising the non-recognised label of FMS for some 623 cases, and that may also mask some DID identification. Using a sophisticated adapted analysis of the DES (DES-Taxon), Waller and Ross (1997) have estimated the prevalence in the general population of Canada and the USA to be 3.3%. The results of the current survey suggest a figure significantly below 1% in the UK. Unlike Waller and Ross, the current survey is extrapolating from clinical reports, though that should, if anything, be inflated by comparison to the general population figure unless, because of a climate of disbelief in the UK, DID cases are strongly undetected

11.5 Clients' Experience

Despite an apparently low prevalence rate internationally, and perhaps especially in the UK, there is an indication that there should still be cognizance of these rates not being so dissimilar to other conditions thought worthy of treatment, and even a small number of clients should be able to access the treatment they require. This raises the issue of the consequence if there is dissonance between the experience of clinicians

and that of the clients. Clinicians prepared to listen to the reports of their clients, and deliver as client-centred a service as possible, need to make a response to what clients are showing and telling. One client described the experience of dissociation as follows:

> There was this awful pressure. I felt as if I was going to explode. The part of myself that was my body did not seem capable of remaining intact. And all the time there was this immense yearning, searching emotion, somewhere around my naval.
>
> I lay in bed and concentrated really hard on escape, and slowly I felt myself gathering some kind of speed and I disappeared through my feet and finally through my toes.
>
> This feeling of being filled up. That you can not contain the structure and at any minute some catastrophe will happen where your body will separate and no longer exist. The physical struggle to contain the structure.

Another client explained what it was like to be disbelieved:

> We tell you no stories, we tell you no lies, we tell you only what we see through our eyes or hear through our ears.
> We are the innocent children you sent away. You are the grown-ups who chose not to listen.
> We were not born with knowledge or thoughts we brought to you. We knew nothing of men's or women's private parts, of the nasty things they do.
> We told you only what we had seen or been taught. We were not born so distressed or distraught with our lives in a mess.
> We are human beings just like you with true feelings and thoughts. We are after all small versions of you who needed to be cared for and protected from all the evil people who did us so much wrong, not turned away or ignored just because we were small.
> We are the children who never grew up because we were left with so much pain, fear and sorrow. You were the grown-ups who left us holding all the guilt and shame because you turned away and did not listen when we came to you, leaving us believing we were all to blame. You are the grown-ups who were supposed to be our guardians of love, care and protection instead of turning us away, calling us liars and story tellers with huge imaginations.
> We are the children who ended up feeling crazy or insane, keeping secrets because we dared not tell you as you chose not to listen when we tried so hard to tell you about our journeys through hell, causing us to become split up and divided inside, it's a miracle we ever survived. McIntee and Crompton (1997, p139)

11.6 Limitations of the Research and Future Directions

This research has presented a single case study of a client receiving psychotherapy for what the author assessed to be DID. The client continued in eclectic psychotherapy for twelve years, and reached a satisfactory level of co-conscious functioning and daily living as an independent adult, and as a mother of three children who also fared well. This clinical experience and continuing study has led me to agreement with much in the models of Putnam (1997), Schore (2001), Forrest (2001) and Conway et al (2000). I am unconvinced by the universality of seemingly intractable structural impact of early trauma on brain development and function, as clinical experience suggests greater plasticity, at least in DID cases, than Schore would predict. It appears to me that intellect, composed of capacity, processing speed and inhibition, suggests that if a critical positive level of intellect is available, humans have the potential to encapsulate even quite complex sub-sections of integration, and then utilise highly developed inhibition mechanisms to prevent untimely integration on a larger scale. A positive and secure attachment, perhaps with specialised professional intervention, appears to be needed to permit adequate affect processing and neural integration of full autobiographical experience.

In addition, the survey has produced useful data on clinicians' beliefs about the potential existence of some few hundred DID cases in Britain. Limitations of the survey are that there was no way to control for the accuracy of clinician respondent diagnosis. Clinicians' diagnostic specification for dissociation did match closely to the DSM-IV criteria so there appeared to be a good understanding of the diagnosis and the clinical phenomena being reported.

Another limitation is that data for this survey was not collected directly through the use of psychometric or clinical instruments, such as the Dissociative Experiences Scale (Carlson and Putnam op cit), the Dissociation Questionnaire (Vandelinden op cit), the SDQ (Nijenhous op cit), or the Structured Clinical Interview for DSM IV Dissociative Disorders (SCID-D-R, Steinberg op cit) as has been possible in small scale incidence studies. The survey did not request data as to whether identified and reported cases had been screened with any of these kinds of tools, and there is no data about inter-professional corroboration of diagnosis. These are limitations often found in case reports, and are ameliorated by the fact that potential prevalence results

in this survey are comparable with results of the incidence studies in the UK, where such tools were used. The use of such screening and diagnostic instruments is more pertinent to smaller scale incidence studies, and these were used to verify data in the studies reported by Davis and Davis (ISSD(UK) Annual Conference, 1997 op cit) with a population of clinical psychology referrals, and Acquarone's (op cit) electronically published study of a psychiatric population.

Some relatively small, technical errors occurred with the survey, such as questionnaires that were misprinted or had become separated, either from their envelopes or from the stamps placed on the envelopes. This had not been noticed before dispatch, but became obvious because of comments from one or two respondents, or faulty questionnaires that were returned. This accounted for only a handful of responses, and it is not possible to know the print error rate with any accuracy. The volume of questionnaires to be placed in envelopes made it a very time consuming task, and questionnaire booklets could only be randomly checked. Set against these few complaints by respondents, it was very gratifying that so many respondents took the time and effort to add extra comments, over and above what was requested, indeed some took a lot of time and trouble to give additional information, and even wrote letters. This qualitative data will need to be more carefully examined at leisure, and was not systematically available for inclusion in this report.

Several years have elapsed since this data was collected, and there is no way to know how much they reflect the current situation. This survey obtained data from psychiatrists and clinical and counselling psychologists, and a repeated survey of those professionals is recommended. The long-term nature of the change required in DID clients means that a psychodynamically based eclectic approach is indicated, thus suggesting that psychotherapists may be a very important source of case data. Coons (1986b) reported that psychodynamic therapy and hypnotherapy were mostly used by therapists. Counsellors and psychotherapists, in addition to those who are also psychiatrists and psychologists registered with the RCP and BPS, could potentially provide valuable data. Of the respondents in this research, only 16.4% had counselling or psychotherapy qualifications. Females were 50% more likely to

have acquired therapy qualifications than males, but other demographic variables were not significant.

Despite the limitations of this research, it has been successful in documenting a fuller history of the study of DID, and has re-vitalised the important contributions of British professionals, reporting an in-depth case study of a single case of DID, treated largely pschodynamically but also integrated with cognitive/behavioural and psycho-educational interventions, and a survey also identifying clinicians' beliefs in the existence of dissociation and DID who also reported a meaningful number of modern cases. The need for fuller research, appropriate training and skilled supervision are also described.

11.7 Summary

- History showed development from belief systems to science without true paradigm shifts

- A struggle still exists between biological reductionism and psychological approaches but integration is also apparent

- Modern times show belief still competes with science but that integration of psychobioneurological data is beginning to produce helpful complex models

- UK and US integration is hampered by some anti-American sentiment in the UK

- Patriarchy and class-base in medicine hamper DID identification and independence of clinical psychology in the UK

- Scarce resources, lack of training and litigation can lead to clinicians' disbelieving clients

- The Social Constructionist nature of psychiatric labelling means diagnostic arguments are fatuous

- Despite a lack of a central all encompassing model of DID there is general acceptance of a trauma basis and links with PTSD with a suggested neurological basis. The case study is based on an integrative information processing model

- Transference and counter-transference in therapy have highly intense quality and raise particular management issues

- Traumatic splitting and encapsulation of experience provides functional survival with long-term negative consequences

- Management of aggressive alters and stages of therapy are described

- Interpretive timing and pressures on such long-term therapy are discussed

- The confrontation of abusers is examined in terms of risk management

- Facilitating skill transfer in negative alters requires training and skill

- Integration of alters versus co-consciousness of alters is examined

- Therapeutic parameters require stricter clarification and adherence

- Client parameters and unusual phenomena are discussed

- DID is a functional survival mode of development, maintaining functionality and safety during years of trauma

- Emphasis is on the holistic nature of DID and its relevance for psychological and psychotherapeutic study

- DID is not merely a US phenomenon

- The limitations of this research are acknowledged and future directions are recommended

11.8 Final Conclusions

The historical literature demonstrates that, like most mental health conditions, dissociation moved from the theories of possession, based in a philosophy of metaphysics and religion, through proto-scientific theories, coinciding with the development of anatomy in the West and a new age of rational philosophy, to the modern era of scientific endeavour, and increasing ways in which technology such as PET scans can examine the interface between the psychological and the physical. The Mind-Body question is often at the heart of the historical conflict but, in modern times, conflict again centred on belief systems. In the 1602 case of Mary Glover, opinion centred on organic disease versus fraud or the supernatural; in modern times this theme re-emerges as the controversy between biological/organic disease versus fraud or iatrogenesis (e.g. Merskey, op cit; Aldridge-Morris, op cit). A modern echo of the simplistic dual brain and dual personality concept is found in the uncritical acceptance of separate personalities, instead of the more complex pattern of separation and integration that is actually extant in clients' reports, giving rise to the change in name from Multiple Personality to Dissociative Identity Disorder, and more adequately explained by modern psychoneurological theories.

DID has been unique, in the history of mental illness, in the charges laid against it of not only malingering, but also of iatrogenesis. Brenner describes it as "probably the most controversial entity in psychiatric history" (op cit, p37). There is still a mystery as to why DID is so singled out, but some ideas have been suggested as to the varying influences that have produced such vitriolic attacks, such as the influence of pressure groups set up to defend parents accused of child sexual abuse, and to defend against litigation. Litigious attacks being turned onto the therapists instead of clients had the effect of disempowering both client and therapist, often leading to retractions by clients.

A fuller history has documented the relatively modern rise of US hegemony, and suggested that the rise of female emancipation has been a major contributing factor to the identification and treatment of DID. Ross (1989, p37) has suggested that

several factors have led to the demise and neglect of DID, but mainly cites Freud's abandonment of the seduction theory as pivotal and related to the adumbration of DID by schizophrenia.

Impediments to the linear development of the study of DID can be traced through the convoluted history and philosophical struggle about theories of mind. Political dominance and patriarchy have been major influences, and litigation defence has led to vitriolic attacks upon clients and professionals. In the modern era, the short-term planning of evidence-based services is not conducive to the long-term treatment of DID and other complex cases. Successful outcome in long-term complex cases is undermined by the impact of intervening life events. In my own clinical experience, therapy often lasts at least ten years in complex cases, and has had to encompass a variety of life events, such as birth, divorce, bereavement, breast cancer and surgical misadventure. Coons (op cit) found that DID clients who did not achieve full integration were twice as likely to have experienced contemporary emotional trauma. Statistical necessities in NHS evaluation can lead to practices that are service need led, and not client-centred, and there have been recent investigations of the way funding pressure has lead to statistical misrepresentation and poor professional practice. Revolving door clients can even boost statistics, and count as short-term successes. Psychological interventions are often not compatible with biological psychiatry and the interests of the drug industry, resulting in the possibility of false economy and a lack of appropriate service to clients that could carry high risks for financial resources, human costs and potential litigation. Training and supervision regarding DID is not generally available, nor is regular data collection about the prevalence or incidence of DID.

The study of DID has been promoted by the rise of psychology as an independent discipline; female emancipation, predominantly in the USA; the trauma of wars and disasters, particularly WWI and Vietnam; new technology, especially the development of the PET scan, and a recent trend towards integration of data via interdisciplinary co-operation. Vital contributions have come from the establishment of pressure groups, inclusion of DID in DSM and ICD, sound scientific study and the highly developed field of PTSD.

Fashions and trends have been shaped by personalities and subjective predilections and defences, so that the true history of DID in Britain and Europe has become distorted and neglected. Britain has had some pioneering authors and clinicians, of whom we should be proud, and the current survey report demonstrates that, despite a lack of publication, psychiatrists and psychologists report that they are identifying and treating at least some few hundred cases, which they believe to be DID, in Britain at the close of the twentieth century. This identifies the need for adequate training, supervision, publication and further publicly funded research, as well as a climate where cases can be reported in the professional press.

The author first encountered DID, in 1987, with a sceptical attitude about the concept, but not being naturally dismissive of clients' subjective experience. Critical self-examination has excluded the possibility that Susie and other cases treated could have been caused to have DID iatrogenically, although some aspects of iatrogenic production did become apparent during therapy and were immediately corrected. As the author's clinical experience in recognising and treating DID has developed, I have routinely encountered clients such as Susie, who had no apparent previous exposure to media influence regarding DID and had the condition from early childhood, contesting Merskey's claim that no such cases could exist. The great diversity in presentation of DID organisation in clients, that is clearly autobiographical, is greatly impressive. It is this author's opinion that this research survey has demonstrated that UK clinicians believe that cases of DID exist and that, throughout the UK, clinicians report treating such cases but they are not generally achieving publication. It is hoped that journal editors will reflect accurately the small but important prevalence of work in this area, and that future research will examine prevalence amongst counsellors and psychotherapists, and further inter-disciplinary team research will produce a clearer model of both the phenomena and the cognitive and neurological substrates in DID. Dorahy, who is from Australia but working in Northern Ireland, is continuing to provide interesting experimental research in this area, and it is to be hoped that others, particularly of UK origin, will complement his work. This author is now convinced of the reality of DID as a creative organising principal in some people, when development and functioning is impeded by substantial overwhelming trauma, and that the phenomenon has much to teach about the development of self and models of mind.

This case example of DID, in the light of the historical literature and the theories of mind, thus suggests, a model of mind, where conscious and either/both pre-conscious and unconscious processes can be vertically split and relatively separated from each other in the service of protection from trauma, whilst also having horizontal divisions such as Freud described, all against un underlying unity. This case example goes beyond the choice of model between Freud's horizontal division of mind and Janet's vertical concept, to suggest that in fact a mixture of the two may be the norm in cases of DID and, by extrapolation, possibly in all human minds. Modern Integrationist theories, such as those by Schore (2001), Forrest (2001) and Conway and Pleydell-Pearce (2000), in their suggested concept of "event specific knowledge", go some way towards proposing the neurological substrates that may help to explain a greater complexity of mind functioning that furthers historical models. It is the author's opinion that an information processing model of considerable complexity, offering explanation that is consistent at the behavioural, cognitive and neuropsycholigcal level, is required to explain DID. Perhaps the modern research and integrationist approaches to understanding the development of intelligences, sense of self, model of mind and attachment are largely accurate, but perhaps there is greater plasticity than they currently suggest, as well as even greater complexity than they can currently describe. DID may be, as has long been suspected from clinical data, an exceptional survival system. Perhaps it achieves this by limiting the left serially analytic hemisphere and allowing all energy to be utilised in ensuring that the receptive and holistic right hemisphere is not totally overwhelmed and overloaded by the extremity of the abuse experience. The necessary focus on bodily survival would require right hemisphere, limbic system, dominance. Perhaps a de-emphasis on the sympathetic nervous system and a dominance of the parasympathetic system maintains sufficient acquiescent action, but maintains adequate conservation and withdrawal to tolerate and survive the extremity of the event. Since this level of abuse is a lifestyle and not a single event, brain organisation adapts to facilitate coping responses. Since, even during extreme abuse, such as that described by Susie, a number of things pertain: the child may be required to speak; complete complex motor behaviours; long-term memory is evidenced; and sometimes emotions are processed, albeit within state dependent limits. It is therefore evident that, even within one self-state, several brain areas, including aspects of the lateral cortex, long term memory data, are involved.

Perhaps the state dependent separation is managed via the orbitofrontal system, which is thought to be where working memory is facilitated. Perhaps potential networks exist at a preconscious level, primarily in the right hemisphere but likely to be in both hemispheres, and an executive management system, that need not necessarily be fully conscious, uses the inhibitive capacity of working memory to ensure that stringent limits are placed on conscious awareness. The necessity for rapid switching between state-dependent self-parts is likely to require at least pre-conscious control in the right hemisphere, even though both hemispheres are then likely to be employed in behavioural responding. As clinical data attests, the inhibition does not always work optimally and self-states appear in situations that they should not, even if only momentarily. Perhaps this means that research relating to inhibition mechanisms in working memory require future attention, taking us full circle to some of the clinically derived concepts of dissociation.

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Appendix 1

School of
Psychotherapy
and Counselling

Regent's College
Inner Circle
Regent's Park
London NW1 4NS

Tel: 0171-487 7406
Fax: 0171-487 7406

Dear Colleague,

NATION-WIDE SURVEY REGARDING FMS AND DISSOCIATION

PLEASE help to inform future training needs by taking part in this valuable research. It has never been more important for psychiatry and psychology professionals to be well informed about the issues regarding False Memory and Dissociative Disorders.

I appreciate that your time is very precious, but you are a valuable source of important information and your help is much appreciated. As part of my PhD research I am asking **all psychiatrists and clinical/counselling psychologists in Britain** to take approximately 15 mins to complete the questionnaire overleaf.

Thank you very much indeed.

Yours sincerely,

Jeanie McIntee
PhD student
Regents College
London.

Dissociation & False Memory Syndrome (FMS)

Survey Questionnaire

Professional Details

1 What is your profession ? _____

2 What is your gender and age ? Male ☐ Female ☐ ____ yrs

3 Professional & Academic Qualifications : _____

_____

4 What is your current role ? *and spcialism e.g. Child, Adults,..)* _____

5 What Service do you work in? *(NHS, Private, Voluntary,..)* _____

6 Since qualifying, how long have you been in clinical practice? ____ yrs Still to qualify by ____ yrs

Key:	***DD-***	*Dissociative Disorders*	***DID-***	*Dissociative Identity Disorder*
	FMS-	*False Memory Syndrome,*	***DDNOS***	*Dissociative Disorder not otherwise stated*

Dissociative & FMS Awareness

	FMS		Dissociation	
	Yes	No	Yes	No
7 Have you heard of FMS / Dissociation ?	☐	☐	☐	☐
8 Do you agree that FMS / Dissociation exist?	☐	☐	☐	☐
9 Have you encountered FMS / Dissociation in a client?	☐	☐	☐	☐
10 Do you agree that FMS/DID are consequences of iatrogenesis?	☐	☐	☐	☐
11 What year did you become aware of FMS/Dissociation?	19		19	

12 How did you became aware? _____

_____

13 In your definition, what is FMS? _____

_____

14 In your definition, what is dissociation? _____

_____

Therapeutic Intervention

IF the answer to ALL PARTS of question 15 is NO - GO TO LAST PAGE

		Yes	No	Yes	No
15	Are you providing treatment for FMS and Dissociative clients?	☐	☐	☐	☐
16	What year did you first provide it?	19		19	
17	In what capacity did you provide it? *(e.g. Doctor, Therapist,..)*	☐		☐	
18	What form did it take? *Individual therapy*	☐	☐	☐	☐
	Group therapy	☐	☐	☐	☐
	Supervision	☐	☐	☐	☐
	Drug therapy	☐	☐	☐	☐
	Assessment only	☐		☐	
19	Hours per week spent working with FMS and Dissociation?	____ hrs.		____ hrs.	

DD/FMS Survey

Key:	***DD-***	*Dissociative Disorders*	***DID-***	*Dissociative Identity Disorder*
	FMS-	*False Memory Syndrome,*	***DDNOS***	*Dissociative Disorder not otherwise stated*

Details of your Clients :

20 Number of clients ever treated by you within given age groupings:

		FMS	DD	DID	DDNOS
Male	<10				
Female	<10				
Male	<18				
Female	<18				
Male	19-25				
Female	19-25				
Male	26-35				
Female	26-35				
Male	36-50				
Female	36-50				
Male	51-65				
Female	51-65				
Male	>65				
Female	>65				

21 Number that have left prematurely

22 Number that have transferred out / referred on

23 Number that have completed therapy

24 Average length of completed therapy *(Years)*

25 Number still in therapy

26 How long on average did therapy last per session? *(Mins)*

27 Average time in therapy for current clients *(Yrs.)*

Key:	**DD-**	*Dissociative Disorders*	**DID-**	*Dissociative Identity Disorder*
	FMS-	*False Memory Syndrome,*	**DDNOS**	*Dissociative Disorder not otherwise stated*

Teaching & Training

	FMS		Dissociation	
	Yes	*No*	*Yes*	*No*
28 Have you received any training concerning FMS/Dissociation ?	☐	☐	☐	☐
29 Training was provided by : *Individual*	☐	☐	☐	☐
Academic Inst.	☐	☐	☐	☐
Agency	☐	☐	☐	☐
Others	☐	☐	☐	☐
30 Have you provided teaching/training for individuals working with:	☐	☐	☐	☐
31 To which professions ? _____				
32 Level provided				
Introductory	*hrs.*		*hrs.*	
Intermediate	*hrs.*		*hrs.*	
Advanced	*hrs.*		*hrs.*	
33 Content outline _____				

Supervision

34 Have you provided any supervision for individuals working with	☐	☐	☐	☐
35 To which professions? _____				
36 How many hours (In total)	*hrs.*		*hrs.*	

Research

37 Have you conducted research in these areas?				
Research started	☐	☐	☐	☐
Research completed	☐	☐	☐	☐
Publications achieved	☐	☐	☐	☐
Publication rejected	☐	☐	☐	☐

Resources

38 What is your experience of support from professional colleagues ?

1 non existent; 2 basic; 3 average; 4 good; 5 excellent

	FMS					DID				
Within your own work group	1	2	3	4	5	1	2	3	4	5
Within your profession	1	2	3	4	5	1	2	3	4	5
With other profession	1	2	3	4	5	1	2	3	4	5

PLEASE POST IN THE ENVELOPE PROVIDED - ***Thank you very much for your help***

DD/FMS Survey

Executive Board
American Medical Association
515 North State Street
Chicago, IL, 60610

Dear Members of the Executive Board:
I am writing to ask that you act now to rein in flagrant malpractice by psychiatrists whose continuing use of discredited "memory recovery techniques" is harming patients and their families and bringing the medical profession's reputation into disrepute. Inaction in the face of this epidemic of malpractice will silently condone the worst excesses of irresponsible and incompetent therapists, leave clients and families vulnerable to irreparable harm, and justifiably erode the credibility of your organization, your profession, and all of its members.

What concerns me is the American medical profession's failure to issue clear, principled, unambiguous, scientifically-based guidelines banning the use of so called "memory recovery therapy," a set of techniques which was rushed into use nationwide in the 80s without any testing for safety and effectiveness and which has been utterly discredited by the impossible "memories" it "recovers" including alien abduction, ritual satanic abuse, and past lives.

Defining the standard of what constitutes ethical medical conduct is the American Medical Association's responsibility by the principle of professional self-regulation. Silence on the topic of so-called "memory recovery therapy" demonstrates a glaring lack of concern for the welfare of clients and the protection of the public and a clear abrogation of your duty.

The contrast of the American medical profession's conduct with that of the Royal College of Psychiatrists in the U.K. is painful. The Royal College formed a Working Group on Reported Recovered Memories of Child Sexual Abuse and adopted the group's "Recommendations for Good Practice" as official practice guidelines. These guidelines state in part that "Psychiatrists are advised to avoid engaging in any 'memory recovery techniques' which are based upon the expectation of past sexual abuse of which the patient has no memory. Such 'memory recovery techniques' may include drug-mediated interviews, hypnosis, regression therapies, guided imagery, 'body memories', literal dream interpretation and journaling." Your organization's failure to issue equivalent guidelines silently condones the continued use of these harmful, discredited techniques in the U.S. by your own membership.

This failure has not gone unnoticed. In their report "Recovered Memories of Childhood Sexual Abuse: Implications for Clinical Practice" in the British Journal of Psychiatry, Sydney Brandon et al note that "the polarisation of views and fierce controversy within the American psychiatric community was in danger of bringing psychotherapy into disrepute." Evaluating the statements issued by the American Psychiatric Association, the American Psychological Association, and the American Medical Association, Brandon further notes that "In their efforts to remain impartial they have failed to resolve the impasse between research and clinical observation."

Much damage has already been done. History will judge psychiatry harshly for failing to base its practices on the results of scientific research and for failing to insulate its practitioners (and even continuing education programs!) from therapeutic fads arising from pop psychology bestsellers and the beliefs of untrained, unlicensed "authorities" like Ellen Bass and John Bradshaw.

However, it is not too late for your organization to reform the profession and reduce the risk of future malpractice and injustice. In order to protect clients and their families from the use of demonstrably harmful "therapies," please take the following steps at once:

Form an official working group to issue a statement on "recovered memories" of childhood abuse by evaluating the Royal College's "Recommendations for Good Practice" and adopting them as binding practice guidelines for your own membership. These guidelines can be found online at: http://www.fmsfonline.org/fmsf97.o29.html#royal

Revise your code of ethics to make it mandatory for your organization's members to inform clients about the known risks, benefits, and alternatives to any proposed therapy and to gain their informed consent prior to beginning therapy.

Following the example of the Canadian Psychological Association, publicly call for a government review of all convictions which were based on so-called "repressed memory" testimony.

If you fail to take these minimal steps to ensure patient safety and professional responsibility, the American public will have to wonder why you fail to act where the Royal College has taken a clear stand. Will it be because you are less well informed, less responsible, or less concerned about patient welfare and justice than your British and Canadian counterparts?

Sincerely,

The International Society for the Study of Dissociation

Guidelines for Treatment

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Guidelines for Treating Dissociative Identity Disorder (Multiple Personality Disorder) in Adults (1997)

Members of the committee were Peter Barach, PhD (chair), Elizabeth Bowman, MD, Catherine Fine, PhD, George Ganaway, MD, Jean Goodwin, MD, Sally Hill, PhD, Richard Kluft, MD, Richard Loewenstein, MD, Rosalinda O'Neill, MA, Jean Olson, MSN, Joanne Parks, MD, Gary Peterson, MD, and Moshe Torem, MD.

Members of the 1996 Executive Council were Elizabeth Bowman, MD, James Chu, MD, Colin Ross, MD, Nancy Perry, PhD, Jean Goodwin, MD, Marlene Steinberg, MD, John Curtis, MD, Peter Barach, PhD, Susan Oke, Bsc OT (C), and Esther Giller, MA.

Introduction

By Peter M. Barach, Ph.D.
Former Chair, Standards of Practice Committee

At its meeting in Vancouver, BC, Canada, in May 1994, the Executive Council of ISSD adopted "Guidelines for Treating Dissociative Identity Disorder (Multiple Personality Disorder) in Adults (1994)." The guidelines present a broad outline of what has thus far seemed to be effective treatment for DID.

The guidelines are not intended to replace the therapist's clinical judgment, but they do aim to summarize what most commonly has been found to benefit DID patients. Where a clear divergence of opinion exists in the field, the guidelines attempt to present both sides of the issue.

Guidelines like these are never finished. This revision is the first since the adoption of the guidelines in 1994. The Executive Council is aware of several areas that the present guidelines overlook, such as partial hospitalization/day treatment programs and the treatment of children with DID. In addition to adding new domains, future revisions of the guidelines will take account of new knowledge arising in the dissociative disorders field.

The guidelines were written by the members of the ISSD Standards of Practice Committee, a diverse and opinionated group who nevertheless found much common ground. Following seven revisions in three years, the committee invited input from ISSD members by publishing a draft in the October 1993 ISSMP&D News. I received about 100 letters from members of the society. Most of the respondents liked the document but wanted minor changes. I summarized their comments and passed on another draft to the committee members. The committee's feedback was incorporated into a final draft that received minor changes from the Executive Council. The Executive Council updated the guidelines in 1996.

I would like to thank the members of the committee for their contributions. Writing this document was a time-consuming and exacting job requiring thought, creativity, and tact from all contributors. I would also like to thank members of ISSD who sent comments after reading the draft published in ISSMP&D News. I hope that ISSD members will continue to provide suggestions and comments to the Executive Council to aid in the next revision of the guidelines.

Given the complexity of dissociative disorders, patients have been frequently misdiagnosed for a period up to 20 or more years. However, considerable progress has been made in the diagnosis, assessment, and treatment of dissociative disorders during the past decade, as reflected by increased clinical recognition of dissociative disorders, the publication of numerous scholarly works focusing on the subject, and the development of specialized diagnostic instruments. As there are at present no controlled outcome studies of different treatment regimens, future research, depending upon the use of new specialized clinical and research tools, will further add to our present understanding of the efficacy of the various therapies for the dissociative disorders.

The guidelines attempt to summarize the numerous publications on the dissociative disorders, including case reports, open clinical trials, and investigations utilizing standardized tools. The guidelines reflect current scientific knowledge and clinical experience specific to diagnosing and treating dissociative identity disorder (DID), supplementing generally accepted principles of psychotherapy and psychopharmacology.

Given the fact that ongoing research on the diagnosis and treatment of dissociative disorders will undoubtedly lead to further developments in the field, therapists are advised to consult relevant published literature subsequent to the publication of these guidelines. It should be noted that the guidelines are not intended to dictate the treatment of specific patients, as treatment should

always be individualized. Therapists should always conform to the local mental health code and related laws, as well as to ethical principles of their professional disciplines.

I. Diagnostic Procedures

Accurate clinical diagnosis of the dissociative disorders allows for early and more appropriate treatment and may be supplemented by standardized tests. Such tests, while not designed to replace the clinician's judgment, may provide additional information critical to both diagnosis and/or adequate treatment planning. A mental status examination augmented with questions concerning dissociative symptoms is an essential part of the diagnostic process. Specifically, the patient should be asked about episodes of amnesia, fugue, depersonalization, derealization, identity confusion, and identity alteration (Steinberg, 1995) as well as age regressions, autohypnotic experiences, and hearing voices (usually internal) (Putnam, 1991).

Screening tools such as the Dissociative Experience Scale, Dissociation Questionnaire, Questionnaire of Experiences of Dissociation and informal office interviews are available to identify patients who are at risk for a dissociative disorder (Bernstein & Putnam, 1986; Loewenstein, 1991; Riley, 1988; Vanderlinden, Van Dyck, Vandereycken, Vertommen, & Verkes, 1993). While some investigations also indicate that psychological testing, such as the Rorschach, may help to improve understanding of the patient's personality structure (Armstrong, 1991), other investigators note that the use of tools such as the MMPI and WAIS-R contribute to misdiagnosis of dissociative disorders (Bliss, 1984; Coons & Sterne, 1986). As screening tools and psychological tests are not able to diagnose the dissociative disorders, identified patients should then be evaluated further to rule out a dissociative disorder utilizing more comprehensive methods.

Structured interviews for the detection of dissociative disorders are now available and can be used to confirm a clinician's diagnosis or to identify a previously undetected case. Such tools include the Structured Clinical Interview for DSM-IV Dissociative Disorders-Revised (SCID-D-R) (Steinberg 1994a, 1994b), which allows clinician to systematically evaluate and document the severity of specific dissociative symptoms and disorders, and the Dissociative Disorder Interview Schedule (Ross, 1989), a highly structured interview developed to diagnose dissociative and other psychiatric disorders. Investigations using a diagnostic interview demonstrate that the diagnosis of DID can now be made as reliably as any other psychiatric diagnosis for which a structured interview exists.

The existence of DID might also be unexpectedly revealed during hypnotherapeutic treatment of another condition. Patients with DID who are diagnosed by using hypnosis do not differ with respect to diagnostic criteria and symptoms from DID patients diagnosed without hypnosis (Ross & Norton, 1989). When alternative diagnostic measures have failed to yield a definite conclusion and diagnosis is necessary or in situations of urgency when the establishment of a diagnosis is a matter of medical necessity, hypnosis or amytal interviews may be helpful. However, it should be noted that amytal and hypnosis, which alter the patient's state of consciousness, may yield symptoms that mimic dissociative pathology in patients who do not have DID. Such procedures should avoid leading and suggestive questions and should be used

by trained practitioners.

II. Comprehensive Treatment Planning

Depending on individual circumstances, treatment teams may include a variety of professional disciplines. Goals are symptom stabilization, control of dysfunctional behavior, restoration of functioning, and improvement of relationships. These goals must be addressed in an ongoing way, both through direct approaches and through psychotherapeutic work that leads to increased coordination and integration of mental functioning. Close coordination with other medical specialists may be required when there are (1) physical sequelae of child abuse or other violence, (2) prominent somatic expression of traumatic material (i.e., functional or sensory changes that correlate with the patient's reported abuse history) or other psychophysiological symptoms, (3) fears about medical care or similar symptoms. When comorbidity is a problem, the associated diagnoses may require specific treatments. Frequent diagnoses in this category include addictions, eating disorders, sexual disorders, mood disorders, and anxiety. Treatment plans may also include psychoeducational interventions, especially when illness has intruded on normal development. Such interventions may include retraining, education, bibliotherapy, expressive therapies, and other treatments. Patients may have multiple legal involvements, which also may require supportive intervention. In patients who have legal involvement, it is wise to try to avoid planned therapeutic interventions that may compromise the credibility of the patients in forensic proceedings at a later point in time.

III. An Outline of Psychotherapy for DID

A. Integration as an overall treatment goal

The DID patient is a single person who experiences himself/herself as having separate parts of the mind that function with some autonomy. The patient is not a collection of separate people sharing the same body. The terms personality and alter (short for alternate personality) refer to dissociated parts of the mind that alternately influence behavior in DID patients. Some clinicians prefer terms such as disaggregate self state, part of the mind, or part of the self.

Wherever possible, treatment should move the patient toward a sense of integrated functioning. Although the therapist often addresses the parts of the mind as if they were separate, the therapeutic work needs to bring about an increased sense of connectedness or relatedness among the different alternate personalities. Thus, it is counterproductive to urge the patient to create additional alternate personalities, to urge alternate personalities to adopt names when they have none, or to urge that alternate personalities function in a more elaborated and autonomous way than they already are functioning in the patient. It is counterproductive to tell patients to ignore or get rid of alternate personalities. Also, the therapist should not play favorites among the alternate personalities or exclude unlikable or disruptive personalities from the therapy, although such steps may be necessary for a period of time at some stages in the treatment of some patients.

Additionally, the DID patient is a whole person, with alternate personalities of adult patients sharing responsibility for his or her life as it is now. In the psychotherapeutic setting, therapists working with DID patients generally

ought to hold the whole person to be responsible for the behavior of all of the alternate personalities.

B. Framework for Outpatient Treatment

The optimal primary treatment modality for DID is usually individual outpatient psychotherapy. Although the patient's feelings and preferences need to be explored while devising and implementing a treatment plan, the therapist, not the patient, ought to be the primary architect of the treatment plan. The minimum number of sessions provided per week should reflect the patient's functional status and stability. The minimum recommended frequency of sessions for the average DID patient with a therapist of average skill and experience is twice a week. Some therapies, especially with patients of high motivation and strength, can be conducted on a once-a-week basis either with a single prolonged session or with a single session. Some therapists of considerable skill and experience are able to treat many such patients in once-a-week psychotherapy. With some patients, a greater frequency of scheduled sessions (up to three per week) aids the patient in maintaining the highest possible level of adaptive behavior and (as an alternative to hospitalization) in containing disruptive behavior. For patients newly discharged from inpatient treatment, a period of sessions at a greater frequency may sometimes be necessary to help the patient make the adjustment from the high frequency of sessions provided in many inpatient programs. If more than three sessions per week are routinely provided, the therapist should note the risk of fostering regressive dependence on the therapist.

Marathon, or lengthy sessions (i.e., sessions longer than 90 minutes), if used, should be scheduled, structured, and have a specific focus such as completion of amytal- or hypnosis-assisted processing of traumatic memories and imagery, or administration of a diagnostic battery. Lengthy sessions may also be used judiciously for the provision of structure and support in dealing with difficult material. They may also be indicated when logistics force the patient to come to the therapist infrequently, but to work intensely when there.

Opinions diverge on the length of treatment. Early anecdotal reports on treatment outcome showed that over 2-3 years of intensive outpatient psychotherapy, patients could reach a relatively stable condition in which they did not experience a sense of internal separateness. However, most therapists now see 3-5 years following the diagnosis of DID as a minimum length of treatment, with many of the more complex patients requiring 6 or more years of outpatient psychotherapy, often with brief inpatient stays during crises. The length of treatment varies with the complexity of the patient's dissociative pathology, usually lengthening with severe Axis II pathology or other significant comorbid mental disorders.

The most commonly cited treatment orientation is psychodynamically aware psychotherapy, often eclectically incorporating other techniques (Putnam & Loewenstein, 1993). For example, cognitive therapy techniques can be modified to help patients explore and alter dysfunctional trauma-based belief systems; however, standard cognitive therapy protocols for depression and anxiety usually require modification when used in the treatment of DID. Most therapists employ hypnosis as a modality in the treatment of DID (Putnam & Loewenstein, 1993). The most common uses of hypnosis are for calming, soothing, containment, and ego strengthening.

Behavioral analysis, or operant conditioning, has not been shown to be an optimal primary modality for treating DID. Aversive conditioning is particularly not recommended because the therapeutic relationship and treatment procedures may unconsciously resemble abusive experiences. However, behavior modification techniques may be useful when taught to the patient as self-control techniques for symptom management.

C. Inpatient Treatment

There is general agreement that inpatient treatment for DID should be used for the achievement of specific therapeutic goals and objectives. Treatment should occur in the context of a goal-oriented strategy designed to restore patients to a stable level of function so that they can resume outpatient treatment expeditiously. This remains the case, whether the hospitalization is emergent or planned, on a specialized or a general psychiatric unit. Efforts should be made to identify what factors have destabilized or threaten to destabilize the DID patient and to determine what must be done to alleviate them, if possible, and to minimize their impact. Emphasis should be placed on building strengths and skills to cope with the destabilizing factors. Optimally, these interventions should be planned and contracted for prior to or very early during an admission, but it is acknowledged that this may not be possible. Planned judicious processing of traumatic material (sometimes called abreactive work), confronting traumatic material in the supportive structure of a hospital setting, and working with aggressive and self-destructive alters and their behaviors are frequent concerns.

There is a general agreement that decompensation or failure to improve during a hospitalization may occur in several circumstances. There is consensus that DID patients often require hospital care for other intercurrent mental disorders, such as major depression or anorexia nervosa. There is consensus that a small minority of DID patients, including massively decompensated and dysfunctional individuals, and those destabilized by severe present-day trauma, may require prolonged inpatient treatment in order to be restabilized. Treatment-related factors that may impede clinical improvement include unfocused inpatient treatment or inpatient treatment with global and unrealistic goals, such as "getting out all of the memories," an exclusive focus on past traumatic material to the exclusion of contemporary issues, or pushing for rapid integration early in treatment.

There is a divergence of opinion as to whether brief stays are less likely to be associated with regressive dependency than longer stays. Some find instances in which they suspect that longer hospital stays are conducive to regression. Others find instances in which it appears that a pressure to keep hospital stays short leads to discharge of the patient in an insufficiently stable state and at greater risk for readmission or undue suffering. Regardless of the length of the patient's hospitalization, the therapist should maintain a stance that encourages progression and independence.

There is agreement that DID patients optimally should be treated in a manner that prepares them to do the work of therapy on an outpatient basis, including processing traumatic material when necessary. There is also agreement that for some overwhelmed patients and for a variety of patients under some circumstances, the structure and safety of a hospital setting make possible therapeutic work that would be impossible or prohibitively destabilizing in an

outpatient setting.

D. Group Therapy

Group psychotherapy is not a viable primary treatment modality for DID. However, some believe that time-limited groups are a valuable adjunct to individual psychotherapy in promoting a sense in patients that they are not alone in coping with dissociative symptoms and traumatic memories. Carefully structured groups with a high leader-to-patient ratio, a clear focus, and clear time frames seem indicated. Some have found that open-ended therapy groups promote acting out among the group members and do not have a positive outcome; others report that such groups have been a helpful adjunct to individual psychotherapy, particularly where the leader describes clear expectations in areas such as extra-group contact among members and therapeutic boundaries (see Appendix 1). Some patients utilize 12-step groups effectively as an adjunct to their individual psychotherapy. Marathon groups (i.e., longer than 2 or 2_ hours) may prove destabilizing for some DID patients.

E. Electroconvulsive Therapy

ECT has not been shown to be an effective or appropriate treatment for dissociative disorders, but it may be important in relieving an associated refractory depression.

F. Psychosurgery

There is no evidence to support the use of psychosurgery in the treatment of DID.

G. Pharmacotherapy

Psychotropic medication is not a primary treatment for dissociative disorders, and specific recommendations for pharmacotherapy of dissociative disorders await systematic research. However, anecdotal reports support the use of various medications for purposes such as treating some anxiety-related dissociative symptoms, posttraumatic stress disorder symptoms, and coexisting affective symptoms or disorders. Most therapists treating DID report that their patients have received medication as one element of their treatment (Putnam & Loewenstein, 1993). Therapists prescribing medication need to make patients aware when any medication protocol is experimental in nature, following applicable ethical and legal guidelines. Doctors who prescribe medication and therapists who treat patients on medication need to be aware that personality states within the same patient may report different responses and side effects to the same medication.

H. Therapist telephone availability

Because many DID patients are prone to crises at certain points in treatment, patients need a clear statement about the therapist's availability in emergencies. Generally, offering regular, unlimited telephone contact is not helpful, but providing for limited availability to the patient on a predefined basis is essential. Except under unusual circumstances, regular calls initiated by the therapist to check in with the patient are not recommended. The payment policy for telephone contact should be discussed with the patient in advance wherever

possible.

I. Scheduling extra sessions

Although extra sessions are sometimes needed, when the patient frequently requests or requires the scheduling of extra sessions because of crises, the therapist needs to examine whether the patient perceives the scheduled frequency of sessions to be adequate for his or her needs. As in any requested gratification of a patient's need, the therapist needs to examine such requests in the light of the patient's unconscious wishes for reparenting or for other emotional gratification from the therapist. Repeated crises may also reflect the patient's inability at that time to function outside a structured full or partial hospital setting.

J. Physical contact

Physical contact with a patient is not recommended as a treatment technique. Therapists generally need to explore the meanings of patient requests for hugs or hand-holding, for example, rather than fulfilling these requests without careful thought and consideration. Simulated breast-feeding or bottle feeding are unduly regressive techniques that have no role in the psychotherapy of DID. Some therapists find that for some patients undergoing planned abreactions, holding the patient's hand or resting a hand on the patient's arm may help the patient stay connected to present-day reality. However, other therapists feel that patients may misinterpret such contact and that it should be avoided. Some patients may seek out massage therapy or other types of body work; the risks and timing of such work should be carefully discussed with the patient and the adjunctive therapist.

Sexual contact with a current patient is never appropriate or ethical. Laws and ethical standards of the various healthcare disciplines regulate such contact with a past patient. Because DID patients have a relatively high vulnerability to exploitation and because of the intensity of the therapeutic interactions that DID patients have with their therapists, any sexual contact a therapist might have with his or her former DID patient would be likely to be exploitive and therefore inappropriate.

K. Physical restraint

There is a divergence of opinion on the value of voluntary physical restraint in treatment. Some believe that the technique is a helpful last resort when physically aggressive or self-destructive alternate personalities are otherwise unable to participate in therapy. Others believe that voluntary physical restraint is inappropriate and that verbal techniques will suffice to involve all the personalities in therapy. If physical restraint is being used with great frequency and/or for prolonged periods, the therapist should reassess the pace of the therapy and the dynamics of the patient-therapist relationship.

In inpatient treatment, seclusion and physical restraint may be indicated for the DID patient who is acting out violently and has not responded to verbal or pharmacological interventions. These treatment modalities should always be applied in accordance with the legal and ethical standards applicable to the inpatient unit and the professional disciplines involved in implementing them.

L. Hypnotherapy

DID experts generally agree that hypnotic techniques can be useful in crisis management to help patients terminate spontaneous flashbacks and reorient themselves to external reality when these states occur outside therapy. Hypnotic techniques are also useful for ego strengthening and for supporting DID patients during crises, and to help patients remain stable between sessions in which they are recalling or discussing traumatic material. Other commonly described uses of hypnosis include its roles as an aid in the safe expression of feelings (e.g., the "silent abreaction" for the release of anger), cognitive rehearsal and skill building, relief of painful somatic representations of traumatic material, and fusion rituals (when previous psychotherapeutic work has caused a particular separateness to no longer serve a meaningful function for the patient's intrapsychic and environmental adaptation and when the patient is no longer narcissistically invested in maintaining the particular separateness). In the hospital, staff can be trained to calm the patient exhibiting violent behavior by means of temporizing techniques but without using formal hypnosis unless credentialed to do so by the hospital (Kluft, 1992). When these techniques are employed, the patient is generally informed beforehand and the intervention becomes part of the nursing treatment plan.

There is a divergence of opinion concerning the role of hypnosis in the ongoing psychotherapy of DID. Some believe that hypnotic techniques are useful in increasing communication between alternate personalities or in bringing alternate personalities into communication with the therapist. Some believe that hypnotic techniques are useful in memory retrieval; others believe that hypnotically facilitated memory processing increases the patient's chances of mislabeling fantasy as real memory and increases the patient's level of belief in "retrieved" imagery that may actually be fantasized. The therapist needs to be aware that hypnosis induced by the therapist may leave patients with an unwarranted level of confidence in the accuracy of the details in hypnotically retrieved material. The therapist should minimize the use of leading questions that may in some cases alter the details of what is recalled in hypnosis.

The therapeutic use of hypnosis should be conducted with appropriate informed consent provided to the patient concerning its possible benefits, risks, and limitations.

M. Veracity of the patient's memories of child abuse

Frequently, DID patients describe a history of abuse, usually including sexual abuse, beginning in childhood. Many DID patients enter therapy having continuous memory for some abusive experiences in childhood (Barach, 1996; Ross et al., 1990). In addition, most also recover memories of additional previously unknown abusive events, with recovery of material occurring both inside and outside of therapy sessions, and sometimes prior to the commencement of psychotherapy. Discussion of this material and its relationship to present beliefs and behaviors is a central aspect of the treatment of DID.

Clinicians and researchers have issued several statements concerning recovered memories of abuse (American Psychiatric Association, 1993; Australian Psychological Society Limited Board of Directors, 1994; Working Group on Investigation of Memories of Childhood Abuse, 1996; Working Party, 1995).

These statements all concluded that it is possible for accurate memories of abuse to have been forgotten for a long time, only to be remembered much later in life. They also indicate that it is possible that some people may construct pseudomemories of abuse and that therapists cannot know the extent to which someone's memories are accurate in the absence of external corroboration. Patients' recall of child abuse experiences, as well as their recall of other experiences, may at times mix literal truth with fantasy, confabulated details, or condensations of several events. Therapy does not benefit from telling patients that their memories are false. Neither does therapy benefit from telling patients that their memories are accurate and must be believed. A respectful neutral stance on the therapist's part, combined with great care to avoid suggestive and leading interview techniques, seems to allow patients the greatest freedom to evaluate the veracity of their own memories.

There is a divergence of opinion in the field concerning the origins of patients' reports of seemingly bizarre abuse experiences. Some believe that patients' reports can be the result of extremely sadistic events experienced by the patient in childhood, perhaps distorted or amplified by the patient's age and traumatized state at the time of the abuse. Others believe that alternative explanations suffice to explain these patients' reports. Therapists who take extreme positions on either side in the therapy setting may diminish the likelihood of timely progress toward the patient's clarification of the historical accuracy of such memories.

N. Management of Traumatic Memories (abreactions)

Traumatic material may surface spontaneously, or its processing may be planned; both situations occur in the treatment of DID patients. The use of planned processing of traumatic material (abreactions) is a treatment technique of value with many patients but is not a therapy in itself. Patients benefit when the therapist helps them use planning, information, exploration, and titration strategies to develop a sense of control over the emergence of traumatic material. When patients spontaneously experience intrusive traumatic imagery, they often benefit from learning strategies that help them delay or control the level of intrusiveness of the traumatic material into their daily functioning. However, some patients develop such control more rapidly than others.

Clinicians experienced in treating DID agree that therapeutic attention to emergent traumatic material is an essential part of the resolution of dissociative pathology. Ignoring this material does not make it "go away," although the timing and nature of therapeutic attention paid to this material will vary according to the needs of each patient.

Many clinicians believe that occasionally extending preplanned trauma memory-processing sessions beyond their usual length is of distinct value in the treatment of some patients. At certain times such a session will unavoidably extend past its scheduled endpoint, but the therapist should try to minimize this. Therapists need to attempt to help patients to reorient themselves to external reality and end processing of traumatic memories before the scheduled end of therapy sessions, although they can only influence, never control, the patient's ability to reorient to the present.

O. Nonverbal adjunctive therapeutic approaches

Like other victims of childhood trauma, DID patients are often uniquely responsive to nonverbal approaches. Art therapy, occupational therapy. sand tray therapy, movement therapy, other play therapy derivatives, and recreational therapy are reported as helpful toward achieving treatment goals, including integration. Nonverbal therapies need to be conducted by appropriately trained persons and be well timed and well integrated into the overall treatment plan. Many psychotherapists find nonverbal techniques (such as patients' drawings and journals) useful as part of ongoing psychotherapy.

P. Fees

Therapists should follow relevant legal and ethical guidelines concerning disclosure of fees, payment arrangements, barter, and collections procedures.

IV. Publications and Interactions with the Media

In all interactions with the media concerning DID, the therapist's primary responsibility remains the welfare of his/her patients. Thus, the therapist must maintain the highest ethical and legal standards of confidentiality with respect to clinical material.

Appearances by patients in public settings with or without their therapists, especially when patients are encouraged to demonstrate DID phenomena such as switching, may consciously or unconsciously exploit the patient and can interfere with ongoing therapy. Therefore, it is generally not appropriate for a therapist actively to encourage patients to "go public" with their condition or history.

V. The Patient's Spiritual and Philosophical Issues

Like other victims of trauma by human agency, DID patients may struggle with questions of moral responsibility, the meaning of their pain, the duality of good and evil, the need for justice, and basic trust in the benevolence of the universe. When patients bring these issues into treatment, ethical standards for the various professional disciplines specify the need to conduct treatment without imposing one's own values on patients. Although patients may experience certain personalities as demons and as not-self, therapists should approach exorcism rituals with extreme caution. Exorcism rituals have not been shown to be an effective treatment for DID, have not been shown to be effective for "removing" alternate personalities, and have been found to have deleterious effects in two samples of DID patients that experienced exorcisms outside of psychotherapy. Exorcism rituals may provide a way for some patients to rearrange images of their personality systems in a culturally syntonic manner. Education and coordination between therapist and clergy can be helpful in ensuring that patients' religious and spiritual needs are addressed

VI. Patients as Parents

Because many DID patients may have difficulty in parenting and a minority admit to being abusive toward their children, and also because DID may involve a biological predisposition to dissociate, some have recommended that the children of DID patients be assessed by a therapist familiar with dissociative disorders and indicators of child abuse. Other family interventions, such as couples therapy and sibling group sessions, may be indicated.

Appendix 1: Boundary Management

Victims of child abuse or neglect have generally grown up in situations where personal boundaries were either not established or were invaded. For this reason, their treatment ought to include a therapeutic relationship with clear boundaries. The therapist is responsible for clearly defining such a therapeutic relationship.

Boundary issues arise throughout treatment, with negotiation and discussion of these issues occurring as needed. Most experts agree that the patient needs a clear statement near the beginning of treatment concerning therapeutic boundaries. This statement may not always be understood immediately by the patient, may take several sessions to convey, and may require repetition at various points in the therapy. The discussion concerning therapeutic boundaries might include some or all of the following issues: length and time of sessions, fee and payment arrangements, the use of health insurance, confidentiality and its limits, therapist availability between sessions, procedure if hospitalization is necessary, patient charts and who has access to them, the use (or nonuse) of physical contact with the therapist, involvement of the patient's family or significant others in the treatment, discussion of the therapist's expectations concerning management by the patient of self-destructive behavior, legal ramifications of the use of hypnosis as part of the treatment (i.e., material recalled in trance is not likely to be admissible evidence in any legal action undertaken by the patient), among others.

Treatment should ordinarily take place in the therapist's office. It is not appropriate for a patient to stay in the therapist's home or for members of the therapist's family to have ongoing extratherapeutic relationships with the patient. Treatment usually occurs face to face instead of on the analytic couch, though the latter is also acceptable for therapists with psychoanalytic training. Treatment should ordinarily take place at predictable times, with a predetermined session length under most circumstances. Clinicians experienced in treating DID generally strive to end each session at the planned time.

Therapists need to follow relevant legal and ethical codes with respect to gifts exchanged by the therapist and patients, dual relationships, and informed consent for treatment.

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INTERNATIONAL SOCIETY FOR THE STUDY OF DISSOCIATION

Guidelines for the Evaluation and Treatment of Dissociative Symptoms in Children and Adolescents[1]

ISSD Task Force on Children and Adolescents, February, 2003[2]

The ISSD Task Force on Children and Adolescents is pleased to present the Guidelines for the Assessment and Treatment of Dissociative Symptoms in Children and Adolescents. In utilizing these Guidelines, you might keep the following principle in mind. According to the Criteria for Evaluating Treatment Guidelines of the American Psychological Association (2000), "Guidelines should avoid encouraging an overly mechanistic approach that could undermine the treatment relationship." We hope these Guidelines prove to be useful rather than prescriptive, and improve the care of children and adolescents with dissociative symptoms and disorders.

Joyanna Silberg, PhD, Task Force Chairperson

These Guidelines are dedicated to the memory of Elaine Davidson Nemzer, 1952-2000.

I. RELATIONSHIP TO ISSD ADULT GUIDELINES:

The ISSD Standards of Practice Committee issued "Guidelines for Treating Dissociative Identity Disorder (Multiple Personality Disorder) in Adults" in 1994 and updated them in 1997. As these made no reference to children and adolescents, the ISSD Executive Council requested the Child and Adolescent Task Force to draft guidelines summarizing current clinical knowledge in the field applying directly to children and adolescents.

II. SCOPE OF DIAGNOSES ADDRESSED:

Although the ISSD Adult Guidelines are specifically directed to the treatment of Dissociative Identity Disorder (DID), dissociation in children may be seen as a malleable developmental phenomenon which may accompany a wide variety of childhood presentations. Symptoms of dissociation are seen in populations of children and adolescents with other disorders such as Post-Traumatic Stress Disorder (PTSD; Putnam, Hornstein & Peterson, 1996), Obsessive-Compulsive Disorder (OCD; Stien & Waters, 1999) and reactive attachment disorder, as well as in general populations of traumatized and hospitalized adolescents (Sanders & Giolas, 1991; Atlas, Weissman, & Leibowitz, 1997) and delinquent adolescents (Carrion & Steiner, 2000). These treatment principles, therefore, are intended for children and adolescents with diagnosed dissociative disorders, as well as for those with a wide variety of presentations accompanied by dissociative features. In other words, the Guidelines identify general principles applicable to dissociative processes regardless of the child's[3] presenting diagnosis.

Diagnosis itself seldom communicates much about the nature of the child and his or her world. These Guidelines are not intended to be a basis for differential diagnosis. While a dissociative diagnosis specifically geared to children has been proposed (Peterson, 1991), this has not been included in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, Text revision (DSM-IV-TR; American Psychiatric Association, 2000). Although even very young children appearing to meet the criteria for DID have been described (Riley & Mead, 1988; Putnam, 1997), the prevalence of DID in childhood is currently unknown. The diagnosis of Dissociative Disorder Not Otherwise Specified (DDNOS) is the most common in populations of dissociative children and adolescents (Putnam et al., 1996), even though no diagnostic criteria have been set for this diagnosis. While individual case studies of children with puzzling and atypical dissociative presentations described variously as Depersonalization Disorder (Allers, White & Mullis, 1997), Dissociative Amnesia or Dissociative Fugue (Coons, 1996; Keller & Shaywitz, 1986), and DID (Jacobsen, 1995) continue to be published in peer-reviewed journals, there is still no real consensus about the typical case and thus no consensus about diagnostic criteria. For this reason, in these Guidelines the perspective on assessment and treatment is symptom-based.

III. INTRODUCTION:

These Guidelines are derived from the published literature, material from conferences, and the clinical experience of members of the ISSD Child and Adolescent Task Force. As this field is in an early developmental stage, these Guidelines are to be viewed as preliminary. As the field develops, they will be modified to incorporate new research into diagnosis and treatment. In fact, the literature reviewed here, spanning over 16 years of reporting on dissociative phenomena in children, already shows shifts in emphasis and recommendations over time (Silberg, 2000). Despite the changing and provisional nature of our knowledge in this area, it is still important to have some guidelines in approaching dissociative symptomatology for the following reasons:

1. Treatment strategies aimed at increasing integration and reducing dissociation can be highly effective in treating some of the most seriously impaired child victims of maltreatment who are engaged in disruptive and self-destructive behavior.
2. Information on the treatment of dissociation was not available when most clinicians did their training, and it is important to organize clinical information to help familiarize clinicians with current treatment approaches.
3. Without careful consideration of developmental issues, the simplistic application of treatment approaches for adult dissociation to children may be potentially dangerous to children.

For these reasons, these Guidelines are presented for the benefit of the ISSD membership and the clinical community at large. It is our hope that research will continue to amend and refine these Guidelines, and that their presentation will stimulate discussion, debate and further analysis that will enrich the field as a whole. These guidelines must be used in conjunction with all ethical codes, health codes, laws or professional regulations which govern the individual's discipline or place of practice.

IV. QUALIFICATIONS OF CHILD AND ADOLESCENT PRACTITIONERS

At this point in the development of this field, information about child and adolescent dissociation is still evolving. A good safeguard for doing "No harm" is a solid grounding in child development. Clinicians who treat dissociative children should have training in child therapy and child development through accredited programs in their respective disciplines and be familiar with a variety of treatment approaches for traumatized children (Cohen & Mannarino, 1998b; Deblinger & Heflin, 1996; Donovan & McIntyre, 1990; Friedrich, 1996; Gil, 1996; Heineman, 1998, Hughes, 1998; James, 1989, 1994; Myers, Berliner, Briere, Hendrix, Jenny, & Reid, 2002; Pearce & Pezzot-Pearce, 1997;

[2]*Chairperson: Joyanna Silberg, PhD. Members: Frances Waters, Elaine Nemzer, Jeanie McIntee, Sandra Wieland, Els Grimminck, Linda Nordquist, Elizabeth Emsand. The committee thanks Peter Baroch, James Chu, Beverly James, John O'Neil and Gary Peterson, Margo Rivera, and John Curtis for critical comments and suggestions.*

[3]*The word child is generally used in these guidelines to mean both children and adolescents through high school age.*

Prior, 1996; Terr, 1991; Tinker & Wilson, 1999; Wieland, 1997, 1998.) In addition, it is recommended that clinicians treating children with dissociative disorders participate in continuing education conferences, develop collegial relationships such as study groups or peer supervision, and stay current in the literature. As some of these children have suffered some of the most severe forms of maltreatment, collegial support for the therapist is particularly important to avoid secondary PTSD and burnout. It is important to understand the subtle countertransferential issues that affect therapists who work with traumatized clients (Dalenberg; 2000).

As the literature on the treatment of dissociation in children has come from a variety of treatment orientations, the treatment of dissociative processes in children does not require allegiance to any one particular treatment model. Readers of these Guidelines are encouraged to adapt these ideas into the frameworks with which they are most comfortable. The most successful treatment approach to an individual case is often the most eclectic, with the therapist showing flexibility and creativity in the utilization of a wide variety of available techniques. This is well demonstrated by Cagiada, Camaido & Pennan (1997) who successfully treated a boy in a dissociative coma following war trauma using a variety of modalities, including hypnotherapy, computer-assisted communication and art therapy. Therapists are advised to be open-minded to a variety of approaches and take the best from each in dealing with the challenges of any individual child or adolescent.

V. THEORETICAL BASIS

There is no consensus yet on the exact etiological pathway for the development of dissociative symptomatology, but newer theoretical models stress impaired parent-child attachment patterns (Barach, 1991; Carlson, 1998; Liotti, 1999; Ogawa, Sroufe, Weinfield, Carlson & Egeland, 1997) and trauma-based disruptions in the development of self-regulation of state transitions (Putnam, 1997; Siegel, 1999). Newer theorizing ties maladaptive attachment patterns directly to dysfunctional brain development which may inhibit integrative connections in the developing child's brain (Schore, 2001; Stein & Kendall, 2003). From the vantage point of treating children and adolescents, a developmental understanding of dissociation makes the most sense. That is, dissociation may be seen as a developmental disruption in the integration of adaptive memory, sense of identity, and the self-regulation of emotion. According to Siegel (1999), integration is broadly defined as "how the mind creates a coherent self-assembly of information and energy flow across time and context" (p. 316). In other words, Siegel sees the development of an integrated self as an ongoing process by which the mind continues to make increasingly organized connections which allow adaptive action.

Children and adolescents may present with a variety of dissociative symptoms that reflect a lack of coherence in the self-assembly of mental functioning:

1. Inconsistent consciousness may be reflected in symptoms of fluctuating attention, such as trance states or "black outs."
2. Autobiographical forgetfulness and fluctuations in access to knowledge may reflect incoherence in developmental memory processes.
3. Fluctuating moods and behavior, including rage episodes and regressions, may reflect difficulties in self-regulation.
4. The child's belief in alternate selves or imaginary friends that control the child's behavior may reflect disorganization in the development of a cohesive self.
5. Depersonalization and derealization may reflect a subjective sense of dissociation from normal body sensation and perception or from a sense of self.

Dissociative symptoms have been found to correlate with traumatic histories of significant sexual abuse and/or physical abuse (Trickett, Noll, Reiffman & Putnam, 2001; Macfie, Cicchetti & Toth, 2001; Coons, 1996; Hornstein & Putnam, 1992; Dell & Eisenhower, 1990), as well as war trauma (Cagiada, et al., 1997) and natural disasters (Laor, Wolmer, Kora, Yucel, Spirman & Yazgan, 2002.) Dissociative symptoms in children have also been associated with parenting styles described as neglectful (Brunner, Parzer, Schuld & Resch, 2000; Ogawa et al, 1997; Sanders & Giolas, 1991), rejecting and inconsistent (Mann & Sanders, 1994). However, it must be noted that each child's reaction to life events is a constructive process that is idiosyncratic, and what might overwhelm one child may not overwhelm another. While not all trauma necessarily results in dissociation, events which have not necessarily been defined as major trauma (e.g. repetitive losses of attachment figures, peer rejection, observation of domestic violence, medical procedures, chronic living instability, emotional abuse) have nevertheless been found in the backgrounds of children displaying dissociative symptoms. There may be individual differences in children's susceptibility to dissociative symptoms which may be related to other traits, such as fantasy-proneness (Rhue, Lynn & Sandberg, 1995) or other inherited personality traits (Jang, Paris, Zweig-Frank & Livesley, 1998). Considerable controversy remains as to the contribution of genetic factors in the development of dissociative symptoms (Grabe, Spitzer & Freyberger, 1999).

According to Siegel (1999), "interpersonal processes can facilitate integration by altering the restrictive ways in which the mind may have come to organize itself" (p. 336). Therapeutic intervention, therefore, can aim to provide those new interpersonal relationships which foster the integration and coherence of self, and improve adaptation.

VI. ASSESSMENT

In assessing the severity of dissociation, it is important to determine how disruptions of identity, consciousness or memory impede the achievement of normal developmental tasks. In the best case scenario, a child's self-disclosure about fragmented identity or discontinuous experience may allow a sensitive therapist to help the child acknowledge previously disowned affect and experiences, minimize self-destructive and disruptive behavior, increase personal responsibility, and eventually achieve developmentally normal integration. Those assessing children and adolescents should keep this therapeutic goal in mind.

A. General Framework

Diagnosis may include the following components:

1. Screening tests
2. Clinical interviews *
3. Structured clinical interviews
4. Psychological testing
5. Comorbid conditions *
6. Medical evaluation *
7. Pharmacological and hypnotic interventions
8. Ongoing assessment during treatment.

* these are essential.

1. Screening tests:

These are useful, though neither essential nor diagnostic, and may alert the clinician to more depth interviewing of child and caregivers regarding dissociative symptoms and experiences:

a. Self-report questionnaires for the child include the Adolescent Dissociative Experiences Scale (A-DES; Armstrong, Putnam, Carlson, & Libero 1997; Smith & Carlson, 1996; Farrington, Waller, Smerden, Faupel, 2001), the Children's Perceptual

Alteration Scale (CPAS; Evers-Szostak & Sanders, 1992), and the Dissociative Questionnaire (DisQ; Vanderlinden, Van Dyck, Vandereycken, Vertommen, & Verkes, 1993). One self-report questionnaire that may prove to be diagnostic is the adolescent version of the Multi-Dimensional Inventory of Dissociation (MID; Dell, 2002; Ruths, Silberg, Dell & Jenkins, 2002).

b. Caregivers may be screened about dissociative behaviors with the Child Dissociative Checklist (Putnam, Helmers & Trickett, 1993), which has excellent validity and reliability (Putnam & Peterson, 1994).

2. *Clinical interviews:*

A complete history, from reliable informants as well as from the child, is the basic starting point for assessment. In interviews of the child, the family, and of other third parties, pay attention to the following:

a. Imaginary friends and other transitional objects, auditory and visual hallucinations, perplexing forgetfulness, intrusive thoughts and feelings, numbing, anxiety, nightmares, self-injury, flashbacks, somatic concerns, sexual concerns, depersonalization and derealization, and identity alteration and confusion (see Symptom Assessment below). Fairly structured interviews have been described (Lewis, 1996; Hornstein, 1998) as have cautions in interviewing (Silberg, 1998c).

b. The family environment: physical and emotional safety; dysfunctional family patterns; history of psychiatric illness of all family members; family secrets that may impact on the child (Donovan & McIntyre, 1990); sources of support outside the immediate family; practices or beliefs which are unusual for the family's culture and ethnicity.

c. Areas of specific relevance to dissociation: the child's familiarity with material about dissociation from books, movies or family conversations; the family's investment or interest in, or understanding of, dissociation; multi-generational history of dissociation (Braun, 1985; Coons, 1985; Yeager & Lewis, 1996).

c. The child's functioning in other settings, e.g. school, with peers.

d. Balancing predisposing, precipitating and perpetuating factors. The latter includes current life circumstances that maintain the disruptive symptoms, even if the dissociative patterns were established at an earlier age. Perpetuating factors are important for appropriate treatment planning, as families may try to focus exclusively on the child's past history and resist looking at their own current dysfunction.

3. *Structured clinical interviews:*

No diagnostic interview schedules have been validated for children and adolescents. However, the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1994) has been used for adolescents who can maintain adequate attention and have an average or higher level of cognitive functioning (Steinberg & Steinberg, 1995; Carrion & Steiner, 2000).

4. *Formal psychological testing:*

This is not diagnostic, but may be corroborative. Behavioral signs and response features typical of dissociative patients include forgetting, traumatic imagery, and evidence of a passive problem solving style (Silberg, 1998b).

5. *Comorbidity assessment:*

Comorbidity is common with dissociative disorders. Current practice guidelines (American Academy of Child and Adolescent Psychiatry, 1998) may be helpful in screening for: Obsessive-Compulsive Disorder (OCD), eating disorders, PTSD, reactive attachment disorder (RAD), Attention Deficit Hyperactivity Disorder (ADHD), affective disorders, substance abuse disorders, and specific developmental disorders (Hornstein, 1998; Peterson, 1998).

6. *Medical evaluation:*

The evaluator must rule out general medical disorders that may mimic dissociative symptoms. These include seizure disorders, other neurological conditions, allergy, exposure to toxins, or legal or illegal drug effects (Graham, 1998; Lewis, 1996).

7. *Pharmacological and hypnotic diagnostic probes:*

a. Sodium amobarbital or other pharmacological interventions are not recommended in the assessment of children and adolescents.

b. There is mild support for the use of hypnosis as a diagnostic tool for assessing children and adolescents for DID or DDNOS (Benjamin & Benjamin, 1993; Kluft, 1985; Williams & Velazquez, 1996). However, there are legal complications in the United States of America which may also apply in other jurisdictions: the legal guardian must give explicit permission; risks must be explained, including legal risks regarding the possible inadmissibility of testimony in future court proceedings. For these reasons, hypnosis is recommended only as an urgent assessment/intervention strategy for reaching severely unresponsive children where other methods have been ineffective.

8. *Ongoing assessment during treatment.*

a. The best assessment is that which takes place in the context of ongoing therapeutic work, where the child's receptivity to intervention can be continually assessed, and where multiple input from teachers, parents, and other observers of the child can be attained in an ongoing way.

b. Assessment should be guided by pragmatic concerns about how to best interrupt disruptive behavior. The treatment team ought to plan frequent assessments of dissociative symptoms in order to gauge progress.

c. Diagnosis may become a source of conflict and dissension among members of the treatment team. Sometimes dissension in a team replicates contradictory pulls within the family or child, and sensitivity to this level of analysis may encourage integrative problem solving for the team, the family, and the child.

B. Trauma Assessment

1. *Dissociation and trauma.*

There is a strong correlation between traumatic events and dissociative symptoms. Thus, some children will present for evaluation with both dissociative symptoms and a documented legal and social service history of trauma. But others will present with just the symptoms or the history, but not both; still others will present with neither symptoms nor history.

a. When there is a clearly documented trauma history, the child will not necessarily have dissociative symptoms, though such a history ought to prompt a closer examination for dissociation. The child may manifest instead the conditions commonly comorbid with dissociation (see above), without dissociative symptoms *per se*.

b. When there are dissociative symptoms, but no documented trauma history, or disclosures by the child, the family, or other

witnesses to abusive acts, the presence of dissociative symptoms or disorders are not in themselves sufficient evidence of prior trauma, such as sexual abuse or other specific trauma.

c. The trauma history may be masked by the child's amnesia, the family's denial, or the lack of records. Later disclosure by the child, the family or other witnesses to abusive acts may occur over the course of an extended assessment period.

2. Keeping the foregoing in mind, the clinician ought to conduct a thorough assessment of traumatic events in the child's history. This would include

a. Physical abuse, sexual abuse, emotional abuse, painful peer rejections, witnessing violence, and involvement in organized criminal activities such as child pornography or sex rings (Bidrose & Goodman, 2000).

b. Neglect, inadequate attachment.

c. Loss: death of a parent, loss of a parent through separation, other losses or experiences with death, illnesses of the child or other family members.

3. Cautions in assessment:

a. Keep in mind multiple hypotheses about the reasons for reports of seemingly bizarre and improbable traumatic events, including that they may be true (Everson, 1997). Beware of inaccuracy, distortion, manipulation, deceit, or confabulation which may affect the child or family's report of trauma. Continue to assess and reassess as new information becomes available.

b. Avoid suggestive (leading) questioning in evaluating children's responses in interview (Coulborn, Faller & Everson, 1998; Fivush & Schwarzmueller, 1995; Goodman & Bottoms, 1993; Peterson & Biggs, 1997).

c. Follow professional guidelines about separating the roles of forensic evaluator and therapist (American Professional Society on the Abuse of Children, 1997; American Psychological Association, 1998).

4. Trauma and amnesia.

a. Some autobiographical amnesia is a normal developmental phenomenon (Siegel, 1996).

b. While the frequency of traumatic amnesia in children and adolescents is unknown, clinical experience suggests that children and adolescents may have sudden recall of previously unavailable traumatic memories during or outside of therapy sessions. This process has been documented in cases where the traumatic events were corroborated (Corwin & Olafson, 1997; Duggal & Sroufe, 1998).

c. Because children's memory is enhanced from practice and rehearsal and is superior for events that are familiar (Ornstein, 1995), sexual abuse experiences, may not be as accessible to recall, especially when shrouded in secrecy.

d. Memory for traumatic events for children in incestuous families may also be affected by the intense contradictory pulls for attachment and for safety, when the source of abuse is also the source of nurturing (Freyd, 1996). In addition, violent threats from a perpetrator may produce powerful incentives to dismiss certain traumatic events from conscious awareness so that a child can more effectively cope with day-to-day expectations.

e. Children may lack verbal memories for traumatic events, but display sensori-motor modalities or somatic symptoms instead (Burgess, Hartman & Baker; 1995; Fivush, Pipe, Murachver & Reese, 1997; Stien & Waters, 1999; Terr, 1991). Evaluators ought to be sensitive to how children's play, art, behavioral re-enactments, and somatic concerns may be reflections of or communicate information about traumatic events.

5. Just as with the assessment of dissociative symptoms, in taking a trauma history attention to past stressors ought to be balanced by attention to current stressors (perpetuating factors), as these may promote continued dissociative adaptation.

C. Symptom Assessment:

In assessing the severity of dissociative symptoms, take into consideration how severely the symptom disrupts normal developmental experiences like playing with friends, or attending school, and how far the child's behaviors and experiences deviate from what is characteristic of normal developmental phenomena.

1. Trance states.

Trance states or "black outs" may span the range from momentary absences of attention (normal in children and adolescents), to longer periods of non-responsiveness, to excessive sleeping or fainting, to states described as coma (Cagiada et al., 1997). Determine what elicits these absences in attention, how long they last, what seems to interrupt them, what consequences these disruptions have for the child, and what the child experiences during these states.

2. Amnesia and transient forgetting.

True amnesia about one's own recent behavior is quite rare, and diagnostic of a more severe dissociative process. More common is amnesia for past traumatic events. More common still is transient forgetting which quickly disappears after the child is working with an empathic therapist; e.g. parents may report the child has no memory for an event; children may use the expression "I forget" as a distraction, out of guilt or shame, or because of lack of rapport with the interviewer. Asking children about whether they forget good things (good grades, birthday parties), as well as misbehavior or angry episodes (Hornstein, 1998) may help discriminate between amnesia and unwillingness to report.

Other useful techniques for assessing memory problems are the following:

- Gently inquire with the parent out of the room.
- Help the child express feelings associated with the forgotten behavior.
- Role-play the forgotten behavior.
- Provide abundant contextual clues.
- Decrease the child's sense of shame.

3. Imaginary playmates.

Take special care to differentiate normal imaginary playmates and fantasy material from pathological dissociative symptoms. Dissociative pathology is suggested when the involvement in fantasy interferes with normal activity, when the child feels his behavior is outside of his/her control, when he/she experiences the imaginary playmates as real, and when the child perceives imaginary figures in conflict with each other (Silberg, 1998c; Trujillo, Lewis, Yeager & Gidlow, 1996).

4. Identity alteration and changes of state.

Some children may feel the presence of internal others, alters, ego states, self states, personalities, etc. (for the purpose of these Guidelines, all these terms are synonymous). Don't be too suggestive in questioning as this may encourage the child to feign behavior to please the evaluator; use child-familiar language.

Instead of encouraging the child or adolescent to switch to alternate identities, or "self-states" (Peterson, 1996), encourage the child to make the internal connections that promote awareness of other states, affects, or identity shifts.

If a child is observed to shift behavior or affect spontaneously during the evaluation without direction from you, try to determine which stimuli elicited the shifts in state and to understand the functions of the state switches for the child (i.e., avoidance, encouraging caregiving behavior, expression of rage). Then evaluate the child's memory for the state change, and help the child make connections between feelings and behaviors and explore alternative coping strategies. That being said, some therapists argue that refractory cases of severe dissociation in adolescents may require more directive assessment and interventions (Kluft, 2000).

Children normally go through changes in affect and behavior during the course of an interview. Be careful not to overpathologize normal state shifts. Inquire about the subjective sense of discontinuity and about any stimuli that preceded a change in state, mood, ability or perceived identity. Frequently, the stimulus may be a feeling associated with a traumatic event or associated thought which children find too frightening or embarrassing to acknowledge. Children with dissociative symptoms often have very colorful ways of describing these phenomena that make it clear that their changes feel to them dramatic, uncontrollable, and puzzling. Even during the assessment, try to connect these initially puzzling changes with the child's own perceptions, feelings, goals, intentions, and communicative meanings, even if these are not at first obvious. Making these connections even during assessment will give you a better idea of the child's receptivity to therapy and the seventy of the dissociation. Shifts that are dramatic and perplexing to the child and may involve sudden regression, rageful behavior, apparent loss of consciousness, or suddenly talking about oneself in the third person or with a new name are shifts that suggest difficulty in the integration of affect, consciousness, and identity and are consistent with DID. Assess the family's and others' reactions to these shifts for a context for understanding some of the ongoing shaping influences that may promote dissociation.

5. *Depersonalization, derealization, substance abuse.*
Some feelings of transient depersonalization are common in adolescents. Distinguish this from depersonalization and derealization complicated by substance abuse, which may contribute to it (Carrion & Steiner, 2000).

6. *Somatic symptoms.*
Inquire about somatic symptoms (e.g. headache, stomach aches, other undiagnosed pain) as well as somatoform dissociation, which includes symptoms of loss of physical sensations, unusual pain tolerance or pain sensitivity, and other sensori-perceptual anomalies (Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996).

7. *Post-traumatic symptoms.*
These include positive symptoms, such as nightmares, night terrors, disturbing hypnagogic hallucinations, intrusive traumatic thoughts and memories, re-experiencing or flashbacks, and traumatic re-enactments; as well as negative symptoms, such as numbing and avoidance.

Standardized screening instruments such as the Trauma Symptom Checklist for Children (TSCC; Briere, 1995), The Trauma Symptom Checklist for Young Children (Briere, Johnson, Bissada, Damon, Crouch, Gil, Hanson, Ernst, 2001) or the Children's PTSD Inventory (Saigh , Yasik, Oberfield, Green, Halmandaris et al., 2000) may also assist with this evaluation (see also Nader, 1997).

8. ***Sexually reactive or sexual offending behaviors*** may occur in traumatized children and may co-occur with dissociative symptomatology. Distinguish between normal sexual behaviors, sexually re-active, and sexually molesting behaviors in children and adolescents and evaluate the role dissociation plays in the maintenance of these (Johnson, 2002; Friedrich, Gerber, Koplin, Davis, Giese, Mykelbust, Frackowiak, 2001).

9. ***Self-injurious behavior*** is common among dissociative teens which may include cutting, burning, scratching, or headbanging. This behavior may be secret, may serve an affect-regulating function, and may be performed in a dissociative trance state, or used to facilitate or interrupt such a state. Gently inquire about all stages of self harm (cutting, burning, hitting, etc.), i.e. planning, preparing, doing, and recuperation, as some or all stages may be done in a dissociated state (depersonalized, numbed, trance state, robotic state, dream-like state, etc.). Inquire as to relief experienced by such self harm, as the infliction of external pain commonly reduces internal pain.

VII. TREATMENT

A. Length and Course of Treatment

1. Most child and adolescent cases of severe dissociation are not as difficult and lengthy as adult cases. An optimistic attitude facilitates recovery. Despite the refractory nature of many adolescent cases (Dell & Eisenhower, 1990; Kluft & Schultz, 1993), there are many cases of successful outcome as well (Dell & Eisenhower, 1990; Silberg & Waters, 1998; Silberg, 2001a; Silberg, 2001b; Silberg, 2001c). Adolescent therapy in cases of unstable families may have more limited goals of crisis intervention and promotion of stability with intermittent services (Wieland, 1997). With younger children in unstable homes, treatment efforts should work to stabilize placements.

2. Length or frequency of treatment cannot be prescribed, but must rely on the severity of the patient and family circumstances and family constraints. It is appropriate to maintain an open-minded and hopeful stance about the possibility of rapid treatment, even for the most severe presentation, as this has occurred in many cases (Kluft, 1984, 1985; Peterson, 1996; Silberg & Waters, 1998). In some cases, treatment can be intermittent as the child's needs change.

3. The therapist must assess at the outset the availability of resources and plan for the eventuality of more restrictive services, if needed (Kluft, 1996). However, multi-disciplinary coordination can often prevent the need for more restrictive services.

B. Role of the Therapist

1. Therapists must forge an empathic connection with the whole child, including disowned experiences and affects that the child may perceive as being contained in voices, imaginary friends or self-states, so that the child feels fully accepted at all levels of experience. This empathic connection is key for the child to begin to accept his/her disowned experience and affect and to take responsibility for moving on.

2. Continuity in the therapist's relating to the child across all changes of state is a key ingredient in the therapy.

3. Treatment of children and adolescents with the severity often presented in these cases is often a team effort, involving parent, therapist, school, pediatrician, and any significant others involved in the case. Therapists must acquaint themselves with all members of the

team and develop a format for regular communication. No child can be fully treated in isolation, and consistency in approaching the child within all settings may help to promote integration and defeat dissociative barriers. Communication within the team should focus foremost on safety and support for the child and development of consistent expectations for the child, as well as on understanding the internal influences which affect the child's ability to contain destructive or disruptive behaviors.

4. As with all treatment of children, the therapist must balance confidentiality offered to the child with the legal rights of custodial parents for access to records and to information that may have life-threatening implications and must disclose policies regarding this to both child and parent at the outset of therapy.

C. Special Cautions in the Treatment of Dissociative Symptomatology

The following are common pitfalls in working with dissociative children and families:

1. Achievement of physical safety is a primary goal that supersedes any other therapeutic work. Reports to local child protection services are required whenever issues of child maltreatment are suspected. Clinicians must follow reporting guidelines within their own regional jurisdictions. In cases where the therapist concludes that current legally-dictated arrangements are not in the child's best interest, it is the therapist's obligation to provide recommendations to the child's current caregiver, advocate, case worker, court-appointed attorney, or guardian *ad litem* regarding the therapist's findings.

2. The therapist should recognize his/her role as a potentially powerful reinforcer and shaper of the child's or adolescent's behavior. A stance of gentle, empathic, non-judgmental listening and open inquiry may encourage children to describe in their own language the contrasting influences, imaginary friends or self-states that they perceive as affecting their behavior.

3. An important goal of therapy is for the child to learn increasingly adaptive and flexible ways to manage affect and to integrate past, current, and new experiences so that development is not compromised. The child should be encouraged to participate in normalizing activities such as sports, art, or music. If the child appears to be regressing in therapy, the therapist should review the course of treatment, evaluate safety in the environment, evaluate possible stressors (e.g., court testimony, visitations, too much focus on traumatic events), and seek other consultations regarding how to modify the treatment approach so that the child is progressing along a developmental trajectory that is as normalizing as possible.

4. Overly special or zealous interventions (e.g., isolating children from peers or school for long periods of time, physical restraint systems) tend to reinforce dissociation rather than curb it, and may support a family's or system's entrenched beliefs about a child's incapacities.

5. Families may defensively concentrate on the past and avoid discussion of the current stressors that maintain dissociative adaptations. The therapist should help the family find creative solutions to current problems, while exploring feelings from past events that continue to contribute to current difficulties.

6. All treatment should include intervention with the family currently providing care to the child or adolescent. The family needs to be helped to understand the child's fears and underlying anger without accepting these as excuses for irresponsible behavior. This intervention can occur as part of the regular therapy or from a separate family therapist with close coordination. Therapists should stay alert to the need for referral of the parents for treatment when the parents' own mental health issues interfere with the child's treatment.

7. The therapist must help the child and the family understand that any self states or alternate identities are really part of the child and that the whole child is responsible for his/her behavior. The child as one, unified, responsible person must be emphasized. The family needs to be encouraged not to ask for the "good child" or the "good behavior" but to interact with the child as a whole, while assisting the child to accept responsibility for the disowned behavior or affect. The therapist can help the child gain increasing control over the behavior, and the adults must be cautious not to un-wittingly increase dissociation through undue emphasis on separateness.

D. Therapeutic Goals

1. ***Help the child achieve a sense of cohesiveness about his affects, cognitions, and associated behavior.*** Although the child may perceive his/her emotions and behavior as outside of his/her own control, the therapeutic goal is to increase in the child a sense of awareness of his/her feelings and responsibility for associated behavior. The therapist gently but firmly should help the child to accept responsibility when limits are imposed for behavior that feels outside of his/her control, and parents must continue to impose these limits despite the child's sense of frustration. This frustration is, in part, what stimulates the internal awareness (or "co-consciousness") that leads to change. When the child perceives that the behavior is controlled by an imaginary friend or other dissociated aspect of the self, treatment gently highlights the motivations, memories and feelings which the child has had trouble inte-grating into central awareness and, over time, this promotes a cohesive and integrated sense of self.

2. ***Enhance motivation for growth and future success.***

   a. Help the child believe in his/her own skills and potential. Enhance motivation for success and future accomplishment. This promotes integration and helps defeat the resistance to change.

   b. Educate about how dissociation prohibits growth and change. This encourages the child to abandon dissociative strategies over time.

3. ***Promote self-acceptance of behavior and self-knowledge about feelings viewed as unacceptable.***

   a. Dissociation may protect the child from awareness or experience of his/her own feelings of rage, disappointment, grief, self-doubt, fear, shame, physical pain or sexuality. Enhancing knowledge about these helps promote integration. Education about sexuality (Wieland, 1998) and affect may assist with this process. Education on early implicit memories, and how they can affect one's developmental integration, can also help both children and parents understand the child's experience of dissociation.

   b. Gestalt techniques involving dramatizing and thus giving voice to a variety of opposing feelings (Shirar, 1996; Waters & Silberg, 1998a, 1998b) may stimulate this process of self-awareness and promote acceptance of dissociated feelings.

   c. Model the acceptance of all contrasting feelings, and remind the patient of these feelings when they are not immediately accessible. This helps break down dissociative barriers.

4. Help the child resolve conflicting feelings, wishes, loyalties, identifications, or contrasting expectations.

a. The child may perceive these as conflicts between internal voices, imaginary friends, or conflicting identities. The therapist helps the child find ways to express these conflicts directly, examine both sides of the conflict, and problem-solve towards integrative solutions, so that over time there is no longer a need for dissociative escape or a fragmented sense of identity.

b. Play therapy in which these various conflicts, contrasting role expectations or dissociated feelings are enacted in play, and brought to conscious awareness by the therapist's comments, can encourage a natural integration and development of cohesive identity in younger children (Albini & Pease, 1989; Laporta, 1992). This may be facilitated by specific play activities, or by imagery and hypnotic techniques (Gil, 1991; Shirar, 1996; Waters & Silberg 1998b; Kluft, 1985; McMahon & Fagan, 1993). With teenagers, some therapists recommend having the client write letters to him/herself or dramatize aloud internal dialogues to facilitate resolution of competing wishes or feelings. These exercises promote self cohesion without reinforcing the separateness of identities. Therapists should take note of situations where these conflicts cannot be resolved without a concomitant change in the environment. For example, children may be caught in custody battles, with widely divergent expectations between parents, that may lead to a fragmented sense of identity. The child alone cannot resolve this unless the environmental pressure is relieved.

5. Desensitize traumatic memories, and correct learned attitudes towards life resulting from traumatic events.

a. Talk to the child about overwhelming experiences and their associated affects and perceptions. This helps to desensitize the child's conditioned fear responses to any frightening memories. The child's access to these memories may be variable as treatment progresses. However, as the child moves towards a more cohesive sense of self, such memories may become more accessible. Be careful to titrate discussions about traumatic content and not overwhelm the child (James, 1989). Eye Movement Desensitization and Reprocessing (EMDR) can assist children in working through experiences for which they have very little or no explicit memory or experiences that they find too difficult to talk about in detail (Tinker & Wilson, 1998: Greenwald, 1993). Ego-strengthening and calming techniques are advisable prior to using EMDR to avoid destabilization. When dealing with traumatic content, techniques that help improve the child's sense of efficacy and mastery are encouraged (Gil, 1991; Gil, 1996; James, 1994; Friedrich, 1991). Play therapy with trauma patients tends to involve more active intervention for re-working of traumatic themes than other kinds of play therapy.

b. Traumatic re-experiencing may take the form of flashbacks, in which the child or adolescent experiences past events as if they were really happening. Imagery techniques (Wieland, 1998) or formal hypnosis to guide the child towards mastery experiences (Williams & Velazquez, 1996; Friedrich, 1991) may be helpful. Families can set designated times to discuss unpleasant memories so that these do not interfere with daily functioning (Waters, 1998). Some traumatized children engage in flashbacks during parental fights or when asked to do chores, so understanding the complete context in which these flashbacks occur is essential before recommending interventions.

c. Traumatized children may develop a variety of learned attitudes which may include helplessness, belief in a bad self, being destined for bad things, and being unlovable, and these beliefs need to be corrected in the therapy (American Academy of Child and Adolescent Psychiatry, 1998; Deblinger & Helfin, 1997; Wieland, 1997). Dissociative children may hold contradictory beliefs, or contradictory attachment styles (Liotti, 1999) with associated beliefs which may make this aspect of treatment particularly challenging. Gently pointing out these contradictions within the context of an accepting therapeutic relationship eventually leads to integration.

6. Promote autonomy and encourage the child to independently regulate and express affects and to self-regulate state changes

a. Therapists can help children identify precursors to state changes so that they become better at self-monitoring (Allers & White; Gil, 1991; James, 1989).

b. Self-injury may become a mood-altering addictive behavior which serves to distract from emo-tional pain or express feelings of despair and anger. Children engaging in repetitive self-harm must learn alternatives such as more direct feeling expression, improved methods of mood regulation, and families must assess ways in which they can learn to reinforce positive methods of affect-regulation.

c. Self-monitoring may be encouraged by use of special code words whereby a parent or teacher can let a child know a shift has occurred or these words or slogans can stimulate focused attention. Cognitive-behavioral techniques can help chil-dren learn to manage self-destructive and impulsive behavior, including impulsive sexual behavior. Children can be reinforced for identifying changes in moods or states, interrupting dysfunctional impulsive habits, and engaging in drawing, writing, talking to adults, or other ex-pressive alternatives. Therapists can teach children techniques of promoting active attention which may help interrupt sexual misbehavior or other disruptive behavior that occurs during dis-sociative states (Johnson, 2002). Teaching use of positive imagery and relaxation for self-soothing and stress reduction may be useful.

7. Promote healthy attachments and relationships through direct expression of feelings.

a. Encourage children to communicate feelings of anger, fear, and regressive needs to their caregivers so that these are not enacted in dysfunctional ways. Teach caregivers to tolerate these direct expressions. This promotes healthy attachment though it may be difficult for families that are uncomfortable with affect and have poor boundaries.

b. Help families and children view the therapist as a stable attachment figure, particularly for children and families from chaotic environments.

E. Adjunctive Treatments

1. Family Therapy

a. Work with the primary caregivers may include education about dissociation (Waters, 1998), specific guidance about parenting strategies which facilitate therapy (Boat, 1991), family sessions to encourage the family to accept all aspects of the child (Waters & Silberg, 1998b), correcting interactive pat-terns that promote dissociation (Benjamin & Benjamin, 1993; Silberg, 2001), helping parents process guilt or denial about

traumatic events (Keren &Tyano, 2000; Silberg, in press), working through of feelings about issues of safety and betrayal to help establish trust (Waters, 1998), and straight-forward parenting advice or training which is part of all good child therapy.

b. In educating parents, change any literal views the family may have about the reality of "alters" as separate from the child, while explaining how dissociation evolves in a traumatized child. Parents can be taught to encourage the child's direct expression of thoughts and feelings without reinforcing dysfunctional dissociative strategies. The therapist can also help the family identify current reinforcers that maintain the symptomatology, such as family indulgence or overly punitive responses in the face of regressive behavior.

c. For children residing in original homes in which maltreatment or unintentional exposure to traumatic events occurred, acknowledgment of the trauma and an apology for the lack of protection is a basic starting point for much of the family therapy work

d. Dyad work with the parent figure and the child can be particularly valuable in helping the therapist understand the subtle negative dynamics that may be occurring in the home. This would be a time when the therapist, parent and child can develop ideas for handling problem situations at home.

2. Hypnotherapy

Hypnotherapy for children and adolescents has been described for rapidly accessing ego states and promoting integration (Bowman, Blix & Coons,1985; Dell & Eisenhower, 1990; Kluft,1985; Kluft, 2000) or for containment of intense affect, ego strengthening, education, and support (Williams & Velazquez, 1996), but hypnotherapy is not advised for memory retrieval. In cases where hypnosis is deemed appropriate, the therapist should gain informed consent from caregivers or guardians, as well as clients. The therapists should explore all legal implications, given that witness credibility for any upcoming court hearings could be affected.

3. Pharmacotherapy

a. There are no controlled studies on the use of medications with dissociative children, adolescents or adults.

b. Some clinicians have found that psychotropic medication may be of benefit for children and adolescents with dissociative symptoms and disorders as an adjunct to psychotherapy to ameliorate targetable symptoms, such as incapacitating anxiety, insomnia, lability, behavioral dyscontrol, inability to focus attention, and depression (Nemzer, 1998; Putnam, 1997; Silberg, Stipic & Taghizadeh, 1997; Putnam, 1997).

c. Medications may be utilized to treat co-morbid conditions such as attention deficit hyperactivity disorder (ADHD), major depression, OCD, or PTSD.

d. Close communication and teamwork between the prescribing physician and the therapist is essential.

4. Art Therapy.

Strike a balance between art that encourages mastery and art that is regressive, limiting the latter if it simply becomes a form of traumatic re-enactment without trauma resolution. Most child therapists use some art in their work, and art therapy from a licensed art therapist may be a useful adjunct to individual treatment in some cases (Sobol & Schneider, 1998).

5. Group therapy.

Group therapy may be useful, particularly if it is psycho-educational in orientation (Brand 1998: Silberg et al, 1997). Promoting positive peer interactions may help build in long-term resiliency for children and adolescents.

6. Inpatient/Residential Treatment

a. Admit dissociative children and adolescents to inpatient care when they are engaged in dangerous, self-injurious or destructive behavior that cannot be contained in a community environment, or where the child is at risk and needs a safe environment for a complex assessment (Hornstein & Tyson, 1991). However, avoid hospitalization, if possible, through close monitoring, more frequent sessions during a crisis, or respite care.

b. Admit the child or adolescent to residential treatment if he/she requires ongoing close monitoring and a carefully structured environment for his/her own protection or protection of others. A more intensive treatment milieu may be needed for stabilization, processing of traumatic material, and learning appropriate problem-solving.

c. The goal of the inpatient or residential treatment is to stabilize behavior by identifying the internal motivation for the dangerous behavior, which may not be readily accessible to the child if dissociated from awareness, and negotiating and resolving internal and external conflicts until commitment to safety is achieved.

d. If seclusion or therapeutic physical containment is required for destructive behavior, it is essential that these procedures be explained to children in advance. Once calm, such episodes may be worked through with the child or adolescent, so that they can best identify traumatic associations or internal and external stimuli that prompted this behavior. The child's belief that other parts of the self were responsible for the misbehavior should not be viewed as the child willfully escaping responsibility, as this stance may serve to increase oppositional behavior. Instead, the child should be gently encouraged to take ownership of the feelings associated with the destructive behavior, while exploring constructive ways to gain control. If the child presents as having no memory for the experience, the staff can gently explain what the behavior involved, and follow through with appropriate consequences.

e. The hospital or residential center must have the structure to provide protection to the child from his/her destructive impulses, which may be directed towards the self or others, and from retraumatization from other residents or patients.

f. Staffmembers dealing with dissociative children and adolescents should have basic familiarity with dissociative and post-traumatic reactions and know how to help children with the experience of flashbacks and post-traumatic anxiety.

g. An approach that deals only with observed behavior and is based solely on behavior modification will in most cases be inadequate. This kind of approach will not assist with identifying the feelings, traumatic stimuli, or internal states that led to the destructive behavior. It is important to help the child plan for future similar events, so that the child achieves the self-control necessary to move to a less restrictive environment.

h. The setting should provide close cooperation with the child's outpatient therapist, protective service workers, or legal advocates, to provide for a smooth transition to discharge.

7. Educational interventions.

a. Children and adolescents with dissociative symptoms may require special education modifications if their disruptive behavior, mood instability and poor attention interfere with academic functioning. With supportive staff, however, many children with dissociative symptoms can succeed in regular classrooms.

b. School staff should help encourage the child or adolescent to stay focused even while mood and attention fluctuate. It should be assumed that the child or adolescent will bring his/her full potential to the school setting, and an attitude of gentle accountability is encouraged. The school staff should convey an attitude of understanding and reward effort and approximations of desired goals. Pre-arranged code words or signals that stimulate attention and focus may be useful.

c. The staff should encourage children and adolescents to monitor themselves to access the greatest potential possible, should set clear and firm limits about expectations, and provide regular opportunities for the child to communicate about sources of stress in the school environment or at home that may impact on performance.

d. Discourage special attention from other students related to extreme shifts in behavior. Designate one member of the staff to deal with any dramatic shifts, such as age regression.

e. Incorporate expressive arts into the curriculum for expression of feelings (Waterbury, 1998).

f. Be attentive to the children's needs to have stable attachment figures in the school setting (counselors, advisors, or teachers) with whom they have a special relationship and with whom they can communicate frequently (Kobak, Little, Race, Acosta, 2002).

VIII. SUPPLEMENTARY ISSUES

Refer to the Adult Guidelines published by the ISSD for questions addressing discussion of fees, relationship with the media, boundary issues and spiritual and philosophical issues. In addressing any of these issues with the child or adolescent, be sensitive to the patient's emotional and cognitive as well as chronological developmental level. Approach parents or caregivers of children and adolescents in treatment with consideration for boundary management, dual relationships and protection from exploitative relationships.

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300.14 Dissociative Identity Disorder (*formerly* Multiple Personality Disorder)

Diagnostic Features

The essential feature of Dissociative Identity Disorder is the presence of two or more distinct identities or personality states (Criterion A) that recurrently take control of behavior (Criterion B). There is an inability to recall important personal information, the extent of which is too great to be explained by ordinary forgetfulness (Criterion C). The disturbance is not due to the direct physiological effects of a substance or a general medical condition (Criterion D). In children, the symptoms cannot be attributed to imaginary playmates or other fantasy play.

Dissociative Identity Disorder reflects a failure to integrate various aspects of identity, memory, and consciousness. Each personality state may be experienced as if it has a distinct personal history, self-image, and identity, including a separate name. Usually there is a primary identity that carries the individual's given name and is passive, dependent, guilty, and depressed. The alternate identities frequently have different names and characteristics that contrast with the primary identity (e.g., are hostile, controlling, and self-destructive). Particular identities may emerge in specific circumstances and may differ in reported age and gender, vocabulary, general knowledge, or predominant affect. Alternate identities are experienced as taking control in sequence, one at the expense of the other, and may deny knowledge of one another, be critical of one another, or appear to be in open conflict. Occasionally, one or more powerful identities allocate time to the others. Aggressive or hostile identities may at times interrupt activities or place the others in uncomfortable situations.

Individuals with this disorder experience frequent gaps in memory for personal history, both remote and recent. The amnesia is frequently asymmetrical. The more passive identities tend to have more constricted memories, whereas the more hostile, controlling, or "protector" identities have more complete memories. An identity that is not in control may nonetheless gain access to consciousness by producing auditory or visual hallucinations (e.g., a voice giving instructions). Evidence of amnesia may be uncovered by reports from others who have witnessed behavior that is disavowed by the individual or by the individual's own discoveries (e.g., finding items of clothing at home that the individual cannot remember having bought). There may be loss of memory not only for recurrent periods of time, but also an overall loss of biographical memory for some extended period of childhood. Transitions among identities are often triggered by psychosocial stress. The time required to switch from one identity to another is usually a matter of seconds, but, less frequently, may be gradual. The number of identities reported ranges from 2 to more than 100. Half of reported cases include individuals with 10 or fewer identities.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with Dissociative Identity Disorder frequently report having experienced severe physical and sexual abuse, especially during childhood. Controversy surrounds the accuracy of such reports, because childhood memories may be subject to distortion and individuals with this disorder tend to be highly hypnotizable and especially vulnerable to suggestive influences. On the other hand, those responsible for acts of physical and sexual abuse may be prone to deny or distort their behavior. Individuals with Dissociative Identity Disorder may manifest posttraumatic symptoms (e.g., nightmares, flashbacks, and startle responses) or Posttraumatic Stress Disorder. Self-mutilation and suicidal and aggressive behavior may occur. Some individuals may have a repetitive pattern of relationships involving physical and sexual abuse. Certain identities may experience conversion symptoms (e.g., pseudoseizures) or have unusual abilities to control pain or other physical symptoms. Individuals with this disorder may also have symptoms that meet criteria for Mood, Substance-Related, Sexual, Eating, or Sleep Disorders. Self-mutilative behavior, impulsivity, and sudden and intense changes in relationships may warrant a concurrent diagnosis of Borderline Personality Disorder.

Associated laboratory findings. Individuals with Dissociative Identity Disorder score toward the upper end of the distribution on measures of hypnotizability and dissociative capacity. There are reports of variation in physiological function across identity states (e.g., differences in visual acuity, pain tolerance, symptoms of asthma, sensitivity to allergens, and response of blood glucose to insulin).

Associated physical examination findings and general medical conditions. There may be scars from self-inflicted injuries or physical abuse. Individuals with this disorder may have migraine and other types of headaches, irritable bowel syndrome, and asthma.

Specific Culture, Age, and Gender Features

It has been suggested that the recent relatively high rates of the disorder reported in the United States might indicate that this is a culture-specific syndrome. In preadolescent children, particular care is needed in making the diagnosis because the manifestations may be less distinctive than in adolescents and adults. Dissociative Identity Disorder is diagnosed three to nine times more frequently in adult females than in adult males; in childhood, the female-to-male ratio may be more even, but data are limited. Females tend to have more identities than do males, averaging 15 or more, whereas males average approximately 8 identities.

Prevalence

The sharp rise in reported cases of Dissociative Identity Disorder in the United States in recent years has been subject to very different interpretations. Some believe that the greater awareness of the diagnosis among mental health professionals has resulted in the identification of cases that were previously undiagnosed. In contrast, others believe that the syndrome has been overdiagnosed in individuals who are highly suggestible.

Course

Dissociative Identity Disorder appears to have a fluctuating clinical course that tends to be chronic and recurrent. The average time period from first symptom presentation to diagnosis is 6–7 years. Episodic and continuous courses have both been described. The disorder may become less manifest as individuals age beyond their late 40s, but may reemerge during episodes of stress or trauma or with Substance Abuse.

Familial Pattern

Several studies suggest that Dissociative Identity Disorder is more common among the first-degree biological relatives of persons with the disorder than in the general population.

Differential Diagnosis

Dissociative Identity Disorder must be distinguished from **symptoms that are caused by the direct physiological effects of a general medical condition** (e.g., seizure disorder) (see p. 165). This determination is based on history, laboratory findings, or physical examination. Dissociative Identity Disorder should be distinguished from **dissociative symptoms due to complex partial seizures,** although the two disorders may co-occur. Seizure episodes are generally brief (30 seconds to 5 minutes) and do not involve the complex and enduring structures of identity and behavior typically found in Dissociative Identity Disorder. Also, a history of physical and sexual abuse is less common in individuals with complex partial seizures. EEG studies, especially sleep deprived and with nasopharyngeal leads, may help clarify the differential diagnosis.

Symptoms caused by the **direct physiological effects of a substance** can be distinguished from Dissociative Identity Disorder by the fact that a substance (e.g., a drug of abuse or a medication) is judged to be etiologically related to the disturbance (see p. 192).

The diagnosis of Dissociative Identity Disorder takes precedence over **Dissociative Amnesia, Dissociative Fugue,** and **Depersonalization Disorder.** Individuals with Dissociative Identity Disorder can be distinguished from those with trance and possession trance symptoms that would be diagnosed as **Dissociative Disorder Not Other-**

wise Specified by the fact that those with trance and possession trance symptoms typically describe external spirits or entities that have entered their bodies and taken control.

Controversy exists concerning the differential diagnosis between Dissociative Identity Disorder and a variety of **other mental disorders,** including **Schizophrenia** and **other Psychotic Disorders, Bipolar Disorder, With Rapid Cycling, Anxiety Disorders, Somatization Disorders,** and **Personality Disorders.** Some clinicians believe that Dissociative Identity Disorder has been underdiagnosed (e.g., the presence of more than one dissociated personality state may be mistaken for a delusion or the communication from one identity to another may be mistaken for an auditory hallucination, leading to confusion with the Psychotic Disorders; shifts between identity states may be confused with cyclical mood fluctuations leading to confusion with Bipolar Disorder). In contrast, others are concerned that Dissociative Identity Disorder may be overdiagnosed relative to other mental disorders based on the media interest in the disorder and the suggestible nature of the individuals. Factors that may support a diagnosis of Dissociative Identity Disorder are the presence of clear-cut dissociative symptomatology with sudden shifts in identity states, reversible amnesia, and high scores on measures of dissociation and hypnotizability in individuals who do not have the characteristic presentations of another mental disorder.

Dissociative Identity Disorder must be distinguished from **Malingering** in situations in which there may be financial or forensic gain and from **Factitious Disorder** in which there may be a pattern of help-seeking behavior.

Diagnostic criteria for 300.14 Dissociative Identity Disorder

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behavior.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g., complex partial seizures). **Note:** In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

300.6 Depersonalization Disorder

Diagnostic Features

The essential features of Depersonalization Disorder are persistent or recurrent episodes of depersonalization characterized by a feeling of detachment or estrangement from one's self (Criterion A). The individual may feel like an automaton or as if he or she is living in a dream or a movie. There may be a sensation of being an outside observer of one's mental processes, one's body, or parts of one's body. Various types of sensory anesthesia, lack of affective response, and a sensation of lacking control of one's actions, including speech, are often present. The individual with Depersonalization Disorder maintains intact reality testing (e.g., awareness that it is only a feeling and that he or she is not really an automaton) (Criterion B). Depersonalization is a common experience, and this diagnosis should be made only if the symptoms are sufficiently severe to cause marked distress or impairment in functioning (Criterion C). Because depersonalization is a common associated feature of many other mental disorders, a separate diagnosis of Depersonalization Disorder is not made if the experience occurs exclusively during the course of another mental disorder (e.g., Schizophrenia, Panic Disorder, Acute Stress Disorder, or another Dissociative Disorder). In addition, the disturbance is not due to the direct physiological effects of a substance or a general medical condition (Criterion D).

Associated Features and Disorders

Associated descriptive features and mental disorders. Often individuals with Depersonalization Disorder may have difficulty describing their symptoms and may fear that these experiences signify that they are "crazy." Derealization may also be present and is experienced as the sense that the external world is strange or unreal. The individual may perceive an uncanny alteration in the size or shape of objects (macropsia or micropsia), and people may seem unfamiliar or mechanical. Other common associated features include anxiety symptoms, depressive symptoms, obsessive rumination, somatic concerns, and a disturbance in one's sense of time. In some cases, the loss of feeling that is characteristic of depersonalization may mimic Major Depressive Disorder and, in other cases, may coexist with it. Hypochondriasis and Substance-Related Disorders may also coexist with Depersonalization Disorder. Depersonalization and derealization are very frequent symptoms of Panic Attacks. A separate diagnosis of Depersonalization Disorder should not be made when the depersonalization and derealization occur exclusively during such attacks.

Associated laboratory findings. Individuals with Depersonalization Disorder may display high hypnotizability and high dissociative capacity as measured by standardized testing.

Specific Culture Features

Voluntarily induced experiences of depersonalization or derealization form part of meditative and trance practices that are prevalent in many religions and cultures and should not be confused with Depersonalization Disorder.

Prevalence

The lifetime prevalence of Depersonalization Disorder in community and clinical settings is unknown. At some time in their lives, approximately half of all adults may have experienced a single brief episode of depersonalization, usually precipitated by severe stress. A transient experience of depersonalization develops in nearly one-third of individuals exposed to life-threatening danger and in close to 40% of patients hospitalized for mental disorders.

Course

Individuals with Depersonalization Disorder usually present for treatment in adolescence or adulthood, although the disorder may have an undetected onset in childhood. Because depersonalization is rarely the presenting complaint, individuals with recurrent depersonalization often present with another symptom such as anxiety, panic, or depression. Duration of episodes of depersonalization can vary from very brief (seconds) to persistent (years). Depersonalization subsequent to life-threatening situations (e.g., military combat, traumatic accidents, being a victim of violent crime) usually develops suddenly on exposure to the trauma. The course may be chronic and marked by remissions and exacerbations. Most often the exacerbations occur in association with actual or perceived stressful events.

Differential Diagnosis

Depersonalization Disorder must be distinguished from **symptoms that are due to the physiological consequences of a specific general medical condition** (e.g., epilepsy) (see p. 165). This determination is based on history, laboratory findings, or physical examination. **Depersonalization that is caused by the direct physiological effects of a substance** is distinguished from Depersonalization Disorder by the fact that a substance (e.g., a drug of abuse or a medication) is judged to be etiologically related to the depersonalization (see p. 192). **Acute Intoxication** or **Withdrawal** from alcohol and a variety of other substances can result in depersonalization. On the other hand, substance use may intensify the symptoms of a preexisting Depersonalization Disorder. Thus, accurate diagnosis of Depersonalization Disorder in individuals with a history of alcohol- or substance-induced depersonalization should include a longitudinal history of Substance Abuse and depersonalization symptoms.

Depersonalization Disorder should not be diagnosed separately when the symptoms occur only during a Panic Attack that is part of **Panic Disorder, Social or Specific Phobia,** or **Posttraumatic** or **Acute Stress Disorders.** In contrast to **Schizophrenia,** intact reality testing is maintained in Depersonalization Disorder. The loss of feeling associated with depersonalization (e.g., numbness) may mimic a **depression.** However, the absence of feeling in individuals with Depersonalization Disorder is associated with other manifestations of depersonalization (e.g., a sense of detachment from one's self) and occurs even when the individual is not depressed.

Diagnostic criteria for 300.6 Depersonalization Disorder

A. Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream).

B. During the depersonalization experience, reality testing remains intact.

C. The depersonalization causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The depersonalization experience does not occur exclusively during the course of another mental disorder, such as Schizophrenia, Panic Disorder, Acute Stress Disorder, or another Dissociative Disorder, and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., temporal lobe epilepsy).

300.15 Dissociative Disorder Not Otherwise Specified

This category is included for disorders in which the predominant feature is a dissociative symptom (i.e., a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment) that does not meet the criteria for any specific Dissociative Disorder. Examples include

1. Clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder. Examples include presentations in which a) there are not two or more distinct personality states, or b) amnesia for important personal information does not occur.
2. Derealization unaccompanied by depersonalization in adults.
3. States of dissociation that occur in individuals who have been subjected to periods of prolonged and intense coercive persuasion (e.g., brainwashing, thought reform, or indoctrination while captive).
4. Dissociative trance disorder: single or episodic disturbances in the state of consciousness, identity, or memory that are indigenous to particular locations and cultures. Dissociative trance involves narrowing of awareness of immediate surroundings or stereotyped behaviors or movements that are experienced as being beyond one's control. Possession trance involves replacement of the customary sense of personal identity by a new identity, attributed to the influence of a spirit, power, deity, or other person, and associated with stereotyped "involuntary" movements or amnesia. Examples include *amok* (Indonesia), *bebainan* (Indonesia), *latah* (Malaysia), *pibloktoq* (Arctic), *ataque de nervios* (Latin America), and possession (India). The dissociative or trance disorder is not a normal part of a broadly accepted collective cultural or religious practice. (See p. 727 for suggested research criteria.)
5. Loss of consciousness, stupor, or coma not attributable to a general medical condition.
6. Ganser syndrome: the giving of approximate answers to questions (e.g., "2 plus 2 equals 5") when not associated with Dissociative Amnesia or Dissociative Fugue.