CHAPTER ONE

1.0 INTRODUCTION

Overview

Dissociative Identity Disorder (DID) is a controversial condition that centres on the presence of alter personalities. Sceptics say that the alter personalities, which are the hallmark of DID, result from therapist iatrogenic bias and/or from patients who are malingering or responding to reinforcement. Non-sceptics say that alter personalities are a defensive reaction to unmanageable trauma.

Past studies are defective because there have been no checks for reliability or validity that the alters are present and that they can be identified as present by independent judges. Nor have there been checks to see if the alters are an artefact introduced or encouraged by the therapist. Therefore, the information that they offer is not seen as credible.

This study examines the presence and operation of alter personalities through a detailed case study of a person with an independent psychiatric diagnosis of DID. It differs from other studies by firstly attending to past criticisms and presenting independent external confirmation that the alters are present, can be recognized, and are not a result of therapist induction. It also attends to another criticism of past studies by using a therapeutic model consistently during treatment and describing it in detail. Secondly, it proceeds by examination of transcripts of this case to determine what factors contribute to the development of alter personalities and what indications for the process of therapeutic integration present themselves in the course

of treatment. The study then proceeds to consider some of the implications regarding the development of DID and its treatment that can be drawn from the data.

Background to the Study

During the 1990s, few clinical psychiatric diagnostic groups experienced the level of controversy engendered by the dissociative disorders (Klein & Doane, 1994). The controversy has continued into the present decade (Scheflin, 2000) with most of the scepticism focused upon one form of dissociative disorder, namely, Multiple Personality Disorder (Dell, 1988). Multiple Personality Disorder, now known as Dissociative Identity Disorder (DID), is a complex and chronic disorder that is characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behaviour. This is accompanied by an inability to recall important information that is too extensive to be explained by ordinary forgetfulness. Such disturbances are not due to direct physiological effects (DSM-IV, American Psychiatric Association, 1994; Kluft, 1996a).

Despite the controversy surrounding DID, the history of this condition is extensive and parallels the development of modern psychiatry (Putnam, 1989a). Indeed, in the late nineteenth century an understanding of dissociative phenomena was central to theories of psychopathology and valued as a way of understanding mental processes. William James and Morton Prince, for example, theorized about the organization of mental processes based on their personal experience with patients suffering from DID (Ellenberger, 1970).

Pierre Janet (1859-1947) is widely acknowledged as an important pioneer in the study of dissociation (Brown, Macmillan, Meares, & van der Hart, 1996). His studies of patients suffering from amnesia, fugues, “successive existences” (his description of DID), and somatic dissociation led him to postulate that these symptoms were attributable to the existence of “split-off” parts of the personality capable of independent life and development. He argued that the dissociative

elements (splitting of mental functions) that gave rise to patients' symptoms or behaviours frequently originated in traumatic experiences (Pitman, 1989).

Freud, in his early writings, considered the core of psychopathology to be the internal impression of a traumatic experience that, because of its unbearable nature, was sealed off from the rest of the personality (van der Kolk, Weisaeth, & van der Hart, 1996). In Aetiology of Hysteria (1896), Freud argued that the ultimate cause of hysteria was the sexual seduction of a child by an adult. He later abandoned this "seduction theory" in favour of the notion that what hysterics repressed from consciousness was not sexual trauma itself, but a childhood sexual wish. This shift in attention from the study of the effects of actual traumatic experience to the psychology of repressed wishes and instincts marked the shift away from a trauma dissociation model of psychopathology to a repressive one. This polarization is still evident in the current literature on repressed memory (van der Kolk et al., 1996).

The acceptance of psychoanalytic theory resulted in an absence of research on the effects of real traumatic events on children's lives. This led to a gross underestimation of the frequency of sexual abuse (Steinberg, 1995). Henderson (1975), for example, reported in the widely read professional text Comprehensive Textbook of Psychiatry, that the proportion of incest victims was about 1.1 to 1.9 per million. Since this publication, however, a plethora of epidemiological, clinical, and developmental studies leave no reasonable doubt that many more children are victimized and abused physically and sexually than was previously understood (Knutson, 1995). Russell (1986) reported that 16% of women in the North American population are abused by a relative and 31% are sexually abused by a non-family member before their 18th birthday. In terms of the hospitalized population, 50-75% of general psychiatric patients reported histories of childhood trauma. Myers (1991) considered that such findings lend support to the hypothesis that the profound and deleterious effect of childhood abuse continues throughout the individual's life.

Paralleling the recognition of the widespread incidence of actual childhood trauma there was a resurgence of interest in its sequelae in adulthood. DID and the

dissociative processes again became central features in models and theories of the organization of mental processes in adults (Fischer & Pipp, 1984; Hilgard, 1977). As with childhood trauma, the number of reported cases of DID have increased in the last decade. The actual prevalence of DID is unknown. However, it is conservatively estimated to occur in 1% of the general population (Ross, 1997), in 3-6% of psychiatric inpatients and, in 5-18% of patients in substance abuse treatment settings (Kluft & Foote, 1999). Some researchers argue that the condition has frequently been confused with schizophrenia, borderline disorders, and hysterical neuroses (Bliss, 1986). It is a chronic disorder, and Kluft (1985) observed that without proper treatment it appears to be a life long disorder though it may manifest itself differently over the lifetime of an individual.

Since the 1980s there has been a significant increase in the number of DID cases reported in the literature. Kluft (1987) proposed several factors to account for this:

1. More widely disseminated information about DID.
2. Narrowing of the definitions of other conditions such as schizophrenia, with which DID may be confused.
3. Greater scrutiny of cases where there is failure to respond to appropriate treatment for some other condition.
4. Increased awareness of the hitherto unacknowledged high prevalence of child abuse and incest.

Piper (1994) finds it implausible that these factors alone could account for the increase. Instead, he believed that vague and over-inclusive diagnostic criteria accompanied by mutual shaping between patient and therapist account for much of the increase. He also noted that many of the techniques used to diagnose and treat the condition reinforced its symptoms. Furthermore, as Kihlstrom (1995, p. 950) recently observed, “even though hundreds if not thousands of MPD cases have been reported since 1974, fewer than two dozen have been subjected to any kind of experimental investigation.” Whilst Kihlstrom’s assertion regarding the number of

experimental studies is debatable, there is a paucity of experimental studies of DID and this has contributed to criticisms regarding its validity.

Many contemporary clinicians working with DID cases have noted, as did Janet decades before them, that some adult patients increasingly remember their abusive experiences during the process of their lives and in psychotherapy. Such findings have led some researchers such as Loftus and Ketcham (1994) and Ofshe and Watters (1994) to claim vigorously that such "memories" are frequently not the product of historical and real traumas, but "pseudo memories". It is claimed that these memories are iatrogenically implanted by well meaning therapists who create vivid "recollections" by procedures like hypnosis, abreaction, and other psychotherapeutic techniques. Individuals with DID tend to be highly hypnotizable (Bliss, 1986) and vulnerable to suggestive influences (Bowers, 1991). This, along with the complex and unusual nature of the disorder, has led some clinicians and researchers to question not only the validity of earlier memories of trauma, but also the diagnosis of DID itself. Instead, they argue that DID is an iatrogenic phenomenon created by demand characteristics on the part of the therapist.

Complex arguments about the authenticity, aetiology and nosologic status of DID, however, cannot be resolved without adequate information describing and delineating the disorder through systematic investigation (North, Ryall, Ricci, & Wetzel, 1993). The aim of the present study is to investigate whether the manifestation of alter personalities in a DID case can be identified by clinically trained observers, and whether iatrogenic bias can be detected before this emergence. If alter personalities can be identified, and if observers judge that these have arisen spontaneously, then alternative hypotheses about their emergence will be proposed.

Treatment of DID is a complex undertaking (Mollon, 1996). The process of integration proposes that the separate identity states "fuse" together and that this process continues until complete integration is achieved (if ever) (Putnam, 1989a; Ross, 1997). The exact nature of this "fusion" is not completely understood. Reported treatment of individuals with DID have identified two principal strategies:

stabilizing the most functional or competent personality (Oltmans, Neale, & Davidson 1985), or integrating the disparate personalities into one, of course the latter strategy necessarily involves stabilization (e.g., Putnam; Ross). Few accounts describe the way the stabilizing or integrating was attempted and there are no between-methods comparative studies. Greaves (1993) suggests that current DID research has suffered from the absence of theories of the self such as that of Kohut (1971, 1977, 1984). He argues that self psychology would make a significant contribution to research because of its elucidation of external events as determining factors in the development of an individual. There are also possible advantages with self psychology as a treatment model. Its emphasis is on listening from an empathic vantage point and tracking emotion shifts rather than interpreting and thus could be expected to minimize iatrogenic bias. It also has a clear methodology that can be described and carefully adhered to throughout each therapy session. For these reasons the therapeutic method of self psychology has been used consistently in this study.

1.1 Dissociation and the Development of Dissociative Disorders

Overview

Lynn and Rhue (1994) consider that the topics of dissociation and the dissociative disorders provoke fascination and consternation in roughly equal measure. In part this is due to the purported link between child abuse and pathological dissociation such as DID. This is partially exemplified by the recent surge of interest in whether delayed recall of memories of sexual abuse is fact or fiction (e.g., Loftus. 1993; Lynn & Nash, 1994; Piper, 1997). Proponents of DID regard dissociation as a mechanism by which traumatic experiences such as child abuse are processed, and by which painful memories are kept sealed from consciousness (e.g., Kluft, 1999a; Putnam, 1997). Conversely, antagonists of DID (e.g., Merskey, 1995a; Piper), whilst not denying the concept of dissociation, do refute that it is a central factor in the development of DID.

Before examining these differing views further, issues regarding the development, classification, and function of dissociation will be considered.

Development of Dissociation

Ray (1996) considered dissociation to be a normal developmental process and that all individuals are born in a dissociative state. This, Ray proposed, may result from either the immaturity of the infant's nervous system or from a break in the physiological entrainment process between the mother and infant at birth. Ray further proposed that before birth the infant's developing nervous system is organized around that of the mother. This entrainment process is broken with birth and the various aspects of the child's nervous systems initially function in an unintegrated manner. Following birth, the development and integration of physiological, emotional, cognitive and motor responses continue until a unified sense of "self" develops. Ray considered that traumatic events occurring during this phase of development interrupt the normal development of a coherent sense of self and can lead to the fragmentation of self evident in severe psychopathology including DID. From this perspective, dissociation is conceived to be a function of normal developmental processes but susceptible, under certain conditions, to pathological processes.

Putnam (1994) identified dissociative amnesia as a principal feature that distinguishes normal and relatively adaptive forms of dissociation from pathological symptoms. Sufferers from dissociative disorders also differ along a range of psychophysiological variables (Putnam, 1989a; Ross, 1997). Spiegel (1984) suggested that individuals subjected to recurring trauma early in life (5 or 6 years) are more prone to the spatial fragmentation of the personality that is typical of DID. Those who have passed through the major developmental stages before being subjected to trauma experience temporal fragmentation or other more circumscribed dissociative symptoms. In this respect DID is not qualitatively different from any other kind of character pathology such as narcissistic or obsessive personalities (McWilliams, 1994).

Classification of Dissociation

There are two major models of dissociative phenomena (Putnam, 1997). The most prevalent of these is the concept of a dissociation continuum ranging from normal dissociative processes such as daydreaming, through dissociative episodes and disorders, to the major pathological forms such as fugue states and DID (Bernstein & Putnam, 1986; Braun, 1993; Putnam, 1989a). From this perspective dissociative tendencies such as absentmindedness or "spacing out" seen in the normal population lie at the basis of the more pathological forms seen in patient populations (Ray, 1996). The second model is a typological one where pathological dissociation and normal dissociation are viewed as representing different and distinct types of dissociation. This model is associated with Janet's work and his belief that pathological dissociation is the consequence of a combination of constitutional vulnerability, suggestibility, and powerful emotional events (Putnam, 1997).

Current research into the classification of dissociation has been assisted by the development of measurement tools such as the Dissociative Experiences Scales (DES), (Bernstein & Putnam, 1986; Carlson & Putnam, 1993). Waller, Putnam and Carlson (1996), for example, reanalysed DES data gathered from seven clinical sites and concluded that a typological model was a better fit of the data for clinical samples than a continuum model. Putnam (1997) believes that the data thus far support both models: The continuum model needs to be invoked to account for some findings, and the typological model invoked to account for other results. Whilst this is an area requiring further research, Putnam's observations are consistent with Cardeña's (1994) proposal that dissociative episodes can be best understood within a multidimensional model. Cardeña suggested that dissociative episodes be classified as to whether they are considered pathological or normal, and whether their cause is assumed primarily neurological or psychological. Thus, as presented in Figure 1 (adapted from Cardeña, 1994), dissociative disorders are classified as pathological and of psychological origin. Dissociative episodes considered pathological but the cause of which is thought to be primarily neurological are considered to be of a different type.

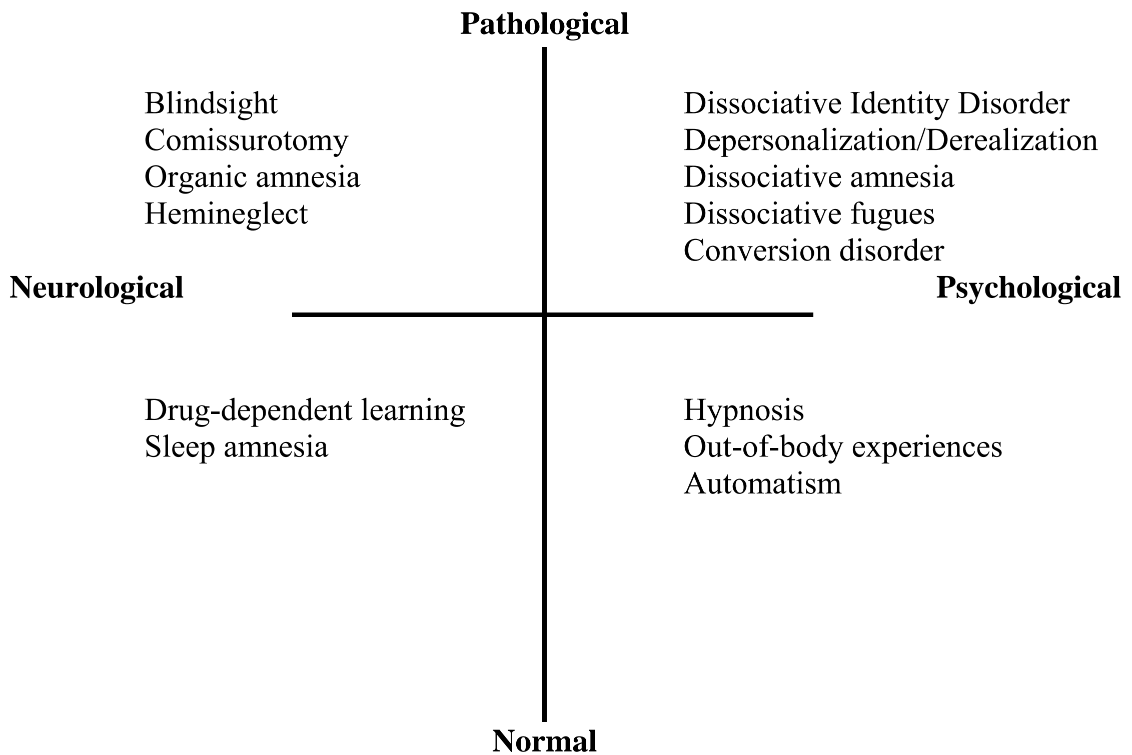

Figure 1. Dissociative phenomena (Cardeña 1994)

A model that preceded some of these principles is the BASK (Behaviour, Affect, Sensation, Knowledge) model of dissociation proposed by Braun (1988a, 1988b). In his scheme, dissociation can occur in various permutations and combinations of four continua: Behaviour, Affect, Sensation, and Knowledge. The model subsumes many processes that often occur together but have not always been seen as related. According to Braun, one can dissociate from the *Behaviour*, as in motor conversion disorder, or dissociate from the *Affectual* memory, as in painful feelings and emotions or from the *Sensation* as in conversion anaesthesia and "body memories" of abuse, and *Knowledge* as in fugue states and amnesia. The BASK model regards repression as a subsidiary of dissociation and puts a number of phenomena that have previously been regarded as hysterical into the dissociative domain. It also links to historical trauma many issues that have tended to be seen as solely expressing intrapsychic conflict.

Definition of the Dissociative Disorders

The Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV, American Psychiatric Association, 1994, p. 477) defines the essential feature of the Dissociative Disorders as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic". The DSM-IV (1994, p. 477) classifies five dissociative disorders.

1. Dissociative Amnesia is characterized by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.
2. Dissociative Fugue is characterized by sudden, unexpected travel away from home or one's customary place of work, accompanied by an inability to recall one's past and confusion about personal identity or the assumption of a new identity.
3. Dissociative Identity Disorder is characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behaviour accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
4. Depersonalization Disorder is characterized by a persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing.
5. Dissociative Disorder Not Otherwise Specified is included for coding disorders in which the predominant feature is a dissociative symptom, but that do not meet the criteria for any specific Dissociative Disorder.

The DSM-IV (1994) definition of the dissociative disorders is reflected in Cardeña's (1994) psychological/pathological content distinction. Dissociative symptoms are also included in the DSM-IV in the criteria sets for Acute Stress Disorder, Posttraumatic Stress Disorder, and Somatization Disorder.

Function of Dissociation

An understanding of the dissociative disorders is still at an early stage (Putnam, 1997) and within the literature the function of dissociation has been defined in different ways. Cardeña (1994), for example, identified three distinct ways in which the concept of dissociation is used. First, the concept is used to describe mental processes that are not consciously accessible, and that can function independently of an individual's stream of consciousness. This is the broadest sense in which the concept of dissociation is used and ranges from behaviour peripheral to the individual's awareness such as driving and changing gear whilst talking, to behaviours seemingly outside of the individual's awareness such as sleep walking. Such descriptions of dissociation refer to non-pathological states and are considered parts of an individual's normal functioning. Second, dissociation is used to describe a fundamental alteration in consciousness, which can involve a disconnection or disengagement between the individual and some aspect of his or her self or the environment, as is apparent in the clinical syndromes of depersonalization and derealization. Third, the concept of dissociation is used as a defence mechanism that accounts for disparate phenomena such as non-organic amnesia and the warding off of physical and emotional pain. It has been proposed, that the dissociative warding off of physical and emotional pain serves as a mechanism for the development of severe and chronic conditions such as DID (Kluft, 1999a).

Dissociation as a Defensive Response to Overwhelming Trauma

The concept of dissociation as a defensive response to overwhelming trauma is central to current thinking regarding the development of severe and pathological dissociative disorders such as DID (Kluft, 1999b; Putnam, 1998; Ross, 1997). Janet is not only acknowledged as a pioneer of theoretical discussion of dissociation but is also credited with the first systematic study (Ellenberger, 1970; van der Kolk & van der Hart, 1989). His theory of dissociation developed from his work with patients suffering from hysteria, together with his interest in hypnosis and the psychological effects of trauma (Atchison & McFarlane, 1994). He proposed that dissociation might occur when a person experiences "vehement" emotions, including terror,

which narrow attention and disorganize the ordinary integrative functions of consciousness. These experiences and related memories, Janet maintained, are not integrated into the person's identity and long-term memory but become, instead, simple "fixed ideas" or complex alter identities that continue to have separate mental existence. These sometimes continue to affect the person in insidious ways such as in DID (Putnam, 1989b; van der Hart & Horst, 1989).

While a "defence mechanism" is ordinarily assumed an individual's way of warding off anxiety or pain, Ludwig (1983) has proposed an explanation based on evolution theory. He proposed that dissociation serves adaptive and defensive purposes including automatization of behaviours, efficiency and economy of effort, resolution of irreconcilable conflicts, escape from the constraints of reality, isolation of catastrophic experiences, cathartic discharge of feelings, and enhancement of herd sense. Further, he states that the sham death reflex among slow animals may be analogous to dissociation. In a similar vein, Ironsides (1980) concluded that alterations in consciousness and behaviours (e.g., "being in a daze," passivity) that some humans exhibit after a catastrophe is a biological response of conservation/withdrawal to save physical and psychological resources when dealing with inescapable trauma.

Recently, Putnam (1997) arranged the defensive functions of dissociation identified by Ludwig into three categories. These he identified as (a) automatism of behaviour, (b) compartmentalization of information and affect, and (c) alteration of identity and estrangement from self. These functions, Putnam affirmed, reflect the multi-dimensional defensive nature of dissociation and can operate independently or in concert. In an acute traumatic situation, however, they function together to reduce extreme psychological and physical pain.

Automatism of behaviour is divided into "normal" and "dissociative". Putnam (1997, p. 68) maintained that one of the "benefits of 'normal' dissociation is the capacity of the mind to divide attention into two or more streams of consciousness; this allows an individual to perform more than one mental task at a

time." In contrast, dissociative automatic behaviours are not controlled by conscious thought and may have survival value in times of severe and repeated trauma. Putnam, for example, considered that automatic dissociation may provide the psychological means for an abused child to comply with the demands of the perpetrator without having to be fully aware of what is happening and of how he or she is responding.

Putnam (1997) defined compartmentalization as the failure to integrate experience and knowledge. Defensively, compartmentalization permits the isolation of overwhelming affects and memories thus providing an individual with a mechanism to store and recall emotionally laden information separately from other information. This is particularly the case where intense psychological dissonance might result if conflicting sets of information should become associated. Putnam reasoned that by compartmentalizing overwhelming experiences and feelings, a child can both "know" that he or she is being terribly maltreated by a parent and can simultaneously idealize that parent. Compartmentalization assists the child to avoid painful cognitive dissonance and irreconcilable conflicts in situations in which there can be little control. Such painful experiences, however, remain dissociated and are not psychologically transformed over time in the manner that other memories have been. Instead they remain largely out of consciousness and continue to influence and shape the individual's behaviour (Putnam; van der Kolk, 1996a; van der Kolk & Kadish, 1987).

Putnam (1997) identified alterations of self and identity as constituting a core symptom of pathological dissociation. He suggested that, whilst they may take a variety of forms, the defensive dynamic behind these alterations is to protect the individual, if only transiently, from psychologically unacceptable experience. In time-limited disorders such as dissociative amnesia or dissociative fugue, alterations of identity are selective and time-limited and may only disturb those aspects of identity associated with a specific event; full awareness of primary identity returns relatively spontaneously. In more chronic identity disorders such as depersonalization disorder and DID, the defensive aspects typically become more and more elaborated with the passage of time. In DID, for example, the emergence

of the first alter personality state is frequently reported to have arisen in the context of an overwhelming traumatic event and to have had an immediate protective survival value. The persistence of such defensive mechanisms, however, frequently leads to the development of internal persecutory alters whose function is apparently at odds with their initial adaptive purpose (Putnam, 1989a). The development of such psychological processes warrants further study. This is particularly the case when the problematic and long-term maladaptive function of these elaborations is considered (Putnam, 1997).

Summary

1. Dissociation is considered part of a normal developmental process and contributes to the development of "self". The development of "self" is, however, susceptible to fragmentation and under certain conditions dissociation can lead to severe pathology including DID.

2 Two major classification models of dissociation have been described. Currently, both models account for some, but not all, of the data. The typological model, however, appears to be a better fit for clinical samples than a continuum model.

3 The DSM-IV (1994) endorses and classifies five dissociative disorders.

4 Dissociative disorders can be understood as adaptive responses to overwhelming trauma. In time limited disorders, alterations of identity are selective and limited whereas, in more chronic conditions such as DID the adaptive and defensive aspects become elaborated with time. This frequently leads to the development of internal persecutory alters whose function is apparently maladaptive and in contradiction with their initial adaptive purpose and their functioning within the alter system requires further investigation.

It is now necessary to examine the particular manifestation of dissociation pertinent to this study.

1.2 Dissociative Identity Disorder

Overview

This chapter has so far has been concerned with the dissociative disorders in general of which DID is one manifestation from the psychological/pathological quadrant (Cardeña, 1994). In this section DID, as a discrete entity of the dissociative disorders, and its treatment are considered. DID is described by researchers as incorporating all of the dissociative experiences described within the pathological/psychological quadrant defined by the DSM-IV (American Psychiatric Association, 1994) definition of the dissociative disorders (North et al., 1993; Putnam, 1989a). In this section the DSM-IV diagnostic criteria for DID are given along with a brief review of the history of DID. Consideration of the relationship between DID, trauma, ritualistic abuse, the impact of trauma on memory functioning, and the aetiology of DID are discussed.

Diagnostic Criteria for Dissociative Identity Disorder

The DSM-IV (1994) definition of DID used in this study is as follows:

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 behaviour.

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 behaviour during alcohol intoxication, or complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

A Brief History of Dissociative Identity Disorder

As previously observed DID is not a new development; evidence of DID is said to exist in the images of shamans changed into animal forms or embodying spirits in Palaeolithic cave paintings (Putnam, 1989a; Ross, 1997). Throughout recorded history cases of demonic possession have been reported that many experts now believe are cases of DID (Golub, 1995; Putnam). Detailed accounts of DID being a mental condition began appearing in the 18th century (Ellenberger, 1970). Although there are reports of an earlier account by Paracelsus who wrote in 1646 of a woman who had amnesia about an alter personality who stole her money (Bliss, 1980), Eberhardt Gmelin is usually credited as being the first to report a case of DID (Ellenberger; Greaves, 1993). Whether it was the first written report or not, Gmelin's 1791 account of "exchanged personality" is the first known detailed account of DID (Greaves).

During the late 19th century and early 20th century reports of DID became more frequent and its symptoms increasingly elaborated (Ross, 1997). Pierre Janet, for example, described a number of cases of multiple personality including the cases of Leonie, Lucie, Rose, Marie, and Marceline (Merskey, 1995b; Putnam, 1989a). Leonie appeared to have three or more personality states including a child alter named Nichette, a childhood name. In the case of Lucie, who also reputedly had three personality states, there was an alter personality named Adrienne who seemed to experience flashbacks of a traumatic childhood event. In the case of Rose, she suffered from a variety of somnambulistic states. In some, she was paralysed and in others she was able to walk.

According to Greaves (1993), the published case literature on DID during the 19th century and the early part of the 20th century would occupy several volumes. In 1944 Taylor and Martin published a paper that surveyed all the cases of DID known to its authors and "was the most quoted reference in the history of the illness" for the next 30 years (Greaves, 1993, p. 361). Thereafter few accounts of DID were published in the English speaking world until Thigpen and Cleckley's (1954) paper, "A case of multiple personality". Their book based on this case The Three Faces of Eve was published in 1957. Despite Taylor and Martin's (1944) paper and the work of Thigpen and Cleckley (1954; 1957), little new work on DID was reported during the period 1910 to 1980 (Ross, 1997). Fine (1988), however, reported on several cases previously unknown to most students of the condition that had been reported during this period in the French and the European literature (Kluft, 1994a).

The decline of interest in the dissociative disorders was paralleled by the rise of Freudian concepts, with Bleuler declaring DID a form of schizophrenia, and with the predominance of behaviourism in academic psychology (Kluft, 1994a). Thigpen and Cleckley's (1954, 1957) work renewed interest in the study of DID. However, this was in part offset by their assertion that the disorder was extremely rare, by the patient's minimal responsiveness to treatment, and by the absence of clarity regarding issues of aetiology and treatment (Greaves, 1993). Thigpen and Cleckley (1984) continued to view DID as extremely rare and stated that they had only seen one additional genuine case. Greaves considered that the absence of a clear aetiology and treatment approach contributed to the decline of interest in the study of DID. It was not until the publication of the book Sybil by Schreiber (1973) that the relationship between childhood abuse and DID begin to gain wider recognition. Schreiber's book was based on Cornelia Wilbur's treatment of Sybil. Greaves (p. 364) considered this case to be "the most important clinical case of multiple personality in the twentieth century".

Greaves (1993) proposed that the case of Sybil is significant in several respects. Firstly, Wilbur went to great lengths to validate the accounts of abuse including interviews with Sybil's parents, a visit with Sybil to her childhood home and discussion with Sybil's doctor including a review of his records. Secondly, the

case firmly linked DID with child abuse. Thirdly, graphic description of the amnesia, fugue episodes, and conflicts among alters in Schreiber's book “served as a template against which other patients could be compared and understood” (Putnam, 1989a, p. 35). Wilbur's therapy included hypnosis and other therapeutic interventions and produced a successful resolution which “served as an example for many multiples and their therapists” (Putnam, p. 35).

As the 1970s continued, case reports of DID became more frequent. However, many of the articles and reports on DID over the next two decades focused on proving that DID existed rather than on contributing new clinical knowledge. Putnam (1989a) considers that the “critical and conservative tone” that had been adopted in the review articles of Taylor and Martin (1944), and Sutcliffe and Jones (1962) contributed to this. In a discussion of these reviews, Putnam (p. 32) observes that “although both concluded that multiple personality was a real clinical entity that could not be discounted as fad or fraud, they set a stance of defensive scepticism that later authors were forced to adopt for purposes of credibility.”

Ross (1997) identified the year 1980 as a landmark in the history of DID because the dissociative disorders were given official diagnostic status in the Diagnostic and Statistical Manual of Mental Disorders-3rd ed. (DSM-III) (American Psychiatric Association, 1980). Putnam (1989a, p. 35) considered that this “conferred a legitimacy upon DID that no other form of ‘proof of existence’ could”. The DSM-III discussion was important in several ways. First, it differentiated DID from other disorders such as schizophrenia. The finding that DID patients are often misdiagnosed as suffering from schizophrenia has been confirmed several times since (Bliss, 1980; Bliss & Jeppsen, 1985; Putnam, Guroff, Silberman, Barban, & Post 1986). Second, the DSM-III also assisted in the establishment of specific criteria for DID which provided many clinicians with their first exposure to the disorder. Third, the recognition of DID by the DSM-III also stimulated renewed interest in the disorder and encouraged many clinicians who were treating DID cases to share their knowledge more openly (Putnam, 1989a).

Ross (1997) considered that the modern scientific study of DID commenced in 1984. He attributed this to the formation of the International Society of the Study of Multiple Personality and Dissociation (ISSMP&D) renamed the International Society for the Study of Dissociation (ISSD) in 1994. The ISSMP&D was the first major conference on DID. It was held in Chicago in 1984 and brought together many leading figures in the field. The conference became an annual event and assisted in promoting research into DID and its publication in the scientific literature.

An increase in reported cases such as the series of 50 patients reported by Coons, Bowman and Milstein (1988) led to the removal "rare" designation from the description of DID in DSM-III-R (American Psychiatric Association, 1987). More recently additional large series of cases have been reported by Boon & Draijer, (1993), Middleton and Butler (1998), Ross, Miller, Reagor, Bjornson, Fraser and Anderson (1990), Ross, Norton and Wozney (1989b), and Schultz, Braun and Kluft (1989). In the most recent edition of the DSM-IV (1994), the text on the dissociative disorders and DID has been expanded and the diagnostic criteria for DID improved by the addition of amnesia criterion. The addition of the amnesia criteria is empirically supported in the literature and its inclusion further assists in differentiating DID from Borderline Personality Disorder (Gleaves & May, 2001). The increased understanding of the link between trauma and DID has led to an increased level of research (Kluft, 1994b).

Despite this activity and the long history of the DID the dissociative disorders are still marginalized within psychiatry and psychology and considerable scepticism of DID remains. Despite tremendous North American interest, British and Australian publications "carry few articles on dissociative disorders: they tend to be sceptical of MPD [DID], viewing it as more a figment of American mental health professionals minds than psychiatric illness" (Atchison & McFarlane, 1994, p. 593).

Dissociation Identity Disorder and Trauma

Many clinicians and researchers in the field of dissociative disorder argue that DID is amongst the most severe psychological responses to repeated childhood sexual trauma (Kluft, 1999a; Putnam, 1997) and that it is accompanied by pervasive changes in neurological functioning (Streeck-Fischer & van der Kolk, 2000). Bowlby (1988) defined trauma as any perceived threat to the self. He noted its pervasive effects on the developmental well being of the individual. From this perspective the experience of trauma is a function of the interaction between the event itself and the perception of the individual experiencing it (Bowlby). Van der Kolk and Saporta (1991) proposed that trauma is qualitatively different from routine stress and that intense experience of trauma results in lasting biological changes to the central nervous system. Yehuda and Harvey (1997) recently refuted a putative linear relationship between routine stress and a number of psychobiological variables, in particular, serum cortisol. Biological differences were also found between acute stress and chronic posttraumatic stress disorders. Further, Yehuda (2000) reported that the biology of traumatic stress seems to be different than biological alterations observed in other psychiatric disorders such as depression.

A number of studies support the relationship between childhood trauma and DID. Coons and Milstein (1986) reported that 85% of a series of 20 patients with DID had documented histories of childhood abuse, while Frischholz (1985) and Putnam et al. (1986) reported rates of severe childhood abuse in more than 90% of their patients. Coons (1994a) also established confirmation for 18 out of 19 cases of adolescent DID and Dissociative Disorder Not Otherwise Specified (DDNOS). Similarly, Hornstein and Putnam (1992) documented abuse in 61 out of 66 children and adolescents suffering from DID or DDNOS. Kluft (1999c) similarly established validation that abuse had taken place in 19 of 34 DID adult patients whom he had treated. Furthermore, of these 19, 10 had always recalled the abuse and 13 of the 19 were able to obtain documentation of events that had been retrieved during their treatment. Ross (1997) reviewed the epidemiological literature on DID and reported that at least 88% of DID patients report either sexual or physical childhood abuse during their first assessment. Ross also discovered that these patients had continuous memory before treatment for some of the abuse and that they recalled further details

during the course of therapy. The sex incidence is about 85% female (Coons, 1980). This increased incidence of DID in women may occur because sexual abuse and incest, which are strongly associated with DID, occur predominantly in female children and adolescents. Putnam (1989a, p. 49) stated that the type of abuse suffered by DID patients tends to have been significantly more "sadistic and bizarre than that suffered by most victims of child abuse". The degree of incapacity may vary from mild to severe. Subsequent adult impairment may result not from the trauma alone, but from the destructive context in which it is embedded (Tillman, Nash, & Lerner, 1994). Spiegel (1988) concurred. He argued further that although dissociation remained the central consequence of trauma it needed to be examined within the broader context of disturbed cognitive development and identity formation. In a similar vein, Terr (1991, 1994) postulated that the type of trauma experienced in childhood could be divided into two basic types. Traumatic events that are singular and unanticipated lead to "Type I" trauma. Full detailed memories "omens" and misperceptions characterize this type of trauma. Whereas, longstanding repeated exposure to extreme traumatic events leads to "Type II" disorders. Denial and psychic numbing, self-hypnosis, rage, and dissociation characterize these. Terr proposed that the repeated use of dissociation as defence against overwhelming trauma is the progenitor of dissociative disorders in adulthood.

Dissociative Identity Disorder and Ritualistic Abuse

Since the middle of the 1980s there has been an increase of DID patients recalling extreme sexual and physical maltreatment occurring as part of a ritualistic abuse practice (Kluft, 1997). These patients frequently allege that family members had participated in the ritualized abuse experiences (Kluft). Ritualistic abuse is at the extreme end of trauma and one of the most severe forms of abuse reported by people suffering from DID (Coons, 1997). Young and Young (1997), for example, reported that DID patients who report ritualistic abuse manifest the most complex dissociative and posttraumatic features of the severe abuse syndromes. The case for ritualistic abuse is, however, hampered by a lack of confirming evidence and despite extensive legal investigation there has so far been no external verification (Coons 1994b; Lanning, 1992).

Fraser (1997a, 1997b) reported that there has been little formal research into the ritualistic abuse phenomenon. Coons (1997) concurred and observed that despite the fervour of disputant beliefs regarding ritualistic abuse research into it has only just begun. Greaves (1992) distinguished four approaches frequently adopted by professionals interested in the ritualistic abuse area: (1) nihilism, (2) apologist, (3) heuristic, and (4) methodologist. Nihilists, he argued, seem to explain away presentations of ritualistic abuse because they can conceive alternative explanations and that therefore allegations of ritualistic abuse cannot be true. Greaves divided apologists into two categories: (a) those who conceive their task as explaining why ritualistic abuse productions must be true, and (b) those who argue that many of the ritualistic abuse claims could be true. Heuristics, Greaves stated, are clinicians who are mainly uncommitted to any objective conclusions about the whole matter, but who have found that treating their ritually abused patients' reports in a confirming manner has resulted in favourable treatment outcomes. Methodologists, Greaves proffered, have the least developed perspective in the ritualistic abuse field. Greaves maintains that in any scientific investigation, observation always precedes method and that from a psychiatric perspective there has been insufficient systematic investigation for a clear methodology to evolve. He states that there is disagreement on such fundamentals as what data should be observed and that researchers are frequently working from different data bases which results in a failure to make key discriminations between issues. Greaves (p. 48) concluded that the confusion regarding such issues has allowed researchers "to engage each other in endless 'straw man' arguments".

Fraser (1997b) stated that the term ritual abuse was probably first used in the book Michelle Remembers (Smith & Pazder, 1980). Other more recent terms are sadistic abuse, sadistic ritual abuse and satanic ritual abuse. Fraser (1997a, p. xii) summarized the major features that are alleged in reports of ritualistic abuse as including some or all of the following:

- Perverted physical, psychological, and sexual abuse of children and adults is reported in groups frequently claiming or pretending to worship Satan.

- Mind coercion techniques, including terror and isolation, are reputedly used to obtain compliance, discourage defection, and ensure future obedience, allegiance, and secrecy.
- Enforced membership lasts for many years and ideally for life.
- Members may believe themselves wedded or committed to Satan and unable to escape his ever-watchful eye.
- There is obedience to a hierarchy of leadership. Leaders are often called priests or priestesses.
- Ceremonies are said to include the ingestion of blood and urine obtained from humans or animals.
- Human sacrifices allegedly occur, and human body parts may be disposed of in ritualized cannibalistic ceremonies.
- Inbreeding and the subsequent desecration of the foetus or newborn are reported. In other cases, some infants are supposedly groomed as future leaders or recruiters.
- Members may come from all strata of society. Multigenerational familial participation is said to be common.
- Sexual orgies, including paedophilia, promiscuity, and bestiality, reputedly take place. Frequently these acts are done under the influence of mind-altering chemicals. These acts may be filmed for future sale in the pornographic market.
- Ceremonies supposedly occur on major Christian feast days or on days relating to natural planetary phases such as the summer solstice or the cycles of the moon.

Van der Hart, Boon and Jansen (1997) observed that most DID patients alleging ritual abuse present a consistent and persistent set of severe symptoms. These include severe posttraumatic stress symptoms, somatoform symptoms, extreme and unusual fears and phobias. They also experience repeated dissociative states in which behaviours associated with ritualized abuse are exhibited and reported. There is frequent substance abuse, recurrent self-mutilation such as cutting and burning, repeated attempted suicide or feelings that one has to die, extreme

feelings of guilt and shame, and indoctrinated belief systems. Typically, these patients have a long history of medical and psychiatric care, and many of the symptoms and behaviours outlined above were present before specific DID treatments were started. Ross (1995) observed that ritual abuse patients talk about, and are more preoccupied with, calendar dates than DID patients with no claims of ritual abuse.

Coons (1997) estimated that of those patients reporting ritualistic abuse only a minority is suffering from psychoses or a factitious disorder which leaves the question of how to treat those who report ritualistic abuse and are not psychotic or factitious. Many, as previously noted, have severe dissociative symptoms. For therapists, the treatment of patients who report having been involved in ritual abuse is "experienced as significantly more complex, more difficult, more challenging and more professionally 'draining' than clinical work with other client groups" (Youngson, 1994, p. 296). Kluft (1997) reported that length of treatment for DID patients alleging ritual abuse is nearly doubled compared with the treatment of DID patients not alleging ritual abuse. Further, DID patients alleging ritual abuse are likely to experience significantly more crises, regressions, hospitalizations, and episodes of self-injury during treatment than DID patients not alleging ritualistic abuse. Kluft concluded that it was not clear whether the increased pathology and length of treatment was due to the severity of the trauma and abuse, whether it was due to iatrogenic bias during treatment, or whether it was due to factors applicable to these patients.

Coons (1997) reported that patients who report ritualistic abuse and do not have evidence of either factitious disorder or psychosis sincerely believe that they were victims of ritual abuse and express emotions associated with such traumatic events that must be respected. Similarly, Kluft (1997) considered that if the patient continues to produce ritualistic abuse material then it would have to be addressed during treatment despite any uncertainty about its historical reality. Sakheim and Devine (1992 p. xiii) affirmed that in order to understand allegations of ritual abuse we must maintain scientific scepticism and clinical empathy and that we "need to

avoid the hysteria of overreaction and the denial mechanisms triggered when one is confronted with horrible material". Sakheim and Devine (p. xiii) observed that:

> Despite our psychological understanding of post-traumatic stress reactions, we tend to disbelieve most victims. We preferred not to believe the reports of incest and other forms of child abuse for years. In general, we demand tremendous amounts of proof before we are willing to believe that people can be horrible to one another. Although we know that this has occurred throughout history, each time such practices come to light we try to avoid the pain of knowledge.

In a similar vein, Mollon (1996, p. 184) considered that "Accounts of ritual abuse suggest profoundly perverse activity. The question of the existence of cults that abuse children is controversial. What is less in doubt is the existence of pornography depicting deeply perverse abuse of children, including murder". In treating these patients Mollon (1994) stressed the need for the therapist to maintain an "open mind" regarding such material and to be ready to revise tentative hypotheses as further data emerge.

Trauma and Memory

Williams and Banyard (1999) believed that the contentious nature of the debate about the accuracy of memories of childhood trauma recalled in adulthood may, in part, be the result of the different strategies used for clinical and laboratory research. The study methods for traumatic memory in normal humans may not be applicable to victims of extreme trauma, such as childhood abuse. Much of the research on adults forgetting trauma that occurred in childhood is based on studies of clinical samples of adults in treatment for the consequences of such trauma (e.g., war veterans, survivors of childhood sexual abuse). Such studies often necessarily have to rely on uncorroborated trauma histories and retrospective reconstruction of memory states. Conversely, the research focusing on "recovered memories" of fictitious events has occurred in laboratory controlled studies (e.g., Loftus 1993; Loftus, Donders, Hoffman & Schooler, 1989; Loftus & Hoffman, 1989) that maximize specificity but draw criticism in regard to ecological validity (van der Kolk, 1996b; van der Kolk & Fisler, 1995).

In response to this debate Williams and Banyard (1999) propose that it may be more appropriate to consider research that investigates the effects of extreme stress on memory function (Bremner, Krystal, Charney & Southwick, 1996; Bremner, Krystal, Southwick & Charney, 1995, 1996a, 1996b). Current research generally supports the view that memory organization is a dynamic process that changes over time and that can be affected by the intrusion of new events and by the act of retrieval itself (Bremner, 1999; Loftus & Hoffman, 1989; Yapko 1994; Zola, 1997). Conversely, there are also carefully controlled laboratory studies showing that information that was initially processed consciously and stored, but later forgotten, can be brought back, a phenomenon called hypermnesia (Erdelyi, 1984, 1996). Current research indicates that the brain is made up of anatomically distinct regions that constitute a cohesive and integrated system organized in a way that is not completely understood (Greenfield, 2000/1998). Similarly, current research also indicates that there is more than one kind of memory with different kinds of memory dependent on different brain systems (LeDoux, 1996; Squire, 1992; Zola & Squire, 1986). The different memory systems are linked by the medial temporal lobe (Alvarez & Squire, 1994). This region of the brain encompasses several areas, including the hippocampal region and the entorhinal, perirhinal, and parahippocampal cortices (Zola & Squire, 1993). The medial temporal lobe region binds the disparate aspect of a memory from the separate specialized regions distributed in the cortex and helps make them into a cohesive whole again at the time of recollection. Zola (1997) reasoned that if there is more than one kind of memory then memory is not a unitary entity and that it is, therefore, necessary to qualify statements about memory in any discussion of "recovered memory".

That there are different kinds of memory dependent on different brain systems has generated considerable research on the distinction between explicit and implicit memory (Bremner, 1999; Parkin, 1999; Zola, 1997). Explicit, conscious or declarative memory is mediated by the hippocampus and related cortical areas, whereas implicit or unconscious forms of memory are mediated by different systems (Bremner, 1999). One implicit memory system is an emotional (fear) memory system involving the amygdala and related areas (Davis, 1997; Davis & Whalen, 2001; Schacter, 1996). In traumatic situations, implicit and explicit memory systems

function in parallel (LeDoux, 1996). Subsequently, stimuli similar to those experienced in the original trauma can activate both the explicit memories of the event and the implicit emotions associated with them. LeDoux (p. 202) described the process thus:

> Later, if you are exposed to stimuli that were present during the trauma, both systems will most likely be reactivated. Through the hippocampal system you will remember whom you were with and what you were doing during the trauma, and will also remember, as a cold fact, that the situation was awful. Through the amygdala system the stimuli will cause your muscles to tense up, your blood pressure and heart rate to change, and hormones to be released, among other bodily and brain responses.

Bremner (1999) submitted that current research supports the proposition that traumatic life events can alter the human hippocampus and its memory functions (Jacobs & Nadel, 1985) and can impair explicit conscious memory functions (Bremner et al., 1993; McEwen & Sapolsky, 1995). Bremner (1999) also proposed that these differences might be invoked to provide a rationale for delayed recall of childhood abuse. Because the hippocampus is thought to be involved in memory recall and the placing of memories in space and time, it has been hypothesized that hippocampal dysfunction is involved in memory fragmentation and delayed or impaired recall evident in post traumatic stress disorder (PTSD) patients (van der Kolk, 1996b). Nijenhuis, Spinhoven, Vanderlinden, Dyck and van der Hart (1998) argued that since DID may be regarded as a complex form of PTSD (Herman, 1992; Spiegel, 1984; van der Kolk, Herron & Hostetler, 1994), explanatory models of PTSD also could be applicable to DID. Recent studies, for example, have shown that in survivors of trauma, such as victims of repeated childhood abuse or Vietnam veterans with PTSD, the hippocampus is shrunken (Bremner et al., 1995; McEwen, 1992). These same persons exhibit significant deficits in memory ability, without any loss in IQ or other cognitive functions. It is generally accepted that adrenal steroids, released by the amygdala in response to stress, account for these physical changes in the hippocampus and in the memory problems that result (Diamond & Rose, 1994; LeDoux, 1996; McEwen & Sapolsky, 1995).

The research outlined above indicates that the hippocampus plays an important role in the formation and later recall of traumatic memory. LeDoux (1996) proposed that if the hippocampus were completely overwhelmed by stress at the time of the trauma then it would have no capacity to form an explicit memory of the event. It would therefore be impossible to "recover" a conscious memory of the event since no such memory would have been formed. If, however, the hippocampus was only partially affected by the trauma it is likely that the formation of memory will be weak and fragmented, such that there would be deficits in retrieval and delayed recall (Bremner, 1999; Bremner et al., 1995). In such a situation, it may be possible to reconstruct aspects of the experience mentally, however, the accuracy of the memory will depend on "how much filling in was done and how critical the filled-in parts were to the essence of the memory" (LeDoux, p. 244).

The reverse appears to be the case for implicit memory since stress does not seem to interfere with the performance of the amygdala (Bremner, 1999; Zola, 1997) and may even enhance its functioning (Christianson & Loftus, 1987, 1991). LeDoux (1996) hypothesized that victims of trauma might have no explicit recall of a traumatic event, but at the same time form very powerful implicit, unconscious emotional memories through amygdala mediated fear conditioning that potentially can become a source of intense anxiety. Due to the conditioned fear effect, later exposure to cues related to the original traumatic event in the relatively "safe" environment of the therapeutic process might later facilitate retrieval of the traumatic event (Bremner, 1999; Bremner et al., 1995).

Van der Kolk (1996b) suggested that what might most complicate the capacity to communicate about traumatic experiences is that memories of trauma may have no verbal (explicit memory) component. Instead, he proposed traumatic memories might have been organized on an implicit or perceptual level, without any accompanying narrative about what happened. Rauch et al. (1996) found some support for this proposition. During the provocation of traumatic memories in PTSD patients, Rauch et al. found there was a decrease in activation of Broca's area, the part of the brain most centrally involved in the transformation of subjective experience into speech. Simultaneously, the areas in the right hemisphere (including

the amygdala) that are thought to process intense emotions and visual images showed significantly increased activation. That is, traumatic material appeared to be organized on a perceptual (implicit) level rather than on a narrative (explicit) level (Terr, 1994; van der Kolk, 1996b; van der Kolk & van der Hart, 1991).

Van der Kolk (1996b) proposed that strong emotional arousal experienced in trauma interferes with hippocampal functioning and therefore explicit memory. He suggested that sensory input from the thalamus is initially processed by the amygdala (LeDoux, 2002) then the hippocampus and then the prefrontal cortex where integration and planning occurs. In traumatic situations, however, extreme arousal disrupts hippocampal functioning and its capacity for the consolidation of memories (Greenfield, 2000/1998), leaving the memories to be stored as affective states in the amygdala or in sensorimotor modalities, as somatic sensations and visual images (van der Kolk, 1996c). These amygdala-mediated emotional memories (implicit memories) are thought to be relatively indelible, but their expression can be modified by feedback from the prefrontal cortex (van der Kolk, 1996b, 1996c).

Aetiology of Dissociative Identity Disorder

Whilst trauma has been identified by many researchers as the main progenitor of DID it is also acknowledged that DID can develop from other pathways. Ross (1997), for example, proposed that DID can develop from one of four pathways. He identified these pathways as (1) childhood abuse, (2) childhood neglect, (3) factitious disorder, and (4) iatrogenic bias. He considered that each pathway has a unique pattern that differentiates it from the other three. Childhood abuse, as a pathway to DID has already been discussed; its main features being that DID is understood as a defensive adaptation to severe, chronic childhood trauma. In these circumstances Ross considered that the manifestation of DID will be apparent before the age of 10 years, and that the child will exhibit symptoms of complex dissociation on a chronic basis.

Ross (1997) described childhood neglect DID pathway patients as having developed from the emotional unavailability or absence of one or both parents. The parents themselves are often suffering from DID or from such disorders as depression, alcoholism, and psychosis. Childhood neglect may involve such incidents as being locked in cupboards and basements or left in a cradle alone for prolonged periods. Ross described the pervasive trauma experienced by neglected and emotionally deprived children as the absence of a secure attachment figure (Bowlby, 1988). In the absence of a secure attachment figure these children retreat into an internal fantasy world which they populate with imaginary identities with whom they can form attachments.

Ross (1997) proposed that once such an elaborated inner world has been created the neglect pathway patients apparently develop in one of three sub-pathways. In some cases the person activates inner personalities who take executive control in dealing with the outside world prior to therapy. In these patients Ross considers that diagnostic representation is predominately one of DDNOS (Dissociative Disorder Not Otherwise Specified) with some pre-existing "relatively simple" DID. On the second sub-pathway the DDNOS is elaborated iatrogenically by therapist error into a speciously created DID. On the third pathway the patient is DDNOS at the beginning of therapy and DID does not develop. Childhood neglect patients are usually very responsive to hypnosis, but not to the same extreme level as patients with DID childhood abuse pathways. He considered that childhood neglect patients typically present as dependent personalities and that the preferred treatment modality is a modified DID/trauma model in which the therapist treats the patient as a whole entity rather than working with each individual alter personality, as in childhood abuse DID patients.

For both childhood abuse and childhood neglect patients, Ross (1997) identified attachment to the perpetrator as the fundamental developmental problem to which the child has to respond. For the child the biological imperative is the need for an attachment figure (Bowlby, 1991/1971, 1991/1973, 1991/1980), but frequently the only figure available is that of the perpetrator. Ross stated that in such circumstances the child is caught between the need for attachment and the need to detach from a

destructive environment. Such circumstances create confusion for the child, "The environment, through the abuse, signals the child to shut down her attachment systems, but her genes override this environmental imperative. The two realities do not fit together, and the world does not make sense" (Ross, p. 65).

As discussed in the previous section on dissociation, DID is generally understood as an adaptive response to overwhelming trauma. The adaptive and defensive aspects of severe dissociation become elaborated with time and leads to the development of alter personalities (Putnam, 1997). Ross (1997) extended this model suggesting that the biological need for attachment may be the mechanism that enables the child to form a relationship with the perpetrator. Ross considered that the child must dissociate in order to retain his or her psychobiological integrity; the dissociation allows attachment responses to develop. However, in such circumstances the need for attachment becomes "personified as separate identities that idealize the parents, and are amnesiac for most or all of the abuse. The amnesia barriers need not be absolute, as long as they downregulate [modulate] the traumatic psychophysiology sufficiently to permit attachment." This allows for the creation of stable alter personalities that are "always available for attachment, safety, security, and nurturing" (Ross p. 65).

Factitious Disorder patients presenting as DID are on the third pathway. Factitious Disorder is characterized by physical or psychological symptoms that are intentionally produced or feigned and motivated by a psychological need to assume the sick role (DSM-IV, 1994). These patients do not have a history of dissociative symptoms before therapy, but they do usually have an elaborate medical-surgical history and often have an extensive knowledge of medical terminology and hospital routines. Ross (1997) reported that they are not as receptive to hypnosis as childhood abuse and childhood neglect patients but, because they are seeking to deceive, may report extreme high scores on measures of dissociation such as the Dissociative Experiences Scale. Confronting these patients with evidence that their symptoms of DID are factitious usually leads either to relatively rapid remission of the DID, or their departure to seek treatment in another facility where they again present with factitious DID.

The iatrogenic pathway differs from Factitious Disorder where there is a deliberate attempt by the patient to feign DID symptoms. In iatrogenic cases Ross (1997) considered DID to be caused by poor therapy techniques. In the predominately iatrogenic case, there is no history of chronic, severe dissociative symptoms before therapy, although some fantasy proneness and hypnotic ability is required to create iatrogenic DID. Similarly, like the patients from the neglect and factitious pathways, iatrogenic patients do not seem to have the extreme trance proneness that is evident in childhood abuse DID patients. During the iatrogenic DID phase, iatrogenic patients present like factitious disorder patients with high scores on measures of dissociation such as the DES, however, their scores return to normal once they receive appropriate treatment.

Ross regarded pure iatrogenic cases as developing from one of three premorbid conditions. One group of patients has bipolar mood disorder (Merskey, 1995a), which is interpreted by the therapist as switching of alter personalities. The second group of patients has complex symptoms of anxiety, mood disorder, eating disorder, personality disorder, and dissociation, but no diagnosable dissociative disorder. The third group of patients has posttraumatic stress disorder but no DDNOS or DID before contact with the therapist. Ross (1997, p. 71) reported that, of the pure iatrogenic cases he has examined, the amount of control and influence by the therapist has “been extreme and has involved inpatient admissions for as long as two years or 10 to 15 hours of outpatient contact per week for years”.

Kluft (1984a) proposed a four factor theory for the aetiology of DID and severe dissociation. His four factors relate to the childhood abuse pathway elaborated by Ross (1997). Kluft proposed that these four factors are necessary for DID to occur. Simply expressed the four factors are:

1. That the child possesses a high capacity for dissociation.
2. That the child has experienced severe and chronic trauma that overwhelms the normal adaptive function of dissociation.

3. Dissociative responses are shaped by particular childhood influences and to some extent rewarded by the family. The form and organization of DID depend on the child's temperament and other non-traumatic experiences.
4. The abuse is persistent with inadequate soothing or comfort during and after traumatic episodes. There is also a systemic family collusion to deny feeling, to forget pain, and to act as if the abuse was imaginary and did not occur.

Ross's (1997) four pathways to DID proposed that DID cases can be created as in iatrogenic cases where there is extreme and prolonged therapeutic error. DID cases can also be created when factious disorders are not properly diagnosed and, in childhood neglect cases, where DDNOS or relatively simple forms of DID are exacerbated. Kluft (1999a) concurred that iatrogenic factors can further complicate and cause deterioration in the condition, but is not convinced that the "full" DID condition can be iatrogenically created. The "full" DID condition is described in the childhood abuse pathway (Ross, 1999). Kluft's (1984a) four-factor theory describes this pathway. The DSM-IV (1994) is a phenomenological diagnostic system. Its criteria for DID (as presented earlier) describe the childhood abuse pathway and distinguish the other factors detailed by Ross when differential diagnosis criteria are applied to a diagnosis of DID. The DID criteria specified by the DSM-IV (1994) are applied in this study though consideration is given to the other pathways discussed by Ross.

Summary

1. The diagnostic criteria for DID are as presented in the DSM-IV.
2. DID has a long and well documented history, with modern studies dating from Janet's work. Despite this the study of DID is still marginalized within psychiatry and psychology (Ross, 1997).
3. Many researchers have detailed the lasting impact of trauma on the central nervous system. Exposure to extreme and repeated traumatic events is understood as the progenitor of DID in adulthood (Streeck-Fischer & van der Kolk, 2000).

4. Since the middle of the 1980s there has been an increase of patients who report ritualistic abuse. Whilst there has been little formal research into the topic, patients alleging such abuse tend to present with the most complex dissociative and posttraumatic features of the severe abuse syndromes (Fraser, 1997b; Greaves, 1992).
5. Recent research has confirmed that there are different kinds of memory each dependent on different regions of the brain. Such findings have led some researchers to suggest that traumatic memories are organized and processed differently from "normal" memory and that this impacts on the later recall of traumatic memories (LeDoux, 1996; van der Kolk, 1996b; Williams & Banyard, 1999).
6. Whilst trauma is identified as the main progenitor of DID other pathways such as factitious disorder, and iatrogenic bias are acknowledged (Ross, 1997).

In this chapter some of the issues requiring further study were discussed along with an overview of the literature on dissociation and dissociative identity disorder. In the following chapter issues pertinent to this study are considered.

CHAPTER TWO

2.0 ISSUES PERTINENT TO THIS STUDY

Overview

Discussion has so far focused on the broad issues relevant to a diagnosis of DID and the dissociative disorders. Issues regarding DID that are applicable to the present study will be considered in this section. Three areas of research are discussed: (1) DID and iatrogenic bias, considered under the headings of (a) therapist bias (b) malingering, and (c) single case studies; (2) alternative personalities and their function in the presentation of DID; and (3) the treatment of DID.

2.1 Dissociative Identity Disorder and Iatrogenic Bias

Therapist Bias

Whether DID is a naturally occurring disorder or the result of therapeutic bias and/or malingering is one of the most enduring debates regarding DID. Sceptics of the disorder consider that all alter personalities and the full DID condition itself are the result of therapeutic bias and/or cultural influence (e.g., Ofshe & Watters, 1994; Piper, 1997; Simpson, 1995). Simpson (p. 100) for example, considered that therapists exert strong pressure "to get the patient to accept the diagnosis of MPD" and that such therapists commonly use "leading and repeated questions" to shape and "coach" patient responses. As previously discussed, Ross (1997) agreed that iatrogenic bias can influence the development and symptoms of DID. However, as Ross noted, to induce pure iatrogenic bias requires considerable effort and persistence on the part of the therapist. Kluft (1999a) acknowledged that iatrogenic factors can further complicate the condition, but noted that such bias is not

representative of the full DID condition and that the full manifestation of DID cannot be created iatrogenically by error on the part of an inexperienced therapist.

Concern that therapeutic intervention might exacerbate the condition is evident in the literature and is of particular importance to therapists working in the area of DID. Putnam (1989a) identified possible iatrogenesis and exacerbation of symptoms as the most common fears of therapists beginning to work with DID. Not surprisingly, the therapist's attitude about iatrogenesis can play a significant role in both the under and over-diagnosis of DID (Braun, 1989). Putnam (p. 132) argued that:

> The most convincing evidence that alters are not being iatrogenically induced comes with time. Although new personalities may be created in therapy, the vast majority of alters in any given multiple's system will have a history that predates the diagnosis and therapy by many years.

Kluft (1999a) noted that it has long been clear that many of the symptoms of DID can be created by suggestion or experimental manipulation and that, with minimal suggestion, individuals can be induced to enact several DID behaviours. Spanos (1996), for example, considered that DID is a social construct that exists within a particular cultural and historical framework. He suggested that some therapists routinely encourage their patients to construe themselves as possessing multiple personalities. From this perspective, patients "learn to reorganize and elaborate on their personal biography so as to make it congruent with their understanding of what it means to be a multiple" (Spanos p. 3). Spanos (p. 3) maintained that therapists play a particularly important part in the generation and maintenance of DID providing "official legitimization for the different identities that their patients enact". Some of the research on which these observations are based come from studies in which actors are taught to simulate DID. However, conclusions from experiments on normal individuals such as college students or actors cannot be generalized to authentic patients suffering from DID and are not proof that DID does not exist outside of iatrogenic biasing (Putnam, 1989a; Ross, 1997). Likewise, the enactment of behaviours associated with a mental disorder does not constitute proof that one has the mental disorder or provide evidence that the disorder does not exist (Spitzer,

1976). Kluft (1999a) submitted that even if some symptoms can be induced by hypnosis or suggestion in normal individuals or even in some patients, this does not explain all DID cases, such as those never exposed to hypnosis or overt suggestion (Spiegel, 1988).

Similarly, with cultural influence, expectations may exert a significant impact upon the presentation of DID, but it does not necessarily make the condition invalid. Tutkun, Sar, Yargiue, Ozpulat, Yanik and Kiziltan, (1998), for example, found that the percentage of DID and dissociative disorders in Turkey was similar to those reported in North American studies. Moreover, their study reported that patients presented with the same clinical issues as those reported in North American studies, yet DID phenomena are not part of the popular Turkish culture and patients had not been exposed to antecedent suggestive influences (Tutkun et al.). In a similar vein, Somer and Weiner (1996) studied the diaries of a small group of patients diagnosed with DID and found evidence of early dissociation years before they had sought treatment and long before discussion of DID had become popular in the media.

Ross, Norton and Fraser (1989) hypothesized that, if DID is due to iatrogenic bias, then specialists ought to exert this influence more strongly than do general psychiatrists. They collected data from 236 cases of DID reported by 203 general psychiatrists. Additional data were gathered on 45 cases seen by two psychiatrists who were specialists in the area of DID. Ross et al. found no differences between these groups, either on the diagnostic criteria for DID or the number of personalities identified. Specialists in DID, they argued, were not influencing their patients to create an increased number of personalities, nor to meet more diagnostic criteria. The authors concluded that their data provide evidence against the contention of iatrogenesis in DID and compelling evidence supporting DID as a genuine disorder with a consistent set of core features.

Proponents of DID also point to documented physiological differences between personality states in DID as further evidence of its diagnostic validity. These conditions cannot be fully replicated by normal or professional actors

simulating different personality states (Ross, 1997). The physiological documentation cited includes findings of distinctive patterns among the various alternate personalities in studies of positron emission tomography (PET) scans, evoked potential (Larmore, Ludwig, & Gain, 1977; Putnam, Loewenstein, Silberman & Post, 1984), voice prints (Putnam, 1984), visual acuity, eye muscle balance, visual field size (Miller, 1989), galvanic skin response (Bahnson & Smith, 1975; Brende, 1984; Putnam, 1984), electroencephalographic patterns (Coons, Milstein, & Marley, 1982), electromyography (Larmore, Ludwig & Gain, 1977), and cerebral blood flow (Matthew, Jack, & West, 1985). Moreover, physiological findings specific to particular ages of the alternate personalities being tested have been reported (North et al., 1993).

Ludolph (1985) questioned the wisdom of using hypnosis in the treatment of DID, given the evidence that DID-like manifestations can be hypnotically induced. While hypnosis is advocated as a valuable tool in the treatment of DID (Maldonado & Spiegel, 1995; Spiegel, 1989), experts (Bowers, 1991; Herzog, 1984; Kluft, 1989) also caution that only therapists highly skilled in its use should apply hypnosis to the treatment of DID. They argued that hypnosis could potentially inadvertently foster further dissociation and create new alternative personalities when ineptly handled. Kluft (1982) reported an example of a patient who developed 18 iatrogenically created “alter personalities” due to mishandling by an inexperienced therapist who had not been trained in the use of hypnosis and had not previously used it. Braun (1984a), however, wrote that while it is possible that personality fragments can appear under hypnosis, there is no evidence that personalities with separate histories and a full range of affect can be created with hypnosis. Putnam et al. (1986) also detected no differences in clinical presentations, symptoms, or history between patients who had been hypnotized and those who had not. Similarly, Ross et al. (1989b) found that only a third of the 236 patients they studied had been hypnotized before receiving the diagnosis of DID. Bliss (1988) and Braun (1984b) argued that the alternative personalities routinely begin in childhood, long before individuals are ever introduced to hypnosis. The mean time of first splitting is typically reported to have been between the ages of 4 and 8 years (Coons, Bowman & Milstein, 1988; Fagan & McMahon, 1984; Putnam et al.) and usually before age 12 (Putnam et al.).

However, younger patients may remember further back than adults can and in one study, eight of 11 adolescent patients retrospectively reported alternates beginning by age 3 years (Dell & Eisenhower, 1990). Kluft considered that the available information strongly indicates that DID occurs naturalistically, but that the condition can be responsive to suggestive influences. However, he also noted "if it were completely responsive to suggestion, it would be easy to treat!" (Kluft, 1999a, p. 7).

Kluft (1995) considered the allegation that DID develops from therapeutic bias is easy to make but difficult to sustain, and suggested that allegations of iatrogenic bias need to demonstrate:

1. That neither DID nor DDNOS were present before the questioned therapeutic interventions.
2. That DID can be created by the interventions that are alleged to have created it.
3. That the interventions that are alleged to have created the DID have occurred.
4. That efforts to prevent such an outcome were not made, or were insufficient.
5. The absence of alternative credible explanations for the presence of DID.
6. That if iatrogenic factors necessary to cause DID are present, they were the definitive causative agent rather than a minor contributing factor.

Kluft (1995, p.358) observed, that nowhere in the literature is "there a demonstration rather than an allegation of the iatrogenesis of the full and sustained picture of DID/MPD". Equally, however, according to North et al. (1993), studies "proving' that DID exists outside of iatrogenic biasing are also not forthcoming.

Malingering

Kluft (1995) considered that DID patients, along with most of those abused as children, become skilled at anticipating and responding to the needs of others. In response to stressful situations DID patients are capable of manipulation in order to achieve at least an illusion of safety or control. Kluft suggested that those sceptical

of the disorder may perceive the capacity to dissociate as evidence of iatrogenesis and confuse such symptoms with Factitious Disorder/Malingering patients who feign or produce physical or psychological symptoms in order to achieve and maintain the patient role. The ability of DID patients to form new alters in response to their external circumstances, Kluft maintained, should not be construed as evidence for iatrogenesis by those who do not appreciate the adaptive value of such a capacity. Given such concerns, it is not surprising that DID has received considerable attention in forensic settings and as Kluft (1987) observed, many experienced forensic experts are inclined to see individuals with DID as "fakers", "liars", and "malingerers". He compiled a list of behaviours characteristic of malingering and considered whether similar behaviours occurred in DID patients who were not facing any charges and who were under no pressure to prove they had DID. Kluft found that all of the indicators of lying and malingering were also found to occur among genuine DID patients. There were, however, important differences. No malingerer was able to consistently present with an assumed personality's voice, movement characteristics, or memory, except in situations related to criminal allegations. In malingerers, emotional responses to affectively charged issues unrelated to alleged offences often ceased. They were renewed in interviews known to be for the purpose of forensic evaluation, and when they were under observation by individuals whose reports might influence their assessment. True DID patients were much more consistent, and these differences were significantly maintained regardless of the topic of conversation or with whom the individual was speaking. Furthermore, no malingerer endorsed more than two front rank symptoms of schizophrenia (Schneider, 1959), symptoms which have been shown to be prevalent in DID (Kluft, 1985a, 1987). No malingerer had an extensive prior history of unsuccessful medical treatment or psychotherapy, again indicators of DID (North et al., 1993). In forensic examination malingerers invariably maintained the focus on their legal situation, whereas DID individuals, usually talked about other areas of concern and often had difficulty keeping the forensic purpose of the study in mind.

Coons' (1989) review of the literature lent further support to these findings. He warned that treatment may obscure the diagnostic presentation of DID, in particular the distinction between personalities. He also found, that in some cases,

behaviours such as absence of appropriate affect, were discriminating and only obvious to trained clinicians. Coons concluded that the most difficult symptoms to fake accurately are the switching phenomena, and consistent reproductions of alter personalities over time.

Kluft's (1995) observation that DID patients can form new alters in response to external circumstances is not surprising given that alters are thought by many clinicians and researchers to be formed in response to overwhelming traumatic influences and have adaptive value. Equally, however, it is difficult to distinguish between characteristics of malingering and those of a DID disorder. Coons (1989) found that behaviours that assisted discrimination between malingering and DID were appropriate affect and the switching phenomena along with consistent reproduction of alter personalities over time. These issues will be considered in the present study.

Single Case Studies

The present study employs a single case methodology. It is therefore important to consider other single case studies where iatrogenic bias has been reported. Information on the outcome of treatment of DID have been obtained from meta analyses (Ross, 1997). These pool and analyse outcome data from numerous small studies. Comparative treatment outcome studies can explore the efficacy of specific treatments, but are of limited value in testing therapeutic constructs (Jones, 1993). To examine dissociative processes, such as emergence of alters and switching between alter personalities in the therapy session, research must employ a case study methodology. Hilliard (1993), in supporting the use of single-case designs for testing clinically important hypotheses about patient change, noted that such studies are frequently merely descriptive, lacking formal hypotheses and neglecting validity issues.

Despite the intensity of debate on DID, few detailed case studies have been reported. Even fewer attempts have been made to institute external validity checks

on events occurring within the treatment session. This is true also of those studies that adopt a sceptical stance. While many have advocated iatrogenesis as the cause for DID, most have failed to apply validity checks when conducting their own research. The following brief review necessarily includes single case studies that are methodologically unsound, and case studies that are sceptical of the disorder.

Cutler and Reed (1975) reported a case in which the development of DID was attributed to social reinforcement. They documented a history of DID-associated phenomena extending back to the childhood of the patient. They argued that the patient was suffering from psychogenic fugue, albeit rare, that she entered when under stress. In it she adopted alternate personalities drawn from past experiences of actual people. These dissociative phenomena, they believed, were then subject to reinforcement from others. Treatment combined recurrent hospitalization with monthly outpatient supportive therapy for three years. Five years later there was a further period of supportive therapy and medication during a period of marital stress. At 15-year follow-up the authors found that the patient had not sought additional psychiatric care. They also reported that the patient's appraisal "of her illness, and particularly of her episodes of multiple personality, is that it is a mechanism for avoiding trouble" (p. 23). Cutler and Reed explained their patient's symptoms within a social learning paradigm but did not provide independent validation of their findings, and gave insufficient data to judge whether, or for what reasons, the symptoms remitted. Possible factors explaining the diminishing treatment contact, and implied remission include a possible minimalist therapeutic approach, patient suggestibility (Kluft, 1987), and dissimulation to "please" the therapist. Cutler and Reed (1975, p. 23) wrote "the gradual remission of symptoms has been most helped by accepting the personality changes and thus being less worried by them". No consideration appears to have been given to behavioural alternatives. Their study failed to meet the basic criteria for good single-case research set out by Hilliard (1993) and its findings are therefore of limited value.

Freeland, Manchand, Chiu, Sharma and Merskey (1993, p. 246) reviewed four cases diagnosed as DID. In one case the patient commented to her treating doctor that, "I was also treated by a psychiatrist who discovered under hypnosis that I

had four different personalities". The treating doctor replied, "I don't altogether buy the idea of MPD", to which she responded, "nor do I." The authors regarded this comment as "proof" that the earlier diagnosis was erroneous. They did not consider the possibility of iatrogenic biasing by the treating doctor against the earlier diagnosis.

A second case, in which one of the differential diagnoses was DID, but which was treated for bipolar affective disorder, is described. After one month of treatment with lithium, the patient reported feeling the best in 10 years. The authors reported that the patient no longer "believes she has a multiple personality disorder, but has mentioned that she knew the existence of a personality named Shelley who liked to swear, deceive and lie" (p. 246). This, they concluded, is evidence of deception, and that the disorder is not one of DID. The authors argued that publicity given to DID has biased its diagnosis because "it cannot be assumed that anyone with the 'condition' will have developed it without prior preparation or suggestion, whether from the media or from health care professionals"(p. 247). Whilst the popular press has promulgated the symptoms of DID, the same is true for any psychiatric disorder that has been reported or discussed in the media. Media exposure does not invalidate diagnostic conditions. In a study aimed at identifying experimenter bias, the authors completely ignored the possibility that their own comments regarding DID could have biased their patients' descriptions of their symptoms, and influenced their treatment.

Seltzer (1994) argued that the apparent development of DID was mediated by patient dependency. He reviewed five cases previously diagnosed with DID by a colleague and failed to find evidence of the disorder in five putative cases. Seltzer, however, did not attempt to validate his proposition. Unfortunately, insufficient clinical data were provided to either establish or exclude any DSM-IV diagnosis. He wrote of case five, "She has improved on clomipramine 200 mg at bedtime but continues to hear the voice of one former alter with some insight into its implantation by the therapist" (p. 444). He discounted the possibility of DID and concluded that the cases "voices" were the result of biasing by his colleague. Without an appropriate validation process, however, they could equally be an indication of DID.

In a recent review of the literature, Sarbin (1997) cited Seltzer as supporting the notion that DID is caused by iatrogenic influences. However, he did not consider the methodological shortcomings of the paper, and did not cite any other study purporting to support the iatrogenic argument. Coons and Grier (1990) recommended the same objective approach to the diagnosis of DID as with any psychiatric disorder. They suggested that this include a careful history taken over several days, careful clinical observation, and collection of collateral information and, where appropriate, psychological testing. They presented a case in which careful observation failed to provide confirmatory evidence of DID and instead, factitious disorder was diagnosed.

The case study has a pre-eminent position in the study of psychology and psychiatry and most researchers and clinicians acknowledge the importance to research and theory development of clinical observations gained from case studies (Schwartz, 1992). The case studies discussed here purport to support the hypothesis that the aetiology of DID is iatrogenic bias. These studies, however, have been poorly designed and fail to meet the basic criteria for good single-case research (Hilliard, 1993), the conclusions that can be drawn from them contribute little to our understanding of this disorder and their findings are therefore of limited value. It may be that DID is iatrogenically generated, but these studies have failed to test this hypothesis. Kihlstrom’s (1995) assertion applies here: Though many case studies of DID have been reported, few have been subjected to any kind of experimental investigation. To advance our understanding of this disorder and the issue of iatrogenic bias what is required are well constructed case studies that apply accepted levels of design methodology. It is the intention of this study to test the hypothesis of iatrogenic bias in a case study where an appropriate design methodology has been applied.

2.2 Development of alter personalities

One of the most striking features of DID is the alter personalities that recurrently take control of the body (Pica, 1999). Putnam (1997, p. 175) suggested that alter

personalities arise in the context of severe trauma and "reflect the creation of a set of complex, enduring, identity-based, discrete dissociative states that evolve during childhood and adolescence". Putnam proposed that severe trauma creates a state of dissociative consciousness and that when traumatic events are chronic and repetitive an alter personality system develops with each alter becoming increasingly differentiated. The repetitious nature of specific traumatic events contributes to alter differentiation with each alter taking on specific functions and characteristics. Therefore, memory for particular traumatic events becomes dependent on that particular alter personality and such events are not readily retrievable from other alters which have been created to cope with other specific traumatic events. Putnam considered that this leads to the fragmentation of identity that is the hallmark of DID. According to Putnam (p. 176), fragmentation is not the

> 'Shattering' of a previously intact identity, but rather a developmental failure of consolidation and integration of discrete states of consciousness. In particular, it is a profound developmental failure to coherently bind together the state-dependent aspects of self experienced by all young children that leads to the [DID] patient's experience of multiple 'selves'.

Alter personalities do not exist as separate entities or individuals but as discrete dissociative states of consciousness (Kluft, 1999a; Putnam, 1997; Ross, 1997) and it is "Only when taken together can all of the personality states be considered a whole personality" (Coons, 1984, p. 53). Kluft, (1998, 1999b) considered that an individual's particular alter systems reflect an underlying adaptive strategy that has allowed him or her to respond to circumstances that are frequently irreconcilable, such as a father who is abusive in one situation but caring in another. Such responses become incorporated into a child's autobiographical memories through fantasy and cognitive restructuring and result in the development of alternative realities that are modified and endorsed as actual (Kluft, 1999b).

Pica (1999) stated that though several theories have been proposed to explain the manifestation of alter personality states in DID, the majority have failed to explain how alters develop over the life span and why the disorder becomes more

complex after childhood. Pica hypothesized a three-stage model of alter personality formation in which alters evolve out of childhood imaginary companions and merge with dissociative states of consciousness in response to childhood traumatic events before individuating into distinct personality states during adolescence. Pica believed that many questions regarding the development and function of alter personalities (such as whether alter personalities are formed by a gradual process of increasing differentiation or appear as fully differentiated separate identities) remain unanswered and require further research.

Structure of alter systems

Although cases with dozens or scores of alter personalities have been reported the mode is three and the median typically eight to ten (Kluft, 1991; Putnam, et al., 1986; Ross, Norton & Wozney, 1989b). The differences in alter personalities can be striking, but authorities consistently stress that these are more apparent than real (Putnam, 1989a; Kluft, 1991). A study by Ross et al. (1989b) found that mental health professionals consistently reported the same basic structure in the alter personality systems of their DID patients. The respondents reported the presence of three basic types of alter personalities: a child alter personality, a persecutor alter personality, and a protector alter personality. These findings replicate those reported by Putnam et al. .

Ross (1995) reported that child alter personalities usually hold the traumatic memories though not all hold the feeling of being bad and some alters may be quite content and well adjusted despite the abuse they have experienced. There may be child alter personalities of different ages and there may be a different child alter for each episode or variety of abuse (Mollon, 1996). The cognition of being bad is held by the persecutor alter personalities which routinely believe that the child alters caused the abuse and deserve to be punished. These are often based upon identification with the original abuser/s (Mollon). The persecutor alters may be extremely dangerous and may act out this cognition on the host personality through such self-injurious behaviour as cutting or burning, and frequently urging other alters

towards suicide. The natural tendency of the organism to protect itself then gives rise to protector alter personalities (Ross).

Kluft (1984b) identified two other types of alter personalities: the host and the original personality. Kluft, (p.23) defined the host personality as "the one who has executive control of the body the greatest percentage of time during a given time". It is often the host personality that first presents for treatment and the one who becomes identified as the "patient" prior to the diagnosis of DID (Putnam, 1989a). The host is typically described as depressed, anxious, and as suffering from a variety of somatic symptoms, particularly headaches and usually is unaware about the existence of other alter personalities (Putnam et al., 1986). Kluft (p. 23) defined the original personality as the "identity which developed just after birth and split off the first new personality in order to help the body survive a severe stress". Putnam stated that the original personality is typically not active and is often described by other alters as having been "put to sleep" or otherwise incapacitated at an earlier point because he or she was not able to cope with the trauma. The original personality usually only emerges during the later stages of therapy when much of the traumatic material has been processed by other alters. In most patients the host personality is not the original personality.

Kluft (1998) emphasized that it is important to recognize that when alter personality systems are relatively small they may all share similar beliefs regarding the inner and external world. When the trauma has been severe and chronic, however, the alter system is more complex and layered. Kluft (1991) proposes, that in those patients with a large number of alter personalities, the alters constitute a cognitive system in which most alters relate to each other as if they were actual people. Consequently, constellations of alters frequently develop secondary autonomous inner worlds and develop a life of their own in which they may have inner relationships, alliances, and discord and experience themselves as constituting an inner family or society with its own rules and mores (Kluft, 1991). Mollon (1996) noted that whilst some alters may not be cognizant of the existence of any others, it is more common for alters to have some knowledge of each other, though some have a more complex awareness of the dissociative system than do others.

Structure of alter systems in ritual abuse

Mollon (1996) reported that the system of alter personalities in patients who report a background of ritual abuse is more complex than in other DID patients; they are also likely to have a greater number of alters and the most virulent persecutor alters. Van der Hart et al. (1997) considered that systems of alter personalities for these patients are usually layered with different sub-systems of alter personalities. Within these sub-systems four different types of abuse are commonly reported: (1) abuse taking place in the home, (2) ritual abuse associated with satanic worship, (3) pornography and prostitution, and (4) some form of mind control.

1. *Abuse taking place in the home*. Van der Hart et al. suggested that abuse taking place in the home usually involves one or both parents, often along with other perpetrators. The nature of the abuse can be sexual, physical, and/or emotional. The basic sub-system consists of alter personalities that are involved in the patient's daily life and that keep memories of home abuse. Most of these alter personalities are unaware of ritualistic abuse experiences and express disbelief when confronted with reports or allegations from other alters of ritualistic abuse. These alters apparently belong to different subsystems of personalities. They usually present narrative fragments of ritualistic abuse during the course of therapy. There exists one-way amnesia between these different subsystems, with the "daily" alter personalities absent when alters with ritualistic abuse experiences take over executive control, and not the other way round.

2. *Ritual abuse associated with satanic worship*. All patients report participation in rituals that include chants and symbols. Common elements include witnessing or participating in torturing and killing of animals, children, or adults; physical abuse; forced impregnation and sacrifice of one's own child (or foetus); forced cannibalism; forced drug usage; and being buried alive in coffins. While reporting such extreme experiences, alter personalities are usually extremely anxious and hardly able to relate such material without starting to re-experience them.

Sometimes they relate material in their drawings. All patients refer to extreme intimidation and threats to keep silent.

3. *Pornography and prostitution*. Most patients (i.e., specific alters in these patients) report being both victim and perpetrator in the production of pornography, or being exploited as prostitutes, apparently for the financial benefit of a perpetrator organization.

4. *Mind control*. All patients who report alleged ritualistic abuse report some form of mind control, to ensure their loyalty to the perpetrator group or organization (Van der Hart et al., 1997). Some patients, in particular those with multi-layered subsystems of alter personalities, appear to have been subjected to extremely sophisticated mind control techniques, including a combination of drugs and hypnosis, pain, terror electric shocks, isolation, and sensory deprivation or sensory over-stimulation (Gould & Cozolino, 1992; Shaffer & Cozolino, 1992; Young, 1992; Young, Sachs, Braun, Bennett, & Watkins 1991). Patients allegedly subjected to these mind control programs display subsystems of alter personalities that are highly indoctrinated, and some seem narcissistically involved in serving the goals of the perpetrator organization. They seem to have been exploited for criminal purposes.

Ross (1995, p.112) responding to the investigation into ritual abuse wrote that:

> It is curious that there is so much disagreement about the existence of something that is described in such sketchy fashion in the professional literature, by believers and skeptics alike. Except for single-case studies written for general readership, detailed description of the phenomenology of these cases is lacking, even in the peer-reviewed literature.

Notwithstanding the current lack of knowledge of this important area, Mollon (1996, p. 129) concluded, “Such patients pose the greatest difficulties and challenges in

treatment." Pica (1999) believed that many questions regarding the development and function of alter personalities (such as whether alter personalities are formed by a gradual process of increasing differentiation or appear as fully differentiated separate identities) remain unanswered and require further research. Putnam (1997, p. 90), reviewing the literature on alter systems, reported that though various typologies of alter personalities have been offered, there are little systematic data but "Types of DID alters, such as childlike personality states, angry alters, protectors, and persecutors, are found often enough to warrant further investigation". The development and structure of alternative personalities is a hallmark of DID this study provides an opportunity to contribute to this important area of investigation. Moreover, this study also provides an opportunity to contribute to research of alter systems in DID patients reporting ritualistic abuse, an area of research in which a "detailed description of the phenomenology…is lacking" (Ross 1997, p. 112).

2.3 Diagnosis and Treatment

Diagnosis

When DID patients are correctly identified and receive appropriate treatment they have a better prognosis (Coons, 1986). Putnam et al. (1986), however, drew attention to the lack of diagnostic precision with DID. Their study of 100 DID patients revealed that on average they received 3.6 different psychiatric diagnoses (range = 0-11) and spent 6.8 years (range = 0-23 years) in therapy before accurate diagnoses were made. Steinberg (1995) emphasized the burden placed by misdiagnosis on the individual, and economically on the health system, when cases of DID potentially treatable in an outpatient setting end in unnecessary hospitalization. In a study of 33 patients who ultimately received treatment for DID, Kluft (1984a) found that 47% were hospitalized before receiving the correct diagnosis compared with 19% who were hospitalized subsequent to accurate diagnosis. Undiagnosed DID patients received incorrect diagnoses of schizophrenia in 25% and 40% of cases respectively in two studies (Putnam, 1989a; Ross et al., 1989b), while 12% and 16% had received electroconvulsive therapy. More than half

of 102 DID patients in a third study had been treated with antipsychotics (Ross et al., 1990). Data such as these support the contention that undiagnosed DID patients are perceived as suffering from other severe mental illnesses.

In seeking the causes of misdiagnosis it has been suggested that symptoms of DID may not be volunteered because patients are unaware that they have the disorder (Loewenstein, 1989). In Kluft's (1984a) study, 40% of DID individuals gave only subtle hints of DID and 40% showed no overt signs at all. Not surprisingly, the diagnosis was inversely related to the degree of clarity of the symptom presentation. Patients who sought psychiatric help with self-diagnosed DID were less likely to be believed by their psychiatrists, and those without clear signs of DID were discovered only by systematic enquires.

Another factor in misdiagnosis is the tendency of DID patients to dissimulate. Kluft (1986) found that 50% of DID patients withheld evidence of DID at first assessment. Ninety percent said they had at some time tried to hide the manifestations of DID for fear of meeting with scepticism and rejection or of being regarded as crazy. Patients frequently encounter therapists who are sceptical of the diagnosis and who do not respond to complaints of symptoms related to DID (Dell, 1988; Spiegel, 1988). According to Wilbur (1984, p. 27), some, "test the doctor to find out if he or she approves of some or any of their behaviour" before being open about their symptoms. Such findings indicate that the controversy surrounding a diagnosis of DID combined with lack of understanding about dissociative disorders, significantly contributes to the suffering of individuals seeking treatment.

A study by Dunn, Paolo, Ryan and Van Fleet (1994) suggested that an understanding of trauma and its clinical presentation are important factors for therapists in the diagnosis of DID. They found, that from a total of 1,120 psychologists and psychiatrists who responded to a questionnaire surveying their beliefs regarding the diagnosis of DID, more than 97% indicated a belief in dissociative disorders in general and 80% reported a belief in the diagnosis of DID. A significant aspect of this study was that the participants were employed in

Veterans Affairs Medical Centres and were therefore more likely to be familiar with posttraumatic dissociation in returned soldiers (van der Kolk, 1996a).

The return of soldiers from Vietnam was accompanied by the description of posttraumatic stress disorder (PTSD). This diagnosis has several dissociative features (Spiegel, Hunt, & Dondershine, 1988), and many authors have noted similarities between PTSD and the dissociative disorders. Such similarities have encouraged a cross-fertilization of diagnostic and treatment approaches to the spectrum of posttraumatic disorders.

The findings discussed in this section indicate that the formation of an appropriate therapeutic alliance is an important precursor for the diagnosis and treatment of both PTSD and the dissociative disorders. Furthermore, such findings indicate that models of treatment incorporating such an approach are likely to be more successful in their outcomes than those that do not.

Treatment

As previously acknowledged, several researchers have concluded that DID and therefore alter personalities are artefacts of therapist bias rather than an intrinsic aspect of the patient's condition. Simpson (1989, p. 565), for example, writes:

> Spontaneous remission is probably the norm, unless the patient becomes engaged with a clinician already primed and interested in the condition. It seems to be one of the few conditions which almost invariably get worse in therapy. … Where the health care system or health insurance does not subsidize this indulgence, the condition simply does not occur.

Despite such assertions, however, the weight of clinical experience emphasizes that it is important to address the DID and to work with the alter system (Kluft, 1999a, 1999b). Kluft (1999a, p. 16), for example, wrote that "Every published series of DID patients who have made progress or achieved integration has involved treatment by therapists who worked with alters; the most successful therapists in the field work

vigorously with alters”. Kluft (1985) reported that his data indicate that only 2%-3% of DID patients could achieve integration without specific treatments that dealt with the alters and that therefore, unless there are specific contraindications, it is appropriate to work with and to elicit alter personalities. Such observations regarding the diagnosis and treatment of DID, however, are essentially based on clinical experience rather than experimental evidence (Putnam, 1989a; Ross, 1997). Maldonado, Butler and Spiegel (1998) concurred with Putnam’s and Ross’s assessment of the literature and reported that only three authors have published treatment outcome data on DID patients (Coons, 1986; Kluft, 1984c, 1986, 1994; Ross, 1997), and that none of these studies employed control groups.

Kluft (1999a) described three general types of DID patients with different characteristics and treatment prognoses. The first are relatively high-functioning individuals with many assets and psychological strengths. They usually integrate and complete treatment in two to seven years. The second group has fewer psychological resources and presents with more borderline features than the first group. There is usually considerable co-morbidity and interpersonal relationships are often difficult with marked dependency issues frequently evident. Their treatment course is more difficult than for the first group and though some may reach integration most remain unstable for long periods and require ongoing supportive help. The third group’s pathology is the most severe of the three and they exhibit increased difficulties with affect modulation and may manifest psychotic symptoms. Kluft advised that this group must be treated in a supportive manner for long periods and that only a minority ultimately progresses to integration or satisfactory resolutions.

Kluft (1996b) recommended that psychotherapy be orchestrated in stages. Briefly expressed, the initial stage is concerned with the establishment of psychotherapy. During this stage preliminary interventions, history gathering and mapping of alter systems are undertaken. During the second stage the trauma material is addressed and processed, the therapeutic impetus is towards integration and resolution of the material. The final stage involves the learning of new coping skills, solidification of gains and follow-up to assist in the working through process.

Kluft (1999a) noted that the majority of experienced clinicians have found that two or more sessions a week are necessary to treat DID patients successfully. Putnam (1989a) also recommended treatment sessions of 90 minutes duration as necessary to process the dissociative material.

Personality integration, whilst not marking the end of treatment, is a central focus of therapy with DID patients (Kluft, 1997; Putnam, 1989a; Ross, 1997). Kluft (1984a) has provided the following operational definition of integration, namely three stable months of: (1) continuity of contemporary memory; (2) absence of overt behavioural signs of multiplicity; (3) subjective sense of unity; (4) absence of alter personalities on hypnotic re-exploration; and (5) clinical evidence that the unified patient's self-representation includes acknowledgement of attitudes and awareness previously segregated in separate personalities. Kluft based his criteria on the outcome data from 171 cases seen over a 10 year period. Of these, 83 cases (67.5%) achieved stable therapeutic integration. Based on these data, Kluft estimated that two thirds of patients entering treatment should be able to reach stable integration. However, even Kluft (1988, p. 578), who has reported the best results in treatment outcomes described in the literature (Maldonado et al., 1998), warns, "the treatment of [DID] can be arduous, painful and prolonged. … The achievement of integration is usually considered desirable, but in some cases a reasonable degree of conflict-free collaboration among the personalities is all that can be achieved." Given the significance of integration in the treatment of DID, it is important that clinicians are alert to both positive and negative indicators. Greaves (1989), drawing on the literature as well as his own work, proposed "marker events" which reflect the processes of integration. Such markers indicate whether treatment is on course. They can also be used to facilitate therapy (a summary of Greaves' markers of integration is presented in Appendix D). Greaves' "markers" will be considered in this study when issues of treatment and integration are discussed.

Treatment of ritualistic abuse

Van der Hart et al. (1997) considered that the treatment of adult DID patients reporting ritualistic abuse should be the same as for the treatment of DID and other trauma induced disorders. Van der Hart et al. endorsed the stages of therapy proposed by Kluft (1996b) and suggested that treatment of ritualistically abused DID patients be concerned with (1) stabilization and symptom reduction, (2) treatment of traumatic memories, and (3) integration and rehabilitation. Further, Coons (1997) considered that adults describing ritualistic abuse usually have severe dissociative disorders. Such observations, along with clinical experience has led van der Hart et al. to observe that the initial optimism regarding the treatment of DID has changed to a realization that complete personality integration, including the treatment of traumatic memories, is not always feasible. Many DID patients reporting ritualistic abuse seem to belong to this category. Kluft (1994a, p. 67) reported that patients with a background of ritual abuse appear to progress "quite unevenly and unpredictably over the short run and about half as rapidly as patients who have never made such allegations." Van der Hart et al. similarly reported that treatment of such patients is arduous and protracted, and complicated by issues of safety and complexity of the DID.

Concerning safety Van der Hart et al. (1997) reported that most of the adult DID patients reporting ritualistic abuse in the course of their treatment appear to continue to be abused by perpetrator organizations. They consider that in such cases, the only focus of treatment should be to assist patients to remove themselves from the abusive situation. Unfortunately, when DID patients enter treatment it is not often clear whether abuse is still occurring; part of the reason for this may be that the presenting or host personality may be unaware of ongoing abuse. Van der Hart et al. recommended extreme caution in working with these patients with therapy focusing on symptom stabilization and crisis management rather than integration and treatment of traumatic memories (Horevitz & Loewenstein, 1994).

As previously discussed, DID patients reporting ritualistic abuse appear to have more complex systems and structured layers of alter personalities than other

DID patients. In part, this is due to the type of mind control techniques or conditioning applied by perpetrator organizations (Fraser, 1997b; Ross, 1995; Young & Young, 1997). Van der Hart et al. (1997, p. 155) reported that when these individuals are able to cease contact with perpetrators "and when their dissociative barriers are dissolving, they tend to have intense feelings of guilt, shame, and suicidality related to 'perpetrator behaviors' that they themselves have been forced to manifest. These issues are extremely hard to deal with in therapy."

Young and Young (1997) suggested that when these patients begin to talk about ritualistic abuse in therapy, self-abusive, acting-out personality states usually appear to protest or stop the disclosures. These alters often function as, or are identified with, ritualistic beliefs though they have the same characteristics and defensive function as any other alter personality. The formation of ritual alter personalities may reflect the patient's attempt to create internal identities that are as strong and powerful as his or her perpetrators, or an attempt to comply with the perpetrator in an effort to stop the abuse.

Kluft (1997) identified three presenting patterns for patients alleging ritualistic abuse. In the first pattern, the patient becomes deeply involved in treatment and issues regarding ritualistic abuse are heard with decreasing frequency. In this pattern the patient gradually recovers without the ritualistic material achieving prominence or requiring significant work. Kluft suggested that with this pattern the ritualistic material served as an allegory for the actual material.

In the second pattern the ritualistic material emerges later in therapy and after the patient has worked through material that is more mundane. In this pattern the patient improves as the ritualistic material is worked through. Kluft (1997) suggests that two inferences may be drawn: (1) the ritualistic material was deeply repressed or dissociated and/or (2) the patient is not yet ready to leave the therapist and is generating more material to prolong the therapist's interest.

In the third pattern the ritualistic material assumes prominence early in therapy and attempts to put the material aside repeatedly fail. Kluft (1997) suggested three inferences can be drawn: (1) the intensity of the material is so pressing and overwhelming that it needs to be addressed, (2) the patient is still active in ritualistic abuse situations, and/or (3) it serves as a displacement for more mundane experiences and conflicts. Kluft considered that, regardless of the material's origin, because its psychological reality is so intense and compelling to the patient, there is no alternative to working through the material as it is presented. The treatment is usually prolonged and prognosis is guarded.

This study provides an opportunity to scrutinize the therapeutic progress of a patient diagnosed with DID and alleging ritualistic abuse whilst being treated consistently with a specific therapeutic model. Given the lack of objective data regarding this population, such considerations would make a significant contribution to the literature.

Summary

1. This review notes that despite its long history and endorsement in the DSM-III (1980) and DSM-IV (1994), the diagnosis of DID is a hotly debated issue.
2. An increase in the number of cases reported since the 1980's has led some writers to claim that it is more common than previously believed, and that it has frequently been confused with schizophrenia and the hysterical neuroses.
3. Sceptics argue that, in part, the increase is the result of iatrogenic biasing.
4. It may be that DID is iatrogenically generated, but studies have failed to test this hypothesis. There is a lack of design objectivity in most of the studies reviewed. The present study aims to address these weaknesses using a single-subject design.
5. The patient -therapist relationship, according to critics such as McHugh (1995), and Merskey (1995a) is where the aetiology of DID originates. A study of this

relationship using a case study approach will allow for an investigation of this hypothesis.

6. Greaves (1992) proposed that a self psychology perspective would be a fertile theoretical stance from which to explore DID. It would bring a comprehensive clinical model of the self to the understanding of DID. It would thus appear ideally suited to the study of an adult psychiatric disorder of self-functioning, which is regarded as being the outcome of abuse in childhood.
7. Despite the intensity of the debate on DID, particularly ritualistic abuse, Putnam (1997) notes that there are little systematic data on alter personalities, their development (Pica, 1999) or detailed descriptions of ritualistic abused patients (Ross, 1995). Systematic data on these issues would contribute to our understanding of alter personalities.
8. The treatment of DID patients is of fundamental importance in gaining an understanding of the nature of the disorder, this is particularly the case for patients alleging ritualistic abuse and what is required are more studies providing systematic and detailed objective data. It is hoped that this study will contribute to the provision of such data.

2.4 Aims of the study

It has been shown that there are serious deficiencies in the current knowledge of the development and treatment of Dissociative Identity Disorder. Using a focussed and in-depth single-case study of a person diagnosed with DID, this research will seek answers to the following questions:

1. Are the "alter personalities" which are the defining diagnostic component of the disorder recognizable only by the subjective judgement of the therapist or can external observers validate their presence?
2. Do the "alter personalities" appear as part of the patient's response to trauma or are they the result of therapist induction in the treatment?

If the alter personalities can be established as a verifiable entity and are not due to therapist induction, transcripts of the case will be used to ask the following questions:

3. What factors in the patient's life experience contribute to the formation of alter personalities?
4. What indications are there in the treatment that would indicate personality integration or cure of the disorder?

In the following two chapters the methodology used to answer these questions is outlined.

CHAPTER THREE

3.0 PROCEDURE EMPLOYED IN THIS STUDY

Overview

Before a detailed discussion of the methodology, it is necessary to review the case study as a method of examination and self psychology as the consistent treatment modality. It is also necessary to review the patient herself as the focus of the research, initial development of the therapy leading to the diagnosis of DID, and the training/orientation of the therapist.

3.1 The Case Study as a Form of Investigation

Advantages of the case study

The Journal of Consulting and Clinical Psychology (1993) devoted a special issue to single-case studies. The Editorial reported increasing support in the psychotherapy research community for the "empirically based, context-sensitive, discovery-oriented single-case study" (Jones, 1993, p. 372). Yin (1994) noted that case studies are used extensively in social science research. This methodology is a frequent mode of thesis and dissertation research and is increasingly used as a research tool in evaluation research. Jones (1993) and Rice and Greenberg (1984) similarly drew attention to the renewed interest in psychotherapy research in the intensive study of the individual case. Jones (p. 371) attributed this to a recognition that controlled clinical trials had limitations in "informing us about how patients change through psychologically mediated interventions." The author noted "that an understanding of the processes that promote therapeutic change requires a close analysis of the therapist patient interaction" (Jones, p. 371). Person (1991) argued

that whilst comparative treatment outcome studies can explore treatment efficacy, they could only provide indirect validation of underlying clinical constructs.

There is a further reason for the renewed interest in single-case design: the need to test clinical theoretical models. Jones (1993, p. 371), for example, argued that

> Statements about psychotherapy that are derived from group data typically have little direct relevance for the clinical problems that are presented to the psychotherapist, so that much of the therapy research enterprise has remained peripheral to clinical practice and to the major theoretical and intellectual currents in the field.

Disadvantages of the case study

An important objection to single-case study is the possible limit to scientific generalization. However Yin (1994) pointed out that scientific findings are rarely based on single experiments. Instead they are usually founded on a multiple set of experiments, replicating the same phenomena under different conditions. Case studies and experiments are similar in purpose, both seeking to relate their findings to theoretical propositions. In both cases the sample under investigation is understood as a dynamic entity in the context of opposing theories. The single-case study, however, contributes by expanding and generalizing theories (analytical generalization), rather than by enumerating frequencies (statistical generalization) (Yin). Chassan (1979) argued that intensive study of the single participant, which is based on frequent observations of the individual over time, could provide more operationally meaningful information. He felt that this has more direct implications for psychotherapy than end-point observations extending over relatively large numbers of patients. Reliance on averages, Chassan argued, results in a lack of specificity, and vagueness about population characteristics and other important variables from which inferences should be drawn.

Hilliard (1993) proposed that single-case research be viewed as a sub-class of intra-participant research. Aggregation across cases is avoided and findings are generalized through replication on a case-by-case basis. Yin (1994) noted the neglect of intra-participant variation and of mediating process variables in traditional psychotherapy outcome research. He argued that a focus on variability within therapeutic dyads over time however is at the very heart of psychotherapy research (intra-participant variability). Hilliard noted that psychotherapy research has tended to ignore intra-participant variability or to assess it indirectly through cross-sectional group correlations. What is required, according to Greenberg (1986, p. 4), is research that focuses on "identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change over the entire course of therapy".

Reasons for the case study in this investigation

The process/outcome distinction and its relation to methodological issues, is an important one for the proposed study. The central question in the iatrogenic debate is whether DID develops out of the interaction between therapist and patient and is thus an intra-participant question. Single-case methodology, it is argued, is the appropriate method to research this question. It addresses data that are not aggregated across participants, but which are analysed on a case-by-case basis. Hilliard (1993) suggested that premature aggregation across participants might be misleading, when the dimensions of the relation vary widely across participants. Averaging across participants distorts the form of a relation and obscures the very relationship factors that individual studies reveal. Single-case approaches are cautious when proposing that a group is truly homogenous unless this has been clearly shown. While the symptoms of DID are clearly delineated (e.g., DSM-IV), research is needed into how treatment responses vary according to the nature of previous life experiences. Differences in treatment responses may reflect the traumatic origin that many researchers have attributed to DID (Putnam, 1989a; Ross, 1997). It is essential to delineate specific aspects of a case before the process of replication is undertaken. It may be that the assumption of homogeneity has contributed to confusion regarding questions of iatrogenic bias. From this

perspective, a programme of research should begin with the study of single-cases, and then possibly move on to aggregation over groups that have been established as truly homogeneous (Hilliard).

Maldonado, Butler and Spiegel (1998) noted that no controlled treatment studies of DID have been reported. It is argued that an intensive individual study within a specific treatment approach would be a valuable contribution to the literature. Greaves (1992) proposed that a self psychology perspective would be a fertile theoretical stance from which to explore DID. It would bring a comprehensive clinical model of the self to the understanding of DID. Kohut (1971, 1977, 1984) developed much of the work underpinning this model. His observations of patients in treatment are remarkably homologous with findings from recent research on early childhood development (e.g., Stern, 1986). The self psychological model would thus appear ideally suited to the study of an adult psychiatric disorder of self-functioning, DID, which is regarded as being the outcome of abuse in childhood.

3.2 Treatment Modality: Self Psychology

Self psychology developed out of traditional analytical thinking, but diverges from it in its concept of the development of self. From a traditional analytic perspective, the self is formed out of the predominantly unconscious conflicts between instinctual, conscious, and external reality (i.e., id, superego, and ego). Of particular importance is the Oedipal phase of development. The unconscious strivings and fantasies of this period are seen to colour and affect the child's relationship with his parents. Such an approach is an intrapsychic one, in which external events play less of a role in determining the development of the individual than internal forces (Baker & Baker, 1987).

Self psychology also traces the origin of many disorders expressed in later years to childhood, but diverges from traditional analytic thinking in that the

disorders are seen as the result of “developmental arrests” rather than as the results of oedipal conflict. From this perspective, oedipal conflicts would have resolved without recourse to a neurotic defence had the child’s essential needs been met (Kohut & Wolf, 1978). Essential ingredients for healthy development are the child’s relationship with his parents and whether they are able to respond empathically to his or her developmental needs. The infant’s sense of self develops out of this relationship, rather than out of unconscious motivations and instinctual drives.

Self Object

Self psychology uses the term “selfobject” to denote the important others in the individual child’s developing self. The self emerges out of the interactions between the child and its selfobjects (Kohut, 1971, 1977). Early selfobjects are usually the parents. If the child is to emerge with a healthy sense of self-esteem and a cohesive nuclear self, its selfobjects need to engage and gratify three basic needs. These are the need for mirroring, the need for idealization, and the need for twinship experiences. From these experiences the nuclear self develops and a cohesive self forms (Lee & Martin, 1991). These experiences are essential to optimal development and continue to sustain a sense of vigour, well being, and nurturance throughout life. In mature relationships selfobjects are recognized as autonomous, rather than used as providers of service to inner needs.

Kohut (1971, 1977) proposed that when a child experiences adequate and appropriate mirroring and idealizing experiences with its selfobjects, it develops a cohesive sense of self and is able to tolerate and weather the vicissitudes of life, without experiencing them as a severe blow to self-esteem. In contrast when such needs have not been adequately responded to a developmental arrest occurs. The child develops a “false” or “cosmetic” self that may appear adequate but is not cohesive and is prone to fragmentation. The internal structures for regulating and channelling infantile narcissistic needs have not developed in an optimal way and the individual will remain vulnerable to narcissistic injury. As adults, such individuals are likely to suffer from a low self-esteem and an inability to respond empathically to

the needs of others. In therapy, with such individuals, transference is entered into where the basic but unmet mirroring and idealizing needs of the patient can be met as the therapist performs the function of the early selfobject.

Mirroring

The emergent self of the infant has two important narcissistic needs: those of exhibitionism and grandiosity. In the early stages of infancy selfobject needs are intense and absolute and primarily met by the mother (Kohut, 1971; Lee & Martin, 1991). If she is secure enough in her own self-esteem, she will be able to respond with pleasure and acceptance to the proud exhibitionistic displays of the infant (Goldberg, 1988). The mother's ability to participate and respond to the infant's grandiose and exhibitionistic displays confirms his or her emerging sense of well being and self-esteem. Even the most attentive of parents, however, will be unable to meet all the infant's needs without him or her experiencing some delays and frustrations. It is through such delays and frustrations that the infant learns to internalize the functions provided by the selfobject and to develop his or her own inner structure. The infant is then able to transform his or her grandiose demands into self-regulation and self-discipline.

When mirroring needs have not been adequately responded to, such individuals continue to seek confirmation of their self worth and value from others. However, responses that do not seem totally approving are likely to be experienced as an intolerable blow to their self-esteem (Baker & Baker, 1987).

Idealizing

In addition to the need for empathic mirroring, there is also a need for the infant to feel close or merge with someone who will meet his or her needs for safety, calmness and comfort. This function is referred to as the idealized parental imago. The parent is idealized as an omnipotent and powerful selfobject from whom the infant can draw support, protection and approval. The parental imago provides a

template that is internalized by the child. As with other selfobject needs there is a process of maturation, under optimal development the infant idealizes the father or another significant person and then through a succession of minor disappointments with him or her, experiences a slow diminution of the idealization. At the same time the infant begins to internalize the function that the idealized selfobject had previously fulfilled.

When idealizing needs have not been adequately responded to, the need to merge and draw comfort and support from a powerful selfobject remains as an archaic structure in the mature individual. Such individuals continue to seek approving relationships with omnipotent, powerful others with whom they can draw comfort and support (Siegel, 1996).

Twinship

Twinship needs refer to the need to feel a degree of similarity to idealized others. The small boy, for example, may identify with his father, his sense of belonging sustained by the presence of a selfobject that he is sufficiently like to understand and who in turn understands and accepts him (Siegel, 1996). These experiences lead to the feeling of being like others, that one belongs and is connected to the wider community. Initially, the infant seeks to merge with the twinship selfobject, but with maturation develops a tolerance for difference in self and others.

An individual who has not had such needs met will have difficulties in feeling accepted and belonging. This may be reflected in detached and aloof behaviour, or in an insistent need for others (Baker & Baker, 1987).

Constituents of Self

Self psychology conceives the self as consisting of three major constituents. These are referred to as poles: the pole of ambitions, the pole of ideals, and an

intermediate pole of talents and skills. The pole of ambitions develops as a result of accurate mirroring of the infant by the parents. This leads to the development of ambition and an enthusiasm for life. The pole of ideals emanates from the infant's ability to idealize his or her parents and to draw comfort and strength from this. From these experiences the infant develops a sense of self-direction and an ability to set realistic and challenging goals. The third pole develops from the twinship selfobject experience and connects the other two poles. The individual's particular talents and skills are activated by the tension that exists between ambition and ideals (Bash, 1988).

From this perspective, certain types of psychopathology develop from the faulty interactions between the infant and his or her selfobjects. The problems in these cases originate from inappropriate or faulty responding by significant selfobjects at important developmental stages. They do not develop an autonomous and cohesive self and they remain intimately connected to their archaic selfobjects (Lee & Martin, 1991). Instead of being able to draw upon their own inner resources for self-esteem, ideals and talents, they remain tied to others to meet such needs. Their sense of self remains vulnerable and responsive to "injury" by others, rather than being directed by recognition of their own innate needs and abilities.

Therapy

In therapy, the specific transference that the individual makes reflects the earlier deficits. The transferences are understood as the psyche's attempt to establish a more cohesive self than the enfeebled self who resulted from earlier selfobject failures. By working within the transference, the therapist performs the function of a selfobject. The therapy moves to the archaic arrest. In this process the therapist adopts an empathic stance, seeking to understand from the client's perspective and to assist the client experience and verbalize his or her emotions. As with the original selfobject, there will be misunderstandings and errors. It is through such "therapeutic errors" that change occurs. The minute and mutual empathic exploration of such errors enables the client to convert archaic grandiosity into

healthy self-esteem and to transmute external idealized omnipotent figures into a set of internal guiding values and ideals. The process of transmuting internalization allows change to occur at an internal structural level; the archaic self is gradually expanded and the individual is able to take up the thwarted developmental process and develop a cohesive sense of self.

Self psychology has much, it is argued, to contribute to an understanding of the developmental implications early trauma has on the structural integrity of the sense of self (Ulman & Brothers, 1988). The self psychology model of self functioning provides a unique perspective from which to consider the development of alters, the impact of selfobjects in their development and the impact this has on the maturation process. It brings a unique perspective to the transferences formed during therapy and a rationale for their origin. This study investigates the developmental implications of early trauma on the development of the self, using the self psychology model of self functioning.

The self psychological approach to treatment is used in this study for a number of reasons. Firstly, it is non-intrusive. Secondly, it adopts a "following" rather than an "interpretative" approach which would appear to make it eminently suitable to treating a disorder in which issues of therapeutic bias are of major concern. Thirdly, the concept of empathic attunement in the therapeutic relationship and how this is utilized in the restoration of a cohesive self (Baker & Baker, 1987) would make a significant contribution to DID research. Fourthly, the particular focus on self functioning would appear to make it ideally suited to investigating a disorder, DID, whose genesis is regarded as the outcome of trauma in childhood (Greaves, 1992).

3.3 The Participant of this Study

Overview

In this section a description of the therapeutic environment and a detailed description of the participant and her case history are given. Some consideration is also given to the orientation of the therapist.

Setting

During the period of her treatment this participant had been seen in two public mental health settings both administered by the Western Australian Health Department. The first setting was a community outpatient psychiatric clinic situated in Fremantle. The participant was seen at Fremantle Clinic from February 1993 until October 1994, for 182 sessions. The Clinic was later incorporated in a purpose built inpatient and outpatient psychiatric facility located in Fremantle Hospital where the participant continued to be seen. The distance between facilities was minimal and the pending move had been discussed with the participant to ensure minimal disruption to therapy.

Initial Presentation

The participant, referred to here as Ruth, was first seen in February 1993. She had not previously attended Fremantle Clinic. Rockingham Community Services (a community health service funded by the local council) referred her, she had been participating in an anxiety management group. Social workers conducting the group referred Ruth as her anxiety was not responding to their treatment and her level of functioning was deteriorating.

At the initial presentation she complained that she could not attend her local shopping centre without suffering from a panic attack. She described how

approximately 18 months earlier, whilst visiting the shopping centre, she had experienced a panic attack. Before this, she had been living in the country for eight years with her husband running various businesses. They had returned to the city as Ruth had difficulties working in isolated areas. She had been in the shopping centre (a large complex) when she experienced palpitations and a high level of anxiety. She had gone to a doctor in the centre who explained that she was experiencing a panic attack and that she was suffering from agoraphobia. She had not experienced such strong sensations before and thought that her difficulties were the result of stress. She described herself as having always been a tense person.

She felt that most of her difficulties dated from August 19, 1991 when she discovered that her childhood friend, Julie, had committed suicide by taking an overdose of tranquillizers. Her friend was being treated for Bipolar Disorder. Though she did not find out about her friend's death until August 1991, the actual suicide had occurred in December 1987. She described their friendship as a close one, though they had not seen each other for several years, nor had they kept in contact. She attributed this to the isolated nature of the businesses that she and her husband, John, ran which meant that they frequently had to move. She also felt extremely uncomfortable being with her friend once the illness was diagnosed. She was fearful that her friend's behaviour might be unpredictable, though there was no evidence of this. Nevertheless, her discomfort with her friend's illness contributed to the lack of contact.

She described herself as being anxious most of the time and that she would physically shake when meeting people she did not know or when facing new situations. She noted that at times of stress she bit her nails and cuticles and that she ate compulsively. Her biggest pleasure was in eating "junk food" and she had gained 5-10 kilograms during the past two years. For the previous 10 months she had been unable to work. She enjoyed reading and liked to "escape in books". She also felt that she was becoming unrealistic in the way she viewed her family and increasingly felt unhappy with life at home. Her husband drank four cans of beer a night, which she perceived as him being an alcoholic although his drinking had never troubled her in the past. She resented the decision that they had made to go into their last

business and felt that she was not listened to and that in her marriage she "just have to go along with things". She also felt that her three children were all against her.

During the initial session she also alluded to issues that possibly indicated childhood sexual abuse. These are discussed in the section detailing her history. She also described how at times she gets very angry "and loses control" and feels as if "my whole body is rejecting me at the moment". During the initial interview she discussed her fear that "I think I've got something very big boiled up in me".

The therapist's initial impression was of a 39-year-old woman of slightly shorter stature than average and slightly overweight (he later discovered that she was 157 cm and 60 kilograms) with short tightly curled brown hair. She was neatly dressed in casual clothes and expressed her concerns coherently and openly. She was having difficulty coming to terms with issues pertaining to her childhood, having trouble within the marriage, and coping with her children's emotional needs. She was increasingly isolating herself and finding it difficult to contemplate making changes in her life or in confronting some of the issues that were of concern for her. Nevertheless, she was quite articulate, had obviously thought through some of the issues, and had discussed them with previous therapists before attending this Clinic. Though she was clearly experiencing a high level of anxiety, evident in the concerns that she raised, she presented with a blunted and constricted affect and impressed as having a dependent personality. At this stage the therapist agreed to see her for a few more sessions to explore further some of the difficulties she was experiencing and to see what options might be available in terms of treatment.

During the next six sessions, which were weekly, she told how she tried to present as a strong person by not discussing issues with her husband and by being secretive with everybody else. An example that she gave for this was that when her mother left home she told her school friends that her mother had died. She discussed her difficulty in going out especially on her own and how she used large quantities of tranquillizers to cope. She discussed symptoms of anxiety including stomachache, diarrhoea, sweating, light-headedness, breathing hard and fast, and a desire to

continually empty her bladder. She also identified problems with her vision, dizziness, sometimes getting migraines if highly stressed, and several bodily pains that appeared psychosomatic in origin. In sexual relationships she discussed how she tended to distance herself and that most of the time “I don't feel anything”. She reported difficulty in responding emotionally to her children when they were younger though she clearly cared for them.

She described herself as a compulsive type person who liked to keep things in order and that she did not like change. She liked to keep clean and washed two to three times a day. She always washed after sex and washed her genitals with lots of soap and hot water, perceiving herself to be dirty and “smelling” of sex. During subsequent sessions when discussing issues of concern she constantly flexed her legs and feet, contorting her arms and wringing her hands, pulling at her fingers till they were red from the pressure, and often twisted her bracelets round her wrist causing soreness. She discussed how she did not feel “connected and real” and that she tried to disconnect from her feelings to avoid crying, perceiving this as being “really messy”.

Previous Treatment History

Her first child was born in September 1974 just before Ruth’s 20th birthday. Approximately nine months after the birth of her son she was admitted to a private hospital for three weeks with post-partum depression. She was suicidal and had thoughts of driving her car into oncoming traffic. She was treated by a psychiatrist at the hospital for three weeks and then continued to see him for approximately nine months at the outpatient facility of a public hospital. She reported a strong transference to him and that the consultations stopped when she “got attached to him and he stopped me coming”. The hospital’s records indicate that she was a patient. With the participant’s permission, the psychiatrist was contacted; he had retained her case notes and confirmed that he had seen her and his observations agreed with her perceptions. She recalled discussing with him her feelings towards her mother who had left the family when Ruth was 8 years of age. She also discussed her marriage

and her own adjustment to becoming a mother, but they did not discuss some of the earlier issues that were concerning her and since “he did not raise them” she did not discuss them.

Following this she had seen by several other health professionals during the intervening years. These had been on a brief basis. In December 1991 she attended a clinical psychologist in private practice for three sessions, but felt unable to cope when earlier memories of childhood trauma were discussed. She found these “extremely distressing, crying most of the time during the sessions” so she decided not to continue. She later attended a local GP approximately five times and found him supportive. However, she still felt that she needed to deal with issues that she perceived as emanating from her childhood. In response to this need she attended a “psychologist” in private practice. From the middle of 1992 she saw him weekly for 16 sessions. They explored issues regarding her relationship with her father and her sense of having been abused. She perceived him as being overly familiar and stopped seeing him. It later transpired that he was not a psychologist but a defrocked Anglican priest. He was later prosecuted for misrepresentation and his case was reported in *The West Australian* newspaper in January 1995 when other patients made complaints to the local authorities regarding his treatment of them. Ruth had not been aware until she read the newspaper article that he was not qualified and that her instincts regarding his treatment were accurate. She later attended Rockingham Community Services where she participated in three groups, one for women who had been sexual abused, another for anxiety management, and a group for assertion training. Since her condition appeared to be deteriorating and was not responding to treatment they referred her to Fremantle Clinic where she was seen by the author.

In terms of medication, she had been prescribed an anti-depressant, dothiepin hydrochloride though she had not taken any for the six months before presentation. She had also been prescribed the anti-anxiety agent’s oxazepam and diazepam, which she had been taking almost continually since 17 years of age. She reported that she had decreased her use of oxazepam to 15mg when needed though the accuracy of this could not be established. She discussed much later in therapy that she preferred oxazepam or diazepam because it “had a numbing effect”. Due to

complications with her menstrual cycle she had also been prescribed the anti-nauseant metoclopramide hydrochloride. Following the ninth session the therapist arranged for her medical needs to be reviewed by one of the consultant psychiatrists employed at Fremantle Clinic. Following the initial medical review it was agreed that she only obtain medical prescriptions from Fremantle Clinic and she was prescribed, dothiepin hydrochloride 25mg bd. and 100mg nocté and directed to continue using oxazepam on an occasional basis. Regular medical reviews were arranged. The medication that she was prescribed changed over the course of her treatment and will be referred to in the body of the thesis as appropriate.

By the seventh session the therapist referred her to a Coping with Depression Group conducted by a clinical psychologist at the Clinic. The group was based on a Cognitive Behavioural orientation to treatment and was largely educational in focus. The therapist was not part of the group. Later in her treatment, and whilst an inpatient, she attended various groups conducted by the inpatient facility. These were largely occupational or skilled based (e.g., relaxation techniques) in orientation or cognitively based assertion groups. She also attended the 10 sessions of an art therapy group that became available whilst she was an inpatient. The therapist did not participate in any of these groups though he did discuss any material emanating from her participation that she wished to raise. Therapeutic material raised by her involvement in these groups along with material produced by her during the course of therapy will be discussed further in the body of the thesis.

History of Participant

Ruth was born in January 1954 and is the eldest in a family of five children. She grew up in the Eastern States and moved with her family to Western Australia as a young child. She has two brothers who respectively are two years and four and a half years younger than her. She also has twin sisters with whom she has had little contact. They are eight years younger than Ruth. When the mother had given birth to the twins and returned home, she discharged a third child born dead. Ruth discovered her mother lying on the bed, having discharged the baby and in distress,

when she returned home from school. This was a traumatic event for Ruth and she ran out in to the street screaming. A neighbour comforted her and called an ambulance for Ruth's mother. The father was working away at the time.

During the course of therapy she discovered from a relative that her father had been previously married. He has two sons from his first marriage, but apparently has no contact with them. There is also an elder brother, given up by her parents for adoption, and with whom there has been no contact. Her mother later confirmed this. Ruth also discovered, much later in therapy, that she had a half-sister from her father and stepmother. Her sister had also been given up for adoption without Ruth or her siblings being aware of her birth. When she found out about her sister Ruth contacted her, but her half sister did not wish to maintain contact.

Her father is in his mid 80s and is the 11th child in a family of 14. There are three sisters. The family was based in an urban environment in the Eastern States. He came from a family that was relatively affluent until they lost most of their assets during the Depression of the 1930s. She knows little of his background other than he left home at 14 years of age and "disappeared" from the family for several years. He served in the army during the Second World War. Her mother is 10 years younger than Ruth's father and was raised in a farming community. She is the third eldest in a family of four daughters and three sons. She is the eldest daughter. Ruth knows little of her mother's early years.

Ruth's parents separated when she was eight years of age. Initially the mother left without any of the children, but later returned for the twins who were 18 months of age. Ruth recalled few memories of childhood apart from some vague memories around the age of three riding a tricycle. Those memories that she did recall of childhood were of it being "cold" and of her mother being pregnant. She also recalled that when the family sat down at the diner table the father would take off his belt with the threat of it being used if any of the children misbehaved. She did not recall, however, ever being hit, but remembered being very frightened. None of the children were allowed to speak at the table and when they went out together

“there was little gaiety in [their] lives”. When her mother left the father continued to look after the children, occasionally with the assistance of housekeepers. He worked as a cook and occasionally worked away from home for long periods. At the age of 11 years Ruth and her brothers where placed in a Salvation Army Home for 18 months as her father was working away from home. She recalled this as a relatively happy experience.

When she and her brothers returned from the Salvation Army Home they again lived with their father. He employed several housekeepers to care for them but they generally only stayed a short time. This was put down to the children’s misbehaviour. Eventually, they cared for themselves while their father was working. Later, when Ruth was 15 years of age her father remarried, though he and Ruth’s stepmother had been seeing each other for some time. She described her stepmother as the “saving grace” of the family. The stepmother has a son one-year-older than Ruth. They used to be close, but she has not seen him for a while and they have lost contact. She has little contact with the eldest brother and is closest to the youngest brother. Since the age of 27 her younger brother has had problems with his memory; this was caused by aneurysms resulting in brain damage for which he has had shunts.

When discussing her childhood, during the initial session, she spontaneously recalled how on one occasion she remembered touching her father’s genitals while sharing a bed with him, but then stated that she was uncertain as to whether this was “real or a dream”. She also recalled that whilst at the Salvation Army Home she was always attempting to gain attention from men. There was an army barracks at the end of the road and she would do everything “short of laying in front of the truck to get their attention”. She also recalled that whilst at the Home she took a younger boy to the toilet and remembers that she “tried to do something” but could not recall what this might have been. She did not recall any sexual intimacy until she met her husband at the age of 17. She described herself at school as being “available but only up to a point”.

She described herself as being an average student with few friends and as an afterthought added, “I still don’t have any friends”. In grade six she recalled “falling in love” with a male teacher. Her closest friend during these years was Julie. She lived in the house opposite Ruth’s and she described them as being inseparable when younger. In later sessions the depth of Ruth’s feelings for her friend and the important role Julie had in Ruth’s childhood became apparent. As children they had an intimate relationship that continued into Ruth’s early teens. She appears to have idealized Julie who was a few years older than she was. Her relationship with Julie appears to have been the closest and most intimate relationship that she had during childhood. She left school having completed her Junior High School Certificate and worked for a short time as a dental assistant but after six weeks left as she found the sound of the drill distressing. Her father obtained a clerical position for her in the company that employed him. She also met her future husband, John there. She fell pregnant to John and her father insisted that she have an abortion, which he arranged. He later stated that they either had to get married or they would have to stop seeing each other. They married when she was 17 years old and John 19 years of age.

They have three children. Daniel the eldest was born in September 1974, Denis the second eldest was born in July 1978, and Sandra the youngest was born in May 1981. After having given birth to Daniel she had three four-month-term miscarriages. In order to give birth to Denis she stated that she was advised to spend the nine months of her pregnancy in bed. Denis was delivered by caesarean section. In order to carry Sandra her cervix was stitched. Daniel and Sandra were both delivered by forceps. Daniel was born with jaundice and she was not able to hold him until he was two weeks old. Following his birth she had noticed an emission from her vagina but thought it was “normal” and felt too embarrassed and “ashamed” to mention it. It was not until 10 days after giving birth when the discharge had become more vigorous and pungent that she sought attention. Investigation revealed that a swab had been left in the vagina and was the cause of the discharge. Her first miscarriage was also particularly traumatic as it occurred on the steps of the maternity hospital that she was attending for assistance.

Before returning to Fremantle 18 months earlier, Ruth and John had owned various businesses in the North of WA in the previous eight years. Generally, they had been successful in their ventures but Ruth felt that their last business had been too isolated and was unable to continue working there. She had left her husband and had a brief affair with their business partner. She had not worked for approximately two years before attending Fremantle Clinic. She described the first 15 years of their marriage as successful but for the past 6 or so she was uncertain as to whether she loved him or not. She has engaged in other relationships but these have not brought her the reassurance that she thought they would.

Three years before attending the Clinic she saw her mother for the first time since she had left. Before this she had felt very angry towards her mother though this mellowed somewhat over the two days that they spent together. However, she has not kept in contact with her mother (who after leaving the family had moved to New Zealand) and still feels some anger towards her wondering why she had left the children and why she had not kept in contact with them. For the previous few months Ruth had the desire to contact her mother to ask her "what's gone on in my past?" and to explain to her how she now felt. She described her father as never saying he loved her. She felt uncomfortable if he was physically close to her or if he touched her. Though, somewhat in contradiction, she found it extremely distressing to be far from him.

In her relationship with her children she also felt somewhat emotionally cut off. When Daniel was a baby she did not know what to do when he cried. She was distressed with his crying and would walk away from him, often leaving him on his own. She thought his distress was a sign that he was going to die and she regularly took him to the children's hospital for check ups. She also found it difficult to cope with her daughter's desire for attention; it was easier to deal with the boys and tolerate their embraces. She had difficulty responding with emotional warmth to any of the children. She was not prepared to discuss her early experiences with her husband and was secretive towards him regarding her concerns. She would not contemplate attending a parenting course with him or attend the Clinic as a couple.

Although she had some doubts about their marriage she wondered how she would cope on her own.

In later sessions she discussed how as a child she suffered from respiratory illness. During her 11th hospital admission (her admissions are discussed in detail in subsequent chapters) she had difficulties walking even a short distance without becoming breathless. She was referred to a respiratory specialist who diagnosed asthma. He felt that she had probably been suffering from asthma since childhood but it had gone undetected. It was only in recent times when Ruth and John moved to a country region where there is a high pollen count that her condition became apparent. The respiratory specialist later revised this diagnosis and he identified her difficulties with breathlessness as related to either stress and/or angina. Angina had been diagnosed, whilst she was an inpatient, two years earlier. She also reported that around the age of seven she was functionally deaf for a short period. However, an examination at Princess Margaret Children's Hospital found no organic reason for her deafness and her hearing later returned. With Ruth's permission the hospital was contacted for further information. Medical records confirmed that Ruth attended the General Clinic of the Hospital on the 3rd of October 1960 and again on the 13th of April 1964. More importantly, for this study, they also confirmed that she had attended the Ear Nose and Throat Clinic during the period February to May of 1962. Clinical examination along with X-rays of her ears and audiology tests revealed no organic basis for her apparent "deafness". Her birthday falls late in January therefore she would have just turned eight when her hearing was investigated.

3.4 Initial Course of Therapy leading to DID Assessment

This section outlines the initial process of therapy. It illustrates how, in the course of its development, the symptoms of DID presented themselves thus informing this participant as valid for the case study. Several of the issues raised by the participant during the initial phase of treatment were returned to and expanded as the therapy progressed. The significance of these issues and the therapeutic response to them will be discussed later in the thesis. A detailed examination and analysis of

the course of therapy will make up the body of the thesis and is discussed in subsequent chapters.

From the onset of therapy Ruth introduced issues that were of concern to her in an oblique way. During the initial sessions she frequently alluded to material rather than expressing it directly, or she presented it in notes written between sessions, or in her discussion of dream material. Later, she produced drawings of material that was of concern to her. As therapy progressed she introduced and addressed material more directly. During the first few sessions of therapy she discussed concerns regarding her marriage and her role as a parent, but the main issue raised during these sessions related to Ruth's concern with whether she had been sexually abused as a child. During the second session she discussed how on bath night the children would take turns to bathe in the bath water. Being the eldest child she would be the first to bathe. In recalling this she described herself as "I've gone all weird". She shuddered, feeling that she was going to pass out but could not account why this should be the case. By the fourth session she had written a note regarding being in the bathroom and afraid. Her note is reproduced below:

> As I was laying in bed thinking about a bath when I was a kid I see a man in the bath with his penis floating. I feel I'm huddled in the corner. I think it is my imagination.
>
> As I'm writing this I'm also remembering getting into my step mother's bed with my brothers & step brother. I'm sure nothing but touching happened.
>
> I feel very anxious writing this. I even find this very hard to write but I can remember what I did to the little boy at the home. It makes me feel so sick that I did this but here goes: I rubbed his penis up against me. He wasn't very old and I never have done anything else like this ever. Why would I have done this? It makes me sad to think that somebody would do that to a child.
>
> I also remember when I was married a little while and I went to the Drs. and he had to give me an internal exam and he then asked me if I climaxed when having sex. I said I don't know and he then started doing things with his fingers and kept asking me if I was getting the same feeling as I would having sex. I went home to in-laws and told

> my mother-in-law about if I thought it a strange thing to do but he was a doctor and I trusted him.
>
> After I had [Daniel] I got very depressed and I had a lot of trouble with sex. I would just lay there. Sometimes I would cry. [John] used to like oral sex and I hate it. It used to make me feel sick and I would gag but I would let him do it. I very rarely ever participate now because I think [John] now understands that I don't like it. I don't like kissing much either.
>
> I can remember going across the road and walking into their [Judith's] house and looking into their bedroom. They were naked and having sex [Judith's parents]. I looked, they saw us but did not stop. I was not shocked but a little surprised at what I saw. I was around 13 yrs.

In discussing the material related to the bathroom she stated that she was confused and wondered whether an actual event had occurred or she had imagined it. Apparently, several people that she had seen had told her that this was an indication that she has been sexually abused. However she did not know if this was the case or not. I did not of course offer an opinion but empathized with her uncertainty. She also went on to discuss her compulsion with personal cleanliness, often having three showers a day and staying under the water for a minimum of 20 minutes. She used copious amounts of soap particularly round the genital area and she used hot water within her vagina until it hurt. During later sessions she revealed that she inspected her genitals with a mirror to make sure that it was not "dirty". Increasingly, she presented as a chronically anxious individual suffering from panic attacks with obsessive and compulsive behaviour.

By the ninth session she stated that she had written to her mother asking, "what had happened" to her during childhood. She had not heard from her mother but did receive a phone call from her sister. Her sister reported that she was going through a similar situation and that she was undergoing counselling and looking at issues of sexual abuse. By the 10th session her mother had replied saying that she had left the father and children because she "couldn't stand being knocked around any more" and that she felt in fear of her life. Ruth wondered why she would leave her and the children with the father if that was the case. The mother was surprised that Ruth would still be experiencing difficulties with this as Ruth "had not been

knocked around any more than normal" also she had not realized that the violence and explosive environment would have caused distress. The mother also described how the harder she tried to make things "right for him, the worse us kids got it".

Ruth had breast implants at 21 years of age and revealed with some embarrassment and shame that she also had two nipples on her left breast. She went on to discuss how she frequently felt pain in her stomach; this led her to associate to her memories of menstruation at the age of 10. Her first menstrual cycle had been whilst she was at school. She was sent home but nobody told her how to cope with it. Her father gave her some sanitary pads telling her she needed to use them but without any instruction. Not knowing how to use them she carried them around in her bag until her lack of hygiene was obvious to her male school teacher who told her how to use them.

She frequently cried during sessions. During the early sessions she would quickly suppress her tears, however, in later sessions her crying was more frequent and enduring so that at times it was difficult to hear what she saying. She also maintained little eye contact usually looked at the floor and only infrequently glanced in my direction. This continued to be the case until the latter stages of therapy.

Another issue of concern was that of her marriage. She stated that she had been married 22 years but he "does nothing for me other than look after me". She discussed how she was used to being looked after and did not know what would happen to her if John were not there. Nevertheless she was not there emotionally for him. As with many issues in her life she was keen to keep her concerns concealed and not discuss them with her husband for fear that he and other people would judge her to be bad or wrong. She discussed how she responded immediately to people who "send out signals" that make her feel wanted. She continued to discuss how she did not like any form of physical contact except when she was feeling panicky and then she had to "hang on" to someone. She did not like to feel confined and had a "real fear" of losing control over her bodily functions and was afraid that this might happen during a panic attack. She discussed her fear of spiders and how she had the

same fear of humans that they will “wrap around me and I won’t get away”. Whilst at home she often distracted herself from her thoughts by humming or singing.

During the 13th session she discussed a re-occurring dream where a man in a green sweater was “slobbering all over her” and having sex with her. Whilst this dream and fear had never been so clear before she had always been concerned that someone was “out to get her”. She coped with her fear by saying “come and get me” telling herself that she would not worry about him and could “cut him off”. She discussed her sense that she was being “pushed into corner” and how this had been an ongoing fear for her. She also discussed how she had no sense of self and no recognition of “definitiveness” within her. She returned to the theme of sexual abuse fearing that something terrible had happened to her, though it was not clear that this was the case. She stated that as a child she was not allowed to cry in the home, but the emotions that she felt most now were sadness and anger. She discussed some of the feelings of anger that she had for her father clutching her stomach as she did so. She described herself as being petrified of him and that both her abortion and marriage were undertaken because of her father's insistence. She felt inadequate in dealing with her children’s needs and felt completely unassertive in her relationships. She perceived herself as having no power whatsoever and as having to do what other people including her children told her. Consequently she felt very resentful and discussed how she felt fearful and how “my head talks to me all the time, tells me I'm stupid”. Towards the end of one session she began to talk about internal “voices” that she heard, particularly an “abusive male voice”. She identified this as her “abuser” and the source of her “negative thoughts”. She perceived him as having a sickly smile and as taking pleasure in her “powerlessness” and “vulnerability”. At that stage I did not perceive these “voices” to be hallucinatory or dissociative in origin, but rather as reflecting negative thoughts and possibly indicative of earlier experiences. Later that day she phoned me to apologize for expressing anger during the session and explained that she did have real problems that she was concerned about and for which she wanted help.

During ongoing sessions she discussed her feelings of ambivalence towards her father. She was fearful of being physically or emotionally close to him yet

simultaneously professed great love for him. Though he is now old and physically frail she described her reaction to him being as if she was a young child who was fearful and very small. She had always felt this way towards him thought she rarely admitted such feelings even to herself. Indeed when she and John first moved to the country Ruth was distressed at the prospect of being away from her father and it took her some time to adjust to this. Equally, she discussed how she perceived him as an aggressive and violent man and when she thought of this aspect of him it was as if she were an observer watching herself as a small child and seeing her father as he was then rather than how he is now. When discussing this, she thought of her father telling her "you talk about it, or let it out and you'll get it". Frequently during sessions when discussing such material she would complain of feeling nauseous or sick, or felt that she was choking and unable to swallow as well as expressing continual feelings of fear, self-loathing and self-hatred.

On the 17th session she handed me written notes describing how there where "two sides" to her and how she tends to "switch off" when stressed. It reads as follows:

> There is 2 of me Ian [therapist] sees the one that was raped bashed and hurt the one that is not worthy of being loved. The one that if she wants to be loved by her father will do what he wants to the best of her ability. The one who has no protection against him. The one who feels him touching her. Telling her it wont hurt.
>
> Then the other one tells that it is wrong & wicked to think these things. You are only thinking those things because you felt that you were abandoned when young and it is brought about by anger.

The following was written on a separate page:

> I am writing this because nobody cares I am really angry. Does everybody want me to tell them that I can remember this man lying on top of me panting sweating kissing me telling me to be quiet and he won't hurt me. Do you want to know that his breathe smells of alcohol and his penis is huge and I'm scared it will kill me but it doesn't because it goes on and on. Do you also want to know that I used to fight it but I would get a hit so I know that it's easier to do what he wants. I wear a nighty so its easier for him. There is no peace in this house because everyone is scared so one person can do

> what he likes. It is easy to curl up into a little ball and believe this is not happening to you.

In discussing the content of her notes she recalled "images" of herself as a child being cuddled and tickled by her father and of herself as a child of six alone in her bedroom rocking herself for stimulation and comfort. Increasingly she reported feelings of depression and reoccurring nightmares of being attacked sometimes by spiders and snakes. Though she was not at this time suicidal she did discuss that she felt she was dead inside and that she deserved a lot of hurt.

During several sessions she discussed how she continually felt dirty and afraid and that she was having difficulties keeping her legs still particularly whilst trying to sleep. Similarly, when she discussed traumatic material during therapy sessions her legs were constantly moving. She attempted to control this by tensing the muscles in her legs though this appeared to cause her pain. By the 19th session she began to discuss issues of abuse more openly. Before the 20th session she had phoned her eldest brother. She discussed with him some of the issues she had been discussing in therapy and he revealed that their father had molested him although he had few memories and those he did have he "didn't want to know about or to remember". Her husband later verified that her brother had stated similar sentiments to him. By the 21st session she returned to the issue of how frequently she washes herself particularly her genitals washing until she is "red-raw" and that she was showering at least twice a day frequently for 3/4 of an hour. In discussing this she associated to a "memory" of her returning home from school and seeing the housekeeper lying naked on the bed with Ruth's cat licking the housekeeper's vagina.

She also recalled that at 10 years of age she had been taken to hospital with stomach pains something from which she recalled she frequently suffered. Initially, it was thought that her appendix caused the pain but on examination the pain appeared stress related. The examining doctor apparently mentioned that her genitals were well developed. She felt ashamed of this and still feels revolted by her genitalia (the hospital that she attended was a private one that closed down several years

previously and the therapist was therefore unable to check whether they had records of her admission).

She said that as a child she was scared all the time and frequently cut her finger and sucked the blood in order to soothe herself. By the 26th session she brought in a letter that she had received from one of her sisters in New Zealand and asked me to read it. The letter was a long and frank one that discussed her sister's sexual adjustment and identity. She also wrote that the maternal grandfather had been sexually abusive to her when she was five. During this session Ruth returned to the sentiment that she could sense a presence around her all the time like a snake and how she has memories of a man running his hands all over her body. She recalled how, as a child, she was always feeling sick and full of aches and pains. She had also brought along a drawing which depicted a little girl performing fellatio on a man; she explained she had "no choice". She commented that she frequently cleans her teeth and that she always has to have something nice in her mouth. She discussed that there was no escape from the man because he had held her hair and that she would throw up everywhere. Now she would "rather die than vomit" having done so much of it as a child. The worst part for her was in being unable to get away from the memory. She always discussed such memories[1] with great difficulty accompanied by long pauses, attempts to suppress her feelings and a twisting and contortion of her body and limbs. She continued by stating that the angry part of her was shouting "Why can't she just bring it all out and tell him [the therapist] it all?" She felt that she deserved what was happening to her and that her parents had not wanted her. Sometimes she felt that if she said anything he would hit her, "he really stands over me a lot", and she had to keep herself in check. At this stage it was difficult to discriminate between whether she was discussing her "angry part" or her father, or if they were the same. She felt split as if part of her was saying, "I promise I won't tell anything." and feels that by this "he will not lash out" at her. She continued by asserting that her husband was a lot like her father; they do not look the same but she just has the feeling that they both have strong opinions and they both

[1] This thesis acknowledges that memory is a constructive process and that memories such as those stated by the participant are implied and are not necessarily factual unless veracity has been proven.

make her feel angry. She discussed how it makes her feel worse when she has no reason to feel angry.

By the 29th session she brought more writings discussing the issue of anger and that now I would know what it was like for her too. She discussed how inside of her several parts were fighting with each other. She saw them as children. She often saw a mental picture of what is happening but "gives over" her feelings to the children inside of her. One of the children was very angry another had tantrums and the other is a shrivelled up person that just takes the abuse that is occurring. Her writing, each paragraph written in different writing, is quoted in part below:

> The little me – I picture me as a baby, in the fetal (sic) position. I think she knows what a doll feels like that has been pulled poked had arms & legs moved where they don't really want to go. Dressed undressed and thrown around.
>
> The angry one is really scary because she is vicious. She yells at me a lot to listen to her. She is the eldest. Sometimes I find myself hitting myself. I find her hard to control especially when I'm talking to Ian [therapist]. All she wants me to do is hit myself.
>
> There is another who I look gently at because she is 6 yrs old and has a wonderful face but when you look her in the eyes there is nothing there. She sits there rocking herself and sucking her thumb. I wish I could take away her pain.
>
> I know there is one who feels the pain but I don't know how to or don't want to get in touch with her much at all because you then really feel overwhelmed by it all.

She talked about her fear of expressing anger and that she might "explode" with rage during a session. She was particularly apprehensive that she would act out in the same way as her father, or as she had done with other men when she felt grateful. I empathised with the dilemma that this presented her with but also discussed the nature of therapy and its boundaries. She discussed how the anger in her gets expressed in somatic concerns such as in neck aches, back aches, headaches, stomachs and diarrhoea. She described that when memories of abuse occurred she felt them with all her senses - sight, smell, sound, and taste. She described how as a

child she was able to dissociate and go to a place where there were lots of children to play with. She, along with the “children”, looked down on what was happening to her but did not feel anything. She wondered why she would have to go back into her body after the abuse and concluded that it was because she deserved to feel the pain but then wondered if she was going back so that she would remember and could extract some revenge. She discussed how increasingly she was using the therapist in her dreams to protect her and that she would occasionally think of him during the day when she was feeling distressed.

During the 13th session she continued to discuss her sense of worthlessness and how as a child there was little encouragement shown to her. She then appeared to regress asking me “do you want to know something else?” in a childlike voice. She said that when she and John had sex she watches herself and that up to a certain point she gains enjoyment but then at a precise time “I click off”. She stated that she would do “all the motions” but that she is not truly there. During the 31st session she returned to her “memories” of bath time as a child and of having to play a game of “horses” and “submarines” with her father in the bath and that she would have to grab the “reins” or “sink the periscope”. She stated that she felt a “change” when that memory occurred and that she tried “to cut off from it”. She went on to discuss how she did not want to remember about the angry part of her but the “angry child” told her that she did. She talked about the “noise” in her head that she could hear and that this came from all the different voices talking “there are many voices in my head that are talking to me all at once”. She commented on a pain that she felt on the left side of her temple when she thought about her father and that she was sure that he must have hit her a lot. In particular, when she thought about her father, she felt pain in her stomach.

She continued to discuss her experiences of the bath and how the angry part of her was more able to confront the father and that this made her feel good. However, she was frightened because there where other parts of her that were yet unrecognized, she felt that they where different parts raised at different ages. She continued discussing dreams whose content appeared related to her anxiety of being helpless and vulnerable. She also had a reoccurring dream of being unable to move

while a snake was crawling over her; she identified the snake with her father. She noted that when she talked about such dreams she feels as if she was being hit. She discussed how she tried to suppress her emotions and that she did not want to feel because she felt vulnerable when she did. At times she was confused by the intensity of her feelings. An example she gave was when giving birth to her eldest son she believed that she was screaming "the place down" but John told her that she did not make a sound.

At the next session she brought notes written in different handwriting that relayed some of her childhood experiences and how she now abused herself. She often hit herself particularly on the arms and hands with a rolling pin. She would also "punish" herself by taking various tablets and eating the wrong foods and not looking after herself. She later discussed that she would cut herself particularly on her stomach and genital areas. She would also "punish" herself by repeated use of a vibrator that she would use until she was sore. She denied any suicidal ideation just a desire not to exist. She ended the session by wondering whether she was lying when she said that her father had abused her and that perhaps, he really was a loving individual and it was "all her fault".

In subsequent sessions she continued to recall memories of her childhood and her ambivalence with the thought that her father had abused her. An example of this was how she had recently seen her father at the shops and had been "super nice" to him and had kissed him as her way of denying what had "actually happened". Despite such strategies her thoughts remained full of "terrible words" and she recalled that when she was 13 years of age, on weekends, she would phone people that she did not know "yelling 'help, he's got me. He's raping me'". She also discussed how on occasions she was looking at everything as if she were six years of age and wondered how she had got to be so big and that everything in the home appeared so large. A note that she had brought to the session echoed similar themes:

> I had a picture in my mind on Thursday night. I think I'm six and the man is laying on my bed. His fingers are in me and his other hand is touching me. My legs are open and I feel him over me. As I think & see this picture I have no emotion. I can see that she is not aware of

> what is happening. I have the absolute feeling that she is not really me. As I write this there are many voices in my head that are talking to me all at once.

She brought a soft toy to one session and held it in her lap and whilst discussing issues of abuse began to vigorously prod her fingers in what approximated the toy's genital and anal regions. She then spontaneously said that she did not know why she did not just say that her maternal grandfather, her stepfather, and father had all abused her as well as all the others that she had allowed to. During succeeding sessions she continued to recall memories of earlier abuse that occurred within the home and involved her father. She frequently returned to how she felt six years of age most of the time and could remember the fights between her parents. She discussed how her mother would be a "nervous wreck" before her father arriving home from work around 4 30pm. Now 4 30pm was also a particularly difficult time of the day for her, one where she experienced headaches and anxiety. She discussed that the "Angry One" was angrily "screaming" at her saying, "we did not ask to be born into this" and that she was angry with the mother because she "never did anything to stop it". During this session she frankly discussed the dichotomy she experienced between presenting as outwardly agreeable whilst brimming with rage. She discussed how the Angry One, which she viewed as an "evil" part screamed at her that the good part is like a needy "baby sparrow that has always got its mouth open to be fed. She's waiting for him, whatever he wants to do she does. He's wanting to put it in places it doesn't fit. She's like a piece of meat".

During subsequent sessions she continued to discuss the duality that she felt within her and the internal arguing between the different aspects, feeling as if she were a "vehicle for the different parts" and that they talked about her as if their existence was separate from hers. She perceived the "Angry One" as aged from eight to her present age, whereas the other parts remained as young children. Many of her notes were written in different handwritings, these writings she asserted were not her thoughts "they speak I just write". In one note she wrote:

> It's like I'm in the desert or in the middle of the ocean. I'm lost and scared. Nobody can help me or save me. I'm drowning inside. But inside me a very little voice is telling me that I can go on. But I must tell you that I'm getting bloody tired. I think of [Judith] a lot and her

> family. My girls are always with me now. I wish everyone could see them. THEY HURT. But I don't. Please help me.

It continued in different writing:

> Today I feel sick again. My stomach aches. They are looking at me and asking me to do something. What can I do. I'm cold on the inside of me. I have this intense feeling of dread creeping through me. Today I can hardly remember anything that I've already said over the last few months. There is something horrible that I know but I just can't grasp it and tell.

In later sessions she discussed that as a child she was often sick with urinary and chest infections and that she frequently suffered from migraines on weekends. She remembered that she never went to the doctor without her father insisting on being present or with the doctor coming to the home. She frequently reported various pains and aches during and between sessions and at times was concerned that she might vomit during a session. During the 58th session she stated that she could see snakes everywhere even on my office floor. She also stated that she could see several children in my office: a baby of about 6 months in my bin, another child, a bit older, sitting on top of my cupboard, another child floating in the air, and another turning around on my office chair. She recognized that none of these "images" were real. Despite the rather bizarre nature of her material she did not impress as psychotic though her production did impress as regressed. During a later session she returned to the theme of being in the bath with her father. She wrote:

> Well I finished off my picture of me in the bath playing horsey with Dad. It's alright. He puts his hands over mine and rubs them up and down and then he shakes a little and then all this stuff comes out and its yucky. But its alright. Then comes the bit I'm not sure if I like or not. He lays me back in the water and starts to wash me but when he reaches my wee wee he takes a long time and he puts his finger in a little bit. He loves me and tells me I'm Daddy's little girl. <u>I hate this now</u> this is why I feel so bad inside.

Throughout this phase of therapy she usually gazed at the floor rarely casting a glance in my direction. At times an entire session would consist of her crying or

sobbing whilst rocking herself; this became a more frequent occurrence as therapy progressed. She felt as if she was caught in an internal struggle between her desire to feel nothing and her desire to "discover what had happen to [her]". During session 79 she said that the words "[she] was a child of the Devil" kept running through her mind. From this session on she introduced material with ritualistic overtones. She discussed how she was a child of the Devil and that the two nipples on her left breast were proof of this. She also discussed how purple was a significant colour for her and spoke about eating babies hearts and memories of being in a box with a dead person and another of being in a box with bugs crawling over her. The drawings that she now produced also depicted material of a ritualistic nature (some of Ruth's drawings are presented in Appendix F and will be referred to in subsequent chapters). In discussing such material she appeared to dissociate as indeed she did for any material of a traumatic nature. She discussed her self abuse more openly stating that she felt compelled to harm herself. She discussed how various calendar events such as Easter, Christmas and New Year were particularly difficult periods for her. As therapy proceeded her depression deepened as did her self-harm behaviour and by session 117 she was hospitalized for 10 days to allow for some respite. During session 136 she brought in a soft toy monkey as a transitional object. The "monkey" remained in my office and was used by her during subsequent sessions. Before this she had been using a large cushion from my office and she had held on to this when relaying or experiencing stressful material. For a long period she held on to both the cushion and the soft toy clutching them tightly against her chest and burying her face in them at times of distress.

When recalling traumatic events she initially experienced them in an emotionally detached way as if she "was an onlooker". She described how "mental pictures" of traumatic events would be explained to her by an alter named the "Story Teller" so that Ruth could remain emotionally distant from the material and "we [therefore] have time to digest what she [the Story Teller] said". While driving home from one session she said that a voice had come and said, "From Baby came Angel, from Angel came Chris and Carol". Carol was the first alter to identify herself to me during the 125th session. She said that she was six years of age. By the 146th session the process of switching was more evident during sessions and on the 149th

session the alter named the Angry One spoke to me and then during the next session an alter named Mary spoke to me directly for the first time. Mary had first spoken to Ruth before this session. Ruth had been at home when a "voice" spoke saying, "Hi, I'm Mary" and that since then this alter had made more frequent appearances. She was concerned with what was happening and wrote the following:

> I only want to be me not all these inside ones as well. I feel strange a lot of the time. I can see and hear what is being said but I don't feel like I'm part of what is being talked about. I am an observer of myself. When I am talking (even writing this) I can hear other conversations going on. This makes it difficult to follow other people when they are speaking to me.
>
> Sometimes when I get in the car I need to shift the seat and adjust the mirror. When the girls write they use their left-hand – something that I can't do – and you can easily read what they write. I often have a sense of my head floating then my body. Sometimes my eyes flicker and makes things funny to look at. I often have a warm tingling sensation going through my body. I can sit wherever I like and see things but really I'm still sitting in the chair. I must say I often lie on the floor in Ian's office even though I can see that I am sitting in the chair -–WEIRD.

She often declared that she did not "remember too much about the [previous] session". She was concerned as to whether her memories were "real or not, or just pretend" and she experienced great difficulty accommodating the abusive memories that she expressed regarding her father with the love that she professed to hold for him.

The appearances of the alters led the therapist to the diagnosis of DID and treatment continued on this basis. The patient's symptoms were consistent with the criteria specified in the DSM-IV and consultant psychiatrists involved in her treatment later confirmed this diagnosis. Hence, it was not considered necessary or therapeutically appropriate to administer any other assessment tool such as the Dissociative Experiences Scale (Carlson, E. T., & Putnam, F. W. 1993). This patient is eminently suitable for the study: She meets the DSM-IV criteria for DID, three consultant psychiatrists independently confirm her diagnosis, and her presentation is consistent with DID literature. The participant's work with these issues along with

the emergence development and function of alters and their treatment occupies the main body of the thesis.

3.5 Therapist's Training and Orientation

Since many sceptics of DID (e.g., Loftus & Ketcham, 1994; Ofshe & Watters, 1994; Piper, 1997) deem therapist iatrogenic bias to be the genesis of DID the final section of this chapter briefly summarizes the therapist's training and orientation. He graduated from the University of Western Australia (UWA) as a Clinical Psychologist in 1984. The first three years of his career were with the Western Australian Prison Department. In part, because of this experience, he was relatively acquainted with the range of pathologies found in forensic environments and hence was familiar with issues of malingering and factitious disorder as well as issues of sexual abuse. Following this, the Western Australian Health Department employed him. His work in psychiatric clinics has been with both children and adults though since 1991 he has been employed only in adult psychiatric settings. He also maintains a part-time private practice.

Before treating this patient he had not previously knowingly seen or treated a patient suffering from DID, neither did he know of any colleague who had. He held the belief that this was a rare condition, had little understanding of it having only read fleetingly of its occurrence, and was initially unaware of the controversy surrounding it. He had heard of Thigpen and Cleckley's book The Three Faces of Eve (1957) and Schreiber's book Sybil (1973) though at that time he had not read either of them. He considered that the condition was unlikely to present in modern practice and hence this was his first encounter with the disorder. Whilst he had not suspected that this patient was suffering from DID he did maintain an open attitude as to her condition. His initial impression was of an extremely tense and anxious individual evidencing some dependent features and presenting as being overwhelmed by her present circumstances. He also held the possibility that some of her symptoms were indicative of childhood sexual abuse. Her difficulties appeared chronic and he believed it advisable, at least in the short term, to focus on the

presenting issue of panic attacks and assist her to contain her anxiety. Her previous therapeutic history alerted him to the importance of maintaining an open attitude and to allow her to express her narrative in her own time. He did not encourage her to state or resolve whether she had, or had not, been abused but instead encouraged her to develop her own narrative without preconceived notions. His response to any such material was one of empathic understanding in which he followed the participant's productions rather than led them.

The theoretical training for his clinical degree at UWA was based on a cognitive behavioural approach. He had also undertaken postgraduate training in hypnosis though he did not use hypnosis with the participant. Before treating the patient, he was enrolled as a part-time PhD. student in psychotherapy at Edith Cowan University where training in a self psychology approach was offered. Part of the requirement for this degree was individual supervision of cases. When Ruth first presented it was apparent that her issues where likely to be complex and he sought supervision after the 20th session. He remained in supervision regarding this client to the completion of her treatment. From early in therapy all sessions were taped with the patient's permission. These tapes along with other material produced by the patient were used in supervision. The diagnosis of DID was arrived at gradually as the diagnostic criteria unfolded. By session 150 the supervisor and he considered that there were sufficient diagnostic criteria present to warrant such a diagnosis. The patient was also independently diagnosed as suffering from DID by three different consultant psychiatrists also employed by the WA Health Department. Their diagnosis is documented in their case notes and discharge summaries.

Hence, the patient had been in continuous therapy with the author since February 1993. Treatment had been conducted using the self psychology model. The patient's symptoms meet the DSM-IV diagnostic criteria for DID. Over 1050 of the 1125 treatment sessions had been audio taped, and supplemented with cross-referenced case notes for all sessions. Furthermore, during the course of therapy, the participant had written extensive biographical notes, letters from different alters, and drawings that graphically portray this experience. She had been hospitalized 12 times during treatment, her average stay being 5 weeks. During each of these

periods she had been under the medical care of a consultant psychiatrist. In total, four consultant psychiatrists have treated her whilst she has been an inpatient. Three confirmed the diagnosis of DID on the discharge summary. The other consultant who treated her during her first hospitalization diagnosed posttraumatic stress disorder with borderline personality.

In the following chapter the method employed to investigate the research questions is presented.