THE DISSOCIATIVE CONTINUUM:
AN INTERNATIONAL, EXPLORATORY STUDY
OF PTSD AND DISSOCIATIVE DISORDERS

A project based upon an independent investigation, submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2007
ABSTRACT

This qualitative study explored how eleven clinicians, with diverse treatment philosophies, understood dissociation and its relationship to Post Traumatic Stress Disorder (PTSD). It also assessed what symptoms were most relevant to clinicians in recognizing Dissociative Disorders. It then looked at the symptoms of dissociation and PTSD in comparison to the DSM IV. This study was conducted both nationally and internationally with half the sample being clinicians from the U.S. and the other half practicing in Argentina, China, Japan, Africa. In addition there was one U.S. clinician whose work in disaster relief is worldwide.

One of the major findings showed that PTSD and Dissociative Disorders are related. Underlying dynamics tied to history and politics keep the diagnostic categories separate. Another finding is that dissociative disorders need to be treated in a much more complex and sophisticated manner than according to the diagnostic tool, the DSM IV.

Currently there is a great deal of literature written by those whose practice focuses on Dissociative Disorders. A concern is that these studies may have a laser like focus on dissociation without having an overall perspective of the broader population of individuals whose dissociative experience may be more fluid and complex. The study of dissociation has peaked and dipped since it first began to be actively studied in the eighties. Future research is needed in the study of the relationship between PTSD and dissociation, particularly DID.
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CHAPTER I
INTRODUCTION

Post Traumatic Stress Disorder (PTSD) is a widely studied diagnosis recognized not only by clinicians but by much of the general public as well. We understand, and hold compassion for war vets, a large population of individuals who struggle with PTSD. We also have empathy for the PTSD of battered wives and abused children. The DSM IV diagnosis of PTSD categorizes it as an anxiety disorder. Though anxiety is certainly a component of PTSD, PTSD is much more complex than can be contained under the umbrella of anxiety alone.

As someone who has studied dissociation and PTSD at length, as well as encountering clients and others with these comorbid diagnoses (anyone who has Dissociative Identity Disorder (DID) will most definitely have PTSD) I became aware of many areas of overlap between the two disorders. I also came to understand that while PTSD was commonly recognized and understood, there was both tremendous confusion, fear and judgement about DID and other forms of dissociation. Dissociative Disorders, including DID are much less studied by clinicians and mocked by the general public.

As I had come to understand PTSD and Dissociative Disorders to be related I became curious to learn what clinicians, from all different forms of practice, were experiencing in treating their clients. Thus a major area that was researched through this study was clinicians perceptions about the relationship between PTSD, DID and other
forms of dissociation. It was exciting to find that each clinician saw an intrinsic relationship between dissociation and PTSD.

Perhaps the greatest revelation I have had during this research is that PTSD may be what develops in individuals who have intact and competent egos. For the latency age child, adolescent or adult, a traumatic experience becomes a piece of history that is "stuck" in the limbic system and the right side of the brain. Over time and during treatment that stuck piece can become dislodged and processed as an interhemispheric experience; a memory instead of a flashback. This is resolution.

As mentioned by some clinicians in this study as well as in recent literature, DID and other dissociative disorders are postulated to be rooted in attachment disorders. When a young infant or child is unsafe their attachment behavior is fragmented, a small dance of the larger theme of DID. From my research I have come to understand that dissociation and DID are elaborations of PTSD. The abuse that causes DID comes from a repeated exposure to traumatic experiences which need to organized or catalogued in some way. When it is not a single event but a daily event, the psyche organizes these experiences in what could be thought of as alternate personality. This alter's job is to hold years of abuse. The brain is ravaged as it is with PTSD.

When a DID client undergoes treatment the "alter" comes forward and speaks of it's traumatic background. As that trauma is resolved the alter naturally fades away, for it's entire purpose was to hold trauma history. In this way we see that PTSD develops due to a piece of history whereas DID develops due to a seamless sequence (perhaps years or decades) of history. In PTSD the ego is able to contain the history whereas in
DID there is just too much abuse causing the extensive PTSD to be contained by an alternative ego.

Investigating these questions about PTSD, dissociation and DID has been an exciting journey across different cultures and amongst different fields of practice. It is my hope that these findings will be enriching and meaningful for you as well.
CHAPTER II
LITERATURE REVIEW

This is an exploratory study of Dissociative Disorders and their relationship to Post Traumatic Stress Disorder. As part of the exploration clinicians were interviewed from five countries. In this way, themes of universality as well as cultural interpretations shaped the research. It was found that all clinicians who treat PTSD understand it to be intrinsically related to DID. It was also found that there are cultural peccadilloes that can influence the diagnosis and treatment of Dissociative Disorders.

Dissociation is defined in the DSM IV as “a disruption in the normal integrative functions of identity, memory and consciousness” (1994 p. 477). The DSM states that there are two characteristic features that are congruent with all five of the DSM IV’s categories of dissociation; disturbance of the individual’s self-identity, and disturbance of the individual’s memory. The five DSM IV categories are: Dissociative Amnesia, Dissociative Fugue, Dissociative Identity Disorder, Depersonalization Disorder and Dissociative Disorder Not Otherwise Specified. This current breakdown of categories of dissociation in the DSM IV to individuals with dissociation, many of whom are in the mental health system and are misdiagnosed for an average of seven years (Franklin, 1990), most likely because their experience of dissociation is not as categorically definitive as any of these five diagnoses. Such a subcategorization suggests that
dissociation may, for instance, be a subcategory of PTSD. In addition, through the commentary of authoritative voices that present dissociation in its many layered and nuanced forms I am endeavoring to address the stigma affiliated with Dissociative Disorders in our culture and to present information that may bring greater depth to the DSM IV’s descriptions.

Besides the DSM IV definition stated in the introduction, other commonly referenced definitions include dissociation as “the lack of the normal integration of thoughts, feelings and experiences into the stream of consciousness and memory” (Burnstein & Putnam, 1986 p.727), and a “compartmentalization of experience” (van der Kolk et al., 1996, p.306). Another less recognized definition states that dissociation is a form of “cognitive avoidance” (Carlson, 1997).

Pierre Janet first introduced the term dissociation in the 1870’s (Brown et al 1999). The concept was congruent with our contemporary use of it. Janet believed that dissociative symptoms were caused by childhood trauma and that in bringing history into consciousness symptoms would abate (Brown et al, 1999). Trauma is a life-threatening experience. Freud initially shared this view of the women he treated. But since almost all the women in his caseload were symptomatic in this way, he recanted and moved away from a dissociation model to a repression model. Freud defined repression as “complete forgetting” (Berzoff, 1996). As Freud elaborated on psychodynamic theory he explained somatization as the transference of unacceptable contents of the psyche into physical symptoms. Thus, dissociation theory, neglected, became “forgotten.” Although trauma and its correlation to mental distress did resurface on occasion over the next hundred years (e.g. shell shock), it wasn’t until about 1980 that Dissociative Disorders
were finally employed as a diagnostic category in the DSM III. The International Classification of Disease system (ICD), used outside the U.S., included Dissociative Disorders in 1992.

Research is only in the earliest stages of beginning to understand the neurobiology of trauma and Dissociative Disorders (van der Kolk et al.) However, the little that is known proves illuminating. There are several functional abnormalities in the traumatized/dissociative brain (Diseth, 2005). First is that there is more hemispheric activity on the right side than the left side of the brain, indicating that this is where the traumatic memories are stored. The right side of the brain’s role is specific to emotional, non-verbal communication. Thus, the dissociated client may have an alter or a PTSD state in which they are distressed by alexythemia: no words for feelings (Siegel, 1999, Greenberg 1990).

In research by (Panzer & Viljoen 2004 et al.) there may be heightened activity in the areas of the brain is involved with emotional arousal (amygdala, right frontal and prefrontal cortex and right visual cortex). At the same time, these parts of the brain are overstimulated, such as Broca’s area, which is the part of the brain specific to speech, and which is turned off (from the overstimulation).

Next, EEG abnormalities reveal decreased prefrontal activity, which means less expression of positive emotions. And finally, it is known that the dominant hand is affiliated with the opposing side of the brain’s dominance (e.g. left handed people have more developed right brain than right handed people). However, in right handed children with a history of trauma, the right side of the brain is more developed. These findings explain why trauma survivors may function with a more emotional based coping style,
rather than a problem solving based coping style, which would require more development of the left side of the brain (Diseth, 2005).

Other recent findings worth noting: Teicher et al. (2002) were the first to find, and multiple studies have confirmed, a marked reduction in the size of the corpus callosum in those with a history of trauma (van der Kolk, 2003, Bremner et al., 1995, Gurvitz et al., 1998). The corpus callosum is involved in many forms of inter-hemispheric functioning. Individuals with posttraumatic and dissociative symptomology were found to have a corpus callosum up to seven percent smaller, although studies do not have a “before” and “after” measure. It is thought that the longer the stressor and the earlier the onset of stress, the smaller the corpus callosum.

Additionally, the amygdala’s role is to evaluate emotional meaning. It is also central to “fear conditioning” and the control of aggressive behavior. Fear conditioning causes a person to be preconditioned to be hypervigilant and to automatically processing incoming stimulus as a fear based threat. It is in the amygdala that kindling occurs. Kindling is a kind of neuronal excitability that an individual would experience as hyperarousal, anxiety, impulsively or aggression.

And lastly, the hippocampus, which, like the amygdala, is part of the limbic system (emotional part of the brain) and plays the part of putting incoming information in context. One of it's jobs is to avoid over reaction of the stress response. A reduced hippocampus results in perceiving new information as a threat. A poorly functioning hippocampus can also result in the continued fragmentation and isolation of somatic, visual or olfactory experiences (Diseth, 2005).
Moving beyond the neurobiology of dissociation into categorical definitions, there is some controversy about what is called "trait" or "persistent" dissociation versus "peritraumatic dissociation". Coined by Marmer et al. (1996), peritraumatic dissociation describes the dissociated state that can happen to an individual during or in the wake of a traumatic event. Symptoms of peritraumatic dissociation can include vague or fragmented recall, amnesia for the traumatic event, derealization or depersonalization (Eisen & Lynn, 2001). Relevant to this thesis study of dissociation and its relationship to PTSD is the finding that individual's level of peritraumatic dissociation is thought to be correlated to the development of PTSD. This has been found in research with combat veterans (Marmar et al., 1994), survivors of motor vehicle accidents (Harvey & Bryant, 1998), bystanders to human violence (Classen et al., 1998) and victims of natural disaster (Koopman et al., 1994). As cited even in very different forms of trauma, it has become widely accepted that peritraumatic dissociation is related to the development of PTSD.

Peritraumatic dissociation pertains to the amount of trauma and its duration. However we will revisit the controversy surrounding peritraumatic dissociation in a later section. To review the controversy revolves around the question; if a person dissociates during the trauma (peritraumatic dissociation) are they more likely to develop PTSD?

Further contributing to some of the confusion around the concept and categorization of dissociation is its presence under other disorders. For example, dissociation is described under the diagnosis of Acute Stress Disorder. Specific to the first two days to four weeks after a trauma this disorder is in part defined as "a subjective sense of emotional numbing, detachment or absence of emotional responsiveness" as well as "derealization, depersonalization, and amnesia" (DSM IV 1994, p. 432).
considered a progression from Acute Stress Disorder is the diagnosis of PTSD which includes dissociative symptoms such as "acting or feeling as though the traumatic event were occurring," "dissociative flashback episodes," "efforts to avoid thoughts, feelings or conversations associated with the trauma," and an "inability to recall an important aspect of the trauma" (DSM IV 1994, p. 428). Additionally, symptoms of dissociation show up in somatoform disorders, eating disorders, impulse control disorders and reactive attachment disorders (Hornstein, 1992). To further complicate matters, dissociation can be part of any major mental illness such as major depression with psychotic features, mania, and acute psychosis in schizophrenia. Thus it is no small task to separate the wheat from the chaff, that is to sort out when dissociation is the "super-ordinate" diagnosis (Hornstein, 1992), an umbrella under which the other symptoms are contained and when it is comorbid with even a stress reaction to the other symptoms.

In research outside the field of psychology, particularly in the field of neuroscience, (specifically in the area of dementia, Alzheimer's and brain damage) classical dissociation is evident when patient's score on Task X is significantly lower than controls (i.e., score meets the criterion for a deficit) while patient's score on Task Y is not significantly lower than controls (i.e., score fails to meet criterion for a deficit and is therefore considered to be within normal limits) (Crawford and Guthwaite, 2005). In other words a dissociated person scores differently on two tasks, while the control scores consistently on the two tasks. Double dissociation occurs when Patient 1 meets the criterion for a deficit on Task X, and meets the criterion for a classical dissociation between this task and Task Y. Patient 2 meets the criterion for a deficit on Task Y and meets the criterion for classical dissociation between this task and Task X (Bates et al.,
In other words, dissociation is present when two processes occur in the brain, independent of one another, with marked deficits in ability between one task and the other. In clinical psychology we call these independent processes with marked difference in ability alters.

A classical model of dissociation that is not incorporated in the DSM IV definition was founded by Braun (1998). The BASK model characterizes dissociative defenses systematically in the following areas; Behavior, Affect, Sensation, Knowledge. These are the four areas in which a person can split off, across time, either singularly or in combination (see Appendix A). The BASK model illustrates that dissociation may be much more complex and layered than the current definition of the DSM IV. It also demonstrates how interconnected Dissociative Disorders and PTSD are. For example, one client who witnessed her father shoot her uncle in the basement and then was forced to help her father hack the body with an axe abreacted during a session when triggered by a loud noise (see Appendix B). This client was diagnosed as having polyfragmented DID. This meant that pieces of the memory were held in different parts of the mind, separated from each other. The loud noise (sensation) led to terror (affect) which led to paralysis, rocking and staring (behavior) which led to pain in her head (sensation) which led to the act of hand wringing (behavior) which led to an experience of having sticky hands (sensation) which led to the awareness that the stickiness was blood from the gunshot (knowledge). The flashback ended as each compartmentalized memory connected with the next. The client synthesized the disparate behavior, affect and sensation with knowledge, and she experiences calm and relief from what was essentially a PTSD flashback that had been compartmentalized. One can appreciate the ways in
which such compartmentalization served her, as the event, at the time and for many years to follow, was too much to bear in its entirety. As she gained containment, support and tools in treatment it became possible for her to string together what had long been a fragmented, disjointed series of PTSD symptoms. Also, to note: so respected was the BASK model, that when the first volume of the journal *Dissociation* came out in 1988, it was agreed upon by clinicians that it must be included in it.

Also, the model that Braun presents has a continuum from normal dissociative episode, dissociative disorder, PSTD, atypical dissociative disorder, atypical DID, DID, polyfragmented DID (see appendix G). This model postulates that PTSD and DID exist along the same spectrum, with PTSD a more complex form of basic dissociation and DID a more complex form of PTSD. PTSD and DID exist only because a piece of the past is eclipsing safety in the present. In DID that alter is holding the constellation of the past, which is its “identity.” As the past is laid to rest, the alters purpose is also laid to rest and integration naturally transpires. In PTSD it is the disjointed memory (history rather than identity) that is laid to rest as integration becomes possible.

Another model from the cognitive behavioral therapy (CBT) school of psychology, is Fine’s (1999) “Tactical-Integration Model.” Expanding on BASK, this theory pays particular attention to cognitive distortions and dysfunctional schemas which anchor dissociative states in their altered reality. This model postulates that restructuring the trauma based perceptions of alters is the important groundwork to accomplish before embarking on abreactive work. The treatment will progress as alter’s cognitive realities are shared and merge, leading to a gradual and organic integration by “equalizations” (Fine, 1999) of the BASK experience.
We learn from the literature of the positive and negative functions of dissociation. Those with "dissociative traits" have higher suggestibility to hypnosis, trance and other events that are normal in the context of other cultures/religions but viewed as pathological depersonalization/derealization through the lens of clinical dissociation. In the U.S. one study was conducted of alternative healers and traditional therapists, comparing dissociative experiences (Heber, Fleisher, Ross, & Stanwick, 1989). The researchers used a measure of dissociation called the Dissociative Experiences Scale (DES) to assess dissociation. Average scores in the alternative healers were nearly five times higher on the scale of dissociation than the scores of the traditional therapists. In this way, we see some examples of dissociation being used willfully and constructively.

In trauma, it can also be a constructive defense. In studying a group of dissociated inpatients it was found that, when there is no way out, dissociation provides relief from the anxiety and terror. It constructs barriers to protect the ego. It provides a numbing mechanism to prevent pain. It is a self-protective, self-preservation measure (Roose, 1995).

Further, dissociation is evidenced in the recounting of many "ordinary" clients who enter treatment after a trauma, and recount their experience in a flat tone, devoid of affect. If dissociation is understood as a separation of mental processes (Spiegel and Cardena, 1991), this emotionless recounting could be illustrative of dissociation. From a mild case such as emotional disconnection to the most severe case of identity disconnection, the clinician's goal is to reconnect the individual to her dissociated experiences by uniting together the fragmented segments: be it affect and cognition, history and the present, or the self and self. Empathetic mirroring, attunement, respect
and validating the clients’ reality are basic building blocks of the integrative process (Kilgore, 1988).

The expectation, when treating a dissociative client, is that the treatment is centered on integration; be it of an identity (e.g., DID alter), a fugue episode, an amnesic event, or of disremembering history (e.g. PTSD). Integration is what both the BASK and Tactical-Integration Model are working toward. Another, commonly utilized model is “Dissociative Table Technique” (Fraser, 2003). This model can be used in innovative ways when there are conflicting states of mind/memory/self. Often in dissociation, each part feels it is the most real, most central truth and this can make the work chaotic and disruptive as parts compete to be present. By introducing the Table Technique, at which the client visualizes all parts sitting around a conference table (or any other environment that is conducive to building communication), order and continuity can begin to take place. Additionally, by visualizing a spotlight shining on whichever part is talking, it is possible to prevent a cacophony of voices. What is also valuable about this technique is that it helps parts embark on the process of awareness of one another, a critical step towards co-consciousness (Fraser, 2003).

Although the Table Technique was originally created for DID it need not be limited to this diagnosis, especially since only 6% of DID patients present in such clear-cut ways (Kluft, 1984). Concurrently, as described, the DID “BASK model” could best be understood as a process of resolving a series of PTSD flashbacks that have been compartmentalized. It is interesting to look at these two theories in regards to PTSD and DID. Perhaps treatment plans have become overcomplicated and further perpetuated the splits in a client’s psyche that are fragments in the way traumatic memory was encoded.
Treatment of the dissociated client can become more effective when we work with dissociated experiences/identity as an expression of PTSD. In other words, see DID identities as containers for PTSD history. If we get lost in the theatrics of a client’s "otherness," are we not possibly damaging the client’s sense of cohesion and competence? Is there not a "middle-ground" that clinicians can utilize, where both the separateness of the experience form the main narrative and the connectedness of the experience to the whole self can be found?

Some interesting questions have been raised by the false memory advocates in the field of trauma. These include the question of whether "trait dissociation" or "pre-existing dissociative tendencies" exist and are exacerbated by trauma. This is something that I have reflected upon at great length because, of those exposed to trauma, eight percent have significant dissociative symptoms while those who are clinically, significantly dissociated, ninety eight percent have a trauma history (Briere, J., 2006). Those who scored higher on a trait dissociative questionnaire were more likely to experience intrusive memories of an unpleasant videotape than those with low scores (Murray et al., 2002). Research in the field of behavioral genetics has shown that, in general, only one of identical twins (with same DNA) might develop schizophrenia. Something about their genes interacting with their environment activates the illness (Plomin, 2001). It is indisputable that trauma triggers dissociation but only in a percentage of the population. How is that small percent’s DNA vulnerable? This is an area for future research.
Childhood Dissociation

As chronicled by Catherine Fine (1987), Antoine Despine, a medical doctor with an eclectic approach, diagnosed the first case of childhood dissociation in the 1800's. As such he turned to experimental tools such as hypnosis. By 1840 he had treated thirty cases of (then called) Multiple Personality Disorder and published on his work. In July, 1836 he began working with Estelle, an eleven year old client possibly thought to be paralyzed from a spinal cord lesion for twenty-five months. Estelle had already been subjected to many forms of treatment without success, although her mother told Despine that angels comforted Estelle. This made Despine wonder what kind of work could be achieved through what was then called, "magnetism" (hypnosis). He respectfully collaborated with Estelle and soon met Angeline. Angeline provided instruction; for example she stated that Estelle should be allowed to eat whatever she pleased and if this was respected, Estelle would not take undue advantage. While working with Angeline and other alters during hypnosis, for some time, Estelle made slow progress and was able to get angry at her family.

On April 14, 1837, Estelle stated that a hollow ball would explode within her. However troubling, she knew this experience was essential to her recovery. When this happened, she experienced somatic pains. Thereafter, she became able to walk. She and her family returned to Switzerland with intentions to do follow-up work in the next year, but Dr. Despine lost touch with his young client (Fine, 1987).

Not only is this first and earliest case of childhood DID, it is also not unlike what a clinician might encounter today. Perhaps less somatization, but the integration process for a child is often simple and symbolic, not unlike Estelle's.
However, from 1840 until 1979 childhood dissociation has been completely ignored. In the early 1980’s into the mid 1990’s there was some writing done on it, particularly by some of the leaders in the field of DID such as Putnam, Hornstein and Kluft. In my research I have found that beyond a modest series of articles, case studies, and a small handful (under ten) of books, it once again petered out and has continued to be a dormant field of study and treatment. There is no acknowledgement of childhood dissociation in the DSM IV. This is puzzling because the field of trauma has come to accept that dissociative disorders stem from childhood abuse (with a high prevalence of sexual abuse) (Bliss, 1984; Dell and Eisenhower, 1990; Hornstein and Tyson, 1991; Putnam, Guroff, Silberman, Barban & Post, 1986; Ross et al., 1991; Ross, Norton and Wozney, 1989; Schultz, Braun & Kluft, 1989). When treating adults with DID most clients have child alters. Thus we have children experiencing the abuse and adults with pre-latency ego states. These child ego states hold the memory and the emotion for the adult. The implication is that the children themselves are dissociating at the time of the trauma and that these child alters in adults are those child’s selves, stuck in time and space. When a child has an unstable caregiver, the only way a child can internalize the oscillating good/bad parent and defend against overwhelming anxiety is to create a subjective response to each presenting parent. This response becomes a “self” organized around the trauma that it has to contend with (Liotti, 1999).

Research on Childhood Dissociation: The establishment of a link between child abuse and dissociation on firm ground, childhood dissociation was addressed in research over a period of about fifteen years, during which time several case studies were written on childhood DID. As cases were encountered and treated, it became understood that
symptoms of childhood DID were relieved more quickly and succinctly than in adults. Yet, even today, clinical profiles of childhood DID lag behind adult DID. Actually, the writing that took place in the mid eighties to the early nineties has tapered off altogether. That is why I have felt a need to do this study.

One reason for this cessation of research is that dissociation is a normative developmental phenomenon impacting sense of identity and attention. As Freud established, dissociation is an early defense (Berzoff, 1996). It is normative for preschool and early age children to stare off into space and have imaginary companions. Thus, diagnosis of a dissociative disorder is based on frequency, pervasiveness and degree of interference with function (Hornstein, 1992). A chaotic and unsafe environment that stimulates high levels of anxiety in the child, impairing cognitive and organizing abilities as well as the more traditional developmental tasks can further compound normal childhood development. Because of recent research it has begun to emerge that ADD may be trauma related. One way this can be seen is in a child with a trauma history who experienced treatment and the ADD/ADHD symptom remit (Gilmore, 2002).

Treatment issues. Because of the many factors that can complicate diagnosis, a sound diagnosis is critical. The routine tests such as IQ and standard psychological are important for identifying depression, anxiety, attentional and behavioral symptoms (Silberg, 1995). This is not unlike going to the doctor for a physical. Then the “specialist,” (Appendix C), the Childhood Dissociative Checklist (Putnam, Helmers, Trickett, 1993), followed up with a clinical interview with the goal to explore the child’s inner world. One of the first goals is to explore the difference between normal fantasy
and DID fantasy. Developmental psychologists have documented (Silberg, 1995) that between thirty to sixty percent of children have imaginary friends in early childhood (between the ages of four to seven but it can go up to age ten). This point illustrates well the discretion necessary when diagnosing childhood DID.

Thus, in her book *The Dissociative Child*, Silberg (1996) has come up with five ways to distinguish between a DID alter from an imaginary friend.

1. If the child has DID they are confused about if the friend is real or pretend.
2. If the child has DID they feel pestered by the friend.
3. If the child has DID they feel their friend can take over their own body.
4. If the child has DID they feel they need to be secretive about the friend.
5. If the child has DID they feel that their may be conflicting friends who leave the child feeling conflicted within themselves (p. 65-66).

Why else do we not assess children for dissociative disorders? One reason is that parents with dissociative children are often abusers. One form of abuse that can happen in the home to children is ritual abuse. This is a form of trauma that is intergenerational and involves heavy “programming” (brainwashing) to terrorize a child into silence. These children are isolated from treatment, not unlike a domestic violence situation. Hornstein and Tyson (1991) found that DID children that were being brought in for treatment had been removed from the home and were in foster or residential care placements.

The other issue is that children do exhibit more dissociative behaviors than adults to begin with. Normative dissociation can include a child’s fantasy play and imaginary
companionship. Also children do not have a developed sense of time so they may not experience losing time. As such, the most reliable method of assessment for childhood DID is from a teacher, foster parent therapist, etc. (James, 1989). As we review childhood DID, note that the DSM IV’s definition does not translate well to children.

In general, we are not actively assessing for childhood dissociation the way we assess for ADD, separation anxiety, PDD, depression, or even PTSD. These children than become adults who average seven years (Franklin, 1990) between mental health assessment and accurate diagnosis. Once diagnosed, the integration process takes three to seven years. Throughout these years, many adults are unable to function, and are burdened with untold human suffering. The complications of living with DID often can result in a lowered socioeconomic status for the individual, limiting her financial resources for treatment with a qualified provider. Yet identify DID in a child and integration can transpire in a few months, with integration most often enduring, providing the child resolution instead of a lifetimes of fragmentation. However those with DID often have comorbid disorders such as anxiety, PTSD, psychosis, learning disorders, conduct disorders and attention deficits. But these disorders cannot be treated effectively if the DID is not recognized since other symptoms may be held by disparate parts.

The phases of childhood DID treatment are not unlike the treatment phases in trauma work (Gil, 1991; Herman, 1992; Hornstein and Tyson; 1991, Jones, 1986; & Kluft, 1986). Judith Herman (1992) describes them as follows: a healing relationship, safety, remembrance and mourning, reconnection and commonality. As outlined by Silberg (1996), phases specific to childhood DID are:

**Phase 1: Engagement**
• Assessment
• Reassurance and Education
• Stabilization
• Identification of the personality system/team building

Phase II: The Trauma Work
• Develop narrative of the traumatic events
• Process traumatic memories on many levels

Phase III: Resolution
• Integrate the dissociated parts
• Develop age appropriate coping (137)

Some differences between adult and child treatment include the importance of a therapeutic alliance with the family without which any headway in treatment isn’t feasible. Additionally, as with an adult, it is essential that integration work not occur if the child is still in the traumatic environment and would need her alters to cope. It is also critical that the clinician, every effort is made to stay in close communication with other adults in the child’s life (DSS, parent-aide, teacher). And of course, keeping the treatment developmentally appropriate (Silberg, 1996).

Assessment: When working with a child, it is best to gather information about her from other sources such as psychological testing, questionnaires and family interviews. As well as assessing the child, this process is an assessment of protective factors in the child’s life. Does the family have a network of support such as a sport the child plays, involvement with a church, extended family? Additionally what is being assessed is the child’s level of trust. Research (Putnam, 1986) has found that even when the trauma is
severe, a younger child can develop trust with a clinician more quickly than an older child (preteen) whose defenses are becoming more rigid.

**Reassurance and Education:** Presenting DID to a child in a way that is not overwhelming or distressing to them is best achieved through the language of a child’s processing, metaphors. In the assessment phase one area that the clinician most likely learned of is a child’s recreation activities. Borrowing from one of these in order to explain the DID is a reassuring way to educate a child. For example, if a child likes baseball, his alters could be compared to the members of a team who are invaluable. If a child likes ballet, the different dancers in a recital could help explain about her own “system.”

**Stabilization:** In the first phases of treatment, the DID child may decompensate (refer to following case study) due to the interference of parts who have been seriously threatened not to tell, or otherwise badly damaged. Parts may pose harm to self and creating an age appropriate contract is useful. It may even be necessary to make preparation for hospitalization early in treatment. One way to help a child learn to stay stable is to help them find a way to refocus on feeling contained through a word or phrase that has metaphoric meaning to them. This could be anything such as, “everyone is safe,” or “referee.” In addition to having “safe words” it is important to add, to the DID child’s inner world, a safe place. Like DID adults, it is helpful for the child to have a safe place and to implement other new coping patterns, rather than feeling unsafe and leaving/switching with another alter.

**Identification of the personality system/teambuilding:** During this phase, the previously isolated parts begin to know each other. One way to stimulate this could be
with a scrapbook and magazine pictures or through play. Important questions to be explored include: what does each ego state experience as their main feeling? What has been the purpose of holding this feeling? What are the conflicts between parts? This exploration process will be more fluid than with adults. Throughout this ongoing process, the clinician models acceptance and welcoming of each part so that the child can learn to relate to her parts in a similar fashion. Most important is to help the perpetrating alters to know that they are valued and appreciated. The protecting alter and the child alter are also most common. Other alters that can be present include the sexually obsessed alter, the maternal alter, the bereaving alter, the laughing alter, the baby alter, the animal/pet alters and the helper alter. Also, not uncommon is the “retracting alter.” This alter may try to take back what they told happened to them, particularly when court situations emerge, creating distress and feelings to be of blame. Should this occur, it is important to reassure the child that she is in charge of her own process (rather than trying to convince or persuade her to remember her alters). When the child feels safe again, the alters will return. Even during the period of recanting, they will continue to struggle with flashbacks and other symptoms. (Waters, F. & Silberg, J, 1996).

The Trauma Work: It is important to let a child know that the therapist is safe and can listen to difficult material (Benjamin & Benjamin, 1993; McMahon & Fagan, 1993; Peterson, 1996; and Shirar, 1996). From there the goal is for the child to recount her experience and of course for the clinician to help the child with positive outcomes with traumatic re-enactment in play. When working with a particular piece of history of a DID child, it is important to welcome and encourage the parts who experience that event to participate and for other parts to listen. During this phase it is important to be creative
and loving in treating somatic complaints or body memories which can be relieved altogether through treatment. By including all parts of the child throughout treatment sessions and simultaneously being in communication with the significant people in her life, integration is facilitated (Silberg & Waters, 1996)

During the period of emerging research on childhood DID (that is once again dormant), about half of the published work in the field was presented as case studies. There is one recent case study that well illustrates treating childhood dissociation. The most recent in the literature, this case will now be presented with the goal of illustrating and concretizing this unrecognized diagnosis.

*Case Study: “Psychotherapy of an eight year old boy, burned at age three”* (Stolbach, 2005). When Sam was three years old, fifteen percent of his body was scalded accidentally by a pot of boiling water. He was hospitalized for ten days but did not receive any psychological care at that time. Four and a half years later, in a desperate attempt to get some substantive help, Sam’s mother contacted the social worker at the burn unit who referred her to a clinician in private practice. Sam had been described by his mother as a happy boy before the burn, with a complete change in his personality after, including regressing and not eating. Over the past few years, Sam had been diagnosed with separation anxiety disorder, irritable bowel syndrome, receptive language deficits, sensory integration dysfunction as well as an eating disorder. He also could not read.

It was evident from the clinician’s assessment that Sam had PTSD and dissociation. Symptoms included (but were not limited to) the following: rapid personality changes, forgetful, variation in skills, knowledge, wondering if things
happened or were just dreamed, and his body doing things he doesn’t want it to. The clinician was surprised to find that both both mother and child scored high scores for Sam on the Dissociative Experiences Scale, placing Sam high on the dissociation scale. After talking with Sam about his burn experience during the assessment meeting, there was a three-week break during which Sam felt that he was “bouncing off the walls.” Enuresis and encopresis also occurred. Sam had regressed to the age of the burn. Since the burn Sam had basically developed a personality that was cut off from the traumatic material. The clinician helped Sam learn to soothe himself when he was having these flashbacks as a three year old by saying statements like, “I am safe, it’s over, it’s in the past.”

As the work progressed Sam began to have the nightmares he had had after the burn, of being chased by a bear, for him a symbol of the water. Treatment had a dual focus; the integration of Sam’s memories of the event and the integration of his dissociated parts. There are many other symptoms that can be comorbid with PTSD and/or dissociation, both diagnostic (e.g. depression) and risk factors (increased interpersonal violence) and Stolbach, (2005), when working with the trauma that occurred at such a young age, it is a good idea to involve the parent. Early in treatment Sam had described how his sister had gotten angry, pushed his cousin who was carrying the boiling water. Mom did not know this. During this phase of recounting Sam had an increase of nightmares that was reduced by working with a nightlight.

At home and school, Sam began to demonstrate angry behavior. The angry part had been walled off. In therapy he expressed his anger at not being able to read. Through metaphor Sam came to understand that his resources were tied up in the trauma and other kids did not have his challenges.
As treatment continued, Sam and his mother recalled the drive to the hospital, during which he lay with his head in her lap. What emerged is that, during this drive, Sam took care of his mother and continues to take care of her by cutting off the distressed parts of himself that were too distressing for her.

After this session Sam had only one more nightmare, he attended day camp and was able to go away for a week to a camp for burn survivors. Upon his return Sam experienced intense anger at his sister. Sam also began to dream about different aspects of himself. In sum, Sam was able to integrate the traumatic experience in ten sessions, relieving the PTSD and separation anxiety. The “parts work” (integrating alters in children) is an ongoing process as Sam struggles with four parts. According to J. Miller-Sechler (personal communication, November, 2006), Morgan, E (personal communication May, 2004), and Guilette, L. (personal communication, 2003) maintaining dissociation requires tremendous energy. As Sam made progress with integration, his energy was freed up with other tasks like learning to read. With the typical low number of only four alters or dissociated ego states in a child (Fagan et al., 1984), and the ability to for these states to heal in a relatively short period of time, the case study of Sam illustrates how valuable it is to catch dissociation in childhood.

The case study of Sam demonstrates the unique treatment needs of a dissociated child. It teaches us that the age in which the trauma happened may well be the developmental age of the child, as the child becomes stuck there. It chronicles how, through revisiting the trauma with a competent family member there can be symptom relief and even resolution. It offers hope that if dissociation is caught during childhood the ego can be restored, preventing a lifetime of fragmentation, chronic mental illness and
suffering. It warns us that by missing the cues at age three a child is left suspended in their trauma for several years.

Relationship Between PTSD and Dissociation

PTSD is a widely known disorder, first termed "shell shock" during WWI, its symptoms eventually came to be recognized not just in soldiers and prisoners of war but also in victims of domestic violence, incest, and other forms of physical and sexual abuse. The DSM IV (1994) states that, for PTSD to occur, "the person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others. The person's response involved intense fear" (DSM IV, 1994, p. 427). Van der Kolk (2003) in his essay, "Healing Trauma attachment, mind, body and brain" explains that the longer the traumatic experience lasts, the more likely the victim is to react with dissociation (2003). Large scale studies have found that, for example, out of 5877 people, 7.8% had a lifetime prevalence of PTSD (Wilkeson, 2000). Beyond the DSM-IV definition, there are many theories about PTSD and dissociation, some of which we will review. It is my hope, that in visiting these theories, some of which contradict each other, certain themes will emerge.

One of the current assumptions is that, since trauma catalyzes PTSD and dissociation, there is a strong correlation. Recent research (Briere, 2006) establishes that significant dissociative symptoms were found in only eight percent of individuals, all of whom were trauma exposed. Conversely, of that eight percent, ninety eight percent have a trauma history. This is an interesting finding – unto itself it does suggest that there are
more factors than trauma alone that fuel symptoms (these factors will be presented forthcoming). As I have been researching about the relationship between PTSD and dissociation I have discovered that dissociation is consistently comorbid with PTSD. Isn’t avoidance, a symptom of PTSD, also a symptom of dissociation? And there are many factors that can be comorbid with PTSD and/or dissociation including depression or a history of interpersonal violence. According to the DSM field trials (tests conducted to determine the symptoms of a diagnosis for the DSM IV); those with PTSD have comorbid disorders. “Eighty four percent suffer from depersonalization and other dissociative symptoms” (p. 172). Most significant, I found in my research that dissociation consistently preceded PTSD (Murray et al., 2002; Koopman et al., 1994, Shalev et al., 1996, Ehlers et al. 1998). Each researcher, so focused on their research question, moves quickly past this important clue: one’s level of dissociation is what makes one most vulnerable to PTSD. What does this mean about the relationship between PTSD and dissociation? It suggests that dissociation, that diagnosis that is so often overlooked in assessment, is what predisposes a client to the more commonly known and the more commonly studied diagnosis of PTSD.

As I have researched PTSD, with an eye on dissociation, many other perspectives emerged. It is evident that the relationship between PTSD and dissociation is still very much in flux. The more we research the two disorders, both individually and in tandem, the more questions we have than answers. One consistent theme I have found in the research is that PTSD develops out of a convergence of symptoms. Just as behavioral geneticists (Plomin et. al., 2001) have not found schizophrenia to develop out of any one, two or ten genes, but rather out of a spectrum too elaborate for present day science to
distinguish, so does PTSD seem to develop out a convergence of symptoms. In studying the DSM IV definition alone (as well as research from countless other sources) one of the most prevalent symptoms is dissociation.

For example, earlier in this paper the term “peritraumatic dissociation” was introduced. This concept states that a person dissociates, (e.g., feel depersonalized and derealized) during, or shortly after a traumatic event. In other words, they remove themselves from the overwhelming emotional pain or insufferable physical pain. It had become a widely held belief in the mid-nineties (and even now), that those who experienced peritraumatic dissociation are most vulnerable to the development of PTSD (Marmar et al., 1994).

Persistent dissociation, on the other hand, is a state of dissociation not limited to the traumatic event. Persistent dissociation means that the individual was already using dissociation as a coping skill before, as well as at the time of the traumatic event (including up to the time of assessment). This person would, if tested, most likely be diagnosed with a Dissociative Disorder. Current studies (Briere et al., 2005) indicate that those with elevated levels of dissociation are more likely to develop PTSD than those with peritraumatic dissociation (2005). What is important then, is that the dissociation persists across time (before and after). “The persistence of dissociative symptoms beyond the traumatic event may be a stronger predictor of PTSD than initial reactions” (peritraumatic). These measures were taken on clients who had been tested for dissociation before the event, as well as after (Murray et al., 2002). In a recent study by Briere, Scott and Weathers (2005), it was found that over half of those who had PTSD scored high for persistent dissociation. Additionally, those who developed Acute Stress
Disorder whose dissociation did not fluctuate during the first month were more likely to develop PTSD. At six months, those whose ASD symptoms were present at four weeks were more likely to maintain those symptoms at six months. This raises some interesting questions about prior research. Were clinicians screening for persistent dissociation or was whatever dissociation they found peritraumatic dissociation. Why might dissociation trigger PTSD? One theory is that when a person is in a dissociated state they are not capable of processing the event (Murray et al., 2002). This scrambled perception of the event is called memory fragmentation. It is when the client experiences alexthymia. They do not have a sense of linear narrative. Their senses are jumbled as are they themselves.

In addition, as I found in much of the research on PTSD and dissociation, there were other factors also worth knowing in the emergence of PTSD. For example, "emotional constriction," (Briere et al., 2005) which correlates with the numbing symptom of PTSD. Emotional constriction is not uncommon in trauma survivors. At the time of the trauma, emotional constriction was a protective factor. It prevents the client from "going crazy" with pain or being flooded with affect. Sadly, once in place, the client can get stuck there, cut off from the ability, not only to feel the pain of the trauma, but the entire range of emotions including, happiness, joy, and peace.

One of the current assumptions is that, since trauma catalyzes PTSD and dissociation, there is a strong correlation. As mentioned, only eight percent of trauma survivors experience dissociation. Yet in the research about the relationship between PTSD and dissociation it became clear that PTSD is comorbid with dissociation one
hundred percent of the time. For example avoidance, a symptom of PTSD, is also a symptom of dissociation.

Thus it has been found that dissociation and PTSD occur in a subset of trauma survivors most whom have additional risk factors, including comorbid diagnosis (depression) and factors such as attachment style and parental (or family member) abuse and neglect. Recent research has been conducted to find what “internal” risk factors might trigger the dissociative response evidenced in that eight percent of trauma survivors. Here, PTSD is a risk factor (Briere, 2006).

In addition to the mentioned factors is the less studied but worth noting factor of impaired capacity to regulate emotional states (Briere, 2006). This would make sense in that low affect regulation capacities would make one vulnerable to flooding, to triggers, to the need to compartmentalize even oneself in an attempt to get relief from the anxiety, fear, aggression, grief etc., that would intrude, overwhelm and seep through one’s defenses. This need, for affect regulation, is why van der Kolk has changed his treatment plan from helping a client to remember and recounting trauma to facilitating the client’s ability to address their “self regulatory” deficits (van der Kolk, 2003, p.180). In other words, rather than focus on recounting one’s treatment being focused on recounting one’s trauma narrative, the goal of treatment is to provide the client with useful techniques to self-soothe. While struggling with the inability to regulate negative affect, it is not uncommon for the client to re-enact the trauma with intense negative emotions and behavior, further complicating the cycle of negative affect beyond his control. Earlier in this paper this was reviewed under the neurobiology of trauma. Many times throughout the course of her day the client can find herself in the middle of a traumatic re-enactment.
The dissociated client with PTSD has a fixation on the trauma that is enforced by the errant messages of the emotional brain (limbic system) and the lack of activation of the prefrontal cortex. Benign stimuli can be misread as triggers, distressing the client who knows no other solution than to emotionally and physiologically shut down. Dissociation has taken place, moving the client no closer to resolution. Thus we see how poor affect regulation impacts every area of the client's life; both internal and external.

*Trauma Severity and Initial Reactions:* Looked at from another angle, researchers such as Maercker (2000) have found PTSD to be more severely based on the initial response to trauma rather than the amount or duration of trauma. Thus immediate cognitive and emotional reaction at the time of trauma predicts PTSD. (Maercker, 2000). If one is not dissociated, the risk of PTSD increases. This is opposite to the theory of peritraumatic dissociation which suggests that being “more” dissociated at the time of the event predicting PTSD. Other researchers have found that political prisoners who experienced a strong primary emotional reaction scored higher for PTSD than those who had a blunted response. In other words, long term PTSD symptom severity is connected to the initial reactions. Also, multiple long-term traumas result in greater levels of dissociation than single events. PTSD and dissociation each develop in specific responses to phases of the trauma. Some research (Maercker et al.) has found that initial response predicts vulnerability to PTSD while trauma severity predicts vulnerability to dissociation.

Also worth noting is that those in a long term traumatic environment who learned to respond in an “automized” or dissociated fashion would become “stuck” so that this behavioral response becomes habituated and difficult to unlearn once the trauma is over. This is frequently observed in the client with a history of physical or sexual abuse who
sits across from their therapist and recounts terrible grievances in a neutral flat tone. Though this type of client does not fit any of the five dissociative diagnosis she is living with her “head” severed from her “heart.” That is to say she has no ability to experience, much less modulate affect. Though she recalls her history, she is only able to relate to it in a rote manner. What might be an appropriate way to describe her dissociation?

In reviewing this literature it is evident one theme is present in many theories that correlate dissociation and PTSD; one flows out from the other. This raises some interesting questions. Is dissociation hereditary? Can PTSD be prevented by identifying dissociative traits? Does dissociation develop as an exacerbation of PTSD? Is dissociation a risk factor for PTSD? If there is such a thing as trait dissociation than dissociative symptomology would be present in individuals before or after they had PTSD and could this be measured?

In a study (Halligan et al., 2002) of adult children of Holocaust survivors, several groups were looked at: those with current PTSD, and those with past PTSD. All of the above groups had parents who had PTSD. The final group had no PTSD nor did the parents. What is most interesting is that the only group that showed symptoms were those who scored high for dissociation. Once again, research finds that dissociation and PTSD are both present when someone is actively struggling with trauma. But this is only at the time their symptoms are most florid. Once an individual has worked through their PTSD, their dissociation scores lower as well. The findings indicate that dissociation is not a genetic characteristic that makes a client vulnerable to PTSD. It also indicates that environment (growing up in a home with a PTSD
parent/s) wields no influence. Simply, PTSD and dissociation emerge as an organic response to trauma. Resolve the trauma and resolve the symptoms.

Thus far we have found that dissociation is consistently comorbid with PTSD. But we have also found that there are other factors that are probably at play, such as poor affect regulation and memory fragmentation (Briere, 2006; Van der Hart, 2005). Another factor coming up is depression. Studies show that those with dissociation are vulnerable to comorbidity with other diagnoses in addition to PTSD (Wilkeson, 2000). Research has found that those diagnosed with depression score high for dissociation. In Wilkeson’s study (2000) of depressed and nondepressed veterans, the depressed group scored twenty six percent for dissociation compared to the control group who scored three percent. Additionally, the depressed group scored for twenty eight percent for PTSD compared to eight percent from the control group (507).

As the literature on PTSD and dissociation is reviewed, evidence tells us that there is great disorganization based on theory of the two disorders. One camp, that has been popular for several years, says peritraumatic dissociation makes one more vulnerable to PTSD. This is because the individual is dissociated or not present to absorb and process the trauma in a narrative fashion. Another camp says that PTSD emerges when the individual is emotionally and cognitively present during the trauma. Because they are present, the awareness of the trauma renders an emotional distress from which there can only be relief by dissociating. Then there are those who are looking for other factors that might be thought of as the underpinning of PTSD and dissociation, such as memory fragmentation and negative regulation. Other diagnoses such as depression, anxiety and ADD are also routinely comorbid with dissociation and its companion
diagnosis, PTSD. These accompanying symptoms may only exist in direct relation to trauma and once that trauma is resolved, the person can be liberated from symptom distress. One may question, for example, how one can get better from ADD. It might be more accurate to say that the client is presenting with AD/HD symptomology (since the client does not have actual AD/HD). Neurobiological research has shown that the attenuated hippocampus, for example (the one that is seven percent or more smaller in a trauma victim) can recover and be restored to a healthy state. According to UCLA neuroscientist J. Schwartz, neuroplasticity does not only occur in children, but in adults as well (personal communication, November, 1999). Those who recover from symptoms may not only experience a change in behavior, but in biology.

One last point worth consideration is that PTSD may not be tied to trauma as defined in the DSM IV, but rather to an individual's subjective experience of "life events." PTSD and perhaps dissociation are both diagnoses dependent on an event. Because research has found the strong correlation between these disorders and trauma, the focus, in treating PTSD, has been on the trauma population. However one study tested fifteen hundred people for PTSD as related to both traumatic events and "life events" (These "life events" include: experiences such as sudden death of a loved one, non-sudden death of a loved one, chronic illness of a loved one, serious illness (self), problems with study/work (e.g., unemployment), and relational problems (e.g., divorce). Though not "life threatening" as trauma is defined, these events certainly threaten one's sense of their world.

Trauma events include: accidents, witnessing violence, disaster, murder or suicide of a loved one, war and robbery. Besides physical and sexual abuse of children and
adults (which scored significantly higher than any other traumatic or life event), the top range of PTSD scores is reached as often or even more often among those who have had stressful "life events" than as those who have had traumatized events.

Important questions are raised by contemporary research on PTSD and dissociation. Will the individual who struggles with persistent dissociation be more vulnerable to PTSD? Or does PTSD generate symptoms of dissociation? Does peritraumatic dissociation compound (or even create) PTSD? Are the two comorbid when trauma occurs and do they remit over the course of treatment, unlike many other diagnoses which are lifetime afflictions? Are there other factors (e.g. affect regulation) at play such as risk factors, personality characteristics or neurobiological components? Has treatment of the population who might have dissociation or PTSD been so focused on trauma at the exclusion of other populations?

Dissociation in an International Context

This has been a general overview of dissociation. Additionally, a poll (Somers, E., 2006) of the public’s "Google" searches of PTSD and DID (actually the term the public employed more frequently was MPD) shows that PTSD has been most often searched (in ranking order) in Australia, the U.S. and the United Kingdom, whereas DID was highly ranked in the Philippines and off the charts in India where it is germane to daily experiences. Such variance suggests that there are cultural factors at play in dissociation. In interviewing clinicians from the West and the East I hope to be able to identify some of the more salient points. What is the difference between PTSD and dissociation that one diagnosis (PTSD) would score higher in Western countries while the
other (dissociation) is more prevalent in the East? Are the close connections between PTSD and dissociation in the U.S. cultural?

_Puerto Rico_; One clinician in Puerto Rico (Martinez-Taboas, 1993) has conducted several studies (using the Multiple Personality Disorder Questionnaire, MPDQ) on DID in order to identify if DID symptoms are culture bound or universal. In comparing her findings with the extensive research of the American clinicians, Coons, Ross, and Putnam, she has found a great deal of consistency. Some of the top symptoms all four clinicians have tested for include headaches, amnesia, depression, mood swings, somatization, and seizures. The U.S. researchers found headaches to range between fifty-five to seventy two percent. In Puerto Rico, headaches were at one hundred percent. The hypothesis is that clients somaticize more in Puerto Rico. The one other difference was that clients in Puerto Rico scored about three times as high for seizures. This is most likely explained by the fact that most cases for the study were found through the “Puerto Rican Epilepsy Society” (p. 191).

Alters in Puerto Rico also had similarities to U.S. alters such as; alters having proper names (87%), using different tones of voice (80%), having co-consciousness (80%), being different ages (73%) and having amnesia (73%). Depression and suicidality of at least one alter was also high (73%). Child, protector, and persecutor alters were high at 87% for each. One difference with alters in Puerto Rico compared to U.S. studies was the number of alters (4 in Puerto Rico versus 14 in the U.S.) (191). This difference could be explained by the difference in duration of treatment. In Puerto Rico treatment lasted an average of one year. Koons, Ross and Putnam had often treated their clients for over a year, during which time more and more of the system emerged.
Israel: It is worth noting that the oldest (developed in 1986) and most concise test for dissociation, the “Dissociative Experiences Scale,” is now available in eighteen languages besides English (Bowman, 1996). What is responsible for this development? Israeli researcher Eli Somers (2000) suggests that one important factor for clinicians to be able to recognize Dissociative Disorders is trainings. Until van der Hart gave a day workshop on Dissociative Disorders in Israel (in 1987), there was very little understanding among clinicians. Since then about seven hundred people have attended trainings about Dissociative Disorders specifically. By going through the back door and integrating the topic of Dissociative Disorders into training’s on the sequelae of childhood trauma, more progress has been made in educating clinicians.

Israel is an interesting culture to study because it has an unusual cultural composition. A very mixed population is comprised from the Muslim world or from Muslim descent. Studies of clinicians beliefs who are members of this unique population offer some interesting findings.

Somers study was conducted of 211 clinicians. In looking at the attitudes of Israeli clinicians as far as the beliefs in Dissociative Disorders 95.5% believe in the validity of Dissociative Disorders while 84% had a moderate belief (on the Likert scale) of DID. Moving from belief to treatment, 62.6% had neither diagnosed nor treated Dissociative Disorders. However of that 62.6%, 53.3% knew another therapist who had treated an adult with a Dissociative Disorder and 23.1% knew someone who had treated a child with a Dissociative Disorder. At least 42.2% of the clinicians interviewed had diagnosed or treated Dissociative Amnesia. This diagnosis was high on the current caseload of clinicians at 21%. The next highest category for dissociation in Israel was
Depersonalization Disorder. One third of the 211 clinicians had, at one time, treated at least one client with depersonalization disorder while 16% were treating them in the present. 22% had met someone with Dissociative Disorder Not Otherwise Specified (DDNOS). Eight percent had treated someone with DID, 3% currently treating. The rarest Dissociative Disorder is Dissociative y with Fugue with only one clinician currently treating. As stated 62.6% of the population have not had a client with a Dissociative Disorders. However, they had been educated on it through professional literature (89.9%), 54.8% from a lecture, and approximately 30% from documentary film, the media and supervision.

Although research shows that clinicians in Israel are seeing and treating Dissociative Disorders that look very similar as those in the United States, the high percent (42%) of Dissociative Amnesia cases is a surprising finding. One theory is that, since every citizen has to make a two-year commitment to the military, there are elevated levels of amnesia due to this because soldiers are frequently traumatized. This finding (Somers 2000) is similar to the way in which amnesia was not uncommon in WWII. Historically, Israelis have endured seven Arab-Israeli wars. War and Middle East terrorism being so common in Israel, it seems plausible that these stressors, not to be found in the same way in the U.S., may explain the higher rate of Dissociative Amnesia.

In Japan it has been proposed that DID is quite rare because child abuse is rare. According to Dr. Takahashi, Japanese children, from earliest childhood “are disciplined to be appropriately independent in any circumstances. They tend to give harmony within the group top priority” (1990, p. 39). Takahashi had the staff at a Japanese medical college diagnose 489 patients. According to Takahashi, not one incident of DID was
found, although seven were diagnosed with dissociative disorders. Another seven who reported having changes of identity were diagnosed as schizophrenic.

Western clinicians have questioned these conclusions. Different staff in the inpatient unit of the medical college have different perceptions and that does not control for accurate measure. It was subjectively decided by a diverse group of employees with varying degrees of qualification who would be attributed what diagnosis. A different factor, in studying the culture, possession has played a large theme, particularly by “fox spirits.” Exorcism has been widely practiced as “treatment.” Perhaps a large number of DID clients never entered the mental health system, but sought symptom relief in ways that were more congruent with their culture. Another thought is that there are a population of geishas who may never be tested for dissociative disorders. It would be reasonable to postulated that these women are akin to the prostitutes and exotic dancers in the U.S., many of whom demonstrate a high occurrence of dissociative disorders. The same could well be true of geishas.

Otto van der Hart is one of the only clinicians outside the U.S. who is researching and treating DID in the Netherlands and other countries. As other clinicians are trained in the Netherlands, the number of patients with DID has increased many fold. Education is helping people get the treatment they need. Yet those like Takahashi accuse the spike in DID to stem from “culture bound diagnosis.” It seems more accurate that Takashi’s assertion that DID is very rare in Japan to be itself a culture bound diagnosis.

In sum, Takashi states that child abuse is low in his country because a child is disciplined to be interdependent (self as part of a larger whole). Another possibility is that disclosing being abuse is, unto itself, a violation of code. However, the only true
solution is to introduce a scale of measure, such as the Dissociative Experiences Scale (DES) which will utilize uniformity across time.

Later research by Okano (1997) found that if dissociation does occur in Japan it is more likely to do so as amnesia (like Israel) or fugue. Public shunning controls behavior, resulting in a false self. It does seem that culture may, to some degree, influence the presentation of dissociation. However, evidence is also emerging that dissociation itself (form withstanding) exists in every culture.

**Turkey** In Turkey, Dr. Vedat Sar has spent many years doing empirical research on DID and has written alone, at least several articles on childhood dissociation (Sar, 2002 etc). Dr. Sar has created a Turkish version of the standard tool for diagnosis of childhood dissociation, the Childhood Dissociative Checklist (CDC) and compared his findings of reliability and validity to four U.S. studies of the same measure. This test draws the line for dissociative psychopathology above the score of twelve. As such, one hundred percent of the DID patients, 89.2% of dissociative patients as a whole, and 85.7% of the DDNOS patients scored at twelve or above compared to 2.9% for anxiety disorders and 18.2% for ADHD. When retested five months later, the scores were consistent. The same study as conducted in the U.S. by Hornstein & Putnam, (1992), Helmers & Trickett (1993) and Putnam & Peterson (1994), had mean scores of 25.2, 24.5, and 23.6 for children with DID. In the Turkish study children with DID had mean scores of 24.09 and 25. To conclude, this rigorous measure of reliability and validity found that continuity regarding dissociation in the U.S. and Turkey.

To conclude, the research on Dissociative Disorders in the U.S. is limited. This may not be because Dissociative Disorders are limited but rather that there are different
cultural interpretations of them, as in Japan. Or it may be that a different “strain” of
dissociation is more prevalent in another country, also due to it’s culture (e.g., ongoing
wars in middle-east leading soldiers to manifest higher incidences of Dissociative
Amnesia). Studies in Puerto Rico and Turkey seem highly congruent with U.S. findings.
The question worth asking though is; are these findings so parallel because the clinician
is looking for dissociation and screening using U.S. scales of measure (e.g. the DES,
SCID-D, MPDQ)? Or are they only finding what is already there, proving there is some
universality to Dissociative Disorders? Or is dissociation bound to specific cultures
while not present in others? This thesis will move forward now, to explore these very
questions.
CHAPTER III

METHODOLOGY

Formulation

This study was designed to explore dissociative disorders in adults and children; including cultural interpretations, symptom analysis, treatment issues and relationship to Post Traumatic Stress Disorder (PTSD). In order to answer these questions I conducted a qualitative, exploratory study asking four questions within a semi-structured interview (Appendix F). Currently there is little international research, particularly outside the United States and Europe, on dissociation, Dissociative Identity Disorder (DID) and PTSD. Within the U.S. and Europe there are some set theories, particularly on Dissociative Disorders, that are supported by research. However, these theories are not always in keeping with the real-time experiences of clinicians who are "in the trenches" full-time. By conducting in-depth interviews with clinicians from diverse out-patient settings I endeavored to gather research that was as "experience-near" as possible (Anastas, 1999, p.57).

Recruitment: Initially interviewees were sought through the International Society for the Study of Dissociation, or the ISSD (recently renamed the ISSTD with the T standing for trauma). However the possibility that these clinicians might share a similar bias based on their being aware of one another’s research became a cause for concern. As experts in
the field, each of them was at the cutting edge in their research and knowledge on
dissociation. Thus, in order to present a broader perspective, clinicians were also sought
from universities, private practice and outpatient clinics. Recruitment included clinical
psychologists, social workers and a psychiatrist. Because these experts fell under diverse
professional titles, a unifying way to describe them was sought. The term most
commonly used throughout this manuscript is “clinician.” I did not find my interviewees
through advertisement or general recruitment. Rather, through snowball and expert
sample I actively selected clinicians who I knew would provide diverse responses. I did
this by approaching them via email or telephone. Some of the international clinicians
were first contacted by an interviewee who knew them. Then the new clinician knew to
anticipate my contacting them. Once the first contact was made a time was arranged for
the phone interview. At this time I informed the clinicians that the interviews would be
tape recorded. I also offered to send the clinician a copy of the four questions which are
as follows:

1. What are the symptoms you see as particularly important to dissociation/DID?

2. Are you aware of cultural interpretations of these symptoms and ways that
these interpretations may prohibit accessing this population for treatment?

3. Because DID develops in an individual due to experiencing traumatic events, the
individual also shows symptoms of Post Traumatic Stress Disorder (PTSD). Do you
experience PTSD and DID as two separate diagnoses or as interrelated? Do you think
that DID might be more accurately categorized as a sub-category of PTSD or do you
think they should remain distinct and different diagnoses? Why?

4. What is the focus of your treatment approach? What are treatment goals?
Each interviewee was informed that this was a semi-structured interview and they were welcome to allow each question to develop to a further exploration of related thoughts. This led to interesting developments. For example the clinician who utilized the five symptom model showed some brief video clips of different clients demonstrating some of the symptoms such as identity confusion or amnesia.

Participants: A sample of eleven clinicians participated in this study: two were part time researchers/part time teachers at two universities, two were full time faculty at universities whose clinical work was international, two clinicians were from an outpatient clinic. Five were private practice clinicians, one of whom was a psychiatrist who was also a private researcher and one was a psychologist who conducted private research. Four (two clinicians from the United States, one clinician from Japan and one clinician from Argentina) were also members of the International Society for the Study of Dissociation (ISSD). Six clinicians were treating clients in the U.S. and five were International clinicians (working outside the U.S., Canada or Europe). Of these five, one was from South America (Argentina), two were from Asia (Japan and China), one was affiliated with Africa and one U.S clinician worked internationally. By having six clinicians from the U.S. and five international clinicians it was intended to seek as broad a sample as possible.

Originally it was planned to interview four clinicians each from four countries and to focus the study on childhood dissociation. However, the field of childhood dissociation, studied by a narrow population in the United States was virtually non-existent in other countries. As one clinician stated, in an incredulous tone, “Japanese children being treated for dissociation?” Quickly I realized it would be necessary to
broaden my study to dissociation in children and adults. But communicating with international clinicians researching and practicing in the field of dissociation also had some challenges including issues time zones (I conducted one interview at one a.m. and complicated phone calls. One clinician in Argentina articulated her professional life, with its specialization in dissociation as "lonely," isolating her from colleagues. As I came to understand how few clinicians outside the U.S. and Europe are engaged in the field of dissociation I realized it was simply not possible to locate four qualified clinicians in four states. The obstacles of finding a translator and coordinating international interviews, sometimes in the middle of the night, further made this goal unrealistic. It was revised such that the study is now based on six American and five International clinicians.

Clinicians being interviewed came from a wide variety of theoretical orientations. These range from clinicians adhering strictly to a standardized dissection of dissociation as five discrete characteristics (U.S.), to a clinical perspective that such a diagnosis does not belong or exist in that culture (Africa), to dissociation being assessed as high as eighty percent in the general population, but untreated (Japan). Theories were heavily influenced by cultural interpretations.

*Ethics and Safeguards*

During the interview process it was possible that questions may have elicited a strong response, from opposition to personal identification. However, as I was interviewing therapists about their profession I would not consider them part of a vulnerable population. At any point during the process participants were alerted (usually in the preliminary conversation) that they had the option to withdraw from the study, as well as having the option to not answer any question.
Many of the clinicians asked for the findings to be shared with them, particularly relevant to their interview. Each therapist was encouraged to be reflective and introspective by means of giving them space and time. I emphasized that this was a semi-structured interview and they should thus feel at ease to respond in a way that was unique and true to their professional identity. Clinicians were asked to discuss the way their real world experiences with clients have informed their theory.

In regards to confidentiality, each therapist was assured that the utmost effort would be made to uphold theirs. Not one step of my research involved the use of real names. The audiotape interviews were simply initialed so that no one, not the transcriber or my thesis advisor, knew the identities of the therapists. This confidentiality was a surprisingly meaningful issue for each clinician. I have wondered if this emphatic focus on dissociation is related to the ways in which there is controversy about dissociation and PTSD, leading clinicians to feel that they were taking a risk and potentially as therapists by speaking out.

All materials were kept in a locked cabinet and, after three years, will be destroyed or continue to be kept secure. It should be noted that the demographics in this study were kept extremely vague with the exception of geography and professional status. In this instance the U.S. clinicians were not identified by state and the international were not identified beyond country.

Data Collection

Interviews averaged about forty-five minutes. Eight interviews took place one-on-one over the phone and two took place one-on-one in person. One interview occurred
via written correspondence (email). Participants were each interacted with in a uniform manner.

At the time of the interview I explained to each participant that it was protocol that they signed an informed consent form. Although every effort was made to have these documents signed at the time of the interview, because most took place over the phone and half were out of the country it was necessary to mail them. Many were signed after the interview, although they were verbally reviewed over the phone with the international clinicians. These forms established that clinicians agreed to participate, and they had the option to withdraw at any time. Also included in this form were the risks and benefits of participating. Confidentiality was also affirmed.

By using a semi-structured interview that included four questions with four diverse areas of focus, participants could respond in greater depth. Prior to the interview the interview questions were emailed or presented so that each of the eleven clinicians could focus on whatever area may have had the greatest significance to their treatment and theory. In one interview the questions had no context to that country, thus the interview consisted of explaining why this was so.

One modification that this researcher decided to edit from the original interview guide was the question, “Do you do any work around opposing personalities?” This was removed because it seemed too much like a “leading” question. The other change was the decision to not use the “Child Dissociative Checklist.” Originally the goal was to attain three of these forms from each interviewee. However, outside of America (and Europe) these forms are not familiar to clinicians (with the exception of one clinician in
Argentina). Additionally, as it became evident that this study needed to include both child and adult dissociation, the Checklist no longer seemed appropriate.

Before the interview process began a proposal was submitted to the Human Subjects Review Board (HSRB) of Smith College School for Social Work. An HSRB application was presented to the committee. This application outlined the study to the Board to ensure ethics were adhered to throughout the research. When the study was approved the process of recruiting participants moved forward. Nine interviews were approximately forty five minutes, one was approximately one hour and one was half an hour.

In addition to signing the informed consent, participants responded to a diverse series of questions about dissociation. Ten responses were tape-recorded and one was conducted via email. Once the material was gathered, it was analyzed. Each question was examined individually and studied for geographic and/or clinical themes.

Each interview was conducted in a similar manner. Clinicians were invited to preview the questions by having them emailed ahead of time or having them read to them over the phone in the conversation in which logistics were arranged or in the opening of the interview discussion. After some preliminary conversation the first question was introduced, asking clinicians to think about the symptoms they experience as most relevant to Dissociative Disorders/DID. This question often required clarification as there is already a breakdown of symptoms in the DSM-IV. Therefore I frequently added, “in your practice and/or research?” This was important to clarify because real world experience of clinicians is so often disparate with the DSM and it is the “real world” information I was seeking. Question Three asked clinicians to speak of their assessment
of the relationship between PTSD and DID. This is a controversial issue in current research and has particular meaning because the DSM-V is in development and one big question is if PTSD should be re-diagnosed as a Dissociative Disorder or remain where it now stands as an anxiety disorder. The process of data collection for this study was centered on the DSM and its medical model approach. How does the medical model of the DSM, as well as the way it’s categorized, relate to every day work of therapists in different parts of the world? (Note questions two and four did not have complications, refer to page 2 to review).

Data Analysis

As this was an exploratory study, interviews were analyzed through coding strategies. The most useful information was chosen to highlight the most succinct and distinctive responses to questions. How does the theoretical or experiential orientation of clinicians with different trainings and different affiliations interface with the four questions posited in this study? After all the data was collected, each audiotape was listened to, transcribed, and coded. In the other instance the interview was responded to via email and then coded. Common themes of the four questions were manually coded on each transcript and then recoded after another, in-depth review of all transcripts. After this careful review of transcripts, I manually coded the transcripts using the four main categories. Data was further analyzed and broken down under the headings “Within the U.S.” or “International.” In other words, there was a parallel analysis of the U.S. with other countries. First there is a concentration on the U.S. in which all four questions are deconstructed. After this there is a duplicate formatting for the analysis of other countries.
While critiquing each transcribed interview, the vast amounts of data were decreased by highlighting, extracting and categorizing key words that were significant to answering the study question. Each numbered category was assigned a color so that it was possible to go through each transcript and mark the response correspondingly. Coding was used to parse elaborate conversations down into bullet points that could than be briefly presented in the study's conclusive analysis. Each interview was examined individually for general themes. As the material permitted, however, comparison among the interviews allowed for more intriguing themes to emerge. Overall, the information was presented in a way that reflected the most sophisticated analysis possible while protecting the privacy of each interviewee.

In general, as a way to extract the most relevant information from the data, each transcript was read and noted three times. This, in addition to the notes I made as while listening to each interview helped me develop themes. This documentation process helped me outline my ideas while simultaneously keeping in check my potential bias. However, I would also like to add, the material itself, in some categories, provided a broad spectrum of diverse thought, while in other categories there was surprising cohesion.

Instrument

To maintain reliability and validity, both the study questions and the study outline were submitted to the International Society for the Study of Traumatic Stress. The measure was then revised to a version that most realistically measured the questions at hand. Also, in order to enforce the reliability of the study, a pilot test was distributed to one person. This clinician did not participate in the actual study. The information
gathered from this practice interview was used to improve the interview guide so that it might produce the most accurate results.
CHAPTER IV

FINDINGS

The interview, conducted with 6 clinicians from the United States and 5 clinicians from other countries (China, Japan, Argentina, Africa) conveyed notable data on clinicians understanding of dissociation, PTSD (post traumatic stress disorder) and DID (Dissociative Identity Disorder). These findings are especially meaningful to the theoretical issues explored in the literature review. Connection of the interview data to the theoretical framework will be spoken to in the discussion chapter. A data analysis was conducted to form insights about the existence and nature of dissociation across cultures. This will be presented in this chapter. The interview questions were deconstructed in terms of the similarities and differences of clinician responses within the United States, within the International pool, as well as across some cultures (U.S. and International). Using transcriptions of the tape-recorded interviews, confirmation of such emerging themes was documented and analyzed and presented herein.

Because this study sought to expose and explore ideas that are controversial in literature and research, clinicians’ own experiences and descriptions were regarded as the most reliable and valid data. By carefully listening, and, at times asking a clinician to further elucidate their thoughts, it was hoped to illuminate the much shadowed and often debated concept of dissociation and DID and its relationship to PTSD.

The major findings of this study were: that there is a significant relationship, even interconnectedness between PTSD and DID, that there are similarities and differences
amongst clinicians from all five countries when it comes to symptoms identification and treatment approach. Also, there are distinct cultural interpretations of dissociation. Cultural findings were consistent for U.S. clinicians and distinct for international clinicians. Additionally there were spontaneous findings, which will be addressed as well. These findings include; the neurobiological influences of dissociative disorders, the role of attachment in dissociation, the attitudes and understandings of other mental health professionals in the treatment of dissociative disorders, the role of voices in DID as well as the issue of control as an influential aspect of dissociation.

PTSD and Dissociation As addressed in the literature review, current research shows the possibility of there being a strong relationship between PTSD and dissociative disorders. This relationship is not without controversy. Yet, my findings show that clinicians from China, Japan, the U.S. and Argentina understand dissociative disorders (including DID) to be connected to PTSD. It is important to note that our current tool for diagnosis, the DSM IV, defines them as completely separate. However all clinicians disagreed with the DSM IV, instead perceiving them as interrelated.

Though not addressed in the literature review, it is important to note that PTSD is currently categorized as an anxiety disorder, is defined in the DSM IV as follows: the person has been exposed to a traumatic event in which both of the following were present, the person experienced an event that threatened death and they responded with intense fear, helplessness or horror. The traumatic event is re-experienced as follows: recurrent and intrusive recollection and dreams as well as acting or feeling as if the distressing event is occurring, intense distress at exposure to cues, physiological reactivity on exposure to cues. Also, there is persistent avoidance of triggers and
numbing as indicated by efforts to avoid any connection with trauma, efforts to avoid activities, places or people that are triggering, inability to recall an important part of the trauma, anahedonia, feeling estranged from others, lack of affect, sense of foreshortened future. And finally persistent symptoms of increased arousal such as, difficulty with sleep, outbursts of anger, difficulty concentrating, hypervigilance and exaggerate startle response (DSM IV).

In the above diagnosis it is clear that trauma is the issue that has created the PTSD. This contrasts sharply with the DSM IV definition of DID which lists four diagnostic criteria (in addition to the symptoms presented in the literature review). These are: the presence of two or more distinct identities, at least two of which recurrently take control of the persons behavior, the inability to recall important personal information, and finally it is noted that these criteria are not due to substance abuse or a medical condition. In the diagnostic, “at a glance,” box no mention is made of trauma. If one reads the “fine print” it states that individuals with DID “may manifest posttraumatic symptoms or PTSD.” However, the more accurate statement is that those with DID have one hundred percent comorbidity with PTSD (but not the other way round). As these findings progress we will hear the diverse, yet consistent perspective that PTSD and dissociation/DID have a relationship. The questions that were asked of clinicians on this topic were: “Because DID develops due to experiencing traumatic events, the individual also shows symptoms of Post Traumatic Stress Disorder (PTSD). Do you experience PTSD and DID as two separate diagnoses or as interrelated? Do you think that DID might be more accurately categorized as a sub-category of PTSD or do you think they should remain distinct and different diagnoses? Why?”
To carry on from the above outlined diagnostic criteria, let's listen to another US clinician. In response to my question of categorization she referred to the DSM IV and read aloud from it from the DID section so that it was became possible for us to both understand the stance of our tool for diagnosis. As she read she had spontaneous reactions. These responses speak for several respondents:

Individuals with dissociative identity disorder frequently report having experience of physical and sexual abuse, especially during childhood. Controversy surrounds the accuracy of such reports because childhood memories may be subject to distortion, and individuals with this disorder tend to be highly hypnotizable, and especially vulnerable to suggested influences. -DSM IV

I've never read this. This is unbelievable. -Respondent

On the other hand, those responsible for acts of physical and sexual abuse may be prone to deny or distort their behavior. DSM IV

Ok so they're saying that maybe it's actually the perps [perpetrators] who are denying. -Respondent

Some individuals may have a repetitive pattern of relationships involving physical and sexual abuse. DSM IV

Now isn't that interesting. The focus is on the individual having the pattern of relationship with physical and sexual abuse, instead of the reverse. -Respondent

The physical and sexual abuse is present in people who have dissociative identity disorder. -DSM IV

Interesting. So the emphasis in that sentence is on the individuals who keep entering these relationships. Instead of the emphasis being on physical and sexual abuse, it's present in the lives of people with this disorder. It's almost like the DID causes the abuse instead of the abuse causes the DID. -Respondent

This clinician explores the subtext of the DSM IV diagnosis. There is a "blaming the victim" implication in the diagnosis that is a far cry from the PTSD diagnosis that affirms, trauma, trauma, trauma, “something terrifying happened to this person.” As will become evident, the clinicians in my sample believe PTSD to be on a continuum with
DID. But the DSM IV does not organize or present DID as being relevant to PTSD or vice versa.

What is interesting is that clinicians working in the field of dissociation have a keen understanding of the PTSD/dissociation/DID connection. Among the participants the consensus is clear: PTSD and DID are diagnostically related. One clinician from Japan explained to me how things came to be this way when I asked him “Why is it this way?”

Because of history. DID was found 200 years ago, but the study of DID became popular in 1980. And many researchers studying DID, (in those days it was called Multiple Personality Disorder). In the 1980s and 1990s, there were many researchers studied DID. And on the other hand, other researchers pay attention to PTSD, mostly Vietnam veterans. So researchers worked in different fields. One type of researcher paid attention to DID, the other type of researchers paid attention to PTSD. So these concepts were developed in two different academic communities. Nowadays, the two communities are integrating into one place. That’s why we’re talking about DID along with PTSD. But I studied in the DID area. I was educated and researched in DID area last 20 years, and we often talked about DID as the PTSD symptoms. We discussed this issue more than I think since 20 years ago. The DID researchers, they related DID with PTSD. But PTSD researchers, they focused on the PTSD symptoms, and they do not recognize the splitting of personality or splitting of identity. And very recently they began to pay attention to split identities. Now they are coming close to the DID researchers. Now together we are talking about PTSD and DID.

Yes, this is the result of politics and history. It has nothing to do with reality. We just have two camps of researchers studying DID and PTSD.

Such an explanation reveals “the man behind the curtain.” In other words it makes evident that there is a social construction piece to the DSM criteria. This is not to say that PTSD and DID are solely social constructions, but that their presentation (PTSD as a trauma disorder, DID as a pathological one) and organization may be. That said, it is encouraging to hear clinicians talk about the collaboration that is happening in the field.

As participants in this interview, the two are strongly interconnected and would perhaps
be better organized if placed under the same category, continuum or spectrum. One U.S clinician comments on the existing presence of dissociation under the PTSD criteria.

To make dissociation more inclusive under trauma really makes sense, I think. When you look at PTSD one of the other markers is their inability to recall information. Well that’s actually dissociative amnesia, which is one of the criteria for dissociative diagnosis. Then you look at PTSD and one of the other ones is that they feel detached from the world, things around them seem unreal—that’s Depersonalization Disorder. So there are in the PTSD diagnosis, several dissociative symptoms or markers and so I think it would be good to include more information in our subtype for dissociation and I think it would make more sense to have it under PTSD. I think it would help people begin to understand that this is a way of dealing with trauma and that they can have dissociative symptoms or a more serious disorder. I think that would help demystify the diagnosis of dissociation.

As she states, not only are there sound examples of dissociation under PTSD, which alone raises the issue of correct categorizations. But, more, coming back to the issue of politics, the current stigma of dissociative disorders, most particularly DID, could be given a new respect, a new validity and a new acceptance if they were aligned with PTSD. In other words, “The diagnosis of PTSD as it stands is inadequate” (U.S. clinician). There are different possibilities for how this inadequacy can be corrected.

Several clinicians (across cultures) suggested that PTSD and DID be along a continuum of severity in response to trauma.

I see PTSD, as does van der Hart, as being on a dissociative continuum. With PTSD incorrectly listed as an anxiety disorder, even though there’s low anxiety involved, I agree with them. So PTSD would be the first stage and DID is the third. So with post-traumatic stress, a traumatized child may first develop PTSD, and often you’ll see that. And then hopefully the intervention comes in or the child is removed from that traumatizing situation, and it doesn’t go on to develop into secondary posttraumatic stress, which is DDNOS (Dissociative Disorder Not Otherwise Specified), or complex PTSD. The longer you stay in a traumatizing situation, the more dissociative splits takes place, so that DID is the furthest end of the dissociative continuum.
Another U.S. clinician states that all dissociative disorders are posttraumatic conditions. This clinician employs the model of dissociation from the SCID-D. This is a five-symptom model that will be visited later in the chapter. She goes on to describe some emerging research that suggests there may be a subgroup of people who have a kind of PTSD that may be rooted in a latent or hidden dissociative disorder, meaning that perhaps they are not overtly dissociative, such as in DID, but they do use dissociation to cope in a way that is unobtrusive.

I do see these disorders as being interrelated. I think it might be helpful in educating professionals about the disorders to have them in a group of disorders that may be considered post traumatic. After all, the dissociative disorders, especially DID and DDNOS, are post traumatic conditions. They consist of all the symptoms of posttraumatic disorders, plus, we have five symptoms of dissociation.

A significant subset of people with PTSD have an undetected dissociation disorder, and there have been some studies now looking at people with PTSD. On the SCIDD they find that the profiles of more veterans with PTSD are virtually identical on the five symptoms to people with DID and DDNOS, suggesting that they have an undetected dissociative disorder.

In some way these innovative and insightful understandings of dissociation and PTSD belonging in the same category raises more questions than answers. All of the clinicians interviewed are experiencing, in their practice, that PTSD, dissociation and DID are all deeply intertwined. One US clinician suggests it's a continuum, another suggests they be grouped together, and another recognizes the existing presence of dissociation in PTSD. But, as the clinician from Argentina states, each clinician is alone...
in their conviction, uncertain how to think diagnostically when their experiences are incongruent with the firm stance of the DSM IV.

This is a question I have asked myself many times. In my own clinical experience I have always seen both diagnoses inter-related. I can tell you what I have seen. What I have seen is many children that are co-morbid that have PTSD and dissociative identity disorders, and I have seen some children who started being or were diagnosed more like PTSD and after awhile we came to the DID diagnoses.

But what is difficult for me is to know which was the evolution of each of the disorders. When did it start? They came hand in hand. PTSD stands alone as a diagnosis but I don’t know any child who’s had the trauma that leads to DID who doesn’t also suffer with PTSD. I wonder what that means about that consistent co-morbidity.

As I stated in the introduction to this section, she too observes that DID is always accompanied by PTSD. What does that mean? One U.S. clinician thinks that, like a disease, PTSD is the first development and as it evolves and flourishes one is afflicted with a terrible case of PTSD, called DID. The imprint of either is the mark of trauma.

But there’s controversy.

One U.S. clinician, who doesn’t particularly follow the diagnoses that stem from a medical model (DSM IV) has the following perspective.

A lot has to do with your discipline, your philosophy and also are you a researcher, are you a long-term therapist? Are you a disaster health responder? Where are you situated in this puzzle of services and also politically there are different agendas attached to these positions.

This U.S. clinician does disaster work and his practice is all around the world. He talks about the way his work asks him to abandon Western thinking. He also illustrates the mess that could occur if a Western clinician, deeply invested in PTSD and dissociation, were to impose his discipline without cultural understanding.
Well when I say non-interventionist, I’m interventionist as far as mobilizing resources, fostering social support, doing that kind of psycho-ed stuff and psychological first aid or like in Sri Lanka what we were doing was looking at what we know about healing in a Western context and trying to grasp onto do non-Western cultural practices to try and help people who have these practices and they also are overwhelmed and stuck and not sure how to help people. They’re not saying we’ve got it all down they’re not saying we don’t want you to come in and help us but on the other hand there’s this tendency for Western people to go in and say “Oh my God, look at all the PTSD here. Every child needs to go into therapy.” Not taking into account what the culture is and what the cultural practices are. So it’s a really complex area. And I think it’s good that it’s complex. And I think I’m situated and I have a bias but I think it’s good not to start shouting at each other saying this is right and this is wrong.

One way to do that, to diffuse the tension between the “PTSD and dissociation are not related” camp and the “PTSD and dissociation are interconnected” camp is to step back, step out of the Western model. This clinician, speaking about Africa, had the following understanding:

First of all, you take a concept like these psychiatric concepts, posttraumatic stress disorder or dissociation. They are squarely Western concepts. They have meaning, they have importance, they mean something to you and I because we’ve seen it in our society, we’ve seen it in terms of faces of clients, we understand the weight of that label. There’s an aspect of quality that we have because we understand that concept. If I were to apply a concept from another culture, like when I hear about Voodoo from Haiti or Caribbean Islands, I understand that it’s an important concept, but if you tell me that, I have no aspect around it because I don’t understand the weight of it. So somebody could use those concepts with me from that culture, and it wouldn’t mean anything to me

In regards to labels, if you’re going to use them, why are you using them and how are they helpful? Terms like PTSD are not particularly helpful there. They don’t get you any services. If you put that label on it doesn’t automatically imply, “Oh yes we know what to do. We’ll solve it.” what is more important is to find out what the person is doing that is causing the person not to function well.

In closing, we have heard from many clinicians in one sample about PTSD and dissociation. We had diverse perspectives unified under the theme that PTSD and DID are interconnected. The voices of participants express insight when it comes to the
question “What is the relationship of PTSD with dissociation and DID?” I would like to conclude with one thought, from a clinician from China.

In my opinion that they are same continuum, for DID is an extreme development after PTSD. Human beings are such delicate animals that can’t really be divided as distinct categories.

**Symptoms**

As illustrated in the PTSD/DID debate, diagnostic criteria can be subjective. In looking at symptoms, however, clinicians shared some assessments, as well as having some differences. Among participants from this study, one clinician in the U.S. and one clinician in China both used the same model. This test is used by thousands of clinicians in five countries. This model is based on extensive research, much of which had been conducted by the U.S. clinician, an M.D. It has been rigorously tested for universality.

Through strategic, thorough, and standardized testing five symptoms have been identified. Like what the Japanese clinician in an upcoming quote explains about the true self, in this standardized diagnostic tool these five symptoms are hidden in an inner ring. This ring is surrounded by an outer ring made up of more recognized forms of mental illness such as depression, PTSD, bipolar, borderline. What is interesting is that most clinicians would admit to being confused as to what constitutes DID besides the stereotype of multiple personalities. This standardized test breaks it down as follows (as described by the founder of the test):

The first [of these universal symptoms] is amnesia, the second is depersonalization, the third de-realization, the fourth is identity confusion and the fifth is identity alteration. And it’s symbolized as the internal ring because those are the hidden symptoms of dissociation, so people don’t present with that. They present with a variety of symptoms in the external ring.
This standardized test has been tested in adults and it has been tested in various sites of the US, various other countries internationally: Holland, Norway, China. It's being looked some more at in Spain now. We find that those five core symptoms are universal symptoms that not only are seen in dissociative disorders, but that distinguish people with dissociative disorders from people with other psychiatric disorders and normal controls.

This U.S. clinician explained that these symptoms will be consistently found if you know what they are and how to look for them. Her standardized test makes it possible for clinicians from all parts of the world to diagnose DID. The test is used as a therapeutic tool as well as a diagnostic one. It is meant to be used by clinicians in an interview format. If a client answers yes to a question, follow-up questions are available. In this way, the session is not a dry test, but an engaging and useful session. This can be useful when DID is present and you are seeking guidance. It is important to remember that these five symptoms are in the inner ring, hidden deeply, not only from other people but even from the client's own self. Being able to penetrate the inner circle, with these symptoms, is a necessary step to being able to treat DID.

*Inner Messages and Self-Control.*

This is one area in which there were some spontaneous finding; that is clinicians presented diagnostic material (not from the DSM IV) and agreed with each other about very specific ideas. This is remarkable considering the aloneness under which each clinician practice. One would think that if there were going to be many therapists naming the same symptoms their symptoms would be those listed in the DSM IV, a shared diagnostic manual. However, clinicians uniformly spoke about other criteria; "inner messages," control, attachment and neurobiology.
One of the hallmarks of DID is the idea of there being other voices. Sybil is often drawn to mind, presenting a stereotype that most lay people and clinicians alike often fall into of a person walking into the room dramatically in a red hat (when they always wear grey) and greeting the room in another accent. However, as these clinicians articulate, the dissociated identity can be much subtler. DID may not be an outside voice of an outside personality (e.g. alter), although it can be. Most often it is subtler than that. This clinician from China captures DID as she describes her many years of treatment with DID clients as being rooted in their experience of inner messages.

Symptoms generally can’t be ignored and exist quite early in their lives as "messages come from their brains/ minds". Some can just feel the messages or suggestions, which depend on the situation, some can further have dialogue/discuss/argue with the "messages", and even speak out in what looks like "self-talking".

Another clinician from the U.S. reminded me that the difference between psychosis and dissociation is that psychosis is often defined by hearing voices outside your head, such as from a clock or from a plant. DID, because it’s trauma based and, some would argue, related to PTSD, is about having flashbacks. A trigger (i.e. seeing someone who looks like the abuser, seeing something on television that reminds you of the abuse) can jog a memory inside your head, a flashback in which you hear the cruel messages of your abuser. Or, as integration progresses, you may hear the voice of that part of you who took care of you by enduring the abuse you were amnesic to (in other words you may or may not feel the messages from that part without it being a voice).

Here another U.S clinician describes dissociation as being on the trauma continuum (the same continuum as PTSD).
Dissociation is on such a continuum. There are lots of different ways that people can experience alternate personas or alternate voices that don’t necessarily come out in the outside world as different presentations, different names. But they are struggling with other voices inside their head that are holding different parts of the trauma.

Once again the idea of voices is described for DID, but not as voices “possessing” the client. Rather this clinician understands the voices can be present in a quiet way, in a subtle way (inside their head) that would not be obvious to friends or family. This phenomenon of experiencing another message or voice is particularly interesting in children who are too young to contrive voices or others inside them. Here we hear from an Argentinean clinician as she describes the dialogue she has with DID children. The children tell her that they think, that when they dissociate the traumatic material is disappearing. She does some psycho-education and clarifies that the brain is putting this material in another part of the brain. When the children hear this they recognize their experience of internal division. Here the experience of DID is even more subtle than voices or messages. These DID children are having PTSD symptoms that are being “pulled apart” inside them. In this way it is evident how subtle the gradation can be between PTSD and DID as further elaborated by this South American clinician quoted below.

So what do you think your brain is doing with these nightmares or with these terrors or things like that.” And most children say “I guess my brain will erase these things, or they will hide them until they disappear.” And I said “No. Do you know, this is the point: your head doesn’t tell you what it’s going to do. So what do you think they are doing? The head is pulling these things apart, another part of your brain.” And some children are saying “Yes I know, I have.” And they start talking about something like parts.

Another theme that came up among clinicians, and seems to have an inherent connection to the inner messages that come from different parts of a traumatized person
is the theme of control. Struggling with other parts of themselves, unto itself, creates a
situation in which the client feels out of control. But this inner model is often a reflection
of their history where there was nothing they could do to stop the sexual or physical
assault. This clinician has her own traumatic history. She explores why the “out of
control” feelings are so powerful when struggling with trauma and dissociation.

[As a victim of abuse] I think what scared me was I felt that I would have no
control over my body or my thinking or my mind. I think the reason that I felt that
was because in fact I didn’t, that people violated me.

Here a clinician is able to make a connection between the intrusions of the outer
world and her learned expectation, that this would be the case within herself as well.
Perhaps the other parts feel like an invasion, just as the abusers were. At the very least a
more developed part (along the continuum from traumatic memory to traumatic identity)
may feel like a sibling; bringing all the complications that come with that kind of
relationship. It must be difficult to have an inner world that has a life and a momentum of
its own, leaving you in the middle, entangled not only in traumatic history but in
traumatic self/selves. PTSD survivors as well as DID survivors often experience a sense
of unreality (depersonalization). Life is swam through not unlike a dream, but not a lucid
one. People and experiences come at you and you do not feel equipped to deal with
them, although another part of you may. Like being in a movie, with a cast behind the
scenes, your locus of control is not in the center of you, it is dispersed in your divided self
and you are influenced to move in opposing directions. This clinician recounts a classic
conversation she has with dissociated clients.

“Why did you do that?” and they’ll say “I don’t know, I just—something inside of
me made me do it.” or “I do things and I don’t know why I do them, and I don’t
seem to have control over them.”
What is particularly difficult for a child is their experience of an imaginary friend who takes over. As stated in the Literature Review chapter, seventy percent of children have an imaginary friend; this is a friend they can picture outside themselves that is there as needed for solace or play. For the traumatized child, in another example of the “inner messages,” the imaginary friend becomes all too real.

I guess the main point here is about control because the child who’s talking about imaginary friends that are just imaginary friends can have control over these imaginary friends. But when this imaginary friend is becoming a dissociative part is when you see how the child is losing control.

This US/International clinician (U.S. clinician whose disaster relief practice takes him around the world) explains how loss of control could also be understood as a loss of autonomy, the loss of one’s locus of control. This is what defines trauma; one’s life is threatened and there is nothing one can do to change the situation. Just as a tsunami is unstoppable, the sexual violation of a mother, the witnessed death of a loved one, the violent touch of a father all are unstoppable forces to the small child; this small child may grow up to believe she is unable to escape the abuse. So much of treatment is restoring one’s locus of control by learning how to take control back from the parts of you who lost it.

I mean that’s the thing I’ve certainly found is that people lose control when they experience a traumatic event or a disaster. The scariest thing is you don’t have control, you don’t have autonomy, things are done to you. Will this happen again? And taking control of your life is an important task.

In this section the themes of inner messages and loss of control have been explored. Though no conclusions have been drawn, by listening to clinicians from around the world it is evident that there is a correlation. Perhaps the very defense that
was used to protect (inner parts) has resulted in feeling out of control. How can one be autonomous when one is fragmented? How can control be restored? These questions will be explored in the "Treatment" section.

Neurobiology/Attachment: In this subsection of symptoms we will look at the neurobiological underpinnings and how these may affect attachment. These clinicians reported that dissociation is the sensible response of an infant to trauma. Increasingly, as discussed in the literature review chapter, clinicians are looking to traumatic reactions as automatic and neurobiological. Dissociation has recently been categorized under a new response, which some clinicians described to me as the "freeze" response (fight, flight, freeze). What may be a more accurate understanding is of all three being utilized by different parts in different ways. Here this clinician describes how the brain of the traumatized child, because of the PTSD component, is hyperaroused at all times. This hypervigilance can be easily misunderstood as acting out behavior but this clinician emphasizes that it is in fact,

related to the highly sensitive response to minor stresses in environment because of the trauma that has been unprocessed.

It’s an overreaction to the stress response system. There’s the freeze, fight, flight stress response system. When they come in, they’re bouncing off the walls and they are easily agitated and they have extreme mood switches to minor stimuli.

She also makes a compelling point, even if the child has no memory of the trauma, the traumatic imprint is still there, all the symptoms are still at play. By not remembering, the child is not spared. “Maybe even certain traumatic conditions have been blocked out of the child’s memory, but the impact of that continues to affect the child greatly.”
Another U.S. clinician who is also a nurse, spoke to me about another neurobiological component, the startle response. At birth, she explained, the infant is administered a test in which he is laid on a table and a banging sound is made on each side of the head. The child gives a full-bodied response, jumping with its arms, legs and head. That is the anticipated reaction at birth. She continues:

If however, that original all-body startle continues, then there is some problem in the neurological system. It's kind of remained frozen at an earlier time. And you begin to see a part of personality that is still back in that time zone. If you watch behavior in traumatized children you’ll notice their startle response usually is like a very small infant that the whole body goes into a red-alert system, not just the head-turning.

This full-bodied response is not only an indicator that there has been a split within the child, but it is a classic response of those with PTSD and is indeed listed under section D of the DSM as “exaggerated startle response.” One could very much argue that this PTSD response is the response of the self who endured the trauma. This self is latent within some people on the dissociative continuum and it is more pronounced in others (as a full alter).

This nurse/clinical psychologist later addressed the neurobiology of attachment by talking about the “attachment cry.”

It means, very very young child. It’s built into the genes. We share 99% of our genetic material with the primates. We even share 95% with mice. We think of birds being programmed and other animals as having instinctual drives… So infants are born like all mammals are, with a pre-programmed attachment need. When that need is not met, then attachment does not get integrated. Like the startle response, the attachment cry is instinctual.

So infants are born like all mammals are, with a pre-programmed attachment need. When that need is not met, then attachment does not get integrated. It remains separate, and the cry.
The clinician referred to the film footage of babies whose mothers were sent off to prison causing them to regress. Although moving footage at the time we now understand it better.

What we’re finding in the literature that children are more prone to dissociate if they have a month-long loss of a parent. Very young children are more adaptable to dissociating because they don’t have any other defense mechanisms to deal with.

Dissociation, particularly DID, may be the brain’s adaptation to early threat. Another way the parent can be absent is if they (the parent) experience the death of a loved one (usually a parent). This physiological response of the infant is something that may have been lost sight of in the controversy of theory. The nurse/clinician goes on to explain the biological underpinnings of trauma and the psyche.

So attachment is a piece of the normally developing personality. Seeking behavior, again like the rooting behavior looking for the nipple, that is innate in animals. Children attach or bond to caregivers very quickly, and it’s necessary for survival. Again, all children are born with instincts for survival, and those instincts are fight, flight, freeze, and submission. And you see that in the animal kingdom. What happens with normal children, those instincts, because they’re not used, because they’re not necessary for survival, they’re still biologically available in the reptilian brain, but they’re not acted on so they diminish in their importance because the personality is developing normally. Unfortunately for traumatized children, those instincts, because they get a lot of use, begin to expand in terms of the neurological wiring, and they may split into separate personality parts so there may be a part who avoids, or flees, or several. In a good environment, the development is toward integration of these inherent biological tendencies. For the child who’s exposed to trauma, then what happens is the split continues and separate parts are often developed to contain the emotional material that’s involved.

Here the neurobiological path of the psychological split is described; neurological hard wiring, like an overused circuit breaker, frays and splits into branches of fight/flight/freeze becoming more developed, more elaborate. If these primitive
responses are used frequently, identities organize themselves around the split.

Attachment, like rooting, like the startle response is an instinctual need of mammals.

Understanding this raises a critical point; dissociation is a biochemical reality before it becomes a psychological one. All the theory in the world may not be effective enough if we do not understand that the human psyche's response to trauma, with a developed adult ego, is neurologically driven PTSD, and with an immature ego, is neurologically driven dissociation. When we judge a person for having "alters" it is not unlike judging a person for having diabetes. We are only just beginning to understand trauma and the brain but the little we do know, as presented by this nurse/Ph.D., reveals an automaticity to the process that, if accepted, would challenge the attitude of clinicians from all walks of life. There is no place for politics here. She explains PTSD in this way,

What we have come to call a PTSD response is really the primitive survival mechanism that is encoded in the reptilian brain; these are fight, flight, freeze and submit. Those are genetically programmed. In trauma you lose connection with the cortex, the last part of the brain to develop, and the more primitive functions related to survival take over. So the limbic system, which is in the brain, and the reptilian brain, are the ones that activate. There's no conscious spot that goes into the process.

Understanding the visceral, primitive responses to trauma and the way in which the brain regresses to its more primitive states suggests that treatment is, in part, stabilizing those parts of the brain. Attachment, what began as instinct becomes part of social identity. In transition, here are the thoughts from a Japan based clinician who looks both at attachment and treatment. He describes the reparation he does with clients whose true self split off and went deep into hiding as very young children. He says most of the population of Japan have "two faces," a social self and a true self. Less and less of the young adult population are marrying or having children. Instead they stay single, focus
on their careers and live alone (this phenomena is not specific to Japan and its reasons are still unclear). They are this way because they do not have the capability to attach to others. They had parents who they feared deeply, and in response to this they buried their true self from them. This clinician’s treatment of dissociation depends upon his ability to earn the trust of the very young true self so that there can be a new model of attachment that they can take out of the office into the world.

Treatment usually is help my client to have new attachment with therapy. But before you do that, you have to identify the true self, because only true self is capable of making a judgement.

So I have to find out the separate true self first. And the way I find out the true self, I communicate with the true self, and then I develop intimate relationship with true self. Then the true self has the emotional bond with me, then they recover.

I try to have direct communications with the true self. When the true self comes up, then it usually comes out as a child, and I understand the feelings and pain and traumatic experiences. And these children become emotionally attached to me. So this is a new attachment for the client.

Treatment is successful when the true self has been recovered and been able to make an attachment to the clinician. Dissociation is understood to be correlated to disorganized attachment and it sounds as if some of this clinician’s population, with two faces, form a disorganized attachment. Disorganized attachment can be observed and in it one sees how “out of order” a child’s responses are as she perhaps jumps from one state of mind to another as she encounters a parent.

I think if you look at the symptoms in disorganized attachment, you begin to see those symptoms with the child and the caregiver early on, which is very important in detecting their freezing behavior with young children. And that would be one of the markers of a problem, when a child is distressed when a mother goes away for a bit and then returns. When the child is reunited with a mother then the child will freeze, and the child will go forward to be picked up by the mother. Then the child will back away, the child will stare off and the child will collapse.
Cultural Interpretations

International Interpretations: In looking at other cultures it was evident that culture plays a significant role in understanding PTSD, dissociation and DID. Africa, Japan, Argentina and the U.S. all had different perspectives. Because the clinician is following the standardized test, this clinician stated that she believes that the inner ring of DID symptoms is cultural free or universal.

I do think that the early "inner message" is the cultural-free dissociative symptom to DID. Latent DID or other dissociative patients who can't been easily accessed interpreted their long-term inner messages as 'universal phenomena' just like others, so they don't call for help, except for impulsive and violent behaviors.

This clinician sees dissociation as often hiding, unrecognized unless there is some kind of overt behavior. Yet the behavior is not dissociation, it is from the "outer ring." Otherwise the dissociative client may think they are just like everybody else. As addressed earlier, "inner messages" are understood by many respondents as evidence, in any country.

On the other hand the respondents in Japan and Argentina reflected upon the ways they see dissociation as being prevalent in their country. The South American clinician believes the culture's subjection to political abuse, which has caused widespread suffering, contributes to the phenomena of dissociation and DID in her clients.

I really think Argentine society is dissociative itself. Argentina is a country that has undergone many traumatic situations in our modern life too, and what you see is this living in a double consciousness phenomena. So we can walk over the dead valley of people who died in horrible conditions, who were killed by an entire government when we were governed by the military regime. And it's like nothing happened here. So I really think there's a cultural background about dissociation.
In a similar vein the clinician from Japan talks about double consciousness.

I think that the recovering clients, most of them, they say Japanese suffer dissociative identity up to like 80% of the people. And the Japanese special word for dissociative personalities: we have two words honne [?] and atatenai [?]. Honne means “true feelings.” Atatenai is appearance, social appearance. And so the Japanese must have two faces to survive in Japanese society.

Here we learn of the divided self, a division that is pervasive, so deep and so great it is like a fissure in the country itself. The clinician states that all but 20% of his country’s population have this internal split.

On a very different note, Africa does not have PTSD or DID in their belief system. This is not because they are a population without suffering. This may also not mean people are not struggling with some, perhaps many of the symptoms of trauma, but the way in which they might manifest and the way others respond to help has a very different feeling and meaning than the medical model in the U.S.

This clinician worked with the women in the internally displaced-persons camps that replace the villages. Here people are packed in. Thousands upon thousands are cooped up in internally displaced person camps whose populations range from 8,000 to 66,000 people. No one can earn a living because they cannot have animals, but for maybe one. They spend day after day, sometimes year after year in a terrible state of boredom at best, assault at worst. These camps are the NGO’s best attempt at aiding people whose lives have been devastated by war.

The context is that most people have experienced some form of violence, whether it’s a threat of violence or actual violence, 95% of children who have been abducted, had their villages attacked before their own abduction. So we’re talking about people being exposed to attacks, prior to even their own abduction. We’re talking about 88% of the same group knowing a family or a close friend who was abducted. We’re just talking about everybody in a community having some
experience of either being attacked, knowing somebody close to them who was abducted, and then on top of that, having their own abduction.

When the trauma hits home it would do no good to talk to these strong, brave people about PTSD or DID. Trauma in Africa is interpreted quite differently than in the U.S., their process of understanding and reconciling their experiences works well for them.

It is about the integration of life as opposed to breaking off a section here and section there, and addressing this aspect of our life versus that aspect of our life. In traditional African culture, they call it the integration of the spiritual and natural world. It is an important quality.

There an integration of the natural and spiritual world is the way this culture interprets wellness, even in the face of devastations beyond what our country can imagine. To impose a formal diagnosis would be a breach of safety to the client. This does not mean that people who have endured such suffering do not feel some of the feelings in the DSM, but to try to approach them and treat them according to our diagnostic criteria would be disrespectful and fruitless in large part because our DSM is designed to treat for the individual and in Africa, in the clans and communities there is no cultural frame of reference of the individual. More succinctly said, there is no individual, there is a kind of oneness that transcends American concepts and context. This cultural interpretation, grounded in integration illustrates how "unwell" our country is with its fragmentation, separation and isolation. The U.S. treats this affliction of the soul with the medical model and with a diagnostic manual. Perhaps this approach traces back to the founder of psychoanalysis being a medical doctor whose goal was to treat what was empirically evident while recanting his trauma findings to keep the peace with his Vienna community. These findings were of the pervasive incest of young women that he
ultimately dismissed as somatic and hysterical. Perhaps if the birth of psychoanalysis had been a bit more genuine one hundred years ago, our current model, which includes shunning dissociation, would have allowed for more authentic recognition and naming of suffering. The reality of the Western model was described to me by one U.S. clinician:

I mean look at the model that we teach and the model that you’re using in your clinical practice, that most therapists are using come from white male Europeans from the late nineteenth and early twentieth century. It’s evolved and it’s been developed, it’s shifted but there’s certain assumptions that there is an individual, that the individual has thoughts/feelings, that if we talk about with them we can work out plans of action that can help them to respond to it.

If this is looked at it evokes questions: when there are such diverse interpretations of the self, are PTSD and DID universal? When a standardized test is administered there is a standardized response, “yes, yes these symptoms exist.” But is such testing culturally appropriate and fair? This U.S. clinician, who has spent years using the standardized test says it is fair:

So if you don’t ask about the five symptoms, you won’t hear about it, and you’ll have a different external “cultural manifestation.” But if you ask about the five symptoms, you find the very same thing and that’s what researchers cross culturally have found.

This therapist believes that the cultural manifestations are distractions but if you look closely through a particular lens you will find these same five symptoms around the world. She has researched in five countries to prove this. The question then, is when is it important to be culturally sensitive and appropriate and to realize that, even if the same five symptoms are drawn, does this finding do any good to the client who has no individual sense of self?

United States Cultural Interpretations: As stated in the above quote from a U.S. clinician, there is a lineage that brings us to present day models for treatment: CBT (Cognitive
Behavioral Therapy), DBT (Dialectal Behavior Therapy), EMDR (Eye Movement Desensitization Reprocessing) to name a few. All are designed to help the individual function better. Yet interestingly the goal of treatment (to be addressed in a later sequence of this chapter) in Africa is to also help the person function better. The key is to enter a treatment model that is most attuned to the client, family, community.

Here in the U.S. I again came across some spontaneous findings, a cohesive theme among clinicians as they responded to the question of our own country’s cultural interpretations of DID. The broad overview of the cultural interpretation was almost adolescent in it’s tone.

I think its part of the wider stigma in terms of mental illness. “Those are crazy people.” Or another stereotype is that they’re making it up for attention, just trying to get attention, or using it as an excuse. Unfortunately, some of the lawyers trying to get a client off who has committed crimes, kind of trump up charge.

This attitude among the public is disheartening, but perhaps to be expected. One clinician describes a recent conversation with a client about what psychotic means, to which he responded “split personality” and then said “Ask Billy,” (a pretend alter). This young adult thought this was pretty funny and his response is telltale of how people in our culture do not have insight into the difference between dissociation and psychosis. One is a trauma based reaction, specific to highly intelligent people, who can be one hundred percent cured through therapy. Psychosis is . . . psychosis. “But back to that psychotic meets schizophrenia meets split personality. It’s ridiculous.”

So, as disappointing as it is to recognize the myths and misunderstandings about dissociative disorders in our culture it is to be expected from the mainstream public. On the other hand we rely on clinicians to have understanding and respect for dissociated
clients. However, almost all of the U.S. clinicians and one Argentinian found that other clinicians and treatment practitioners were scared, and in this fear many dissociative clients were mistreated or incorrectly treated. One clinician describes the role ignorance plays.

I just think that there’s some fear and ignorance and when there’s fear and ignorance, clinicians are less likely to want to delve into that because they don’t understand it and they don’t know how to deal with it.

People don’t really understand dissociation in terms of all of the different forms it takes, all the different ways it looks. They think dissociation, they think DID, they get scared.

Another clinician also describes the issue as ignorance; ignorance, not in a cold way, but ignorance in a lost way. She goes on to point out how common dissociation is. She also suggests that there is not ongoing discourse about what it is because of confusion. Her compassion opens the door to the possibility that, as a field, most clinicians do not know what to do with the dissociated client; child or adult.

Clinicians get scared. We aren’t taught about it. And the interesting thing is that dissociation is such a natural thing that happens to most of us, even if we weren’t abused. I’ve been in a car accident, and when you’re in a car accident, suddenly everything slows down. That’s dissociation. It’s such a common experience. I don’t know. I think it’s just because people don’t understand it. I think that’s part of why people don’t talk about it. It’s confusing, it’s hard to sort out.

It is important to be patient, to understand the fears of clinicians who do mean well as in the case of this U.S. clinician. She worked closely with a psychiatrist who was also confused. When her client had had a psychotic break, she contacted him for help. But, in his confusion, the doctor thought it was dissociation:

So she became psychotic and she started thinking all these different things were happening. Her psychiatrist told her it was a dissociative episode. I don’t think it
was. I think it’s really confusing. I think there’s a real lack of understanding about it

In this case we have a doctor who meant well and did try to use the diagnosis of dissociation. But he was confused. The issue is to diagnose dissociation when culturally appropriate. (In this instance in Argentina the clinician treating her client is talking with a clinician in a different program that the child will be participating in.) The new clinician observes that something is different about the client and is able to identify dissociation saying, “‘Oh yes I can see, she’s very dissociative.’” And I said, “‘Yes, actually she has DID’” and she said, “‘I guess she’s hysterical.’” When I heard this account I was stunned, I could not believe that this clinician was using a dated concept of hysteria from one hundred years ago. But it is just one more illustration of the poor comprehension that is so prevalent around DID and dissociation.

Many clinicians do not know how to diagnose for it, can mean well, as did this psychiatrist, but they have no concrete knowledge. This is when the standardized test can be valuable.

So if you don’t ask about the five symptoms, you won’t hear about it, and you’ll have a different external “cultural manifestation.” But if you ask about the five symptoms, you find the very same thing and that’s what researchers cross culturally have found.

In sum, as clinicians we don’t understand dissociation. This lack of understanding can cause fear. The clinician with the standardized test has found that, like the Japanese clinician who describes the true self as hidden, the dissociation or dissociated selves can be hidden. As clinicians we are well familiar with a certain spectrum of diagnoses, from major depressive disorder to schizophrenia. Dissociation is not on the spectrum because we don’t even really know what symptoms to look for, much
less how to treat them. When the dissociated client comes forward, knowing how to excavate the trauma, through testing for the five symptoms, can provide direction and support for the fearful, confused or ignorant clinician.

_Treatment_

_Phase-oriented treatment:_ Judith Herman is one of the clinicians who introduced the “Phase Oriented Treatment Model.” This model pioneered the way for clinicians across the country. When asked about treatment approaches most clinicians referred to this treatment model is the one they employ most regularly. “I work very much with a stage-by-dimension model, as Mary Harvey and Judy Herman talked about it, and that’s who I trained with”. This clinician walks me through the phases: safety, remembering and mourning and reconnection, community. She elaborates describing a model that follows the phase oriented approach, but is adapted for DID.

Herman has outlined safety for the first stage; the second stage she calls remembering and mourning, which again is that memory work stage and processing the affect; she calls the third stage reconnection, community. Now in structural dissociation, which is the van der Hart concept, first stage is symptom reduction and stabilization, in phase two there’s the treatment of the traumatic memory, and that is different. That’s the same work, but with DID, you have to work with each of the personalities in terms of treating traumatic memories. You have to process each of the memories that each of the parts have, and that’s different than remembering and mourning, when there’s one personality doing the remembering and mourning, so it’s more complex. But it’s kind of the same thing, you remember and you process feelings. And the third stage in DID is integration and rehabilitation. So you work with all the parts in stage two to identify the memory, and then in stage three you integrate all those parts into one personality and then develop skills for being in the world as an integrated person. So it’s similar, not exactly the same, but it’s similar with the phase-oriented treatment.

It can seem confusing, but she is simply saying that the first step is to reduce symptoms. This would come back to the “outer ring” that is part of the five-symptom
Before it is possible to communicate with the "inner ring," symptoms such as suicidality, self-inflicted injury, binge drinking, insomnia etc. should be dealt with. Once these symptoms are stabilized it becomes possible to go deeper and do the memory work, which is divided among different parts. And finally, once peace has been made so that alters can fall away, there is the task of learning how to live as an integrated person. This requires developing a whole new skill set and resources since dissociation has been the automatic response, often since infancy.

This next clinician does not mention using the phase oriented treatment model, however it is evident that his practice is alignment with it. First he affirms the need for safety, no matter where in the world the client is from. Next he talks about the second phase. He makes an interesting distinction, PTSD and dissociation are different processes than remembering and mourning. This is because the numbness and depersonalization that are present in both PTSD and dissociative disorders inhibit the ability to feel deeply or even, to feel at all. Thirdly he talks about the reconnection and community as a crucial part of restoration of the spirit.

Safety is a big variable when someone’s been traumatized so how do you help someone feel safe and the way you do that with children and young adults in Uganda is different than the way you do it with white kids in Northampton.

The other thing that I wanted to say is that people are not just responding to trauma, they are mourning and grieving losses and these are two separate processes. They overlap a lot but a lot of what people have to do is mourn the loss of life, property, pets, the way they were living.

And by doing it together and collectively, that’s an empowering experience. And that can make you feel good, that can make you feel safer, that can make you feel more hopeful, more optimistic, more trusting.
Another component of treatment is the process of normalizing for the client; not normalizing the event but the reaction; even if it’s symptomatic those symptoms are a normal reaction to having experienced something life threatening. This U.S. clinician who works internationally finds that this normalizing process is meaningful in many cultures.

After a disaster the goal is to provide psychological first aid but basically it’s to offer comfort, security and aid, so dealing with a person’s immediate symptoms that are destabilizing them. There’s a big emphasis on empowerment, resiliency and social support. Normalizing the normal reactions to abnormal events.

Here the U.S. clinician who mentioned training with Judith Herman describes the tools she tries to help the client develop to maintain their sense of safety.

This is a normal reaction of what happened to you. And also, we’ll often say this is a creative way to deal with what happened to you. So there’s this focus on helping to manage the symptoms through a variety of different ways, through relaxation, exercise, safe and comfortable routines in their lives

*Other Treatment Ideas Based on Cultural Interpretations:* This U.S. clinician, who treats dissociated children and adults, refers to her treatment approach with children in which she endeavors to have them in the least restrictive environment. By this she means she does everything she can to keep them out of the hospitals and in their homes.

[My treatment goals are] to maintain the child in a least restrictive environment, resolve the traumatic experiences, and integrate the child to develop a more unified sense of self by integrating the different aspects of the trauma of their resolving it, and to use new coping mechanisms to deal with stressful situations while they’re in a safe environment

Once again we see signs of phase oriented treatment, particularly with some of the treatment the U.S. clinician described for phase oriented treatment of DID; such as safety
(safe environment), remembering (resolve the traumatic experience) and integration (different aspect of trauma).

This clinician of the five symptom model, has found that there are different treatment goals for each symptom. Here she addresses the treatment of identity confusion:

The first step would be to identify that there is that war going on, because otherwise all you’ll hear about is that they have mood changes, they have self-destructive behaviors, they’re drinking alcohol, they’re cutting. As long as you’re just hearing about the external symptoms, that’s where people really get to spin their wheels, because you never get to what’s the underlying cause.

It is fascinating to hear this clinician describe why, so often with dissociation and DID, there is not success in treatment because the core five symptoms of the innermost ring are not identified. Clinicians get lost in treating the more familiar symptoms. This is because they do not know how to look or where to look in treating dissociation.

This clinician from China addresses the DID specific treatment goals as not culturally specific:

Decreasing and preventing the destroyed behaviors of alters, making them corporate with one another, and having well daily and occupational functions are very important. Being one integrated self or multiple-integrated cooperative selves depend on themselves or the primary personality.

These treatment goals can be confusing, but if there is something to guide treatment of DID, such as the standardized test in conjunction with phase oriented treatment, than these goals are integrated into process and it becomes possible to find direction and to have a sense of confidence when dealing with the dissociated population.

The African based clinician painted a beautiful picture of successful treatment. Her understandings and experiences make it evident that treatment is culturally specific.
Understanding that, and perhaps grasping what that means in our culture, is an underpracticed aspect of this profession. As you read, keep in mind that this ceremony is being used to help the most traumatized people one can imagine; people who watched their parents be murdered, or worse, were forced to murder them themselves. Listen here as she describes “successful treatment”.

The cleansing ceremonies that are done with the child walking on the egg in the Achouli if you’ve been away from your clan or away from your village for a long time and the possibility that you were exposed to spiritual impurities, and before you come to your homestead you have to go through a cleansing ceremony that involves stepping through a raw egg on top of a plant that is known for being a slippery kind of plant used to make soap. So the metaphor can be used that you’re being washed before you come back into your home. That plant is on top of a stick, it’s called the granary stick, it’s used to lift the roof of the clan’s granary, which keeps all the food. By walking over the clan’s granary, it symbolizes that the community is taking care of you. When the ceremony is not done, many people feel unbalanced. Some respondents use the words, “I feel that the ceremony psychologically balances us.” It’s a traditional culture, whether people who have not grown up with it will call it a myth, but for those who believe it, it symbolizes cleansing, being purified of all the impurities that you were exposed to, giving you a chance to re-enter and start anew and often symbolizing that the community will take care of you as best they can. For that to be able to psychologically balance you and the community, it’s huge. It shows the connection of all these parts, the physical, the psychological, the conceptual. How does the community understand you coming back into this community? The ceremony captures it.

This culture has a profundity to it, an ability to restore the individual to themselves and to their community, which are not separate. They are the same. But our culture is disparate, most of us do not have a community to witness us and help us call back our spirit, and even if we did we would see ourselves as individuals who are part of a community. We do not understand the oneness that comes from a spiritual integration that is part and parcel of one’s innermost core self. Unlike Japan, Argentina, China and the U.S. the self is not a double consciousness, rather an expansive one. Ceremony
reconnects the broken threads and reinforces the connected ones. The best part is there is no DSM and there are no politics and there is no history, there is just the now and the now is all the time. How can this culture adapt itself or evolve itself? We DO follow the medical model and the question becomes how do we use it and how do we transcend it?

As clinicians our first loyalty is to the psyche, the Latin word for Soul. How do we be doctors for the Soul? It is a powerful responsibility and it’s easy to understand how at times we can become confused or scared about something as unknown as DID. Those will be emotions we manage as long as we see clients. It is only the ignorance that can be corrected.

The closing quote is from a clinician with a lifetime of working with sexually violated and traumatized children and adults. He explains that one of the most important aspects of treatment is to attend to the client’s process in a way that is in no way reminiscent of prior abusers, most who “groom” the victim by praising them and making them feel special. So often in treatment we want to say something to express our feelings of connection and even admiration for the work the client is doing.

When treating a trauma, do not do or say anything that can be construed as the client having said or done something that you find satisfying, or in some way they have pleased you.

This message is one to end on because it is not something we really think about, but it is something that can provide that first stage of safety rather than re-enactment, something the client with PTSD or DID lives at the mercy of on a daily basis, through flashbacks and abusive relationships. And ultimately if we can gather, like flowers, a little bit of wisdom, from each of our clinicians from all of the countries, it becomes
possible to create a bouquet, a gathering of something beautiful, (in the words of Africa) 
“something natural and spiritual” to bring to our work.
CHAPTER V
DISCUSSION

Findings

The design of this study was based on open ended interviews with eleven clinicians, six from the United States and five from other countries. An objective of this study was to explore clinicians' views about the relationship between PTSD and dissociation/DID. Another goal was to learn how different clinicians in different parts of the world understood symptoms and treatment of Dissociative Disorders, with a focus on cultural interpretations. As proposed in the literature review and confirmed in the findings: whatever one's professional modality (e.g. social worker, psychologist or psychiatrist) or wherever one's practice was based (e.g. U.S., Asia, South America) there was a shared understanding that PTSD and Dissociative Disorders are interrelated (but not Africa where any diagnosis one might find in the DSM is considered irrelevant). Perhaps the most significant and meaningful finding is that, where diagnostic criteria keep them separate, clinicians' experience of PTSD and Dissociative Disorders is that they exist somewhere on a continuum.

Bessel van der Kolk, as well as Otto van der Hart and other leading clinicians (some who sit on the panel for the upcoming DSM V) have suggested that the term PTSD and the term dissociation/DID require reorganization underneath the umbrella diagnosis "Developmental Disorder" (as addressed in the literature review). As Freud established, dissociation is the natural response (to a traumatic experience) of an infant or young child.
whose ego is not yet formed resulting in identity fragmentation. PTSD is usually the affliction of someone with a more fixed and developed ego. Rather than the trauma shattering their ego it deals it a blow. Flashbacks, nightmares and numbing are symptoms of the cracks in the psyches, cracks through which the traumatic material seeps through uninvited, but the whole self is not lost, the whole self is intact. Looking at the difference between an undeveloped ego and an adult ego it is possible to see, from yet another light, the continuum upon which PTSD and DID are related. So our first finding is that dissociation and PTSD, according to interviewees, should be presented diagnostically, as related.

When it comes to the issues based on dissociation, my “Findings” chapter reveals the diverse and sometimes divergent voices of clinicians on the issue of dissociation. As a member of the “International Society for the Study of Traumatic Dissociation” the ISSTD is dedicated to understanding dissociation and furthering a cause that is often overlooked, discounted or dismissed by the general population of clinicians. When I began this study, I was insulated. I “spoke dissociation” and believed that it was a widespread disorder. I had, enthusiastically, read articles and books on dissociation. I also had contacted clinicians through the ISSTD, as I sought mentoring and guidance. I was learning and growing. But my first belief, one I brought to the table when I began this thesis, was that dissociation was widespread. The ISSTD never stated that, but it was my perspective. I was at one end of a spectrum that has been much discussed in this thesis (the one with PTSD and DID on a continuum). This end of the spectrum is focused on dissociation particularly DID. I allowed my narrow focus in a specific area of psychology to become distorted because I applied clinicians’ research on dissociation to
broader circles (e.g. the “worried well,” the chronically mentally ill and those in between). In other words from works of the large group of highly educated, skilled and adept clinicians who were experts on dissociation, I generalized. I errantly concluded that the high echelon of extremely bright clinicians active, not only in practice but in research and writing of dissociation had broad answers. Because this group had such a “big” impact on me I concluded it was a “big” presence with “big” reach.

However, during my research process, I began to experience a shift. As I progressed in my interviews with other clinicians, I began to understand that dissociation is not at the center of everything. Instead, it seems it may be happening to a select number of individuals.

This information (that dissociation occurs to a select population) was congruent with the findings of Dr. John Briere, a clinician who has also been active in the development of the DSM. As presented in the literature review, his findings show that, of those exposed to trauma, eight percent have significant dissociative symptoms while those who are clinically, significantly dissociated, ninety eight percent have a trauma history (Briere, J., 2006). In other words, of the trauma population in general only eight percent are dissociative. The other ninety two percent do not score for dissociation. But if you look only at this small subgroup of eight percent, ninety eight percent have a trauma history. This finding provides evidence that of the small populations who are dissociated almost one hundred percent were traumatized. But most who are traumatized do not dissociate. Such a finding humbled me, because I had felt so certain that the small terrain that I stood upon (in which dissociation was widespread) was a world view. My research has challenged me to revise that perspective.
It was not only this statistic of Dr. Briere that began to change my perspective but also the feedback of several clinicians whose research and practice was not in keeping with the ISSTD model. A clinician whose disaster work takes him around the world spoke to me of his experience with disaster survivors whom he encouraged to “do what they do” under stress, such as turn to family, nature or community for support. He stated that, from his diverse experiences, he’s found that only about one in one hundred people develop PTSD (on the continuum). Once again I became aware that the population of PTSD/Dissociation is much lower than I had imagined.

*Implications for Diagnosis and Treatment*

Though Dissociative Disorders are not prevalent, it is critical that when a client presents in treatment with dissociation clinicians know what that means and how to provide appropriate treatment. This is where research brought me to a shift in which I see that dissociation occurs within a smaller population. According to one doctor interviewed for this study, those with dissociation at the crux of their suffering often go undiagnosed because they present an “outer ring” (as mentioned in the Findings Chapter) of symptoms that can be culturally specific. In the U.S. this outer ring might look like borderline personality disorder or substance abuse whereas in China symptoms can include possession by a dead person or moving objects with one’s mind. What this means is that each culture has a “screen” of culturally popular symptoms. Meanwhile, the true symptoms of dissociation are usually buried in the most distrustful of populations who have worked hard to hide their alters or their broken off memories from others as well as themselves.
So what we have is a population of dissociated clients who might get lost in the maelstrom of possible diagnoses because clinicians are grappling to understand what they don’t know how to identify. It seems they do not treat dissociation because they don’t know how to and they don’t even recognize the symptoms. Consulting the DSM IV there are three items that are checked off for DID (1. two or more identities 2. that take over, 3. amnesia). And yet, most clients with dissociation apparently do not have full blown DID, but a variation of dissociative symptoms. Most are on that continuum. And that continuum includes PTSD. As stated by a clinician in the findings, the earlier the intervention the less the trauma progresses in the psyche the less damage it does (e.g. moving from PTSD to DID). This is why early diagnosis and treatment is so important, particularly with children.

The feedback that emerged from this study suggests that many, perhaps even most, do not treat dissociation, due to confusion. This is what it comes down to. Clinicians have heard of dissociation and DID and may even recognize it. This is partly due to dissociative disorders only being present in a subcategory of clients who are seen in an outpatient capacity. Clinicians do not know how or what to look for in even identifying dissociation in a client. As discussed in the literature review, the average diagnosis period for dissociated clients is seven years in the mental health system. This is because most clinicians only know how to recognize the symptoms on the “outside of the ring” meaning culturally common diagnoses. Often therapists simply do not know how or what to look for; or what symptoms are at the heart of their client’s distress. So here is the main issue, confusion and ignorance that can happen to the most savvy and caring of us. We simply do not have an adequate understanding of dissociation.
One respondent, a U.S. doctor has spent many years working to solve the misunderstandings of therapists and clients alike. She has refined a standardized test for dissociation that is also a therapeutic tool that can be used to talk with a client in more depth about their symptoms. Diagnostic resources such as this are crucial in getting past the distractions of the first ring and penetrating the heart of the individual’s suffering so that treatment can occur in a safe and effective manner. Unfortunately this second step (adequate testing) is the most critical and the most often overlooked. As noted in the findings, most clinicians had encounters with colleagues who were confused.

This just occurred to me last week. Recently my placement ended. During my time there I had a client who I diagnosed as DID. I spoke to her about this diagnosis during out treatment. I recently terminated at the agency. Meanwhile somehow the person in the Department of Social Services heard about this and called my supervisor who spoke in a calm way about dissociation. She tried to provide education. An hour and a half later the client was notified that her visits with her children were going to be changed from four sleepovers and five days a week to only hourly supervised visits weekly. This change was the result of ignorance and even panic when learning of dissociation. Sadly, the situation only went from bad to worse because the client, understandably, had amnesia about the conversation she had with me and she was furious with her new clinician because she herself (the client) has no idea what dissociation is, what was happening to her and why. As she learned that it was not the new clinician, but myself, with whom she built some hard won trust, she believed I had betrayed her. The history of our relationship has been irreparably damaged.
This story illustrates that, though dissociation may be affecting a small percent of the population (unlike its cousin PTSD), it is important that clinicians are familiar with its symptoms and how to treat them. The standardized tests for dissociation such as the DES or Dissociative Experiences Scale (see D) and Structured Clinical Interview for DSM IV Dissociative Disorders Revised (SCID D) are tools that can help a clinician be more competent and constructive in treatment. The first test (DES) is given to the client to fill out. At twenty-eight questions, it is brief. It is also not a therapeutic tool since the client quietly fills in their responses with a pen and then “turns it in” to the clinician. The second test (SCID D) is used as a diagnostic and therapeutic tool. During the test, when a client identifies a symptom via the outlined discussion it is further explored, in part with follow-up questions that are within the design of the test.

So here are the two common paths clinicians go down; being avid researchers and practitioners in the field of dissociation or being disoriented or unaware of the field of dissociation. The clinicians who are knowledgeable are actively contributing to the field. But their work often stays within the field of, for example, the ISSTD. These clinicians publish frequently in well-respected journals. But again, it seems those reading and utilizing the articles are those within the group of practitioners who research dissociation. The second group is the folks working in non-profit organization or other inpatient and outpatient facilities. These generous clinicians work hard and with what they know. But most do not know what dissociation means. For those who do know, their work is often sabotaged by the ignorance of their colleagues who don’t know.

And there is a third group. Two of eleven in this study did not use diagnostic resources such as the DSM in their treatment of clients. This was because the trauma
model was meaningless in the cultures they were working in. For example, the clinician in Africa would be unhelpful and useless to the population she was trying to help if she operated out of a medical model. As stated in the findings, these people had no singular individual identity, nor any singular community identity; rather the identities blur. They existed in a liminal place. To impose Western diagnoses upon them would have been intrusive, even destructive to their healing process. It certainly wouldn’t have “fit.” They had their own rituals and forms of support that were meaningful and successful in their recovery from horrors including witnessing the slaughter of one’s parents, or worse, having to kill them yourselves. Certainly the uselessness of the DSM IV was not based on their being a lack of trauma. This population experienced violence and poverty and suffering far beyond what most of us in the U.S. can even imagine. But treatment for them was to be found through dance and song and togetherness.

The interview data from a sample of eleven clinician (six U.S. and five from outside the U.S. and Europe) does not provide the basis for definitive conclusions about the nature of PTSD, dissociation and DID. However, the research does bring to light some important themes for current clinical and theoretical work, and for future research. These themes include testing those with PTSD for dissociation, and spreading the word about what dissociation is through a tool such as the standardized test with five symptoms. And finally, it is important to terminate the one hundred year’s war between the PTSD camp and the dissociation camp. It is time to think in contemporary and constructive ways that will help break the stigma of dissociation while simultaneously uniting PTSD and dissociation in the ways that are clinically sound.
But, behind the closed doors of our offices in private practice and in outpatient clinics we are isolated from one another. Therefore clinicians treating dissociation are finding insights and revelations about PTSD and dissociation but each is unaware that others are experiencing similar findings. On the other hand, many who solely treat PTSD do not know about, understand or accept the role of dissociation.

These DID children are having PTSD symptoms that are being “pulled apart” inside them. In this way it is evident how subtle the gradation can be between PTSD and DID.
References


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Appendix A

**BASK MODEL**

- **B** Behavior
- **A** Affect
- **S** Sensation
- **K** Knowledge

Figure 1. The BASK Model of Dissociation. Dissociation can occur at any level, i.e., any BASK component may be separated from any other(s) at a given point in time and congruent at others. The arrows represent the passage of time.
Appendix B

Woman moving through a series of compartmentalized flashbacks, ending with knowledge.

**Behavioral Clue**

![Diagram of Behavioral Clue]

**B** Behavior

**A** Affect

**S** Sensation

**K** Knowledge

Figure 17. The use of a behavioral clue in psychotherapy. First behavior noticed was patient staring and rocking.

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Appendix C

Child Dissociative Checklist (CDC), Version 3

Frank W. Putnam, MD

Date: Age: Sex: M F Identification:

Below is a list of behaviors that describe children. For each item that describes your child NOW or WITHIN THE PAST 12 MONTHS, please circle 2 if the item is VERY TRUE of your child. Circle 1 if the item is SOMETHING or SOMETHINGS TRUE of your child. If the item is NOT TRUE of your child, circle 0.

0 1 2 1. Child does not remember of denies traumatic or painful experiences that are known to have occurred.

0 1 2 2. Child goes into a daze or trance-like state at times or often appears "spaced-out." Teachers may report that he or she "daydreams" frequently in school.

0 1 2 3. Child shows rapid changes in personality. He or she may go from being shy to being outgoing, from feminine to masculine, from timid to aggressive.

0 1 2 4. Child is unusually forgetful or confused about things that he or she should know, e.g. may forget the names of friends, teachers or other important people, loses possessions or gets easily lost.

0 1 2 5. Child has a very poor sense of time. He or she loses track of time, may think that it is morning when it is actually afternoon, gets confused about what day it is, or becomes confused about when something has happened.

0 1 2 6. Child shows marked day-to-day or even hour-to-hour variations in his or her skills, knowledge, food preferences, athletic abilities, e.g. changes in handwriting, memory for previously learned information such as multiplication tables, spelling, use of tools or artistic ability.

0 1 2 7. Child shows rapid regressions in age-level behavior, e.g. a twelve-yearold starts to use baby-talk, sucks thumb or draws like a four-year old.

0 1 2 8. Child has a difficult time learning from experience, e.g. explanations, normal discipline or punishment do not change his or her behavior.

0 1 2 9. Child continues to lie or deny misbehavior even when the evidence is obvious.

0 1 2 10. Child refers to himself or herself in the third person (e.g. as she or her) when talking about self, or at times insists on being called by a different name. He or she may also claim that things that he or she did actually happened to another person.

0 1 2 11. Child has rapidly changing physical complaints such as headache or upset stomach. For example, he or she may complain of a headache one minute and seem to forget about it the next.

0 1 2 12. Child is unusually sexually precocious and may attempt age-inappropriate sexual behavior with other children or adults.

0 1 2 13. Child suffers from unexplained injuries or may even deliberately injure self at times.

0 1 2 14. Child reports hearing voices that talk to him or her. The voices may be
friendly or angry and may come form "imaginary companions" or sound like the voices of parents, friends or teachers.

0 1 2 15. Child has a vivid imaginary companion or companions. Child may insist that the imaginary companion(s) is responsible for things that he or she has done.

0 1 2 16. Child has intense outbursts of anger, often without apparent cause and may display unusual physical strength during these episodes.

0 1 2 17. Child sleepwalks frequently.

0 1 2 18. Child has unusual nighttime experiences, e.g. may report seeing "ghosts" or that things happen at night that he or she can't account for (e.g. broken toys, unexplained injuries).

0 1 2 19. Child frequently talks to him or herself, may use a different voice or argue with self at times.

0 1 2 20. Child has two or more distinct and separate personalities that take control over the child's behavior.
Appendix D

Dissociative Experiences Scale

(Never) 0%----10----20----30----40----50----60----70----80----90----100% (Always)

01. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don't remember. Indicate what happened during all or part of the trip. Indicate what percentage of the time this happens to you.

02. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Indicate what percentage of the time this happens to you.

03. Some people have the experience of finding themselves in a place and having no idea how they got there. Indicate what percentage of the time this happens to you.

04. Some people have the experience of finding themselves dressed in clothes that they don't remember buying. Indicate what percentage of the time this happens to you.

05. Some people have the experience of finding new things among their belongings that they do not remember buying. Indicate what percentage of the time this happens to you.

06. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Indicate what percentage of the time this happens to you.

07. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Indicate what percentage of the time this happens to you.

08. Some people are told that they sometimes do not recognize friends or family members. Indicate what percentage of the time this happens to you.

09. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Indicate what percentage of the time this happens to you.

10. Some people have the experience of being accused of lying when they do not think that they have lied. Indicate what percentage of the time this happens to you.

11. Some people have the experience of looking in a mirror and not recognizing themselves. Indicate what percentage of the time this happens to you.

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Indicate what percentage of the time this happens to you.

13. Some people sometimes have the experience of feeling that their body does not seem to belong to them. Indicate what percentage of the time this happens to you.

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Indicate what percentage of the time this happens to you.

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Indicate what percentage of the time this happens to you.
16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Indicate what percentage of the time this happens to you.

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Indicate what percentage of the time this happens to you.

18. Some people sometimes find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Indicate what percentage of the time this happens to you.

19. Some people find that they sometimes are able to ignore pain. Indicate what percentage of the time this happens to you.

20. Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Indicate what percentage of the time this happens to you.

21. Some people sometimes find that when they are alone they talk out loud to themselves. Indicate what percentage of the time this happens to you.

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people. Indicate what percentage of the time this happens to you.

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Indicate what percentage of the time this happens to you.

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Indicate what percentage of the time this happens to you.

25. Some people find evidence that they have done things that they do not remember doing. Indicate what percentage of the time this happens to you.

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Indicate what percentage of the time this happens to you.

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Indicate what percentage of the time this happens to you.

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Indicate what percentage of the time this happens to you.
Appendix E

Informed Consent Form

Hello,

My name is Elenore Snow. As a candidate for the Master of Social Work degree at Smith College School for Social Work I am conducting, as required, a research study which will explore insights of clinicians from five countries, about dissociation. The purpose of this study is to examine ways in which symptoms and treatment of Dissociative Identity Disorder (DID) are universal and also to explore the relationship between DID and PTSD. Childhood and adult dissociation was studied in the mid-eighties and early nineties but research has waned in the past ten years. With this data I hope to contribute to an awakening of interest in the field. I also hope to present this material at a conference or as a published work.

You are being asked to participate in this study as a member of the International Society for the Study of Dissociation or a colleague of a member of the society or as faculty at a university or as a clinician in private practice. The letter you are reading is an Informed Consent Letter, and your signature is an agreement to participate in this study.

The information from our interview will not be published in specific detail in the thesis. Rather, a general statement will be made that the clinicians who participated in this study were assessed as qualified because they had a minimum of three years experience treating trauma. From there, a maximum one hour interview will be conducted over the phone, or, if possible, in person. This interview will be audio recorded. An alternative would be to respond to the interview questions via email. In total, participation in this project will take approximately forty-five minutes. Specific
inclusion criteria are that you are a qualified professional social worker, psychiatrist or
psychologist. Candidates will be excluded if they have no education and no prior
experience in the field of trauma..

Risks involved include disclosure of nontraditional perspectives in a controversial
field of psychology and whatever discomfort might accompany that disclosure. Also
disclosure to a researcher that is unknown to you. To further assist you I will be happy to
provide you a list of referral resources prior to the interview. Benefits to you include
having an opportunity to safely voice your unique perspectives on dissociation. The
expression of your views may provide insight and meaning to other clinicians and to
those who struggle with dissociation and to their family and friends. As you are well
aware, there is much confusion and misunderstanding about the field of dissociation. It
will greatly benefit the field of DID for if you share your knowledge and your experience,
which can enrich the understanding diagnostic identification of dissociation. There will
be no financial benefit to you. The benefit will be the contribution to the understanding
of the universality of childhood dissociation and its relationship to Posttraumatic Stress
Disorder.

Though I cannot guarantee confidentiality, every effort will be made to maintain
it. After the interview has taken place, the transcription of the interview will be logged
under a pseudonym on the tape. Confidentiality will be protected in this way. Your
signature below will give me permission to interview you, record the interview and use
the information in the research study. The signature cannot be electronic; therefore I will
mail a hard copy of this letter to you, along with a self-addressed, stamped envelope.
Once I have received the signed document, we can proceed with the interview.
If you have any questions, please email them to me at esnow@smith.edu. You should also know that when responding to the questionnaire or interview questions, you may refuse to answer any question. You may also change your mind and withdraw up until May 12. If you decide to withdraw, all data related to you will be destroyed.

Two copies of this letter have been sent to you. Please keep a copy of this letter for your records.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

______________________________
DATE

______________________________
SIGNATURE OF PARTICIPANT
Appendix F

Semi-Structured Interview Guide

1. What are the symptoms you see as particularly important to childhood and adult DID?

2. Are you aware of cultural interpretations of these symptoms and ways that these interpretations may prohibit accessing this population for treatment?

3. Because DID develops in an individual due to experiencing traumatic events, the child also shows symptoms of Post Traumatic Stress Disorder (PTSD). Do you experience PTSD and DID as two separate diagnoses or as interrelated? Do you think that DID might be more accurately categorized as a sub-category of PTSD or do you think they should remain distinct and different diagnoses? Why?

4. What is the focus of your treatment approach? What are treatment goals?
Appendix G

Braun's Trauma Continuum

<table>
<thead>
<tr>
<th>NORMAL EPISODE</th>
<th>DISSOCIATIVE DISORDER</th>
<th>PTSD</th>
<th>ATYPICAL DISSOCIATIVE DISORDER</th>
<th>ATYPICAL MULTIPLE PERSONALITY DISORDER</th>
</tr>
</thead>
</table>


Post-Traumatic Dissociative Stress
Normal Episode Disorder Disorder
Atypical Multiple Personality Disorder