# EDITORIAL:

# A SECOND LOOK AND MISCELLANEOUS REFLECTIONS

Richard P. Kluft, M.D.

The day I sat down to write the editorial for this issue I had a very unusual, sad, and instructive experience. I interviewed a woman I had not seen in over twenty years, and brought some degree of closure to a mystery that had haunted me since my residency.

In the last month of my psychiatric training early in the 1970s I was assigned to evaluate a young student who had presented to the psychiatric clinic under challenging and trying circumstances. As the clinic's senior resident, it was my obligation to take on cases that were extremely complicated, puzzling, or perceived as high risk. Heather (a pseudonym) fit all of these descriptions. She was inflicting serious injuries to herself on a daily basis. I was asked to treat her until she could be assigned to a new resident the first week of July.

I could get no meaningful childhood and developmental history. It was as if Heather had begun her life in high school. Not surprisingly, given the era and my deep fascination with the work of Otto Kernberg, I concluded that she was a very depressed and chaotic low level borderline personality. Within a few sessions, I succeeded in reducing Heather's infliction of self-injuries. We terminated our work. She was grateful, and I had the feeling that I had done a good crisis intervention, despite my not understanding the patient in depth. I hoped that she would work well with my successor, and hoped that the transfer would not be traumatic.

The evening of June 30 began pleasantly enough. When I left the clinic I was done with my training. The next day I would start a real job, and put the genteel poverty of my residency and fellowship behind me. Stipends then were far less generous than the salaries of today's residents and fellows. A good bottle of wine was opened, and breathing. My wife and I looked back on the grueling road we had travelled together. We anticipated a taste of relative prosperity and freedom. Thankfully, as we talked, we had forgotten about the wine. My head was lamentably clear when I got a call from the hospital at about 11:00 p.m. Heather's friends were worried about her and believed she was suicidal. She was barricaded in her room and not answering her telephone or the door. I told the person who was covering to call the police. Heather had to be brought to the hospital for assessment, and possibly committed.

At 11:05 p.m. I got a call from my almost former chief. The city police would not go to a college campus address, and the university police would not go to the patient's room without mental health back-up. Less than one hour before my residency was over, I was commanded to return to the hospital, link up with the college police, and bring Heather in.

I was a veteran of many home visits with community mental health crisis teams. I appreciated, with reluctance, that I was probably the best person for the job. When I arrived at Heather's dormitory room, which she was occupying for a summer semester, she greeted me with confused cordiality. No, she had not told anyone she was suicidal. Of course we could come in and talk. As we chatted, I noticed that despite the warmth of the evening, she was wearing a long-sleeved blouse. I doubt I was subtle enough to disguise my stare. Blood was seeping through her blouse along both arms and wrists. She looked stunned and shocked. She now admitted that sometimes she found herself cut, but could not recall doing it. She showed me a diary with some entries she did not recall making. Dismayed, but realizing she was in deep trouble, she allowed herself to be admitted to the hospital.

I never forgot Heather, because I knew I did not know what was going on. I had already begun to identify and treat multiple personality disorder patients, but my knowledge was rudimentary and completely unsystematic. What is common knowledge to every neophyte in the field was not yet available. It would be several years before I began to develop a structured series of inquiries with which to diagnose dissociative disorders. I did not know whether Heather had a dissociative disorder, a psychosis, a drug intoxication, a metabolic condition, a partial complex seizure disorder, or just the mother of all borderline states. I asked the inpatient psychiatrist for his opinion, and he muttered something about the manipulativeness and self-destructiveness of borderline patients. My successor as Heather's outpatient therapist never communicated with me. The clinic director told me that Heather had dropped out after several follow-up sessions.

As the years went on, and I developed expertise in the dissociative disorders, Heather was one of four patients from my residency whom I came to believe I had misdiagnosed and misunderstood. One of these patients serendipitously walked into my Reading office in the early 1980s when her

boyfriend's car broke down outside of the building. She was astonished to find my name among the occupants, and dropped in to say hello. She let me do a brief reassessment, and I was relieved to find that my original diagnosis was accurate — I had not missed a multiple. I had no further contact with the other three.

Then I received a call from Heather early this year. She wanted to begin treatment, but I was not in a position to work with her. I referred her to three competent colleagues who were expert in the diagnosis and treatment of dissociative disorders. A few weeks later one of them called me and thanked me for the referral of Heather, that "interesting and brilliant woman with MPD." After several months of treatment Heather hit a rough spot in treatment on the anniversary of a parent's death, and required a brief hospital stay. I jumped at the chance to interview her during her stay, and got her permission to publish some reflections on our two encounters, over twenty years apart.

What was most interesting was the sameness of her clinical presentation. I had no trouble in recognizing her, and her mannerisms had not changed appreciably. I now had names for all the phenomena that perplexed me then, but were so familiar now. Those funny facial twitches were switches. Those prolonged periods of spaciness and unresponsiveness were dissociations. Those disremembered episodes of self harm were the actions of alters. My whole way of perceiving her was different, and governed by a paradigm of understanding that had not existed for me when I first encountered Heather. By the time I interviewed her, Heather already had scored in the mid-40s on a Dissociative Experiences Scale (Bernstein & Putnam, 1986) administered by the admitting nurse, and endorsed phenomena consistent with a DID diagnosis on the Dissociative Disorders Interview Schedule (Ross, 1989). A resident who had been trained in the diagnosis and treatment of the dissociative disorders, using questions from the SCID-D (Steinberg, 1993) and Loewenstein's (1991) specialized mental status examination, had made the diagnosis of dissociative identity disorder in the admission suite.

Heather had wandered through the mental health care delivery system in an exhausting and depleting twenty-plus year odyssey before an accurate diagnosis was made. I am uncomfortable contemplating the price she paid in terms of pain, morbidity, expense, and compromised potential. I am glad to know that she is in good hands, and finally is doing well. It is gratifying to know that the diagnostic and therapeutic skills and techniques I could not even imagine or contemplate those many years ago are now available, and that the young patients of today are less likely to endure the many years of misdiagnosis and mistreatment suffered by my former patient.

Currently, there is a tendency to respond to the backlash against the treatment of the traumatized by a defensive withdrawal from the clinical application of the skills and expertises that our field has acquired over the last twenty-some years. Good clinical work is careful and compassionate, but not cowardly. It is possible to bring to bear what we have learned while maintaining the most lofty and circumspect standards of clinical practice. If we retreat, there will be other Heathers to write about in another twenty-some years.

In this issue of *DISSOCIATION* we have an interesting range of papers. In the first, Trangkosombat and her colleagues take us to rural Thailand for a study of epidemic dissociative symptoms among schoolchildren. Their careful analysis offers us insights into the contagion of dissociative symptoms in a well-defined social context. Next, Coe and his colleagues offer an analysis of the relationships among attachment styles, a history of childhood violence, and subsequent dissociative experiences. We are in urgent need of such studies, because clinical work with dissociative disorder patients often centers on attachment-related concerns for protracted periods of time, and disordered attachment behavior can exert profound influences upon the transference/countertransference matrix and the vicissitudes of the therapeutic alliance.

Everill and her colleagues explore the complex and often perplexing interactions among reports of sexual abuse, bulimic symptoms, and dissociation. They argue that dissociation plays a mediating role between abuse and bulimia, and make a useful contribution to the study of this controversial and clinically important issue. Choe and Kluft report on their admittedly preliminary efforts to use the Dissociative Experiences Scale (Bernstein & Putnam, 1986) to monitor aspects of treatment outcome. They share results that indicate that hospital treatment may effect the subscales of the Dissociative Experiences Scale differentially.

Finally, there are two contributions from Beere. Beere explicates a perception-based theory of dissociation and dissociative responses to trauma, operationalizes his hypotheses to render them falsifiable, and then proceeds to put them to the test. His results are an intriguing effort not only to develop his set of ideas, but to prove the merit of his theoretical model. I chose to publish these related papers together in order to allow the reader to follow this endeavor from speculation through experimentation. We rarely are in a position to observe the process involved in such efforts.

With this issue we welcome Ira Brenner, M.D., as Assistant Editor. Dr. Brenner has published extensively on both dissociative disorders and the psychological consequences of the Holocaust. He is a training and supervising analyst as well, and long has been one of our most skilled reviewers. He will bring a tremendous amount of expertise and experience to the editorial staff.

Let me comment briefly on several issues concerning the publication of *DISSOCIATION*. Despite a limited budget, the lack of a full-time staff, delays in our authors' revision of manuscripts, and difficulties with the speed of our review process, *DISSOCIATION* has a good supply of accepted manuscripts, and will become increasingly timely in its publication. The 1995 Amsterdam papers should be ready for

publication in 1996, and many are outstanding. Considerable effort has been dedicated to "catching up." As of this writing, all submissions have been either acted upon, or are out for review.

Nonetheless, our efforts have been far from perfect. The relocation of our files may have resulted in some manuscripts being misplaced. Authors who feel that their efforts have been overlooked, or who have inquiries that they would like to make, are invited to write to me at 111 North 49th Street, Philadelphia, PA 19139. I must emphasize that I usually cannot respond to telephone inquiries.

Finally, it has come to my attention that for the first time in the history of *DISSOCIATION*, a number of copies of the June, 1995 issue (Volume VIII, Number 2), were printed imperfectly. An unknown number of our readers received June issues with pages missing and/or with some pages duplicated. Please be assured that *DISSOCIATION* will provide replacement copies for all subscribers who received a misprinted issue. Please mail your misprinted issue to the following address with a cover letter requesting it be replaced, and you will be mailed a replacement copy.

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