Dissociation or psychosis?
What is the difference and what impact do these different diagnoses have on treatment?

Giselle Troy
Auckland University of Technology
2008

Table of Contents

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: Date:

Acknowledgements

Ethics Approval

Ethical approval has been given in a general approval of dissertations of this type. The approval number for Dissertation 588869 is 02/33 and was given on the 27th April, 2004, 2007.

Abstract

This is a modified systematic literature review of addressing the question dissociation or psychosis? What is the difference and what impact do these psychopathologies have on treatment?

The purpose of the study is to examine the two conditions of Dissociative Identity Disorder (intially known as Multiple Personality Disorder) and schizophrenia (previously termed dementia praecox) in order to provide a greater understanding and awareness of how each is both distinct from and similar to each other and so diminsh the possiblity of confusion, misdiagnosis and unsuitable treatment paths.

The literature on schizophrenia and DID is extensive and there are many conflicting academic opinions; some theories suggesting that the conditions are distinct while others that they may be synonymous. This review examines the debates around these issues and provides an understanding of how the historical view of mental illness has influenced modern day perceptions. Symptomatology relating to the conditions is outlined, highlighting the complexity in client presentation, trauma issues and shared features between DID and schizophrenia. Differences and other significant influences underlying diagnostic issues are also presented.

The underlying reasons why a diagnosis of schizophrenia often precedes that of DID, are also examined. The aetiology of both conditions is then described, particularly the controversial aspects relating to the causes of DID.

Finally implications for practice from this review are considered with the intention of increasing awareness around the multi-factorial issues relating to these two conditions that often results in differential, delayed or no diagnosis. This increased awareness also has the potential to enhance the relationships between client, whanau (family), community and health professionals.

Chapter One: Introduction

Introduction

This Chapter introduces my dissertation topic: Dissociation or psychosis? What is the difference and what impact do these psychopathologies have on treatment?
I have reviewed Dissociative Identity Disorder in particular as the example of dissociation, and schizophrenia as an example of psychosis.
A discussion follows on what led me to this area of interest, and also what will be addressed throughout this dissertation.

Questions raised

Questions directing this literature search include: 1) what effect does it have on the client to be 'undiagnosed' or 'misdiagnosed'? 2) Why do many clients diagnosed DID have a prior diagnosis of schizophrenia? 3) What ideas or symptoms lead to confusion in diagnosing? Is there confusion between the two disorders? 4) What, if any, are the similarities between Dissociative Identity Disorder and schizophrenia that may lead to a diagnostic confusion?
5) What are the underlying features or issues that influence diagnosing the diagnosis?
6) How does a clinician's opinion about the disorders influence the diagnosis and treatment of a client?

The focus of this dissertation is to present the literature that discusses how similar or different the two diagnoses of DID and schizophrenia are. I have discovered throughout my readings that some authors believe they are very similar whilst in other writings they are addressed as quite distinct and separate (Ross, 1997). How can two seemingly different diagnoses be confused? Upon further investigation DID as a diagnosis was found to have a history of conflicting opinions surrounding it. It would appear that DID itself can be difficult to diagnose at times (due to issues of co-morbidity and symptom presentation). There are many opinions about DID being a rare condition or iatrogenically created and this appears to result in wariness amongst some clinicians. If it is proven that DID has similar features to schizophrenia the wariness and uncertainty about DID as a diagnosis may result in the more dependable diagnosis of schizophrenia.

Several key theorists appear throughout the literature including Ross, Kluft, Putnam Loewenstein and Spanos. Literature from across the disciplines of psychoanalysis, psychology and psychiatry has been included to provide a multidisciplinary perspective.

Influences

I became interested in the diagnoses of DID and schizophrenia in my work with sexual abuse survivors. In my role as a psychotherapist and particularly as a crisis counsellor, I encounter many women facing a continuum of trauma responses. I have been moved by the women who struggle with dissociative experiences and the stories they have shared with me about their treatment from clinicians, family and friends. Throughout their lives some of these women have received numerous diagnoses, which have included schizophrenia, DID or both. Through conversations with colleagues trained within different disciplinary fields (psychotherapy, psychology, counseling and mental health nursing) I became aware of different opinions that surrounded DID as a diagnosis. Colleagues expressed views of both a lack of awareness of DID and of similarities DID has with other diagnoses, particularly psychosis.

I am interested in how clinical opinions affect the clients, therefore in this dissertation my main focus is to explore both clients' and clinicians' experience.

Diagnostic dis-ease

The literature on schizophrenia and DID is vast and in researching this dissertation topic I was often led to a multitude of conflicting opinions about DID. The literature revealed a variety of possible reasons a client may receive both diagnoses in the course of their treatment. Throughout the literature reviewed I saw a common thread of clinicians dis-ease in discussing the diagnosis of DID. This is captured by Brenner (1994) who writes: "many [clinicians] have not seen any cases [of DID], so it is an uneasy topic, which, in some circles, may even be regarded with scorn" (p.270).

Fernado's (2002) comments add to Brenner's point, stating that DID began to recede as a diagnosis when Blueler coined the term schizophrenia and the DID clients may have subsequently been included in this term. "Many of the more severe cases of DID ended up

either in the back wards of institutions, deemed medication resistant, or as one of the striking psychotherapeutic cures of schizophrenia"(p 167).

The work of Collin Ross, a psychiatrist and president of the International Society for the study of Dissociation in America, is of immense value in clarifying the prevalent issues of schizophrenia and DID. He provides a comprehensive amount of literature about DID and detailed consideration of the overlaps with schizophrenia. Most psychiatrists adhere to a conceptual system, which presents a clear differentiation between the two. Ross (2006) states that the distinction between the two disorders has been unclear in the literature for almost a century, the two disorders are often confused or thought to be synonymous.

Waugman (1996) also notes that one of the most significant omissions in the schizophrenia literature is the subject of dissociative disorders and adds that, even though there has been a recent sharp increase in reported cases, DID is still a controversial disorder. Describing the experience of working with dissociative disorders, Waugman's (2000) words are characteristic of many who work in the field of dissociation.

> "Since 1984, I have worked intensively with several DID patients and consulted on many others. I often felt that the result of my efforts to convince skeptical colleagues of the existence of DID as a diagnosis – or especially early on – was to damage my own credibility in the eyes of those colleagues" (p 209).

Chapter outlines
Chapter one has presented the dissertation question and the personal and theoretical influences which guided the research.

Chapter two presents the methodology employed, identifying the databases used, search results obtained and identifies the inclusion/exclusion criteria.

Chapter three will describe the history of mental illness and the evolution of schizophrenia and DID.

Chapter four describes the aetiology of each disorder and the literature on each is compared and contrasted.

Chapter five describes the signs and symptoms of each disorder including literature on similarities, differential diagnostic issues and outcomes/effects on the client.

Chapter six evaluates the outcomes and effects on clients of being diagnosed or misdiagnosed.

Chapter seven concludes with a synthesis of the literature providing a discussion of the limitations of the study as well as possible future research proposals.

Throughout the literature published clinical case studies that may illuminate both the client's presentation and experience are provided. Confidentiality has been maintained by following the publisher's use of anonymity.

Chapter Two: Methodology

Method

This dissertation is guided by the research question: Dissociation or Psychosis? What is the difference and what effect do these different diagnoses have on treatment?

The aims of this research are to contribute to the understanding of DID and ultimately explore the effects and outcomes on these clients throughout their treatment and diagnostic experience of being DID. The methodology therefore takes the form of a modified systematic literature review. Systematic literature reviews arose from 'evidence-based practice' (McKibbon, 1999). It is a modified review because the majority of the literature included is based on qualitative research or case study observations, as opposed to quantitative evidence-based studies which are traditionally used in disciplines associated with the medical model (Fonagy, 2003).

In my search for literature I have included research and insights from academic disciplines including psychoanalytic theory, psychiatry and psychology. I have chosen to look across disciplines, and not just focus on the psychoanalytic, because, to answer my question about why a client may receive different diagnoses (and what the effect of this is), led to the different approaches and beliefs represented by these different disciplines. My desire to study this topic came as a result of client contact in which I realized that (DID and Schizophrenic) clients will not be only treated by psychotherapists, they may spend time in other mental health systems where they encounter different health professionals with different attitudes.

I have included several published case studies to act as vignettes of the literature described.

Search criteria

My main search engines included PEP (Psychoanalytic Electronic Publishing Archive), PsychINFO and PsychArt. Entering the broad terms of schizophrenia and DID initially led to hits of between 72900 and 1000 (respectively) across different databases. I combined my searches to narrow and specify the results.

I used PEP as my first primary database which resulted in three hits when I entered a combined search of DID and schizophrenia. Of these three, two articles were used, both written by the same author whose reference list led me to other relevant articles. Because DID was once known as MPD, and this is still the name used amongst some writers, I also conducted searches using this title (MPD). This often resulted in new and useful articles. Combining MPD and Schizophrenia in the PEP database resulted in 33 hits of which 12 were most relevant.

Across the other two databases, PsychINFO and PsychArt, I entered the same search terms alternating the use of the titles DID and MPD. The PsychArt database resulted in 84 hits for DID and Schizophrenia and 73 hits for MPD and Schizophrenia. Of the 84 hits (DID and Schizophrenia) 12 articles were used, and 13 new articles were found from the 73 under MPD and Schizophrenia. The PsychINFO database resulted in 103 hits for the search terms DID and Schizophrenia, of which 24 were used and four new articles resulted from the search terms MPD and schizophrenia.

All articles that were repeated across database were not included once already accessed. Aware of the similar authors that were replicated in my search results I supplemented my literature by hand sourcing library books and articles written by key theorists that I was not able to access fully online.

Table of Search Results

Database	Results/Used
PEP	
DID	33
Schizophrenia	1000/3
DID and Schizophrenia	3/2
MPD and Schizophrenia	33/10
PsychINFO	
DID	1920
Schizophrenia	72910
DID and Schizophrenia	103/24
MPD and Schizophrenia	62/4
PsychART	
DID	241
Schizophrenia	11852
DID and Schizophrenia	84/12
MPD and Schizophrenia	73/13

I also conducted a 'google' search to widen research into opposing views of DID and also to get the perspective of the general or leading opinions of schizophrenia, thus highlighting the significant differences between the two disorders.

Inclusion and exclusion criteria

Although many articles were brought up under the subject heading DID and schizophrenia, it quickly became apparent that the majority were not of relevance to this dissertation topic as they were far too general. After combining my search terms to narrow hits I was able to then select the most relevant to this topic. There were several repeats of the same article across the databases so I excluded them the next time they appeared.

My inclusion criteria included articles that discussed conflicts about DID and schizophrenia, aetiological perspectives, symptomatology and published information on results or outcomes of diagnostic issues. I included articles that were written by key theorists such as Kluft, Ross, Read, Putnam and Loewenstein.

Through my database searches I became aware that very little has been written in the psychoanalytic material directly on the overlaps and similarities of DID and Schizophrenia. This may be a result of psychotherapy's reluctance to pathologise clients with diagnoses.

To supplement my literature searches I also used reference lists from the most relevant articles to source further articles and books. In this way, I was directed towards other disciplines where the literature discussed these differences and conflicting opinions about the disorders. I found much overlap between writers who seemed to sit in one camp or another (i.e. those who validated DID as a diagnosis and believed some clients are misdiagnosed when told they are schizophrenic, and those who saw it as having the same validity and therefore did not perceive misdiagnosis occurring). I also carried out searches in Google under views of schizophrenia and differential diagnosis of DID.

Literature discussing recovered memory debate has been excluded as it is a significant issue which adds further complexity unable to be attended to within the limitations of this dissertation. Literature that was based upon other forms of psychosis was also excluded. All literature not written in English translation has also been excluded. Articles which had relevant accounts of the history, aetiology and descriptions of the disorder were included, as was information that bore relevance prior to the 1990's, for example, attitudes in the 1980's. However, articles published earlier than these dates that discussed hypnosis and hysteria were excluded.

Chapter Three: History

"If you would understand anything, observe its beginning and its development"
Aristotle (1875 – 1965).

Introduction

This chapter will focus on the history of mental illness with specific reference to DID and schizophrenia. It is from such history that we can see that the views and understanding of mental illness have changed. A general understanding of mental illness is provided from historical times followed by a description of the evolution of the two conditions DID and schizophrenia.

Mental illness

Throughout time, accounts of mental illness are divided into two distinct changes in thought: the supernatural and the scientific. Three thousand years ago in the western world, 'madness' was commonly understood as the influence of evil gods and demons, a divine punishment for breaking the norms of the time (Read, Mosher & Bentall, 2004). Evidence for this is found throughout different religious texts (Read, 2004) such as in the bible where Christians refer to being struck with madness for breaking a commandment. In the 1400's people exhibiting bizarre or unusual behaviours were believed to be possessed by evil demons, and so were not held responsible for their actions (Kraemer & Sprenger, 1486; cited in Read et al, 2004). From the eleventh century onwards, society believed the responsibility resided more with the person (particularly if it was a woman) who it was believed had invited the devil into their lives (Bentall, 2003). This resulted in the period of witch-hunting, where people were held accountable and were punished for their behaviours.

Bentall's (2003) account of the history cites Hippocrates as one of the first to propagate the medical model, reducing complexities of unusual, distressed or distressing human behaviours to a set of categories of illnesses, convinced he was finding a physiological cause of illness. This was in contradiction to the most widely held beliefs about mental illness at that time. Bentall (2003) further points out that it was not until the classical era

(1750-1820) that the supernatural explanations actually began to be replaced with the scientific.

DID throughout the ages

Colin Ross (1994, 1997), a prolific writer on DID, presented the historical Egyptian myth of Osiris who was the Egyptian god of the Underworld. Osiris, murdered by his brother Set, was cut into multiple pieces and scattered over the world. Isis, his wife and sister, gathered up the pieces and resurrected him into his new form. Ross (1994) draws a parallel between this myth and DID, in which he describes the same fragmentation and splitting of parts. A further example is also explored by Ross (1997) when he looked at the shamans – a spiritual group amongst North Americans. According to Ross, shamans' accounts of dissociation throughout their practices give evidence of possibly unrecognized accounts of DID.

Putnam and Lowenstein (1993) also believed historical accounts referred to DID and describe the presence of multiple selves in Greco Roman mythology, the bible and writings in the modern medical era. They cite two examples: in 1646 Paracelsus wrote of one of the first medical reports on alternating selves; and in 1791 there is a record of a German woman, Eaberhardt Gmelin, who apparently alternated between a peasant woman and an aristocratic lady with amnesia between each existence.

By the 1900's writers such as Jung, Prince, Janet and Freud wrote about dissociation and were interested in the effects of trauma. It was within the work of Pierre Janet (1889) that we see the beginnings of today's understandings of DID causation. Janet's contribution was to emphasize the traumatic antecedents of dissociation. At the time, Freud was working with adults with hysteria symptoms whom he believed suffered from the real consequences of childhood sexual abuse. What was then called hysteria would perhaps today be recognised as DID (Putnam & Loeweinstein, 1993). Ross (1997) gives a clinical vignette of *Anna O,* one of Freud and Breuer's patients from Vienna in the 1880's. He describes how two entirely different states of consciousness presented which alternated very frequently and without warning and which became more and more differentiated in the course of the illness.

In one of these states she recognised her normal surroundings; she was melancholy and anxious but relatively normal. In the other state she hallucinated and was 'naughty' – that is to say, she was abusive, used to throw the cushions at people, so far as the contractures at various times allowed, tore buttons off her bed clothes and linen with those of her fingers which she could move, and so on. At this stage of her illness if something had been moved in the room or someone had entered or left (during her other state of conciousness) she would complain of having 'lost' some time and would remark upon the gap in her train of concious thoughts (Ross, 1997, p76).

Ross (1997) recognises this account as reflecting the classic symptoms of DID which include the ongoing amnesia for current events outside the range of ordinary forgetfulness. Ross cited Freud that Anna descibed herself as having a darkness in her head, being unable to think, becoming blind and deaf, of having two selves (a real one and an evil one who forced her behaviours) and amnesia between each self, representing essential features of DID. Freud also noted that Anna had interesting features that included speaking two different languages whilst in different conciousness and exhibited disorientation to time, often believing she was in the year 1881 when it was actually 1882. Anna was recorded as describing " a part of herself which was a clear sighted and calm observer which sat in the corner of her brain and looked on all of the mad business" (p 31). Ross (1997) considered this her third state which would now be called her inner observer or internal self helper.

While Freud does not record any evidence of sexual abuse in Anna's history, he does record that there were features of her presentatation and interactions with her therapist, Breuer, that indicated historical sexual abuse.

From 1910 Freud's repudiation of the seduction theory as a tentative cause of DID led to a rapid decline in the diagnosis and study of dissociation (Ross, 1997). The emphasis shifted from seeing clients as suffering from real trauma to considering the possiblity that they were suffering repressed sexual and aggressive drives. Van der Kolk (2000) reiterates this point, writing that patients with trauma-driven dissociative disorders were understood to be suffering from unresolved, incestuous fantasies (the oedipus complex). In this view, which became increasingly accepted, it was not the actual split-off memories that caused the symptoms, rather it was the unacceptable sexual and aggressive wishes of the child. These wishes threatened the ego and motivated defences against the concious awareness of these wishes. He states that for Freud to keep up the seduction theory would mean his

abandoning of the opedipus complex theory and the importance of fantasy. Van der Kolk and Ross both point here to a historic and underlying difficulty in working with trauma. If one does not treat the trauma as real, an important part of client validation and recovery may be compromised. Gullestad (2005) writes that many of the psychoanalytic writings have been regarded as in opposition to the trauma-based notions of human psychopathology, and maintains that since Freud's renunciation of the 'seduction theory' psychoanalysis has mostly neglected the importance of extreme psychological trauma. On the other hand, Gullestad (2005) says that the loss may be that if some "researchers emphasize developmental and adaptive perspectives, the specific psychoanalytic contribution – the emphasis on unconcious conflict and meaning is for the most part excluded from the discourse on dissociation" (p 339). From these accounts a significant and inhibiting point occurred when Freud's theory of seduction changed.

The resurgence of studies on dissociative disorders was recognized in the Diagnostic and Statistical Manual of Mental Disorders (DSM) III (1980) which listed Multiple Personality Disorder as a diagnostic entity. Prior to this it had been listed as an associated feature and as a neurosis of Hysteria. It was in 1994 that MPD was then revised again and re-listed as DID in the DSM IV (1994) and the DSM IV TR (2000).

Schizophrenia throughout the ages

Kraepelin, a German psychiatrist, studied a set of symptoms for which he then produced a system of classification of mental diseases according to their cause, symptomatology, course, and pathological anatomical findings (Bentall, 2003). He established the clinical pictures of dementia praecox, which was later termed schizophrenia by Blueler in the late 1890's. Many of Kraepelin's followers did not take into account his discussions on other factors that appeared to be significant, such as personal and social factors, sex, age and culture (Bentall, 2003). It appears that by ignoring these factors a whole other body of research and possible understanding of the causation of schizophrenia was neglected. Bentall (2003) describes Blueler's contributions as influenced by the psychoanalytic perspectives of Freud. Blueler was interested in the ideas of mental forces, repressed ideas and the unconscious; however, he also agreed with Kraepelin's earlier descriptions of schizophrenia as connected to degenerative brain disease. Bentall believes that it was

through this combination of influences that Blueler offered a widening of the concept of schizophrenia.

Reid et al (2004) argue that Kraepelin and Bleuler wanted to prove schizophrenic behaviour was a disease and genetically inherited, and searched for evidence within family histories. While the focus of understanding schizophrenia remained with the biomedical origins, Read (2004) argues that no genetic marker has actually been identified to indicate the biogenetic connection. The research required to actually support this biogenetic model was never achieved by Bleuler or Kraepelin, yet today it is still a widely held belief (Read 2004). The consequence of subscribing to the genetic model has had numerous impacts on the understanding and healing of these clients, and may have led to the issues of sexual abuse and trauma being neglected. It is now proposed by Read et al (2004) that early trauma may have a significant role in the development of schizophrenia.

Kurt Schneider, a German psychiatrist in the 1920's, attempted to differentiate schizophrenia from other forms of psychosis by listing the psychotic symptoms (such as audible thoughts, thought diffusion, withdrawal or insertion and delusional perceptions) that were thought characteristic of schizophrenia. These became known as Schneiderian First-Rank symptoms or simply, first-rank symptoms. These symptoms were included in the diagnostic criteria and still exist in the modified form of positive symptoms (Ross, 2004). Blueler's combining of the psychoanalytic theories of Freud and the scientific biogenetic ideas seem particularly relevant as it is thought that it was at this time that the symptomatology of DID began to be integrated with those of schizophrenia Ross (1997). As Ross (2004) mentions, in attempting to establish why many DID clients will have a prior diagnosis of schizophrenia this appears to be a significant point in the history. It would also seem pertinent that as Blueler was exploring Schizophrenia the rejection of studies on trauma and dissociation were occurring, and this may have been a significant influential factor behind these clients being accounted for under this biological model.

Summary

While the historical supernatural explanation of the causation of mental illness would appear to have been replaced with that of science and diagnosis, the theme of personal responsibility for illness and actions still seems to be inherent. As Spiegel (1984) suggests, trauma becomes internalized and clients can begin to see themselves as "bad selves" rather than as victims.

The concept of dissociation can be traced back historically in many cultures, and was unnamed/unrecognised until the early 1900's. Once the range of symptoms had been identified, it was initially thought by Freud that this was a result of childhood trauma, specifically sexual abuse. However, societal norms at this time were less accepting of this explanation and Freud later adapted his theories by explaining symptoms as being unconscious wishes and fantasies instead. Therein followed a change in focus and a decline in the study of dissociation.

Schizophrenia was first recognised as a disorder in the early 1900's, founded on the ideas of Kraepelin and Bleuler. Genetic explanation for schizophrenic symptoms continues to be widely accepted. The symptomatology of DID became subsumed into those of schizophrenia as Bleuler's writings became influenced by both Freud and Kraepelin.

Chapter Four: Aetiology

Introduction

The aetiologies of both DID and schizophrenia are controversial within contemporary clinical psychiatry, psychology and psychodynamic psychotherapy. The theories of the aetiology of DID have been based upon two streams of explanation and understanding: Freud's theory that dissociation/hysteria (DID) was caused by repression of unconscious wishes/ fantasies and Janet's theory that DID was triggered by memories of overwhelming traumatic experiences. More recently the two streams of explanation are that DID is a response to early trauma or sociocognitive (iatrogenic) creation. There are also conflicting opinions about schizophrenia, which is viewed by some as a biological disorder, possibly mediated by adaptive and interactive genes, and by others as having psychosocial causes. This chapter will further explore the aetiology of both disorders, and the controversial arguments arising from the theories.

Dissociative Identity Disorder

Freud initially saw DID as a response to traumatic experience that overwhelmed the psyche, with symptoms arising when traumatic memories were forced upon the patient (Loewenstein & Ross, 1992). Freud described it as a breakdown of the capacity to integrate experience, resulting from childhood trauma. However, later he abandoned the traumatic causation theory and replaced it with the theory of unconscious fantasy and wish fulfillment (Loewenstein & Ross, 1992).

Along with Freud, Pierre Janet (1911) has been referred to as one of the oldest theorists of dissociation (Siegal, 2003). Janet, like Freud, held the early views of dissociation being caused by trauma, however Janet and Freud parted ways when Freud's position changed. Janet's understanding of the aetiology of DID was that a person who dissociates their traumatic experience and then attaches to it will become unable to integrate the experiences and may lose some capacity to assimilate new experiences (Siegel, 2003). Janet thought that the later segregating of mental capacities and contents into separate and autonomous clusters lead to the DID disorder (Siegal, 2003).

There are recent theorists who join with Freud's view that it is internal conflictual wishes which result in a highly organised fantasy system which in turn create alternating idiosyncratic identities which are not compatible (Brenner, 1994; Abse, 1983, 1974; Arlow, 1992). Theorists such as Brenner also add to this view that trauma and autohypnosis are equally significant aetiological components.

Most modern views, however, are centred on the premise that dissociation is induced by overwhelming trauma which leaves the child abandoned and isolated and paralyses the ego (Roth, 1992; Ross, 1997, Skolnick & Davies, 1992; Kluft, 1987, 2000; Putnam & Loewenstein, 1993). The shattering and fragmentation from the experience of severe traumatisation results in rigid organisation of alternating selves. Kluft's (1987) four factor theory clearly demonstrates this perspective.

Richard Kluft (1987, 1985, 2000), a psychoanalytic psychiatrist, has written extensively with clarity and depth about DID. In 1987 he described a 'four factor theory' supporting the trauma basis. Kluft states that DID occurs when a child with the capacity to dissociate (factor 1) is exposed to overwhelming stimuli (factor 2) that cannot be managed with less drastic defences, hence the capacity to dissociate is enlisted in the service of defences. Dissociated contents become linked with one of many possible substrates and shaping influences for personality organization (factor 3). If there are inadequate stimulus barriers and restorative experiences or there is an excess of double binding messages that can inhibit the child's capacity to process experience (factor 4) then DID can result (Kluft, 1987). Kluft's (1984) view is that it depends on the person's susceptibility to dissociate alongside traumatic or overwhelming experiences, particularly sexual abuse, which results in the potential for dividedness at the level of development and at the time of trauma. The value of Kluft's contribution is seen in the references to this theory throughout the literature. His developmental perspective aligned with Janet's ideas of dissociation and led him to believe that DID is a post-traumatic disorder of childhood.

The severe and sustained trauma that occurs from early childhood (0-3 years of age) through to middle childhood (2.5-8 years of age) has been implicated as the time period in which one is most vulnerable to develop DID (Wilbur, 1982).

Although the personality splitting manifests later, it would seem that the tendency toward or the initial splitting occurs very early in life (Bowman, Blix & Coons, 2005).

Gullestad (2005) discusses recent theories on the neurobiological affects of trauma. These theories suggest that overwhelming incidences early in life are connected to biological reactions to threat. Integrative failure can occur when the brain stress regions are overwhelmed by severe early trauma. These modern theories support the notion that the impact of severe trauma may actually result in a failure of mental processing and thus potentially lead to the development of DID (Schore, 2003).

Different aetiological perspectives are further developed by the consideration of attachment dynamics. Putnam (1989) observed that disturbances in early attachment between child and primary caregiver alongside other abnormal family dynamics are implicated in increasing pathological levels of dissociation and the later development of DID. McWilliams (1994) and Putnam & Lowenstein (2003) reviewed research that indicated high levels of dissociation in parents/caregivers, particularly where their own histories of abuse or drug/alcohol issues can be associated with dissociative, disturbed attachment behaviour. This can be a predictor of high levels of dissociation in late adolescence particularly when combined with severe trauma. I believe this to be a significant feature in clients' lives as most often the severe trauma of these children occurs amongst other abusive and chaotic family environments.

Sociocognitive views

The critics of the trauma pathway contend that other possible causes need to be considered. These views are captured under what is known as the SCM (Sociocognitive Model). Supporters of the SCM (Spanos, 1996; McHugh, 2005) emphasise vastly different explanations for the creation and maintenance of DID. In contrast to the view of DID being caused by trauma, Spanos (1996) postulates that the high rate of reported childhood sexual abuse is not a sufficient aetiological explanation that it leads to multiplicity (Alter personalities). Spanos' experiments with both healthy students and spirit mediums showed that multiplicity could be induced in those with no prior abuse histories. He believes that therapists can mould a client to 'act' as though they have DID. Spanos, Weekes & Bertrand (1985) performed lab tests investigating this claim. They interviewed two groups of participants; with one group they used 'suggestive questioning' techniques and with the control group they did not. Through this they were able to elicit the participants of the first

group to exhibit different 'alters' which presented with different names and amnesia for each. Spanos et al (1996) purport that this supports the possible iatrogenic pathway and the influence of the therapist. Having only read of Spanos claims and not sighting the full study I would question its validity as no evidence was provided that the students and psychics participants were 'healthy.' It was simply stated.

Spanos (1996) also suggests that DID may be socially constructed as the disorder changes over time to meet expectations or requirements of the clinician. Spanos contends that evidence of DID in other cultures and social contexts reinforces that DID is a "rule governed social construction." It is established, altered and maintained through social influences. The social influences that Spanos and his colleagues refer to include media influence and therapist expectation. Spanos (1996) states that until recently DID was relatively unknown in North America, Japan, England and Russia; no known cases were previously found in these countries. As research increased so did attention to DID and there was a subsequent increase in diagnosed cases. Supporting his claim Spanos (1996) refers to van der Hart and van der Kolk's work in Holland. He states that as they started to research and publish more articles on DID more diagnoses of DID in Holland were made. This suggests that iatrogenic and sociocultural aetiological pathways account for the resurgence of reports of DID since the 1980's (Spanos (1996), Cormier & Thelen (1998), and McHugh (2005), Lilienfeld et al (1992).

McHugh (2005), in agreement with Spanos, discusses primitive and pre-scientific cultures who, in their sociocognitive context, had their beliefs and behaviours reinforced by traditional and customary social behaviours and expectations.
McHugh suggests theorists may be missing the most significant element in the creation of the self: the sociocognitive context in which our ideas of self and personality emerge. McHugh believes the self and the multiple selves of the DID client are social constructs, not needing a socio-psychological explanation. He suggests we might want to consider that a phenomenological analysis of behaviour which takes that behaviour at face value, or which attributes it to nothing but brain structure and biochemistry, may be missing the most significant element in the creation of the self. He believes that all self is a construct of social influences and reinforcement and this is what leads to the formation of the self.

Whilst Lilienfeld et al (1992) agrees that alters can be created and maintained by social reinforcement, he adds that these role enactments should not be seen as conscious deception, rather that they flow spontaneously and unconsciously. A further challenge to Spanos' studies was made by Gleaves (1996) who believes that the study does not support the notion that DID is created as the participants did not display many of the full associated features of DID. Supporters of Spanos' claims responded that in fact they were not attempting to create DID but to simply prove that, with quite a degree of ease, one could produce situations where people enacted alter type behaviours.

The two models of explanation do not disagree that DID occurs. Where they diverge is in the belief about how it is created and maintained. The trauma pathway supporters believe DID is a naturally occurring response to severe and early trauma, whilst those that support the sociocognitive model believe it is created and maintained by a variety of influences including therapist expectation/influence, media and sociocultural experiences. Two models of explanation are also seen in the aetiology of schizophrenia. What has been traditionally viewed as an endogenous biomedical disease is now the subject of much debate as recent theorists propose that influences including trauma play a significant role.

Schizophrenia

The aetiology of schizophrenia was first addressed by the early theories of Kraepelin in 1893 and Blueler in 1911 who sought to understand the symptoms displayed in the condition that was then known as Dementia Praecox. They believed that this condition was a product of some kind of biological disorder creating a degenerative brain disease similar to Alzheimer's or Parkinson's. Blueler toyed with the idea that it was an accumulation of abnormal metabolites in the blood (Read, 2004).

Building upon these early ideas Conley (2004) postulated that a genetic vulnerability for schizophrenia is mediated by adaptive and interactive genes, each of which exerts a small effect on the other. Further research into the aetiology focused on the genes involved (dopamine and serotonin receptor genes) with neurochemical and physiological mechanisms believed to be associated with the pathophysiology of schizophrenia. (Jooper et al, 2002; Sobell et al, 2002). Williamson (2006) supports this view adding that many genes are implicated and many factors aside from genetic inheritance are involved. This led

to a view that schizophrenia is a problem of structural and functional abnormalities of the brain. Dean, Bramon and Murray (2003), in acknowledging that understanding the aetiology of schizophrenia has been a considerable challenge, cite other factors. There is evidence in their research to support the hypothesis of genetic vulnerability and they add that early life risk factors, for example obstetric complications, have been shown to be associated with the later development of schizophrenia. Similar to Williamson's (2006) contributions, Dean et al (2003) add attributing factors that incorporate a neurodevelopment possibility. This hypothesis has held sway in recent years, thus focusing attention on biological causes acting in early life.

The belief that the causation of schizophrenia was of biomedical origin has also been challenged by other studies undertaken since the 1980's, posing significant questions as to the development of schizophrenia. However, there is much that cannot be explained in purely neurodevelopmental terms. Dean et al (2003) conclude that there is growing evidence of associations between the risk of schizophrenia and factors such as drug misuse, ethnicity/migration, life events, and urbanicity. This view provides a multifactorial model of causation that encompasses biological, social and psychological elements which is arguably both a better representation of current research findings as well as a more appropriate model for clinical practice.

Trauma

Read (1993; 2004), a New Zealand psychologist, has for some time argued that many clients with schizophrenia display trauma symptoms which he believes have been largely ignored or unidentified within their medical records. He has written extensively about the notable absence of consideration of traumatic events (such as child abuse) within the history taking amongst those diagnosed as schizophrenic.

Read (1993) identified that clinicians relied on other "professionals' records" as indicators of a client's history, rather than asking the client themselves. Supporting studies include Friedman & Harrison (1984) who saw that incest survivors scored higher on the schizophrenia scale than their control group, along with Rosenfeld (1979) and Dill, Chu, Grob, and Eisen (1991) who identified significant under-reporting of abuse in clients medical records, yet when clients were asked they disclosed significant abuse histories. Read (2004) cited the research of Young, Read, Baker – Collo, & Harrison's (2001) New

Zealand survey of clinicians, which included a multi-choice question relating to in what circumstances they would not take into account a client's abuse history. The results of this study were that clinicians felt they would be more likely to disregard an abuse history as given by a client if they felt the client may be experiencing psychotic symptoms and therefore felt that the client was imagining abuse that had not actually occurred.

Read (2004) discusses the importance of research into the role of childhood abuse as a psychosocial contribution to schizophrenia. An integration of the biological and psychological paradigms would provide crucial information to the primarily neurobiological aetiology of psychotic disorders, including schizophrenia. The assumption that the aetiology is primarily biological appears to inhibit many clinicians from considering child abuse as a possible causation factor.

Breyer et al (1987) and Herman (1992) believed that child abuse was the most relevant statistical relationship that links with psychosis (Schizophrenia) and was one of the main factors that led a person to seek psychiatric treatment as an adult. In a study of chronically ill inpatients, two thirds of whom were diagnosed schizophrenic, Beck & van der Kolk (1987) found that 46% had suffered incest. Breyer's (1987) research found that abused patients presented in mental health institutions at a younger age and had longer hospital stays than those without a history of abuse. These findings were also supported by Goff (1991), Ross and Clark (1994) and Read (2001), who found in their studies that sexual abuse survivors display higher degrees of hallucinations, paranoid ideation and more psychotic symptoms in general. Read's (2004) study estimated that as much as two thirds of female child and adolescent psychiatric inpatients had experienced childhood sexual abuse or physical abuse, while between 45 – 92% of women identified as being seriously mentally ill had such histories. Mullen et al's (1993) New Zealand research found 85% of women who had hospital admissions for mental illness (irrespective of or perhaps not expectant with their diagnosis) had suffered sexual abuse in childhood.

Read feels that the very nature of child abuse itself needs consideration; child mental health is intrinsically affected by abuse. The abused child is so frequently told that the abuse hasn't happened, or is told that if they speak or make reference to the abuse that they or the people they care about would be hurt.

"... to imagine an event designed to produce madness, to encourage withdrawal from the external world and into an internal world of fearful distortions, it would be hard to come up with a more effective way than by being hurt and betrayed at an early age by someone in a position of power who claims to love you" (Read, 1994, p 54).

According to Read (2004), if there is evidence for trauma then often re-diagnosis occurs. The reinterpretation is commonly to identify these people once known as schizophrenic as 'psychotic like' or 'pseudo psychotic'. This re-diagnosing appears to result from the want to relieve the client of stigma and ensure that they get appropriate treatments. However, Read (2004) believes that the re-labelling of these clients from schizophrenic means that they are no longer captured under this diagnosis and therefore it inhibits investigations into the relationship between schizophrenia and trauma.

Ross (2004), however, acknowledges that it appears schizophrenia does have a genetic component when he reviewed 'twin studies'. These studies, involving twins who had a family history of schizophrenia, conducted research into twins who grew up together and those separated at birth. The twins were later assessed and compared in regard to who developed Schizophrenia and who did not. The results from the twin pairs who both developed schizophrenia ultimately challenged the model of environment as a cause as each twin had a unique environment. However, Ross (2004) contends that data within these studies may be 'unclear' and therefore unequivocal and the environmental factors and trauma appear to be more significant features. From the literature that I have reviewed I would question Ross' claim. The studies of schizophrenia are actually presented with such vigour it is difficult to doubt however on closer inspection of what Kraepelin & Blueler stated it appears that there was much that could not be proven and much that they said that was not taken into account.

Discussion

Most leading treatments and explanations are based on the premise that trauma is the aetiological pathway to DID (Ross, 1997; Roth, 1992; Kluft, 1984, 1985, 1987, 2000). The critics contend that this is not necessarily the case, and suggest that DID may be a creation either by the client, the treatment or sociocognitive influences (Spanos, 1996; McHugh, 2005). The conflict between these two views lies in the explanations of what causes, creates and maintains DID. They have a substantially different emphasis and explanation, with the trauma view claiming DID is a naturally occurring response to severe trauma and the SCM view claiming it is a consequence of therapy, media, and expectation. Exponents of the SCM question the creation and maintenance of DID, however they strongly contend that this is not the same as questioning whether DID is real. The oppositional views have proven to be challenging to the diagnosis of DID and continue the controversies that started when Freud and Janet parted ways.

For all the speculation and criticism over DID it has never been hypothesised that DID has in its roots in the biogenetic model. The controversial proposition of aetiological pathways elicits uncertainty and caution. If clinicians doubt the origin, or fear they may be held responsible, they may be less inclined to want to diagnose it.
The theme of responsibility that emerged in the history is reflected within the contrasting opinions of DID's aetiology. The responsibility shifts from the client who is viewed as manipulative to the therapist who can create it, the society which supports it or the abuser (Radden, 1996).

The literature suggests that DID and schizophrenia may share an aetiological pathway in trauma. While trauma is contested as a causative feature in DID so it is in schizophrenia. The biogenetic model of schizophrenia that is most widely accepted is yet to be proved (Read, 2004). The issue of trauma is often neglected within the schizophrenia literature, however the works of Read et al (1994, 2004) seek to understand both the role of trauma in psychosis and the reasons it may be neglected. If trauma is accepted as a valid aetiology in schizophrenia, it may have both pros and cons for the issues of diagnostic confusion. Acceptance of a trauma pathway to schizophrenia may support that pathway to DID yet simultaneously it may make differentiating the two more difficult – DID may be subsumed by schizophrenia.

Chapter Five: Symptomatology

Introduction

This chapter will focus on the symptoms the diagnoses manifest with consideration to leading diagnostic tools and leading theorists' opinions. From controversy to complication the features which tend to result in diagnostic difficulties will be presented.

Signs and symptoms of DID

"DID is a little girl imagining that the abuse is happening to someone else….this is the core of the disorder…" (Ross, 1997, p59).

Kluft (1987) describes DID as "a complex, chronic dissociative psychopathology characterized by disturbances of identity and memory" (p. 363). He distinguishes DID from other psychiatric syndromes by saying DID is manifested by the "ongoing coexistence of relatively consistent but alternating separate identities plus recurrent episodes of memory distortion, frank amnesia or both" (p. 363). Kluft's description of dissociation as a disruption to the usually integrated functions written in the late 1980's appears to be reflected in the diagnostic criteria of the Diagnostic Statistic Manual IV TR.

The following table provides the standard definition for diagnosing found in the recent edition of the DSM IV-TR (American Psychiatric Association, 2000).

DSM IV TR Criteria For Dissociative Identity Disorder
A. The presence of two distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self.
B. At least two of these identities or personality states recurrently take control of the person's behaviour.
C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
D. The disturbance is not due to the direct physiological effects of a substance (e.g.

blackouts or chaotic behaviour during alcohol intoxication) or a general medical contribution to imaginary playmates or other fantasy play.

Whilst Kluft's (1987) description of DID is from a psychoanalytic psychiatric perspective, other writers of the same era such as Schwartz (1994) and Smith (1989) approached the condition from an object relations perspective. Smith (1989) describes the difficulty in interpreting DID, aligning to Kluft's interpretation of the distinct identity states. Smith (1989) describes the 'absence of continuity of being' the DID client experiences due to the ongoing dissociation she/he may feel. While Kluft (1987) tended to use dramatic examples to describe DID symptomology, Smith notes that DID may be covert by nature. From an object relations perspective, Smith (1984) and Schwartz (1989) explain that the complex organized layers of 'false selves' and the defensive use of dissociation are embedded in the DID individual. These allow fragments of the self to experience the feelings and memories whilst not directly influencing other aspects of the self (Schwartz, 1989). In Schwartz' words: "the mind flees its subjectivity in order to evacuate the pain" (p. 191). The fragmented self allows parts of the self-considered 'not me' to experience the pain with this self-hypnotic process (Schwartz, 1989).

Providing a unique characterlogical description, McWilliams, a psychoanalyst and author of the diagnostic book 'Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process' (1994) as well as a contributing author of the Psychodynamic Diagnostic Manual, (2006) reviews psychoanalytic personality theory and implications for practice for beginning practitioners. McWilliams (1994) discusses her observations of the character structures outlining the particular defense mechanisms, possible histories, schemas and ideas of treatment and transference/counter transference that may be experienced with each client. McWilliams' psychoanalytic view is that the dissociated character 'self' is fractured, having numerous split-off partial selves and presenting as an invisible defense, particularly when one 'alter' is retaining 'executive control' and things are 'running smoothly'. The primary defense, she writes, is "dissociation which is essentially utilizing self-hypnosis" (p.328).

Signs and symptoms of schizophrenia

A classification system for diagnosing schizophrenia was established in the late nineteenth and early twentieth centuries. Descriptions and observations by early psychiatrists (in particular Eugene Blueler and Emil Kraepelin) of schizophrenic clients meet many of today's descriptions (Ross, 2004). Writers such as Frattaroli (2002) reflect a return to early theorist's views (in particular Freud's) by concluding that biological factors do not cause symptoms; rather they influence a degree of vulnerability within a conflict model.

London (1973), in describing Freud's psychoanalytic view of schizophrenia symptoms, observes that the intrapsychic conflict and defenses seen are primarily viewed as an unconscious purposive behaviour, derived from an interplay of intrapsychic drives and defenses. He states schizophrenia is partly viewed as a psychological deficiency derived from the developmental disruption early in the formation of object relations (narcissism). Freeman (1985) contends that Freud concluded that the psychotic process was initiated by a loss or withdrawal of object cathexis followed by attempts at restitution (reconstruction). Where there is recovery or a cyclical course in the schizophrenia, what appears to be restitutional, i.e. the delusional content, is in fact the product of an identification with a real object.

Schneider, a German psychiatrist known largely for his writing on the diagnosis and understanding of schizophrenia in the 1920's, listed the psychotic symptoms that are particularly characteristic of schizophrenia. These have become known as Schneiderian First-Rank Symptoms or simply, first-rank symptoms. The Schneiderian symptoms include: audible thoughts; voices heard arguing; voices heard commenting on ones actions; experiences of influences playing on the body, Somatic passivity (patient believes he/she is passive recipient of bodily sensations imposed from the outside); thought withdrawal; thought insertion (thoughts are ascribed to other people who intrude their thoughts upon the patient); delusional perception; the belief that affect is controlled by outside forces; and the belief that impulses and/or motor activities are controlled by outside forces. These "first-rank symptoms" are still used today to inform mental health clinicians (Ross, 2004).

The current diagnostic classification, the DSM IV, condenses the descriptions into specific criteria. A core feature of the diagnosis is the major disruption in functioning that impairs the client's ability to interact normally with others. The actual symptoms at presentation may vary, but usually include some form of hallucinations (auditory, visual or tactile) or fixed false beliefs (delusions), which are accompanied by problems organizing thoughts and communicating. Disturbances in affect and social drive, which are designated as negative symptoms, may play a role in making a diagnosis of schizophrenia (DSM IV- TR, 2006).

DSM IV TR Criteria For Schizophrenia
A: Characteristic symptoms: Two or more of the following, each present for a significant portion of time during a 1-month period (or less successfully treated).   (1) Delusions   (2) Hallucinations   (3) Disorganised speech (e.g. Frequent derailment or incoherence)   (4) Grossly disorganized or catatonic behaviour   (5) Negative symptoms i.e. affective flattening, alogia or avolition   Note: Only one criterion A symptom is required if delusions are bizarre or hallucinations consist of voices conversing with each other.   B: Social/Occupational dysfunction: For a significant portion of time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

The 2006 Psychodynamic Diagnostic Manual (PDM) offers the current psychodynamic view of schizophrenia reflecting the early influence of Blueler and Kraepelin whilst also highlighting the absence of previous psychoanalytic contributions. The PDM defines schizophrenia similarly to the DSM IV as including constellations of negative and positive symptoms. The positive symptoms include delusions, hallucinations, disordered thinking and speech, and catatonic behaviour. The negative include flattened affect, apathy, and

withdrawal. The subjective experience of schizophrenia includes feelings of emptiness, numbness, feeling adrift, detached from emotions and from other people, and is often accompanied by difficulty expressing or identifying any feelings.

According to Ross (2004) "Schizophrenia cannot occur without psychosis" (p.25) and the criteria raise extensive problems. In the view of Ross (2004), the clinical meaning of psychosis is elusive and varies across clinicians and their clinical orientation. The psychotic person is seen to have a biomedical brain disease or chemical imbalance, which should be treated with medication. Ross(2004) states that if clinicians hold this view it would imply that schizophrenia could not be treated with psychotherapy Variations of descriptions include prominent hallucinations where the individual realizes they are hallucinating whilst broader definitions include other positive symptoms of schizophrenia (Ross, 2004). Read (2004) offers an interesting perspective that the characteristic symptom 'if delusions are bizarre' does not have adequate reliability because it allows a subjective view.

Similarities between DID and schizophrenia

While the DSM IV criteria describe DID and schizophrenia as two distinct categories, Ross (2004) argues this is not the case as they actually have a great deal of overlap, sharing many symptoms and characteristics. He adds this is not considered a problem in the schizophrenia literature as DID is not mentioned. Ross (2004) cites evidence for this in a variety of sources, one piece of evidence being the high rates of prior schizophrenia diagnoses. Ross's (1997) research indicates that DID behaves as a severe variant of schizophrenia, and that those with both diagnoses in their history are often more complicated and complex to treat (p.157). Supporting Ross's views, Welburn, Fraser, Jordan, Cameron, Webb & Raine (2003) have identified that some DID symptoms (derealization and depersonalization, as well as auditory and visual hallucinations) are similar to those used to diagnose other psychiatric disorders such as schizophrenia. Interestingly, some researchers have found that DID patients actually endorse more Schneiderian first rank symptoms than schizophrenic patients (Welburn, Fraser, Jordan, Cameron, Webb & Raine, 2003).

Kluft (1987) and Ross (1997) indicate that it is the Schneiderian first rank symptoms (positive symptoms) of schizophrenia that are leading clinician's astray (p. 130). The presence of these Schneiderian symptoms is considered so common it is suggested that they

act as a diagnostic clue for DID (Kluft 1987, cited in Ross. 1997). Statistics presented by Ross (2006) state that the average DID client will show 6.6 of the eleven Schneiderian symptoms whereas those accurately diagnosed as schizophrenic will show an average of 4.4. Rosenbaum (1980) adds that Blueler may have been including DID patients in his definition of schizophrenia, suggesting Blueler's influences has led to several decades in which many cases of DID were misdiagnosed as schizophrenic. Ross (2006) reports that the absolute specificity for the first rank symptoms has been abandoned; however, he remarks on the fact that the DSM IV still regards 'voices commenting' as so characteristic of schizophrenia it is the only single symptom required to make the diagnosis.

In contrast, Radden (1995) suggests that it may be more than the similarities which result in a schizophrenia diagnosis rather than DID. She suggests that the unreliability of DID as a diagnosis may be due to it actually being another disorder, adding that it is less reliably diagnosed than schizophrenia, and that the two were often mistaken for one another. Radden (1996) also states therapists need to be aware of the risk of possible collusion with clients presenting with DID symptomatology. As she mentions: "it has been suggested that DID is a form of manipulation or a tactic by the client, to elicit sympathy or to have their needs met" (p. 345). Radden's suggestion of the manipulative client raises concerns; it reflects the potential that these clients are met with hostility or wariness by clinicians. I would argue that it needs to be considered that many, if not most, human behaviour is derived from a need to have their needs met. I believe a clinician's role is to help guide a client to have these needs met in the healthiest and most functional way they can.

Gardner (1994) also offers a critical perspective in regard to trauma in DID and believes that in fact what is observed in DID is actually schizophrenia. He believes that DID clients who claimed they were sexually abused as children, developing "alter" personalities to cope with the trauma and having memories of the abuse until therapy, were actually paranoid schizophrenics whose delusions and hallucinations are interpreted in terms of the alleged repressed childhood abuse. In Gardner's view the diagnosis of DID is dispelled and reinterpreted as schizophrenic. The following case illustration is used by Ross (2004) which he indicates is an example of a women whose symptoms overlap with DID and schizophrenia.

I have never fought a fight harder than the fight my mind fights against itself. I have two equally tenacious parts of my mind that are often at odds with one another. I go back and forth endlessly, never able to resolve the struggles, because I do not know which part is true. It takes all my energy to keep vacillating and watch the battle being played out. I can almost see it visually. I see one side arguing with the other; the two are diametrically opposed and each side is equally strong. To me, each of these struggles is the fight of my life; to my therapist, it is something I suffer from called "ambivalence". During these fights, I can be thinking one thing, but then when the antagonistic thought comes in, I can actually feel my brain split. Sometimes it feels as though one part is the good part that punishes the bad part and causes me pain, sometimes one part seems to censor what the other is allowed to feel. One is a victim of the people in my head; the other part joins with my therapist in fighting them. What is similar about all these dichotomies is that they basically separate the part of me that is real from the part that is unreal: it is a battle between sanity and insanity. When my brain is pulled together I feel 'solid'. I can literally feel my feet on the ground, and I can feel that my thinking is clear. This state occurs rarely. When I am crazy, the insane part takes over. I am a victim of delusion, unreal thoughts and severe disorganization. The part that is good and seems to punish the other part is the side of me that knows reality and knows I am crazy. I blame myself for not being able to let go of my crazy thinking and 'get it right'. The good part wants to get well and punishes the bad side for not wanting to get well and instead holding onto falsities. The bad or crazy part, not understanding that these are falsities, feels great pain at the hands of the good part. It is emotional pain, but the kind that is vague and inside, and feels almost physical in the misery it inflicts. Often I am doubled over in pain; usually it is because there is some conflict going on that I cannot resolve (Ross, 2004. p. 185).

This woman's description of her experience is one which could easily fit into either DID or schizophrenia. Her current diagnosis is schizophrenia yet she exhibits the somatic symptoms, depersonalisation, divided self and dissociation, also representative of DID. Ross believes that had this woman's case be presented at a lecture about DID it would easily pass as a typical DID case. This demonstrates just how difficult the two may be to distinguish.

Differences between DID and schizophrenia

Ross (2006) describes the differentiating features of DID and schizophrenia which appear to be found in the negative symptoms of schizophrenia. The negative symptoms include occupational and social deterioration, emptiness, loss of drive, and other 'burn out' type features. Antipsychotic medications have no effect on the negative symptoms of schizophrenia, which Ross (2004) suggests may indicate that the negative symptoms are caused by a progressive biological component. Ross (2004) writes that psychotic voices

tend to be associated with thought disorder and acute phases of a psychotic illness, whereas dissociative voices tend to be chronically present even when the patient is functioning well. Ross (2004) previously believed and published that DID clients' voices led to the false positive diagnosis of schizophrenia. With consideration to the recent data, he now believes he was wrong. It would seem it is the Schneiderian symptoms of schizophrenia that lead clinicians to incorrect diagnoses – not only the presence of voices. However, Brick (2003) agrees with Ross's early assumptions, believing that many patients with DID are misdiagnosed as schizophrenic because they may 'hear' their alters 'talking' inside their heads.

McWilliams (1994) considers the countertransference possibilities that may result in a schizophrenia diagnosis. She describes the re-experience of the abuse that accompanies the processing of abuse in therapy can be so disturbing it may result in a counter phobic response by the therapist who may assume it to be a schizophrenic break. McWilliams (1994) remarks that psychotic transferences are not uncommon, and that when a child 'alter' is present the hallucinatory convictions are so strong that the past feels 'present'.

McWilliams cautions diagnosticians untrained in dissociative phenomena that "this psychotic transference does not equal characterlogical psychosis" (1994, p.336). McWilliams' also offers the view that therapists may feel a benign positive transference from the host personality. This host may stay in treatment for a long time until a period of crisis when the client's recollection of trauma and the 'alter's' somatic symptoms of abuse or reenactments of actual abuse arise.

Briere (2006), in writing about treating sexual abuse trauma, makes links between traumatic responses and psychosis, drawing parallels and highlighting differences. His interpretation can be linked to the similarities and differences seen between DID and schizophrenia. This is interesting because, although Briere is not directly addressing DID and schizophrenia, the parallels support the possible overlaps in these diagnoses.

Diagnostic difficulties

The change of the title Multiple Personality Disorder (MPD) to DID may be a significant feature in the ongoing controversy relating to both the recognition and diagnosis of DID. Ross (1997) believes that the label MPD seemed to raise issues for laymen and clinicians being able to 'believe' the disorder really exists, clouding the ability to recognise it as a defensive splitting of the psyche. Ross (1997) developed a theory he termed the central paradox of DID to respond to this difficulty in believing. This paradox offers the view that the DID client's presentation should be accepted similarly to hallucinations as real experiences. It may be that in fact schizophrenia (schizo = split phrenia = mind) is a more appropriate word for those recognised as DID, and Dementia Praecox may fit with those now described as schizophrenic, possibly further indicating an overlap between DID and schizophrneia . It is also noted repetitively in the literature that Bleuler may have been including the DID client in his work on schizophrenia hence perhaps indicating a major reason why there is overlap between schizophrenia and DID (Ross, 1997).

The call for attention to the diagnostic criteria was raised by Kluft in 1987 when he wrote about the increased frequency with which MPD was being diagnosed. He attributed this to research grouping MPD with dissociative disorders and lessening associations to hysteria. Kluft outlined the controversy to include that the condition was rare or non-existent and that the increase in reportage was attributed to iatrogenesis, cultural factors, loose diagnostic criteria, personal agenda and clients who sought out clinicians who would confirm the diagnosis. He stated the criteria for MPD needed reconstruction and that the less classic cases should be recognized. It was well known and reported (he claimed) that the first rank symptoms of schizophrenia frequently appeared in DID and led to misdiagnosis, however they have never been listed in the criteria. Kluft (1987) hoped that the difficulties in recognition and diagnosis of DID would be addressed by the tightening of the definitions for schizophrenia in the DSM III. However, this was not the case. Some of Kluft's suggestions were reflected in the DSM IV revision but not all.

Putnam (2001), involved in the decision to change MPD to DID within the DSM IV, states the decision was heavily influenced by a belief that MPD was being under diagnosed. Although there were disparities and disagreements about the decision, it went ahead with much controversy, which still exists as an underlying conflict about the disorder. In an

attempt to mitigate critics, Putnam (2001) and Dell (2001) contend that the result was poorly delineated criteria which are still in need of revision and retain its controversial status. Dell (2001) includes the importance of listing derealisation, depersonalization and trance in the associated features, and talks of how the criteria exacerbate the controversial status of DID. Steinberg (2001) agrees the criteria needed changing. However, she questioned the motivation of the clinicians, stating they did so simply in order to support more frequent diagnosis.

Thirteen years after Kluft's suggestions to alter the diagnosis, the literature still suggests the issues of DID diagnostic reliability are unresolved. Currently most psychiatrists believe dissociation is a legitimate phenomenon (Andreason & Black, 2001; Putnum, 1989, 1997; Ross, 1997; Ross, 1989). However, most also believe dissociation's most dramatic manifestation, DID, is a rare condition which occurs spontaneously. In addition, many professionals assert that DID is easy to create iatrogenically (Spanos, 1996; Gardener, 1994 Paddock & Terranova, 2001). Others posit that there is little credible scientific evidence to support the diagnosis and argue that, in the absence of evidence, the diagnosis has no validity and is flawed in its logic (Allen, & Iacono, 2001; McHugh, 1995; Paddock & Terranova, 2001; Piper, 1997).

In an attempt to identify further reasons for confusion, Hayes and Mitchell (1994) offer the opinion it is due to skepticism, stating that 24% of professionals are sceptical about the DID disorder. These statistics are supported by Ross (1997) who states that 20% of professionals report doubt or scepticism about DID's existence. This therefore suggests those who are sceptical of DID would be more likely to accept or diagnose such a client as schizophrenic. Davis and Frawley (1994) claim that in the situation where a clinician may be 'covering' another's practice with a DID client they may never see the clients' alters – thus provoking scepticism. They contend that this is the result of DID being engendered in a relational context (of early abuse) and that it is in the intense transference and countertransference emergence of ongoing therapy that invokes the 'alters'.

Loewenstien (1991) believes it can be difficult to diagnose DID as at times there is an inability to obtain crucial information. It is common for patients to hear an inner voice warning against giving complete answers, therefore false negative diagnosis is common.

Lowenstein also mentions that sceptism and doubt can be enticed by links between antisocial behaviours and offenders which may be viewed as paralleling those with DID who can appear to be lying when they are amnesic for certain 'alters'. These features or aspects of the DID presentation highlight the significant complexity that arises in the treatment and diagnosing of DID.

Kihlstrom (2005) and Brick (2003) both describe dramatic examples of how DID clients are portrayed, particularly in 'Hollywood' accounts of DID, for example, 'Sybil.' and the 'Three Faces of Eve'. This may have led to misunderstandings about the nature of DID as flamboyant displays of DID are actually rare (Chu & Brick, 1991).This is evidenced in longitudinal studies of DID which show that 94 percent of the patients try to hide, deny or dissimulate their condition rather than dramatise or exploit it. Approximately 80 percent experience substantial periods of time in which various personalities do not emerge overtly but instead are in relative harmony or influence one another, without assuming executive control. Some cases never fulfil the DSM IV criteria because the personalities pass as one another or prevent one another from completely emerging.

Research shows the multiple issues influencing misdiagnosis. Features that relate to the client perspective include fear, mistrust, insistence on secrecy, amnesia and conscious or unconscious deception (Coons, 1989). From the clinician perspective the features include "presenting an array of bewildering symptoms" (Chu 1993), and a history of prior treatment failure, three or more prior diagnosis, concurrent psychiatric and somatic symptoms, fluctuating symptoms and an inconsistent level of functioning (Ross, 1997). The following case study is representative of a client that presented with a bewildering array of symptoms, cited in Price, (1987).

May, a woman in her mid-thirties, was referred with an extensive history, which included: multiple suicide attempts; depression; impulsive, angry acting-out; inability to maintain stability in relationships; identity diffusion; multiple drug abuse; affective instability; marked fears at being alone, resulting in a symbiotic dependence on an idealized mother; and physically damaging acts, including cutting herself in the presence of previous therapists. Diagnoses entertained over the years included paranoid schizophrenia and/or a severe borderline personality disorder. She displayed a flatness of affect, time distortion

and lapses of memory. She described a sense of watching herself perform activities and often used a collective 'we' when speaking of herself; she spoke of mysterious others and had the experience of separate internal voices. It was not until well into therapy that an actual example of separate identity with distinct personality state emerged.

Although the diagnosis of borderline may have been equally appropriate, the diagnosis of DID would have allowed for the appropriate therapeutic process (integration) required and thus would have reduced the self-destructive behaviours. In my work the characteristics that this client displays are not uncommon and the complexity of such symptoms often leads to multiple diagnoses and various treatment approaches and facilities. Kihlstrom (2004) states:

> The possibility that some – probably many, perhaps most – recent cases of DID and other dissociative disorders are iatrogenic or misdiagnosed mean that the occasional genuine case should not be taken seriously. As rare as they may be, the dissociative disorders provide a unique perspective on fundamental questions concerning consciousness, identity, the self, and the unity of personality. As complex as they surely are, they deserve to be studied in a spirit of open enquiry that avoids both the excessive credulity of the enthusiast and the dismissal of the determined skeptic" (p. 244).

Issues of co-morbidity
Chu (1998) maintains that co-morbid diagnosis must be recognized. Depression, bipolar disorder or psychosis will exacerbate an existing dissociative disorder whilst issues such as eating disorders or substance abuse are features that may cloud the diagnostic issue of DID and also need to be addressed to reach stabilization. Many DID clients often meet the DSM IV criteria for ten or more simultaneous diagnosis. Clinicians who made these diagnoses in the past were not wrong; their error was to not have diagnosed DID (Kluft, 1987). Ross (2004) purports that "well trained, research orientated psychiatrists miss cases of DID on a regular basis." He attributes this to their having been trained to think DID is rare; he claims they have not been trained to ask necessary questions to establish the diagnosis.

In reference to the DSM criteria, Chu (1993) acknowledges the client will often 'fit' into many of the phenomenological categories in the DSM IV diagnosis. Kluft's (1991)

research also produced findings that many individuals could be represented in most of the DSM III categories. He believes that by using the phenomenological approach, polydiagnosis is the norm. Kluft (1991) raises questions about the psychotherapists' 'why now' approach to treatment and points out that with trauma clients this question can lead to treating ongoing crises and not address the core issues of DID.

McWilliams (1994) writes that the "the problem with dissociative conditions has always been more at the diagnostic levels; when people with multiple personality disorder are misunderstood as generally borderline or schizophrenic, or bipolar or psychopathic, their prognosis is indeed dubious. Not only do they feel misunderstood (often in ways they cannot articulate) and hence distrustful, they are also refractory to treatment because large parts of the self are not participating in it" (p.339). Once the diagnosis can be made clear and the person with MPD or DID can understand the approach which the therapist will use, a trusting psychotherapeutic can usually develop.

Cultural and theoretical perspectives

Read (2004) looks at the incidences of misdiagnosis in schizophrenia based upon cultural differences. He remarks upon the medical model's attempts to make up for such misdiagnosis by describing them as unfortunate and innocent. However, the rate of misdiagnosis amongst different cultures indicates a different explanation. One explanation may be that many clinicians do not understand or consider what is normal or acceptable amongst different cultures. Such influences offer interesting considerations for DID. The effects of cultural differences would certainly have an impact on diagnosis rates and some may argue that it may account for an increase in the diagnosis of DID.

In Chapter Three the history of mental illness was seen to reflect the changing cultural perspectives of both DID and schizophrenia. Another cultural influence may include the different models/disciplines from which clinicians understand these clients. This is alluded to throughout the dissertation as it is from one's perspective that diagnostic issues are dealt with or interpreted and clinical decisions are made. The varying opinions about DID and schizophrenia in part reflects the different perspectives and lenses clinicians may hold.

Summary

In psychoanalytic theory both schizophrenia and DID are viewed as defenses to intrapsychic conflict. However, the leading diagnostic tools base schizophrenia on the biogenetic model and clearly delineate a set of symptoms based upon this. The symptoms of schizophrenia are clear and concise whilst DID symptoms are believed to be vague and undelineated (Putnam, 2001). To counter this Kluft (1987) and Ross (2004, 2006) describe the overlaps between the diagnoses, which are not considered in either diagnostic description. The overlaps make it problematic in differentiating the two and are recognised as a leading cause for the two being confused. Differential diagnosis needs to be based on the features other than the positive symptoms of schizophrenia because these symptoms do not differentiate the two disorders. A client who reports chronic auditory hallucinations may have either DID or schizophrenia.

However, the complexity of DID as a diagnosis, with high co-morbidity rates, and the covert nature of the disorder alongside the inherent scepticism invoked, adds further to the diagnostic issues in differentiating the two. Kluft (1987, 1989) reflects throughout his writings on the attitudes towards the disorder – purporting it is one which is met with either fascination or scepticism. The sudden increase in attention to DID and a notable amount of curiosity has resulted in criticism and conflict**.** Kluft (1987) notes questions of the criticism arise out of why DID has suddenly gained more attention, and that a notable amount of curiosity and conflict has arisen out of this disorder.

Recent theorists continue to advocate for clearer diagnostic criteria in a bid to reduce conflict and also to be able to differentiate DID and schizophrenia. It appears that there are two significant streams of confusion that make DID and schizophrenia difficult to differentiate. One is the similar features they share which are not identified in the diagnostic criteria and the other is the conflict and doubt DID as a diagnosis elicits. The complexity of the disorder elicits uncertainty and strong countertransferences which can lead to difficulty believing in it and also make the DID client appear psychotic (McWilliams, 1994).

It appears that for the last twenty years DID has remained a diagnosis that theorists are attempting to conceptualize in ways that will further understandings. Yet, despite the plethora of published literature on dissociative disorders, it appears that dissociation remains a poorly understood phenomenon. Critics contend that this is due to a lack of systematic study of dissociation including published investigations which suffer many methodological flaws (Ofshe & Watters, 1994; McHugh, 2005; Piper, 1997; Powell & Howell, 1998). Regardless of the flaws, the need to consider the diagnostic confusions and the potential implications for clients necessitates clinicians to take all these diagnostic variables into consideration.

Chapter Six: Outcomes

Introduction

The research on treatment outcomes of DID and the effects of erroneous diagnosis are still in their infancy. The literature expresses a need for such studies because what is available is provided by only a few theorists and much of this is inferred from practice and client accounts. Kluft has provided, over the last decade, the most substantial contributions, which have provided the basis from which recent theorists Ross, Putnam and Loewenstein have since built upon. Given that the epidemiology of DID is estimated to affect between 0.2 and 5% in both general and inpatient populations, there is a need for more attention to these areas. Ross (1997) believes such estimates do not imply DID is rare; it is almost as common as schizophrenia.

Hospitalisations and diagnosing issues

Putnam (1997) and Ross (2006) both report that the average time that elapses from first presentation to the time of receiving a diagnosis of DID is 6.7 - 6.8 years. Putnam (1997) adds that on average they will receive 3.6 erroneous diagnoses during this period. It is possible, as the statistics for co-morbidity show, that some prior diagnoses are not erroneous, but in excluding DID the most pertinent diagnosis is missed and thus the appropriate treatment is not applied. Ross (2004) discusses that the long history a DID client may have with mental health systems is potentially quite hazardous for the client and states that in this time 20 – 40% of these clients will have a prior diagnosis of schizophrenia. Seven years of treatment and hospitalisations before receiving the most appropriate diagnosis has potential to exacerbate the DID client's condition.

Read et al (2004) and McWilliams (1994) remark on the often traumatic experience of being hospitalised and treated as schizophrenic (including isolation, medicating, and effects of physical restraints). For people who have lived the most significant parts of their lives in traumatic environments, the ongoing nature of such potentially intrusive and traumatic treatment approaches may replicate experiences which they have had in their families. One might expect to see an increase in the rates of self-harm and suicidality amongst these

clients as they re-experience the confusion, trauma, pain, isolation and denial of the reality in which they live.

Putnam and Loewenstein (1993) state that a small number of patients claim from the outset of treatment that they have DID, and it is not uncommon that initially they are not believed. Ross (2004) believes an estimated 15% of clients will show classic signs for first or early onset DID, and they will be either diagnosed promptly or the diagnosis will be missed because the diagnostic index of suspicion is low.

Outcomes and effects

The effects of undiagnosed or misdiagnosed DID is addressed by Ross (2004) who gives the most thorough contribution to the topic. Ross (2004) provides data which indicates that one of the main reasons for inpatient admissions prior to diagnosis is self-destructive behaviour (which includes suicidality and self-harming behaviours). According to Ross, self-destructive behaviour in DID clients represents the internal conflict, cognitive errors and hostility that they endure on a daily basis. Ross remarks that often the DID person is amnesic to their suicide attempts or reports depersonalization whilst self-harming. This depersonalization and amnesia is attributed to the co-presence of an alter personality (this alter personality being confirmed in the conversation throughout treatment). Ross's studies indicate that the self-destructive behaviours occur particularly during the seven year period in which the DID client is not diagnosed, indicating that an earlier diagnosis might reduce suicide attempts. It would appear from Ross's work that the rates of suicide decrease once a client is diagnosed DID than compared with individuals with other disorders. This further supports the increased risk to the client that is undiagnosed or misdiagnosed. Putnam and Lowenstein (1993) also believe that a percentage of people undiagnosed or untreated die by suicide or as a result of their risk-taking behaviours, although the percentage is not given.

 Putnam & Lowenstein (1993) report of effects and outcomes, stating "Little is known about the natural history of untreated DID" (p. 10). Therefore comparisons are hard to obtain. They offer recent studies which indicate that patients whose DID remains untreated do not experience remission, and that those who prematurely leave treatment relapse into, rather than cease, DID behaviours. The authors also conclude that those whose treatment does not deal directly with the disorder may cease to show DID to their therapist but

continue to experience it (Putnam & Lowenstein, 1993). However, they discuss other studies of partially treated patients that when followed up later suggested a decrease in florid dissociative symptoms, and less overt and less intrapsychic conflict among the alter personality states, indicating that these partial treatments may have helped. The authors comment that there is a range of clients who exhibit high functioning for long periods and others who are severely impaired.

Putnam (1989) speculates that when left untreated a DID person may continue in abusive relationships and or be involved in violent subcultures. This may further result in traumatisation of their children through 'transmission' or disorder in families. Clients untreated who continue to be involved in abusive relationships put their own children at risk of abuse by being involved in such situations. This aligns to McWilliams (1994) contributions where she recognised that parental dissociation can be a significant predisposition to the development of DID.

Outcome of treatment studies

"Strictly speaking, there are no treatment outcome data for DID in the literature" (Ross, 2004; p. 247). There appears to be a vast gap in the literature. Ellason and Ross (1996, 1997) and Ross and Ellason (2001) are the only two studies on prospective treatment outcome study for dissociative disorders. Based on self-report measures of treatment progress they demonstrated significant score reductions. However, each of these studies had their limitations and bias; the researchers acknowledge this along with the need for further research. The limitations of the studies leave them open to the criticism which is represented by Howell and Powell (1998) who comment on the lack of validity. Ross and Ellason (1997) reported significant gains by 54 DID clients after two years of therapy with the greatest improvement occurring in 12 who became integrated, which they used to demonstrate that clients with this disorder respond very well to treatment. Both studies concluded that significant gains were achieved through their treatment programmes, claiming, "Despite the limitations of the study, our findings add substance to the claims of Loewenstein (1979) regarding the positive course of many correctly diagnosed dissociative identity disorder patients" (Ross & Ellason, 1997; p. 839).

Although integration is utilized to demonstrate achievement of results, Ross and Ellason caution the reader not to infer that integration alone results in symptom improvement. They believe that it simply acts as a marker toward greater recovery. DID requires long term treatment; however, Ross and Ellason (2001) have concluded that their findings indicate that clients will respond well in a reasonable amount of time, dependant on other co-morbidity factors.

Ross and Ellason (1997) also speculate that one possible negative outcome of being diagnosed DID may result in more personalities. The outcomes are uncertain as the client has to live through the trauma in the process to integration and along with other co-morbid features this may result in further hospitalization. There are no long-term outcomes.

Kluft has published over two hundred articles in which he has added the most substantial information on outcome data (Kluft, 1982,1984,1985). He based this research on his caseload, which he studied for over a decade. Using 171 cases, of which he treated 117 and monitored six others, 83 reached stable integration. According to Kluft (1984), integration is the aim of treatment and would result in the reduction of distressing behaviours. According to Kluft's data, two thirds of all patients should reach integration from appropriate treatment. However, Ross (1997) suggests that the clients Kluft observed were not as 'sick' as others in treatments he has observed. To Ross this indicates that Kluft's (1984) data is not sufficient to speculate about the general population of DID clients.

One of the only other theorists to provide data on treatment outcome was Coons (1986) who published one paper on the matter. Basing his studies on the integration of twenty cases, at follow-up these clients were interviewed and assessed. The results indicated that five 'fully' integrated whilst two achieved 'unstable' integration and two 'practically'– these results were achieved after 39 months of treatment. Those clients that were unintegrated experienced twice as much emotional trauma as those that reached integration. Coons (1986) cites that progress was hindered by overuse of mental mechanisms, repression and denial, the ongoing use of secrecy (result of extensive childhood secrecy) and numerous crises. However, he concludes that with perseverance, integration (and thus a reduction in symptoms) can be achieved.

The results of being diagnosed schizophrenic

The results of being diagnosed schizophrenic (even if correctly) appear to be grim. Meltzer (1999) states: "although some patients with schizophrenia may have a single episode and recover, the vast majority of patients remain ill and unable to work for life" (p. 3). Much of the literature indicates that a clinician's attitude, negative or positive, has an impact on the client outcomes (Gottdiener, 2003).

Read (2004) also alludes to the potentially negative implications, both socially and medically, of receiving such a diagnosis as the want to re-diagnosis a psychotic client is to relieve them of this stigma. In comparing who fares better, the schizophrenic or the DID client, it may be difficult to adequately assess. The following case study is a moving first-hand account of one woman's experience of being diagnosed schizophrenic; this reflects the client who so often can be forgotten.

> My first diagnosis of schizophrenia came at age twelve. At that time, I began seeing a psychiatrist and taking medications, neither of which helped the voices go away. Before I was eighteen I had seen several psychiatrists, taken what felt like every antipsychotic known to medical science, and had bad reactions to all of them. At seventeen, after a course of thirty shock treatments the doctors told my parents I was incurably mentally ill and recommended that I be given a lobotomy and placed on the back ward of the state hospital. My parents took me home instead where I lay on the couch all day. I had no self esteem, no hopes, and no goals (cited in Ross, 2004, p.188).

Ross (2004) identified that the DID client with the more severe physical and sexual abuse, and the more severe psychopathology has a higher frequency of past diagnoses of schizophrenia. Ross's work indicates that these DID clients are actually at greater risk of being misdiagnosed as schizophrenic due to the increase in the number of Schneiderian symptoms. This group of clients, according to Ross, will also receive more medication treatments as a result of the increased number of Schneiderian symptoms. He believes they will exhibit on average seven of these symptoms, which include hearing voices, audible thoughts, delusions, thought withdrawal and made feelings. These same clients manifested twice as many personalities (an average of eighteen compared to 7.4 for non suicidal), further indicating they had more complex personality systems, which further complicates diagnosis and appropriate treatment. Ross (2004) concluded that these clients with more

severe psychopathology were at greater risk of diagnostic and therapeutic confusion on the part of the clinician.

According to Ross (2004), on average, undiagnosed DID affects 3.7 percent of the general adult psychiatric inpatient population. Ross adds that, as there are likely to be undetected cases among the subjects with other dissociative disorders, it is possible that undiagnosed DID affects one in twenty five of general psychiatric inpatients, and complex chronic dissociative disorder of some type affects approximately one in ten (Ross, 2006).

Ross (2004) and Read (2004) discuss that outcome studies are affected by the limitation of funding, Ross (2004) offers a political view that research on the treatment outcomes of schizophrenia based on psychotherapy do not happen because much of the funding comes from pharmaceutical companies whose interest is in the results of medication. As DID is not necessarily nor efficiently treated by medication, it is assumed that the limitation of studies is due in part to this lack of funding.

Ross (1997) states: "Of all the diagnostic errors in psychiatry, a false positive diagnosis of schizophrenia is probably the most dangerous and most difficult to reverse. It can lead to a self-fulfilling prophecy of a lifetime of medication, and deteriorating function in the absence of correct treatment" (p. 190).

Reclassifying DID and schizophrenia

One possible resolution to the dilemma of the client who appears to have significant overlaps with DID and schizophrenia is a new dissociative subtype of schizophrenia (Ross, 2004). If DID was reclassified, then the possibility of a traumatic form of schizophrenia treatable with psychotherapy may take place. This may improve the prognosis for schizophrenia. However, he notes that problems may arise. The risk is that psychotherapy for DID might disappear on the grounds of the belief that schizophrenia cannot be treated with psychotherapy. He also mentions that currently a clinician can treat a DID client without medication with little risk (to the clinician) as opposed to treating the same person diagnosed as schizophrenic (Ross 2004). The risk to the clinician here appears to be disapproval (ethically) for not administering the leading and accepted treatment approach. However, this may result in positive outcomes for clients who previously may have been misdiagnosed as schizophrenic and thus receive less adequate treatments. However, it may

also subsume the diagnosis of DID and act as further evidence that DID is not a viable diagnosis.

Gardner believes there are many reinforcements for both patient and therapist in the DID diagnosis. Gardner (1994) contends that it substitutes a hopeless situation with one for which there is the promise of cure; is much more socially acceptable; includes social, psychological, and financial payoffs inherent in the "victim" status; and provides an opportunity for lawsuits against the parents.

Ross (1997) remarks on the paradox of the disorder of DID, describing it as both the most horrendous and the most hopeful mental disorder to have. "No other group of clients has anything approaching the trauma that these clients do and have to work through. But unlike the lithium-nonresponsive manic-depressive, schizophrenic persons afflicted with delusional disorders and many other mental health disorders, the person with DID can escape from the mental health system. DID can be cured."(p. 257). DID, as complex a disorder as it may be, is one that can be treated with hope and with positive expectations of treatment outcomes in contrast to schizophrenia which has often been viewed with negativity and little hope of ever recovering.

Conclusion

Over the last decade the literature on DID has increased exponentially. However, it is apparent that little has developed in the studies of treatment outcomes or effects of misdiagnosing this group. Ross and Ellason (1998) remark that this is because, without a reliable method of diagnosing, no scientifically sound data on treatment outcomes is possible. The contra arguments point out the flaws in the small number of studies published, yet their arguments provide no opposing data to defend what they say.

What is evident from the available literature is that there are potentially negative results of remaining undiagnosed and it is speculated that the person will continue to experience the fragmentation and self-destructive behaviours which can endanger them. The result of being erroneously diagnosed schizophrenic appears to be an increase in unhelpful treatments (for example, medications) and an increase in the client's suicidality. It is suggested that those diagnosed with schizophrenia do not always receive psychotherapeutic

treatments and therefore this client may miss the trauma therapy and relational context in which healing may take place. The leading theorists, Kluft, Ross, Ellason, Putnam and Loewenstein each suggest that DID is one of few mental illnesses that may have a high chance of being cured if the appropriate treatment is provided. Whilst it can be inferred a problem does exist between these two diagnoses the magnitude of this problem is largely unknown due to gaps in this aspect of the literature.

I believe that psychotherapy can offer both DID and schizophrenic client's a treatment approach that is based on hope, a positive outcome and relational treatment approach that can begin to heal the damaging relational experiences of the past.

Chapter Seven: Conclusion

Introduction

This chapter will provide a synthesis and discussion of this dissertation. This will be followed by a review of the theme of trauma that has developed, limitations of the study and my proposal for future research.

Synthesis and discussion

The evolution of the understandings of DID and schizophrenia began over one hundred years ago and since this time significant events have occurred. Freud (1911) and Janet's (1889) early studies of dissociation indicated it was a response to trauma. Freud initially believed that this dissociation was a result of childhood trauma, specifically sexual abuse. Societal norms were less accepting of this explanation and Freud adapted his theory, attributing the symptoms to be unconscious wishes and fantasies. Therein followed a change of focus in the study of dissociation (Ross, 1997).

Blueler influenced psychoanalytic perspectives and Kraepelin's biogenic model widened the concept of dementia praecox and coined the new title schizophrenia (cited in Bentall, 2003). This led to the suggestion that Blueler may have been including DID clients in his studies (Rosenbuam, 1980). Schneider (1920), in an attempt to differentiate schizophrenia from other forms of psychosis, developed a list of symptoms known as the Schneiderian First Rank symptoms.

I see these key points as beginning to indicate where the problem in differentiating DID and Schizophrenia may reside. When the studies of trauma and dissociation declined it is possible that the clients who would have been better understood under the trauma/dissociation model were instead understood, studied and treated as schizophrenic. In modern aetiological understandings the same debate that existed when Janet and Freud's theories parted can be observed and is compounded by oppositional views that DID may also be iatrogenically or socioculturally created. The current understanding of schizophrenia as being of biogenetic origins is also challenged, from the perspective that it too may be caused by trauma. The aetiological arguments reflect that, as with Freud and Janet's understandings of DID, the effect of trauma is still being debated and challenged. It

is clear from the literature that these issues are far from settled. The history shows unsettled notions of dissociation which may have contributed to the difficulty in studying DID and establishing confidence in the diagnosis.

Descriptions of the symptoms for each disorder reflect that they are considered as two distinct disorders. Kluft's (1987) and the DSM IV descriptions appear to be limited as they describe the more exaggerated symptoms that a client may present with (Brick, 2003). The literature descriptions of DID appear more complex, and at times more elusive, than those of schizophrenia. I believe that this has an influence on the clinician who may be grappling with clients' behaviours and symptoms that do not fit with this description.

Other features which appear to have an impact on difficulties diagnosing DID, and which may result in a diagnosis of schizophrenia, include the client who may present with co-morbid features. Recent studies and observations have indicated that the two disorders share similar features, particularly the Schneiderian First Rank symptoms of Schizophrenia. This supports earlier assumptions that Blueler (1911) was taking into account the DID client in his description of schizophrenia, and that Schneider then identified features based on this client group.

The debates about the diagnostic criteria indicate that there is a need to refine the criteria of DID. This is in a bid for clarity and validity. The scepticism and doubt about DID as a diagnosis appears to be the result of diagnostic criteria that is not dependable, and of the studies which indicate it can be created via iatrogenic pathways. It seems understandable, therefore, that a clinician, when diagnosing a client that presents with features that are shared between schizophrenia and DID, prefers to make a less controversial diagnosis.

The thread of trauma

The issue of trauma is recurrent in the literature on DID and schizophrenia. In historical accounts it is proposed that Freud stopped studying dissociation from the premise of trauma (and thus DID) because at the time trauma was a controversial topic. It would seem that this threat remains evident today. Although most clinicians accept that sexual abuse trauma occurs and is real, it is still a difficult issue to address. In my work, the trauma histories that

DID clients often report is of the extreme kind and sometimes so appalling it can be difficult to truly comprehend.

The essence of DID is that of a coping mechanism that develops as a way to keep all of the 'self' from having to experience or believe that the abuse has happened. The nature of child abuse is a world of secrecy, lies and betrayal. I wonder if the doubt and confusion in the different literature highlights the counter transference to this disorder. I have considered that the issue of naming DID as another disorder parallels the DID client's expression of identifying as something or someone else.

Summary
The primary concern of this dissertation has been to explore the issues that arise in diagnosing a client with DID and why a schizophrenia diagnosis frequently precedes that of DID. In doing so I believe that what I have encountered is of immense value to my practice as a psychotherapist working with sexual abuse survivors.

The struggle to integrate the complexity of issues and political undertones in this area indicates a need to acknowledge one's bias. As a psychotherapist my interest in a diagnosis is as an avenue for developing greater understanding of the client's experience and potential struggles. It would seem that what psychotherapy can offer to a client, whether DID or schizophrenic, is a healing, relational dynamic that may resolve the relational wounds that both diagnoses imply.

The content of this dissertation reflects that these clients may experience a milieu of doubt, support and controversy when encountering different theoretical perspectives held by the clinicians. The reasons for this doubt and controversy are far from unfounded and thus one is left with more questions than answers. I wonder if it would it resolve any of the difficulties if the diagnostic criteria were more explicit, reflecting the possibility of shared features to schizophrenia, or is it a question of greater awareness of the clinicians' theoretical perceptive when informing their practice. Being the subject of such debate and controversy must have an impact on the client. I believe the most significant feature is that

ultimately DID is a relational construct, whether caused by trauma, sociocultural or iatrogenic factors, and needs to be worked with from this construct.

Limitations of this study

The subjects of Dissociative identity disorder and schizophrenia are both broadly written about and studied. What became clear in this study is that the literature discussing the issue of both disorders being diagnosed is limited to a few authors who are writing from the DID perspective. Their research and evidence of their claims is therefore restricted to a few studies. The controversy of DID's validity on its own creates complications in addressing this dissertation question. There are those who do not believe DID is a valid diagnosis and that schizophrenia is the right diagnosis and therefore will see no problem in this area.

In producing this dissertation I needed to take into account the influences of those outside of psychoanalytic opinion, yet I always hold a psychotherapeutic view. The formidable challenge of doing this may have resulted in the exclusion of less known but equally valuable psychoanalytic perspectives that are not focused on in the main body of literature on each disorder. However, I believe this broader clinical perspective has added to this study even as it inevitably may have diluted it in parts.

Other areas of relevance to the debates and conflicting opinions about DID as a diagnosis and trauma-related issues necessarily had to be excluded to reduce a general view to a more focused one. This included the false memory debate discussions which, although significant, were outside the scope of this dissertation. Cultural perspectives were limited in this study as it increased the complexity, and was also somewhat neglected in the literature reviewed.

Finally, I am aware that my decision to research this area is the result of my own interest and work with women in the sexual abuse field. Therefore my bias has always been from a position of working with women to support them through their reactions to abuse. A considerable challenge has been to remove my bias as I reviewed the literature and to present each argument from a neutral position. This has resulted in a shift within me and I now find myself holding a desire to do further research and explore changes to diagnostic criteria.

The degree of immersion in the literature has made this dissertation a challenging but necessary task as it has taken me on a journey not dissimilar to those I have heard clients describe.

In the words of Ross (1997) "the DID client can teach us about fragmentation in our history, our worldview and ourselves" (p 382).

Future research

As Ross and Ellason (1998) point out, there are gaps in the research and, without a reliable method of diagnosing DID, no scientific discussion of different treatment outcomes is possible. In reviewing this literature the most significant gap appeared to be the area of client outcomes. Very little is known about the outcome of untreated DID nor was there much information on what the result may be if a client is misdiagnosed. Much of what was available was inferred speculation. I believe this is an area that necessitates much more research.

Spiegel (2006) states that the problem with diagnostic criteria is the essential feature, the identification of the presence of "more than one identity or personality state." He states that this explanation, which expresses failure to integrate versus the phenomena of multiple identities, was a useful response to the critique that MPD invoked: the idea that one person could have more than one 'personality'. However, Spiegel (2006) emphasises that the hiddenness of the disorder is not mentioned, which is an important feature of the disorder and can be why it remains unrecognized. Spiegel's comments indicate that there may be a need to go back to the features listed under MPD and amalgamate something that is more specific.

I would propose that more research into this is necessary. I am also interested in more literature exploring the strong countertransference that such a disorder appears to create. Unanswered questions remain about the clinician's perspective, effect of attitudes towards diagnosing, trauma and the diagnosis. The integrative exploration of psychoanalytic perspectives and also more evidence as to the outcomes of diagnosing a client DID or schizophrenic would be useful. Perhaps if the issues of conflict and doubt are addressed, the

diagnostic issues would become easier to negotiate. Nevertheless they appear to be inextricably interwoven.

Appendix A
Glossary of terms

Alter

Another term for personality, alternate personality or personality state; also called an identity or dissociated part. A distinct identity or personality state, with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self. Alters are dissociated parts of the mind that the client experiences as separate from each other.

Amnesia

Pathologic loss of memory; a phenomenon in which an area of experience becomes inaccessible to `conscious' recall. The loss in memory may be organic, emotional, dissociative, or of mixed origin, and may be permanent or limited to a sharply circumscribed period of time.

Autohypnosis

A self induced trance, usually automatic hypnosis. The act or process of hypnotising oneself.

Cathexis

Attachment, conscious or unconscious, of emotional feeling and significance to an idea, an object, or, most commonly, a person.

Comorbidity

The simultaneous appearance of two or more illnesses, such as the co-occurrence of schizophrenia and substance abuse or of alcohol dependence and depression. The association may reflect a causal relationship between one disorder and another or an underlying vulnerability to both disorders. Also, the appearance of the illnesses may be unrelated to any common aetiology or vulnerability.

Countertransference

The therapist's emotional reactions to the client that are based on the therapist's unconscious needs and conflicts, as distinguished from his or her conscious responses to the client's behaviour. Currently, there is emphasis on the positive aspects of countertransference and its use as a guide to a more empathic understanding of the client.

Delusion

A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility. Delusional conviction occurs on a continuum and can sometimes be inferred from an individual's behaviour. It is often difficult to distinguish between a delusion and an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion). Delusions are subdivided according to their content. Some of the more common types are: bizarre; delusional jealousy; grandiose; delusion of reference; persecutory; somatic; thought broadcasting; thought insertion.

Depersonalization

An alteration in the perception or experience of the self so that one feels detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream).

Derealization

An alteration in the perception or experience of the external world so that it seems strange or unreal (e.g., people may seem unfamiliar or mechanical).

Diagnostic index of suspicion

A medical term referring to the degree a client fulfils the diagnostic criteria outlined and therefore leads to suspicion of that disorder.

Dissociation

A disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic.

Executive control

In the internal system of a person with a dissociative disorder, authority over the body and its behaviour by a particular personality state, usually the host.

Fantasy

An imagined sequence of events or mental images (e.g., daydreams) that serves to express unconscious conflicts, to gratify unconscious wishes, or to prepare for anticipated future events.

Fragmentation

Separation into different parts, or preventing their integration, or detaching one or more parts from the rest. A fear of fragmentation of the personality, also known as disintegration anxiety, is often observed in clients whenever they are exposed to repetitions of earlier experiences that interfered with development of the self. This fear may be expressed as feelings of falling apart, as a loss of identity, or as a fear of impending loss of one's vitality and of psychological depletion.

Integration

The useful organization and incorporation of both new and old data, experience, and emotional capacities into the personality. Also refers to the organization and amalgamation of functions at various levels of psychosexual development.

Fragment

Within the personality system of a person who has a dissociative disorder, a fragment is a dissociated part of that person which has limited function and is less distinct or developed than a personality state. Usually a fragment has a consistent emotional and behavioural response to specific situations.

Iatrogenesis

When medical treatment or psychotherapy causes an illness or aggravates an existing illness. In psychotherapy, this may occur as a result of the comments, questions, or attitudes of the therapist. There are those who feel that DID is an iatrogenic illness produced by a client to meet the expectations of a therapist. There is also a concern that traditional DID treatment approaches may encourage the development of additional personality states.

Magical thinking

The erroneous belief that one's thoughts, words, or actions will cause or prevent a specific outcome in some way that defies commonly understood laws of cause and effect. Magical thinking may be a part of normal child development.

Negative symptoms

Most commonly refers to a group of symptoms characteristic of schizophrenia that include loss of fluency and spontaneity of verbal expression, impaired ability to focus or sustain attention on a particular task, difficulty in initiating or following through on tasks, impaired ability to experience pleasure to form emotional attachment to others, and blunted affect.

Object relations

The emotional bonds between one person and another, as contrasted with interest in and love for the self; usually described in terms of capacity for loving and reacting appropriately to others. Melanie Klein is generally credited with founding the British object-relations school.

Oedipal stage

Overlapping some with the phallic stage, this phase (ages 4 to 6) represents a time of inevitable conflict between the child and parents. The child must desexualize the relationship to both parents in order to retain affectionate kinship with both of them. The

process is accomplished by the internalization of the images of both parents, thereby giving more definite shape to the child's personality. With this internalization largely completed, the regulation of self-esteem and moral behaviour comes from within.

Personality

Enduring patterns of perceiving, relating to, and thinking about the environment and oneself. Personality traits are prominent aspects of personality that are exhibited in a wide range of important social and personal contexts. Only when personality traits are inflexible and maladaptive and cause either significant functional impairment or subjective distress do they constitute a Personality Disorder.

Splitting

A mental mechanism in which the self or others are reviewed as all good or all bad, with failure to integrate the positive and negative qualities of self and others into cohesive images. Often the person alternately idealizes and devalues the same person.

Suggestibility

Uncritical compliance or acceptance of an idea, belief, or attribute.

Transference

The unconscious assignment to others of feelings and attitudes that were originally associated with important figures (parents, siblings, etc.) in one's early life. The transference relationship follows the pattern of its prototype. The therapist utilizes this phenomenon as a therapeutic tool to help the patient understand emotional problems and their origins. In the client-therapist relationship, the transference may be negative (hostile) or positive (affectionate).

References

Abse, D.W. (1974). Hysterical conversion and dissociative syndromes and the hysterical character. *American Handbook of Psychiatry,* 155- 194.

Abse, D.W. (1983). *Multiple personality in new psychiatric syndromes: DSM III and beyond*. New York. Aronson.

Allen, J., & Iacono, W. (2001). Assessing the validity of amnesia in dissociative identity disorder. *Psychology, Public Policy and the Law,* 7, 311-344.

Anderson, N.C., & Black, D.W. (2001). *Introductory Textbook of Psychiatry* (3rd ed.). Washington, DC: American Psychiatric Press.

American Psychiatric Association. (1975). *The diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC.

American Psychiatric Association. (1980). *The diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC.

American Psychiatric Association. (1994). *The diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC.

American Psychiatric Association. (2000). *The diagnostic and statistical manual of mental disorders* (4th ed, text revision). Washington, DC.

Arlow, J.A. (1992). Altered ego states. *Israel Journal of Psychiatry; Related Sciences,* 29, 65-76.

Beck, J., & van der Kolk, B. (1987). Reports of childhood incest and current behaviour of chronically hospitalized psychotic women, *American Journal of. Psychiatry*, 144, 1474-1476.

Bentall, R. P. (2003). *Madness explained: Psychosis and human nature*. London, Penguin Books.

Brenner, I. (1994). The dissociative character: A reconsideration of "Multiple Personality". *Journal of the American Psychoanalytic Association*, 42, 819-846.

Breyer, J., Nelson, B., & Miller, J. (1987). Childhood sexual and physical abuse as factors in psychiatric illness. *American Journal of Psychiatry*, 144, 1426-1430.

Brick, N. (2003). The diagnosis and assessment of dissociative identity disorder. Retrieved March 18, 2007, from http://members.aol.com/smartnews/did_diagnosis.html

Brick, S., & Chu, J.A. (1991). The simulation of multiple personality: a case report. *American Psychological Association,* 28 (2), 267-262.

Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment.* London: Sage publications

Bowman, E. S., Blix, S., & Coons, P. M. (1985). Multiple personality in adolescence: relationship to incestual experiences. *Journal of the American Academy of Child Psychiatry*, 24, 109–114.

Chu, J., Kirby, J., & Dili. (1993). Severity, frequency and age of onset of physical and sexual abuse as factors on the development of dissociative symptoms. *Comprehensive Psychiatry,* 34, 258-263.

Chu, J. (1998). *Rebuilding shattered lives: the responsible treatment of complex post-traumatic and dissociative disorders*. New York: John Wiley & Sons, Inc

Conley, Y.P., Steele, A.M., & Puskar, K.R. (2004). Genetic susceptibility to psychiatric disorders. *Advanced Practice*, 13,319-325.

Coons, P. M., & Milstein, V. (1986). Psychosexual disturbances in multiple personality: characteristics, etiology, and treatment. *Journal of Clinical Psychiatry*, 47, 106-111.

Cormier, J. F., & Thelen, M. H. (1998). Professional scepticism of multiple personality disorder. *Professional Psychology: Research and Practice*, 29, 163-167.

Davis, J.M. & Frawley, M.G. (1994). *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective.* New York: Basic books.

Davies, J. M. and Frawley, M. G. (1992). Dissociative processes and transference-countertransference paradigms in the psychoanalytically oriented treatment of adult survivors of childhood sexual abuse. *Psychoanalytic Dialogue,* 2, 5-36.

Dean, K.M., Bramon, E., & Murray, R.M. (2003). The causes of schizophrenia: Neurodevelopment and other risk factors. *Journal of Psychiatric Practice,* 9(6), 442-454.

Dell, P.F. (2001). Why the diagnostic criteria for dissociative identity disorder should be changed. *Journal of Trauma and Dissociation.* 2, 7-38.

Dill, D., Chu, J., Grob, M., & Eisen, S. (1991). The reliability of abuse history reports: A comparison of two inquiry formats. *Comprehensive Psychiatry,* 32, 166-169.

Ellason, J. W., & Ross, C. A. (1997). Two-year follow-up of inpatients with dissociative identity disorder. *American Journal of Psychiatry*, 154, 832-839.

Fernando, J. (2002). Dissociation of trauma: Theory, phenomenology, and technique. *Canadian Journal of Psychoanalysis*, 10,168-170.

Friedman, S., & Harrison, G. (1984). Sexual histories, attitudes and behavior of schizophrenic and normal women. *Archives of Sexual Behavior*, 13, 555-567.

Freeman, T. (1985). Nosography and theory of the schizophrenias. *International Journal of Psychoanalysis*, 66, 237-243.

Frattaroli, E.J. (2002). Psychoanalysis and schizophrenia. *American Journal of Psychoanalysis*, 50, 307-310.

Fonagy, P. (2003). Genetics, developmental psychopathology and psychoanalytic theory: The case for ending our (not so) splendid isolation. *Psychoanalytic Inquiry, 23*(2), 218-247.

Gardner, R.A. (1994). Finally! An instant cure for paranoid schizophrenia:MPD. *Institute for Psychological Therapies Journal,* 6 (2), 10-23.

Gleaves, D. H. (1996). The sociocognitive model of dissociative identity disorder: A reexamination of the evidence. *Psychological Bulletin*, 120, 42-59.

Gullestad, S.E. (2005). Who is 'who' in dissociation? A plea for psychodynamics in a time of trauma. *International Journal of Psychoanalysis,* 86, 639-656.

Goff, D., Brotman, A., Kindlon, D., Waites, M., & Amico, E. (1991). Self-reports of childhood abuse in chronically psychotic patients. *Psychiatry Research*, 37, 73-80.

Gottinder, W., & Haslam, N. (2003). A critique of the methods and conclusions in the patient outcome research report. *Journal of the American Academy of Psychoanalysis and Dynamic Psychotherapy,* 31, 191-208.

Hayes, J. A., & Mitchell, J. C. (1994). Mental health professionals' skepticism about multiple personality disorder. *Professional Psychology: Research and Practice*, 25, 2-4.

Herman, J. R. (1992). *Trauma and recovery*. New York: Basic Books.

Janet, P. (1889). *L'automatisme psychologique*. Paris: Balliere

Joober, R., Boksa, P., Benkelfat, C., & Rouleau, G. (2002). Genetics of schizophrenia: From animal models to clinical studies. *Journal of Psychiatry and Neuroscience*, 27(5), 336-348.

Kihlstrom, J.F. (2005). Dissociative Disorders. *Annual revised Clinical psychology,* 1, 227-253.

Kluft, R. P. (1984). Introduction to multiple personality disorder. *Psychiatric Analysis*, 14, 19-24.

Kluft, R. P. (1985). *The natural history of multiple personality disorder. In childhood antecedents of multiple personality*, Washington, DC: American Psychiatric Press.

Kluft, R. P. (1987). First rank symptoms as diagnostic indicators of multiple personality disorder. *American Journal of Psychiatry*, 14, 293-298.

Kluft, R.P. (1987). An update on multiple personality disorder. *Hospital and Community Psychiatry,* 38, 363-373.

Kluft, R.P. (1987). The simulation and dissimulation of multiple personality disorder. *American Journal of Clinical Hypnosis*, 30, 104-117.

Kluft, R. P. (1991). Multiple personality disorder. *American Psychiatric Press Review of Psychiatry*, 10, 161-188.

Kluft, R. P. (1993). Treatment of dissociative disorder patients: An overview of discoveries, successes, and failures. *Dissociation*, 6, 87-101.

Kluft, R.P. (2000). The psychoanalytic psychotherapy of dissociative identity disorder. *Psychoanalytic Inquiry*, 20, 259-286.

Kraemer, M., & Sprenger, M. ([1486],1941). *Mallues Maleficarum.* London: Pushkin.

Lilienfeld, S. O. (1992). The association between antisocial personality and somatization disorders: A review and integration of theoretical models. *Clinical Psychology Review,* 12, 641-662.

Lillenfeld, S., Skerm, J., & Poythress, N. (2006). Associations among early abuse, dissociation, and psychopathology in an offender sample. *Journal of abnormal psychology,* 115 (2), 288-297.

Loewenstein, R. J. (1991). An office mental status examination for complex chronic dissociative symptoms and multiple personality disorder. *Psychiatric Clinical Journal of North America*, 14, 567-604.

London, N.J. (1973). An essay on psychoanalytic theory: Two theories of schizophrenia. Part I: Review and critical assessment of the development of the two theories. *International Journal of Psychoanalysis*, 54, 169-178.

London, N.J. (1973). An essay on psychoanalytic theory: Two theories of schizophrenia. Part II: Discussion and restatement of the specific theory of schizophrenia. *International Journal of Psychoanalysis*, 54, 179-193.

Lucas, R. (2003). The relationship between psychoanalysis and schizophrenia. *International Journal of Psychoanalysis*, 84, 3-9.

Loewenstein, R. J., & Ross, D. R. (1992). Multiple personality and psychoanalysis: An introduction. *Psychoanalytic Opinion*, 12, 3-48.

McHugh, P.R. (1995). Resolved: Multiple personality disorder is an individually and socially created artifact. *Journal of the American Academy of Child and Adolescent Psychiatry*, 34, 957-963.

McHugh, P.R. (2005). Multiple personality disorder (Dissociative identity disorder). *The Sceptics Dictionary.* Retrieved April, 14, 2007, from http://skepdic.com/mpd.html

McKibbon, A. (1999). *PDQ: Evidence based principals and practice*. Hamilton, Ontario: BC Decker.

McWilliams, N. (1994). *Psychoanalytic diagnosis: Understanding personality structure in the clinical process.* London: The Guilford Press.

Meltzer, H. (1999). Outcome in schizophrenia, beyond symptom reduction. *Journal of clinical psychiatry,* 60 (3), 3-7.

Moskowitz, A., Barker-Collo, S., & Ellason, L. (2005). Replication of dissociative psychosis in New Zealand students and inmates. *Journal of Nervous and Mental Disease,* 193 (11), 722-727.

Mullen, P., Martin, J., Anderson, J., Romans, S., & Herbison, P. (1993). Child sexual abuse & mental health in adult life. *British Journal of Psychiatry ,* 163, 721-732.

Ofshe, R. & Watters, E. (1994). *Making monsters: False memories, psychotherapy, and sexual hysteria.* New York: Scribner.

Paddock, J.R. & Terranova, S. (2001). Guided visualisation & suggestibility: Effect of perceived authority on recall of autobiographical memories. *Journal of genetic psychology,* 162, 347-356.

Piper, A. (1997). *Hoax and reality: The bizarre world of multiple personality disorder.* Northvale, NJ: Jason Aronson.

Powell, R. A., & Howell, A. J. (1998). Treatment outcome for dissociative identity disorder. *American Journal of Psychiatry*, 155, 1304-1305.

Putnam, F.W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: The Guilford Press.

Putnam, F.W. (1997). *Dissociation in children and adolescents: A developmental perspective*. New York: The Guilford Press.

Putnam, F. And Loewenstein, R.J. (1993). *Dissociative identity disorder.* U.S.A: Kaplan & Sadock Press.

Putnam, F.W. (2001). Reclaiming dissociative diagnoses. *Journal of Trauma and Dissociation,* 2(1), 47-50.

Price, R. (1987). Dissociative disorders in the self: A continuum extending into multiple personality. *Journal of Psychotherapy,* 24, 387-391.

Radden, J. (1996). *Divided minds and successive selves: ethical issues in disorders of identity and personality*. Cambridge, Massey: MIT press.

Radden, J. (1996). Lumps and bumps: Kantian faculty psychology, psychology & twentieth century psychiatric classification. *Philosophy, Psychiatry & Psychiatry,* 3 (1), 1-14.

Read, J., Mosher, L.R., & Bentall, R.P. (2004). *Models of Madness: Psychological, social and biological approaches to schizophrenia.* Now York: Brunner-Routledge Taylor & Francis Group.

Read, J. (1997). Child abuse and psychosis: A literature review and implications for professional practice. *Professional psychology: Research and practice.* 28, 1-9.

Read, J. & Ross, C.A. (2003). Psychological trauma and psychosis: another reason why people diagnosed schizophrenic must be offered psychological therapies. *Journal of American Academy of Psychoanalysis,* 31, 247-268.

Read, J., Agar, K., Argyle, N., & Aderhold, V. (2003). Sexual and physical abuse during childhood and adulthood as predictors of hallucinations, delusions and thought disorder. *Psychology and Psychotherapy: Theory, Research and Practic,* 76, 1-22.

Read, J. (1994). Child abuse and psychosis: why we deny the facts. *Special feature Recovered memory,* 48- 65.

Read, J. (2001). The contribution of early traumatic events to schizophrenia in some patients. *Psychiatry,* 64, 319-45.

Rosenbaum, M. (1980). The role of schizophrenia in the decline of the diagnosis of multiple personality. *Archives of General Psychiatry*, 37, 1383-1385

Rosenfeld, A. (1979). Incidence of a history of incest among 18 female psychiatric patients. *American Journal of Psychiatry,* 136, 791-795.

Ross, C. A. (1997). *Dissociative identity disorder: Diagnosis, clinical features, and treatment of multiple personality*. New York: Wiley.

Ross, C. A. (1997). Dissociative Identity Disorder. New York: Wiley.

Ross, C.A. & Clark, P. (1992). Assessment of childhood trauma and dissociation in an emergency department. *Dissociation*, 5, 163-169.

Ross, C.A. (1994). *The Osiris complex: Case studies in multiply personality disorder*, Toronoto: University of Toronto Press.

Ross, C. A., & Ellason, J. (1997). Two-year follow-up of inpatients with dissociative identity disorder. *American Journal of Psychiatry*, 154, 832-839.

Ross, C. A. & Ellason, J. (1998). Letter to the editor: Dr Ross and Ms Ellason reply. *American Journal of Psychiatry,* 155, 1462-1463.

Ross, C.A. & Ellason, J. (2001). Acute stabilisation in an inpatient trauma programme. *Journal of Trauma and Dissociation,* 2(2), 83-87.

Ross, C.A. & Hayley, C. (2004). Acute stabilisation and three-month follow up in a trauma programme. *Journal of trauma and dissociation,* 5, 103- 112.

Ross, C.A. (2006). *Evolving psychosis.* New York: Routledge/Taylor & Francis Group.

Roth, S. (1992). Discussion: A psychoanalyst's perspective on multiple personality disorder. *Psychoanalytic Inquiry*, 12, 112-123.

Schore, A. (2003). *Affect regulation and the repair of the self.* New York: W.W. Norton.

Schore, A. (2003). *Affect dysregulation & disorders of the self.* New York, W.W. Norton.

Siegel, P.F. (2003). Dissociation and the question of history: What, precisely, are the facts? *Psychoanalytic Psychology*, 20, 67-83

Siegel, D. J. (2003). An interpersonal neurobiology of psychotherapy: the developing mind and the resolution of trauma. *Trauma, Attachment, Mind, Body, and Brain.* New York: Norton.

Spanos, N. (1996). *Multiple identities and false memories: A sociocognitive perspective.* Washington, DC: American Psychological Association.

Smith, B. L. (1989). *Of many minds: A contribution on the dynamics of multiple personality*. Madison, CT: International University Press.

Spanos, N. P., Weekes, J. R., & Bertrand, L. (1985). Multiple personality: A social psychological perspective. *Journal of Abnormal Psychology*, 94, 362-376.

Sobell, J., Mikesell, M., & McMurray, C., (2002). Genetics and etiopathophysiology of schizophrenia. *Mayo Clinic Proceedings,* 77(10), 1068-1082.

Spiegel, D. (1984). Multiple personality as a post-traumatic stress disorder. *Psychiatric Clinics of North America*, 7, 101-110

Spiegel, D. (2006). Dissociative disorder underdiagnosed due to undescriptive criteria?: Dr. Spiegel replies. *American Journal of Psychiatry,* 163 (9), 1646 -1672.

Skolnick, N. J., & Davies, J. M. (1992). *Secrets in clinical work, relational perspectives in psychoanalysis*. Hillsdale, NJ: The Analytic Press.

Schwartz, H.L. (1994). From dissociation to negotiation: A relational psychoanalytic perspective. *Psychoanalytic Psychology*, 11, 189-231.

Steinberg, M. (2001). Updating diagnostic criteria for dissociative disorders: Learning from scientific advances. *Journal of Trauma and Dissociatio,* 2, 59-65.

van der Kolk, B.A. (2000). Trauma, neuroscience, and the etiology of hysteria. *Journal of American Acadademy of Psychoanalysis*, 28, 237-262.

Waugaman, R.M. (1996). Experiences of schizophrenia: An integration of the personal, scientific, and therapeutic. *Journal of the American Psychoanalytic Association*, 44, 395-939.

Waugaman, R.M. (2000). Multiple personality disorder and one analysts paradigm shift. *Psychoanalytic Inquiry,* 20, 207-226.

Welburn, K.R., Fraser, G.A., Jordan, S.A., Cameron, C., Webb, L.M., & Raine, D. (2003). Discrminating dissociative identity disorder from schizophrenia and feigned dissociation on psychological tests and structured interviews. *Journal of Trauma and Dissociation,* 4, 109-131.

Wilbur, C.B. (1984). Multiple personality and child abuse: An overview. *Psychiatric Clinics of America,* 7, 3-7.

Williamson, P. (2006). Mind, brain and schizophrenia. *The Journal of Nervous and Mental Disease,* 195, 712-727.

Young, M., Read, J., Barker-Collo, S., & Harrison, R. (2001). Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology: Research and Practice*, 32, 407-414.