Appendix A

1. Letter sent, by supervisor, to prospective judges seeking their participation in the study.

EDITH COWAN UNIVERSITY

PERTH WESTERN AUSTRALIA
JOONDALUP CAMPUS

100 Joondalup Drive, Joondalup
Western Australia 6027
Telephone (08) 9400 5555
Facsimile (08) 9300 1257

Dear XXX,

I am writing to you on behalf of one of our PhD. students, Ian Brown, to seek your help with one phase of his research.

Ian is writing his dissertation on Dissociative Identity Disorder (DID), using a single case study to examine competing theories about this disorder. One of the problems of using clinical material in this way, which is raised consistently in the literature, is that the reader must accept the therapist's version of the therapy process. In Ian's case all sessions have been taped but the reader of course does not have access to this material. In order to establish validity therefore Ian wishes to submit a random sample of those tapes, which illustrate certain of his hypotheses to the scrutiny of other clinicians who will examine them for specific confounding variables.

One issue for example that Ian is exploring is the genesis of alter egos. There is an argument in the literature that these arise through iatrogenic bias in the therapy sessions. Ian would like to identify tapes in which an alter appears for the first time and from a random selection of such tapes, ask experienced psychotherapists to determine if this appearance of an alter ego could have been engendered by Ian's therapeutic intervention. Since he is examining competing theories, he is genuinely interested in raters' findings about this.

Because of the nature of the disorder, it has been essential since the dissociations began to appear in the therapy to conduct sessions of around 1 hour 20 minutes to allow for this process.

We are seeking psychotherapists who understand dynamic process and would be able to identify clinical phenomena in a therapy session. We would very much value your assistance in this matter but realize it is a lot to ask of you especially as there are no funds in this programme to pay raters. Please do not feel under any obligation to take on the task if it would be difficult for you at this time.

Those clinicians that agree to help Ian with this scrutiny of tapes would be listening initially to one tape and making two ratings as well as giving some open-ended comment on specific aspects of the session. Later, 2 more tapes will be sent.

Raters will listen to the tapes in their own settings and their own time but initial ratings would need to be made over about a month - probably March or April though it could be later. Transcripts of the sessions will be provided.

Could you either respond in writing to 1 Newry St or leave a message on my work answer phone, 9387-8930 or fax my home on [number given] or my work on 9383-7930 letting me know whether or not you are willing to assist Ian in this way.

Kind regards,

Dr Noel Howieson
Associate Professor
Edith Cowan University

Appendix B

Information package sent to the 16 judges who agreed to participate.

Phase One: Reliability

1. Instructions for completing the study.
2. A Definition of Terms criteria for questionnaire items.
3. Questionnaires One and Two.
4. Demographic detail questionnaire
5. One tape, the same for all judges (not included).
6. A typed transcript of the tape (not included).
7. The DSM-IV criteria for DID (not included).

27 February 1999

Dear Colleague,

Thank you for agreeing to participate in this study. As you probably know I am a clinical psychologist enrolled as a part-time PhD. student at Edith Cowan University. My supervisors are Associate Professor Noel Howieson and Dr Allan Shafer.

Overview of study

I am seeking your assistance to investigate issues pertinent to the treatment and development of Dissociative Identity Disorder (DID; formerly known as Multiple Personality). The DSM-IV definition of DID is used in the study, a copy is enclosed. There is substantial controversy regarding DID, both in the literature and community. Basically, the controversy is whether DID is caused by biasing on the part of the therapist or whether it is a naturally occurring disorder whose aetiology is severe childhood trauma.

I am not attempting to 'prove' either the biasing hypothesis or the trauma hypothesis, but rather to avoid the polemic debate and determine whether experienced clinicians can in part, validate issues of therapeutic practise.

The study is divided into three phases:

1. In the first phase, issues of reliability and bias are considered.
2. In the second phase, issues concerning therapeutic bias will be considered.
3. In the third phase consideration will be given to the divergent views regarding aetiology and treatment of DID.

I am seeking your assistance with the first two of these phases.

In the first phase you are asked to listen to the enclosed tape (the tape runs for 1 hr, 20 minutes, the period proposed by Putnam [1989] as necessary to process dissociation). Then you are asked to rate your responses to the tape on two questionnaires, both questionnaires contain five items. The tape is the same for each of you - there are 16 clinicians/judges. During this phase, I need to ensure that the terms and concepts used are explicit before proceeding with phase two. I also wish to provide an opportunity for comments in case I need to alter or refine the concepts that I am asking you to rate. Therefore, I shall appreciate your comments if any of the terms or concepts is not clear. I would also appreciate any comments or observations regarding these sessions or the study that you would like to make.

Once phase one is complete I will send you a further two tapes, along with typed transcripts. These tapes will be different for each of you. I will ask you to rate these against the same concepts used in phase one.

It is necessary for me to provide composition data of clinicians/judges. I have enclosed a questionnaire for this purpose. This data will be reported only in composite form and your identity will remain confidential.

What I would like you to do.

For the first phase I would like you to listen to the enclosed tape, I have provided a written transcript to assist this, and rate its content against the five scales on the two questionnaires. I would like you to rate the extent to which each criterion is present or absent on a 7-point scale. The scales are rated from 1 to 7. Definitions of the terms used in the scales are defined in the following pages. I would like you to read these before rating the tape. If any of the concepts used in the two questionnaire's are not clear to you I would appreciate you indicating this on the relevant questionnaire item/s, or by contacting Noel or myself for clarification.

It would be appreciated if you returned the tape, transcript, and questionnaires in the pre-paid envelope before the end of the year. I would appreciate you letting me know if you are unable to meet this deadline. I will send the remaining two tapes/transcripts early in May 1999 once the first phase is complete.

If you have any concerns, I shall be pleased to discuss them with you. Noel or Allan would also be pleased to discuss any issues that you may have regarding this study. When the study is completed, I shall be pleased to discuss my findings with you.

Thank you for your participation and contribution.

Kind regards

Ian Brown

DEFINITION OF TERMS

Questionnaire One

Yapko (1994) suggested that adult memories of childhood sexual abuse recovered in therapy are least likely to be contaminated by therapeutic processes if therapists pay attention to the factors described below. A question to consider when evaluating these factors: Is the therapist creating the patient's recollections of sexual abuse?

1. They arise on the basis of a free narrative.

A free narrative means that the patient is allowed to express her recollection of the abuse in her own way and *when recall is allowed to flow freely, it is generally more accurate than when direct questioning is involved.*[7] Answers to direct questions, according to Yapko's research, tend to lean in the direction of whatever the question implies. This does not mean that the therapist asks no questions some direct questioning is inevitable in the process of understanding and clarifying. What you are asked to judge is whether she is able to affirm, deny, explain, clarify, or shift her emphasis when expressing her recollections without the therapist interfering and *"blocking the flow"*.

2. Unprompted by leading or suggestive questions.

The absence of leading/suggestive questioning means that the therapist does *not* ask questions such as: *"He touched your genitals, didn't he?"* or *"How did he go about threatening you into silence all these years?"* The more often a leading or suggestive question is repeated, the more likely the respondent is to accept as true whatever the question implies. It is important when rating this scale to separate the *recall of abuse* from *therapeutic correction*. Some therapeutic correction is an essential function of therapy, as is reference to relevant material raised in earlier

[7] Italics are used in this section to indicate that I am quoting Yapko (1994).

sessions. The critical point is whether the therapist is suggesting or leading any memories of sexual abuse, rather than therapeutically working through an issue that the patient raises.

3. In an atmosphere free of coercion.

The absence of coercion means that the patient is allowed to speak freely without the therapist attempting to impose his view. Yapko gives examples of this as *"You'll feel much better if you just tell me how abuse occurred",* or *"You trust me enough to tell me what really happened to you, don't you?"* or *"If you don't tell what happened, he'll just go out and abuse someone else".*

4. With a therapist who manifests a neutral position.

The maintenance of therapeutic neutrality means the therapist avoids adopting extreme positions either for or against a memory of sexual abuse. *The therapist's certainty that abuse occurred is a compelling factor in generating* (such) *beliefs in the patient. It is definitely a contaminant when accuracy is desired.* Therapeutic neutrality does not mean that the therapist does not accept the subjective reality that the patient brings this is a legitimate and necessary function of the therapeutic process. The therapist, however, does not demand that the patient accept that sexual abuse occurred. Some examples of extreme positions are: *"I have reason to believe you were sexually abused as a child. Can you think of any experiences you might have had that would be considered evidence of abuse?"* Or, *"I saw another patient with the same symptoms that you have, and it turns out that she was sexually abused as a child and repressed it."* Or conversely, "I don't altogether buy the idea of MPD".

5. That allows both him/herself and the patient the freedom to plead ignorance about what really happened.

Allowed to plead ignorance means that the therapist allows the patient and/or himself to state that they are ignorant about what really happened. Particularly when there is no reliable means available to determine whether an account is real or not. *It*

is best for therapists to admit that they do not know what happened, thereby reducing or eliminating the pressure on their patients to "pass a test" or to conform to the therapist's beliefs. It is equally important that patients be allowed to say, "I don't know" without their answers being interpreted as "resistance," or some such undesirable label. This does not mean that the therapist has to maintain a perpetual stance of ignorance because of no validating proof being available. It means that it is okay to be unsure if a situation of doubt arises in the session.

Yapko (1994) proposed that memories that surface in conditions other than these are suspect though not necessarily false. I have incorporated these criteria in Questionnaire One. It may be that you feel these are limited or you may disagree with Yapko's summation. I do not suggest that these criteria by themselves are sufficient to rule contamination in or out of the therapeutic process. I am simply attempting to subject some therapeutic sessions to a process of validation so that I can examine other issues related to DID.

Questionnaire Two

Greaves (1992) suggested that therapists were *constantly confronted with ambiguous productions (incongruent verbal utterances, behavior, and emotional displays) by their patients, as well as their own incongruities in response to the patient.* For therapists *to remain oriented to their own sense of what is real* [they have] *learned to apply several simultaneous tests of validity*[8]. Greaves (1992) proposed that therapists educated in psychotherapy have been trained to evaluate the nature of patient productions from at least three concurrent perspectives.

You are being asked to evaluate the patient's productions of traumatic material using these perspectives. The perspectives have been adapted in Questionnaire Two and are described below. A question to consider when evaluating these: Is the patient's recollections of extreme traumatic material consistent with a dissociative response?

1. Is the patient's presentation clear and coherent?

This is a check on the patient's <u>cognitive process</u>. You are asked to consider the content of the patient's thinking in terms of how *logical, rational, well organized* it is compared with thinking that is *disorganized, digressive, tangential, and purely associative* (as in psychotic productions). When considering this question it is important to take into account the emotional or regressed state of the patient. If she is regressed and in a child like state then the rating should be made from that perspective (e.g., Is the presentation logical from the point of view of a child aged 5?).

2. Affect matches content.

This is a check on the patient's <u>affective process.</u> *In the affective process check…the therapist relies on his or her empathic understanding of the emotional*

[8] Italics are used to indicate that I am quoting Greaves (1992).

life of the patient. The therapist evaluates the patient's affect by considering the following: *Is this patient emotionally bland in the face of traumatic material? Over-reactive to minor irritations? Prone to expansive emotional exaggeration? Does this patient's affect match the content of her…reports?* Some account needs to be made for the nature of dissociation. Hence, the material being produced may be traumatic, but discussed in a distant dissociative manner as opposed to a bland uninterested, or inappropriate manner.

3. Presentation and affect congruent.

In question 3 you are asked to note *whether the cognitive, affective, and behavioral components* <u>in combination</u> *fit the content of the material.* That is are the patient's overall presentations consistent with the material they are producing. Greaves' "behavioral" assessment is, in part, of non-verbal behaviour. It is not possible to meet criteria here since it requires visual contact. He writes that the therapist observes whether the patient's body posture, tone of voice, facial expressions, and gestures fit with what is being said. I would ask, however, that you do consider "tones of voice" particularly in passages of therapy where you believe issues related to traumatic material are being expressed.

4. Patient does not contradict herself.

In question 4 you are asked to consider the following questions: *Is the patient's narrative logically possible? Does the patient contradict…herself?* As with question 1 the term logical needs to take account of the patient's emotional state (e.g., whether patient is regressed).

5. Is the patient's narrative consistent?

In question 5 you are asked to consider whether the patient's narrative grows in <u>congruity</u> with repeated telling, or whether her narrative becomes increasingly <u>inconsistent.</u> *Does the material and the* (therapeutic) *process grow* <u>*more congealed*</u> *in the telling, or more and* <u>*more disorganized*</u>*?* When considering this question, as with the other items, account needs to be taken of the patient's emotional state.

As with Yapko's criteria, you may not agree with Greaves' perspective, and I do not suggest that these are sufficient by themselves to validate the patient's productions. Additionally, in therapy such observations are typically made over a number of sessions and in circumstances where the therapist is able to "observe" the patient's responses. For the purpose of this study, however, I ask that you use these criteria to guide your judgements.

Questionnaire One: Tape One

Please rate (by circling the appropriate number) the extent to which each of the five criteria are present or absent in the content of this tape. Please rate all questions.

1

1	2	3	4	5	6	7
Narrative restricted.						Narrative free.

Any other comments?...

....

....

....

....

2

1	2	3	4	5	6	7
Presence of leading/suggestive questions.						Absence of leading/suggestive questions.

Any other comments?...

....

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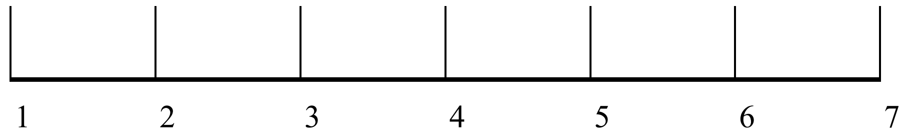
3 

1 2 3 4 5 6 7

Presence of coercion. | Absence of coercion.

Any other comments?…………..
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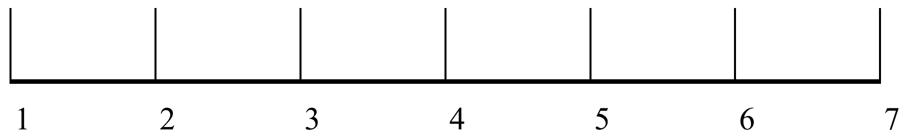
4 

1 2 3 4 5 6 7

Therapeutic neutrality not maintained. | Therapeutic neutrality is maintained.

Any other comments?…………..
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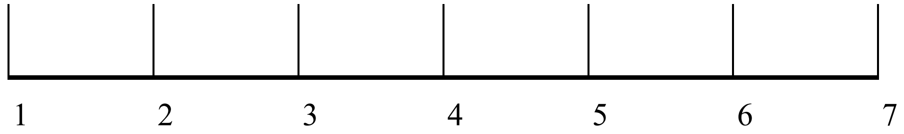
....................…..….

5



1 2 3 4 5 6 7

Not allowed to plead ignorance.

Allowed to plead ignorance.

Any other comments?…………..

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Questionnaire Two: Tape One

Please rate (by circling the appropriate number) the extent to which each of the five criteria are present or absent in the content of this tape. Please rate all questions.

1

1 2 3 4 5 6 7

Presentation not clear or coherent. — Presentation clear and coherent.

Any other comments?...
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2

1 2 3 4 5 6 7

Affect does not match content. — Affect does match content.

Any other comments?...
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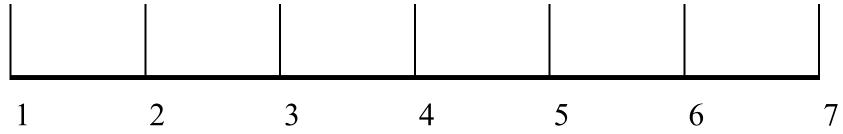
3 

1 2 3 4 5 6 7

Presentation and affect are not congruent.

Presentation and affect congruent.

Any other comments?……...
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....
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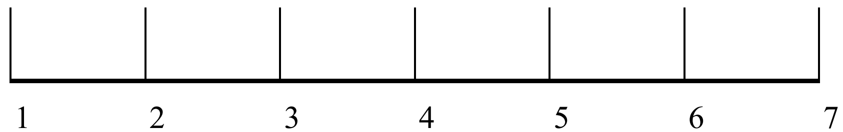
4 

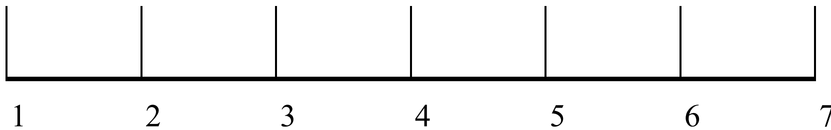
1 2 3 4 5 6 7

Contradicts herself.

Does not contradict herself.

Any other comments?……...
....
....
....
....

5



1 2 3 4 5 6 7

Account becomes disorganized. | Account grows in organization.

Any other comments?.....……………...

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DEMOGRAPHIC DETAIL

Please complete the following questions, your responses will be treated in confidence and used only in a composite form.

1. What are your professional qualifications?

……………………………………………………………………………….

………………………………………………………………………………..

………………………………………………………………………………..

2. How many years have you been working in your profession since qualifying?

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3. What training (if any) have you had in a psychodynamic model?

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……………………………………………………………………………….

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4. **How long have you been working in a psychodynamic model?**

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……………………………………………………………………………………..

5. **Name/Not for publication.**

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6. **Any other comments?**

……………………………………………………………………………………..

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Appendix C

Phase Two: Evaluation of Iatrogenic Bias and Alter Validation

Information package sent to the 15 judges who agreed to participate in this phase of the study.

1. Instructions for completing the study.
2. A Definition of Terms criteria for questionnaire items (see Appendix B).
3. Two copies of Questionnaire One and Two (see Appendix B).
4. Two tapes, one where an alter appears for the first time and another where there is evidence of switching and/or dissociation. Each judge received different tapes (not included).
5. Typed transcripts of the tapes (not included).
6. Any graphic or written material given to the therapist during that session (not included).
7. The DSM-IV criteria for DID (not included).

30th June 1999

Dear Colleague,

Thank you for completing and returning the first phase of the study. I apologize for the delay in sending this the final phase. It has taken me longer to transcribe the tapes than I had anticipated. I hope this has not inconvenienced you.

Overview of study

As you may recall, I am seeking your assistance to investigate issues pertinent to the treatment and development of Dissociative Identity Disorder (DID; formerly known as Multiple Personality). The DSM-IV definition of DID is used in the study. There is substantial controversy regarding DID, both in the literature and community. Basically, the controversy is whether DID is caused by biasing on the part of the therapist, or whether it is a naturally occurring disorder whose aetiology is severe childhood trauma. Such controversy has hindered study of the disorder and its treatment.

I am not attempting to "prove" either the biasing hypothesis or the trauma hypothesis, but rather to avoid the polemic debate and determine whether issues of therapeutic practise can, in part, be validated by experienced clinicians. It may then be possible to consider issues of aetiology and treatment.

The study is divided into three phases:

1. In the first phase, issues of reliability and bias are considered.
2. In the second phase issues concerning therapeutic bias will be considered.

3. In the third phase consideration will be given to the divergent views regarding aetiology and treatment of DID.

I am now seeking your assistance with the second phase - the first phase having been completed.

Your task in the second phase is similar to the first. You are asked to listen to the two enclosed tapes and then rate your responses to them. Responses are rated for each tape on two questionnaires; each questionnaire contains five items. Unlike the first phase, the tapes are different for each of the ten clinicians/judges. I would appreciate you indicating on the enclosed transcript any passage of therapy that appears particularly relevant or any other comment or observations that you would like to make.

To appreciate the "spirit" of the session it is important that you listen to the tapes as well as read the transcripts. Care has been taken to ensure accuracy, however, given the emotional state of the patient, this at times was difficult and inaudible parts of speech are identified as such in the transcript. Anyone mentioned during the session is identified.

What I would like you to do.

1. I would like you to listen to the two enclosed tapes, I have provided written transcripts to assist this, and rate the content against the five scales on the two questionnaires.
2. I would like you to rate the extent to which each criterion is present or absent on a 7-point scale. The scales are rated from 1 to 7.
3. Definitions of the terms used in the scales are defined in the following pages. I would like you to read these before rating the tapes.

It would be appreciated if you returned the tapes, transcripts, questionnaires, and any drawings or written material that was included in the pre-paid envelope by the end of September 1999. I would appreciate you letting me know if you are unable to meet this deadline.

If you have any concerns I shall be pleased to discuss them with you. My supervisor Dr Noel Howieson [Phone number provided] will also be pleased to discuss any issues that you may have regarding this study. When the study is completed I shall be pleased to discuss my findings with you.

Thank you for taking the time to participate, I appreciate your contribution.

Kind regards

Ian Brown

Appendix D

Summary of Greaves' indicators for integration

Integration Markers

Listed below is a summary of Greaves' (1989) integration markers, and negative indicators for integration.

Convergence phenomena

These phenomena are evidence for successful therapy. Convergence includes a broad variety of patient behaviours that indicate focusing of attention. This includes the keeping of regular appointments, attending on time and the production of new material that can be analysed. Such focusing requires the co-operation of several alters. The act of co-operation is in itself a convergence phenomenon.

Spontaneous appearances of alter personalities

The spontaneous presentation of alter personalities within the transference is a marker of trust.

Presentation of a wide range of vague physical illnesses of undefined medical origin

Subjects often present with a long and puzzling medical history, and with concurrent symptoms encompassing several physiological systems. Examination by physicians has frequently failed to establish a medical diagnosis. Symptoms are often somatic elements and somatic memories of the events that they represent. Once the original memories are fully acquired and abreacted, the somatic symptoms typically disappear.

Spontaneous appearances of a hostile alter

Hostile alters are characterized by intensely negative transference projections onto the therapist. These projections derive from traumatic past experiences with authority figures, particularly parents. A therapeutic alliance can be formed as the therapist explores, understands, and empathizes with the hostile alter. Therapist and patient share the goal of promoting integrity of the patient and personality integration.

The presenting or host personality hears voices for the first time

The patient's alters begin to converge and interact with the therapist. At this stage the patient implicitly acknowledges the dissociation as a coping mechanism. Hearing internal voices is the first major marker of integration.

Increased internal communication

The patient freely states that they know a lot more about what is going on inside them.

Increased co-consciousness

Co-consciousness between alters waxes and wanes, depending on the nature of the treatment focus. The personality conflicts dividing alters usually originates in a traumatic event, or series of traumatic events, which gave rise to the original split in consciousness, and which the patient has not been able to resolve. An increase of co-conscious between alters occurs as the issues around the conflict are worked on. It is expressed in rapid switching between alters.

Copresence

In copresence, the patient indicates that other alters are present.

Major alter personalities cannot be distinguished by the therapist

As integration proceeds, the therapist may not be able to recognize which personality is active at any given time.

Personalities cannot distinguish themselves from one another

Personalities that are undergoing integrative processes may not be able to identify themselves at times and may experience identity diffusion in various forms.

Patient requests integration of two or more alters

The motives for this should be explored.

Spontaneous integration

Integrative therapy with DID patients aims to reduce dissociative defences so that spontaneous integration can proceed.

Ambiguous Markers

Greaves regards the following markers as ambiguous for integration:

Flooding of memories

In this, the patient is overwhelmed with new material faster than it can be processed.

Re-dissociation

May indicate a regressive form of stabilization or an indication of the excessive pressure of therapy.

Prolific reports of previously unknown personalities

This could reflect the discovery of new sub-systems, the creation of new personalities as defences against the demands of therapy, retreat into the internal world to thwart therapy, resistance to anticipated termination of treatment. The latter are “hold out” personalities. Greaves argued that these patients generally “hold out” unconsciously as treatment nears the final stages.

Negative markers

The commonest negative markers for integration are:

1. The patient ceases to produce material that can be analysed.

2. The patient frequently becomes psychotic following sessions.

3. The patient focus is consistently externalized.
4. The patient acts out against the therapist and the therapy process with behaviour that is potentially destructive to self and others.

5. Therapist experiences him or herself as becoming less and less effective

Appendix E

Judges' General Comments made in response to sessions that they had been asked to evaluate

1. Direct questions are not in direction of encouraging exaggeration but of developing a more rational explanation.
2. The therapist stays alongside the client's regressed experience. There is no coercion in the sense that the therapist is using their superior understanding to coerce the client.
3. Therapist is genuinely allowing himself to be helpless and ignorance.
4. The presentation is not logical and rational in that the client is regressed and is being allowed to tell the story within the limitations of understanding of a child. There are the beginnings of ego, superego development i.e. an observing self, which can make rational sense of the experience.
5. Dissociation occurs as client shifts from one affect to another. The therapist is naming affect e.g., terror, sadness, comfort in order for sensations to have a name.
6. The client does not name affect but she shows sadness by crying, anger by tone of voice when she dissociates to Charlie. At times affect is confined and in turmoil e.g., in relation to sister as self-object.
7. With this client consistency might take some time as different fragments of the self might experience the same events in different ways.
8. One could follow the content even when the different personality's emerged.
9. The process of therapy means that one cannot be so neutral as to make no comment about what happened. Your responses indicate to me that you do accept her subjective experience as that – there is no pressure to adopt the therapist's point of view.
10. The account grows in consistency if you take dissociation into consideration.
11. She switches to deal with profound childhood abuse, and switches back to deal with the loss of her friend, Julie.

12. Changes position when changing ego states (alters) entirely appropriate.
13. It seems that the client's defence put in place (multiple personality) allows the client to think from many perspectives and therefore she does not contradict herself. Now, if we underline that they are all (Charlie, Les, Mary …etc) one person, then yes, there are contradictions. But Les does not contradict <u>herself</u>, on the contrary, she corrects the therapist when he is confused about who is talking.
14. There are a number of examples of the client correcting and clarifying the therapist.