

UNWARENESS AND DENIAL OF PREGNANCY IN PATIENTS WITH MPD

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ABSTRACT

In female MPD patients, sexual intercourse and pregnancy are experiences of which only one or a few alter personalities may be aware. When the host personality is amnesic for these dissociated functions, severe complications may arise both for the affected woman and those around her. When the amnesia is lifted, the personalities involved may experience pregnancy and delivery as traumatic, and mother-child attachment may be severely hampered. This paper describes four case examples illustrating these complications. Two of them are classic 19th Century cases, Bellanger's (1854) Madame de B. and Azam's (1887) Félicité X. The fact that in the 1854 case it was the treating physician who fathered the child dramatically illustrates Kluft's recent observations that these patients run the risk of sexual abuse by their psychotherapists and other health care professionals. The discussion section deals with: (1) Pierre Janet's views on unawareness and denial in MPD, as illustrated in sexual intercourse, pregnancy, and delivery; (2) the so-called partus stress reaction, for which MPD patients with a childhood history of sexual abuse may be at risk; (3) trauma-induced psychotic reactions to delivery; (4) techniques for supporting patients with these issues; and (5) sexual abuse of MPD patients by therapists.

Although not mentioned as such in the *DSM-III-R* (American Psychiatric Association, 1987), amnesia is a central characteristic of multiple personality disorder (MPD) (Putnam, 1989; Ross, 1989). The existence of amnesia for actions executed by dissociated parts of the personality can create difficulties and complications in the lives of MPD patients. One of the areas where this can be experienced most painfully is sexuality and pregnancy. Because of the frequent presence of sexual abuse in childhood and associated pregnancy fears, these areas are intrinsically problematic for many MPD patients. As reported in 19th Century case reports, amnesia

for intercourse leading to pregnancy and the subsequent unawareness and denial of pregnancy constitute additional complications. Denial of pregnancy has been previously reported before in cross-cultural contexts and in incest victims (cf. Silverblatt & Goodwin, 1983), as well as in psychotic women (Miller, 1990). It is here described in women suffering from MPD, using both early literature reports and examples from the authors' practice. We discuss how amnesia and pregnancy denial relate to each other. Special attention is given to the fact that the delivery itself can be traumatic for the MPD patient, and to techniques clinicians can use to help their pregnant MPD patients control symptoms during pregnancy, labor, and delivery.

MADAME DE B

In his treatise on animal magnetism, Bellanger (1854) described the history of Madame de B, a most impressive, attractive, highly musical, intelligent, and sensitive young woman, who in her normal waking state was unaware of the love affair she had with her doctor. The entire affair belonged to an alter state as did the pregnancy which resulted from this affair.

History

At age twenty-one, Madame de B, then still Mademoiselle de L, watched a violent scene taking place a few steps from her, to which she responded with intense fright followed by a nervous or hysterical attack: She fell down, lost consciousness, and showed convulsive movements. After having regained consciousness, she kept feeling vaguely unquiet and weak. Soon she began to suffer from more frequent, longer, and more intense attacks.

For treatment, Mademoiselle de L was brought from the provinces to Paris, where several expert physicians were unable to alleviate her troubles. Then Dr. X, a young physician who had obtained on several occasions excellent results with magnetism, proposed to treat her. He magnetized her daily in the company of her mother. At first no changes were observed, and the state of somnambulism was not observed. Later it became apparent that the treatment had a calming effect upon her—with a decrease and subsequent disappearance of the attacks. Mademoiselle de L returned to her home town, where she corresponded monthly with Dr. X about her health and well-being.

Submitting to the wishes of her parents but against her own will, she married a frivolous and debauched man,

Monsieur de B, from whom she soon became pregnant and had a child. For some time, she lived calmly, in a rather detached manner, and without complaints. Then the nervous attacks returned, increased in intensity and frequency. She went again to Paris, where Dr. X commenced his treatment anew.

In spite of all Dr. X's efforts, this time the magnetism had no effect whatsoever. Then, one day during a magnetic session, Madame de B entered a state of somnambulism in which she was able to converse with Dr. X. Upon awakening from this state, she believed she had been asleep; she remembered nothing of the conversation that had taken place under hypnosis. Dr. X learned to transform her nervous attacks into this state of somnambulism. However, Madame de B was always amnesic after the sessions. In the state of somnambulism she seemed to remember everything; i.e., her experiences during somnambulism as well as her life during the habitual state of consciousness. During somnambulism, she forbade Dr. X to tell herself in her habitual state about her somnambulist experiences. The nervous attacks became less frequent and less intense. In the somnambulist trance, Madame de B engaged Dr. X in discussions on many subjects. Her character seemed to be modified. She was impressionable and irritable, and she could hardly stand a contradiction, while in her habitual state she had "the sweetness of an angel." Ordinarily so modest and reserved, she had become rather selfish and presumptuous. She was rather capricious, now playing the piano, now changing into an evening dress, now dancing with Dr. X. Before returning to her habitual state, she would put everything back that she had used while in the somnambulist state. Upon awakening she always believed that she had slept. However, when she found things changed at home (rearranged, at other places than before), she became upset and repeatedly questioned her chambermaid.

Once, after Dr. X had changed her hysterical attack into the somnambulist state, Madame de B. professed to him her profound love which she had felt for him ever since she came to him that first time for treatment. Never had she told anybody, and she forbade him to tell her about it in her habitual state. Dr. X was rather shocked. During the next session she continued to share her love for him, and soon Dr. X confessed he loved her, too. Madame de B and Dr. X became secret lovers, but only during the somnambulist state.

Pregnancy

Her husband went abroad for a long period of time. Five or six months after his departure, all the signs of pregnancy became apparent. As Madame de B had not had any sexual contact with her husband for more than a year, he could not be the father. In her habitual state, she was completely sure that she had never had an illicit affair with anybody. In fact, she did not understand at all that she was pregnant. She believed she suffered from an unusual illness of which she had seen examples in her family before. In the somnambulist state she knew very well what was the matter, but then she did not let it bother her too much.

Dr. X was most embarrassed by Madame de B's pregnancy. In her habitual state, she constantly demanded remedies in order to stop this strange illness which progressed every day. Finally, she realized what was the matter with her. She became very anxious, questioning herself all the time as to how it could have happened. Had someone taken her by surprise during her sleep? But that was impossible! Who could be the culprit? Dr. X did not tell her the truth. She went to other doctors, to a priest, to a soothsayer. Her mental state worsened. She began to believe in spirits, in spells which might have been cast on her, in visits from the devil during the night. When she was in the somnambulist state, Dr. X tried to get her permission to tell her in her habitual state what was the matter between them and how she had become pregnant. Madame de B would not hear of it: Because of such a revelation she would lose her reason for sure, and, besides, she did not want to know that she was guilty. Afraid of these consequences, Dr. X kept the facts to himself.

As the end of her pregnancy approached, she became more agitated and her nervous attacks became increasingly frequent and violent, and the magnetism became almost powerless. Madame de B could only stay for a very short time in the somnambulist state, and when she returned to her habitual state she was, in effect, psychotic. Incoherent ideas, bizarre fantasies, shouts, crying spells, laughs and sobs followed each other in a disordered manner. "There one saw this noble and unfortunate woman giving the sad and heart-rending spectacle of an insane." She believed herself to be persecuted by demons, and made continuous efforts to protect her feminine charms from the demons' odious and disgusting outrages. With all his might Dr. X attempted to magnetize her, and when he finally succeeded she would return to her usual intelligence and reason.

Delivery

The start of labor took Madame de B by surprise and evoked a strong psychotic reaction. Dr. X was unable to transform this terrible state into the usual state of somnambulism. Madame de B delivered a baby which lived only a few days. Because of her severely psychotic state, she had to be admitted to a mental hospital.

Follow-up

Madame de B's family found out about the illicit affair. Dr. X felt guilty and unable to defend himself. He wrote to Monsieur de B that he had not seduced his wife: "I have only inspired in her a love which she did not have for you. Do you want justice or revenge? Do you want to turn to the law? Do you want to avenge yourself with hand weapons? I am at your service, monsieur." However, when a medical mission to a foreign country was offered to him, he used the opportunity "to desert, so to speak, before the battle."

After a stay of some months in the mental hospital, Madame de B's mental state improved and she was able to return to her family. There she suffered intensely under her husband's vengeful reproaches and anger. However, she was "innocent, only the somnambule in her was guilty. In reality, Madame de B had to suffer for another and bear the pun-

ishment for a crime which she could not even understand" (p. 288). The hysterical attacks did not return, and neither did the somnambulistic states. Several years later she met Dr. X again. It gave her pleasure talking with him, but she never realized that "he had been the hero of an adventure in which she had been the victim" (p. 289). On his part, Dr. X did not tell her. "Madame de B, who believes herself to have been the victim of the devil, and who does not cease to curse him, has no doubts and so will never know that the object of her maledictions is a devil whom she adores, to whom she has given the rights to her heart and to her person, and who, to her misery, has abused her" (p. 290).

FELIDA X

The best known 19th Century European case of double personality was Azam's patient Félicité X. Azam wrote a series of articles about her and subsequently a book (Azam, 1887), and her history was also described in many French works on memory, hysteria, and hypnosis (cf. Bourru & Burot, 1888; de la Tourette, 1887; Laurent, 1892; Legrand du Saulle, 1883; Janet, 1907, 1911; Pitres, 1991; Ribot, 1883).

History

Félicité was born in 1843 to Bordeaux parents. Her father was a sailor who perished when she was a small child. Her mother had to work in order to raise her children. She later remarried. Although the first years of her life had been difficult, Félicité developed normally. An intelligent girl, she did well as a dressmaker. Near the age of thirteen, just after menarche, she presented symptoms which signalled a beginning hysteria: various nervous symptoms, vague pains, pulmonary hemorrhages unexplicable by the state of the respiratory organs.

At age fourteen, Félicité began to experience—sometimes under the influence of strong emotions—an intense pain at both temples. Then she fell to the ground in a sleeplike state. She stayed like this for approximately ten minutes, after which she spontaneously opened her eyes and seemed to wake up in another mental state, her *condition seconde*. After one or two hours, the sleeplike state reappeared and subsequently she returned to her habitual state in which she did not remember what had happened before. This kind of episode occurred every five or six days, or even less frequently, giving her mother, stepfather, and other people around her the impression that she was mad. Soon the symptoms of hysteria worsened and increased in number. Thus she was also subjected to convulsions and more frequent hemoptysis.

In 1858, at age fifteen, she was referred to Dr. Azam. He found her to be a very intelligent girl, with a rather sad, even morose character. Her conversation was serious, and she spoke little. Her will was little developed and she was very diligent at work. Emotionally, she appeared underdeveloped. She was very preoccupied with her illness and she suffered intense pains in many parts of her body, in particular, her head. The symptom of globus hystericus was particularly well developed. Azam learned that in her second

state her character had completely changed. Instead of being sad, she was cheerful, very lively, and outgoing. She was much more impressionable, and her imagination had become exalted. For the slightest reason, she became intensely emotional. In this second state, she remembered everything perfectly, both with regard to what happened in her habitual state and in this one. She experienced herself in this state as being sane, and in the habitual state as being in a crisis. Azam came also to the conclusion that all her faculties were more developed or complete in this second state. She did not feel the pains from which she suffered so much in her habitual state.

Azam incidentally observed also a third state, which he regarded as just an epiphenomenon of the attack. Félicité then experienced unspeakable terror, terrible visual and auditory hallucinations of ghosts and bloody murder, and repeatedly said, "I am afraid... I am afraid." Except for the boyfriend, age eighteen, who was to become her husband, she did not recognize anybody. This quasi-delirious state, Azam remarked, was of short duration, and it was the only moment that he could observe the confusion that characterized it. As Félicité grew older, she experienced this third state more often. (Today we would probably recognize this state as a traumatized child alter, whom we would have also involved in treatment.)

Pregnancy

The boyfriend had known Félicité since her infancy. Feeling a strong affection for each other, both youngsters intended to marry. In her second state, she gave herself to him and became pregnant; she was oblivious of this during her habitual state. One day, and sadder than usual, Félicité told Azam in her tears that her illness was getting worse, because her belly became bigger and she vomited each morning. Azam kept to himself his suspicions that Félicité was pregnant. Soon she returned in her second state to him, saying: "I remember exactly what I have told you, you should have understood me easily. I admit it frankly... I believe I am pregnant." She was not at all upset about it.

Having become pregnant during her second state, Félicité ignored the fact in her habitual state. She only knew it in her other, similar states, Azam said (thereby indicating, it seems, that he was aware of more alter personalities). This ignorance could not last, however. A neighbor, who about believed Félicité was joking when she denied it, brutally confronted Félicité in her habitual state with the fact of the pregnancy (which Félicité had already told her in her second state). Félicité became very upset and reacted with very violent hysterical convulsions.

Delivery

Azam did not give particulars about the delivery, except for stating that she delivered happily and breast fed her child.

Follow-up

During the following two years, Félicité was in excellent health, and no conspicuous phenomena were observed. Then the personality alterations reappeared "with an average frequency." At age twenty she had a second, very painful, preg-

nancy. She frequently spit up blood, and experienced various nervous symptoms related to hysteria, such as attacks of lethargy which lasted three or four hours.

Azam, who with a brief interval followed Férida during the rest of her life, later remarked that in the course of sixteen years, Férida had had eleven pregnancies, some of which had resulted in miscarriage. The deliveries always took place in her habitual state. Férida continued to suffer from MPD during the remainder of her life. Summarizing Azam's extensive case study of Férida, Janet (1907) remarked that "it was only in her old age that one of the periods [states], the second—that is to say, the better one—during which the subject was more active and had a total memory, encroached upon the first, and filled almost the whole of her life. Henceforth Férida seldom remained three or four days in her former state, called normal; but then her life was intolerable, for she had forgotten three-quarters of her existence" (p. 81).

ELS

A contemporary case concerns Els, a thirty-eight year-old unmarried woman living together with her boyfriend. She had been in treatment for MPD for more than four years when she surprised her therapist by saying that she had a five-month-old baby.

History

At age thirty-four, Els was referred by her physician for psychiatric treatment because she "lost time" and, therefore, experienced great difficulties in combining her work and study. In treatment, the diagnosis of MPD was made, and altogether nine alter personalities, among them two child alters, were met. Because of her fear of "losing control," Els was very reluctant to accept the diagnosis.

With regard to her early history, the therapist learned that Els' mother was very surprised by her first pregnancy (with Els). The mother who had suffered herself from having had a cold, rejecting mother, repeated this behavior towards Els. She physically and emotionally abused the infant. The father seemed to have been only marginally involved in the family. From ages four to six, Els was sexually abused by a neighbor. With regard to the period of ages nine through eleven, Els still experiences amnesia. A referral for psychiatric treatment because of depressive symptoms, at age sixteen, did not result in treatment because of mother's refusal to let her tell her story alone. Around this time, one alter became dependent on a variety of drugs. At age twenty-two, she was sexually abused by her psychotherapist, a psychologist who gate-crashed her house and raped her. The resulting pregnancy ended in an abortion, to which Els responded with a serious suicide attempt.

For several years, Els lived together with her male friend. One alter was able to have sex with him; other alters had additional sexual relations with other men. However, during actual intercourse, often a sexually abused alter took over who would then panic. Because of this, Els usually avoided sexual contact.

Pregnancy

During a holiday period, a new alter personality came into being who felt an intense desire to have a child. This alter engaged in a one-time only sexual contact with her partner, and the patient became pregnant. During the next five months, other alters took over as usual, the new alter later being amnesic for this period. The alters 'out' did not realize that the body took on the usual characteristics of being pregnant. From the fifth month on, and without them being aware of it, the new "mother" alter, who desired the child, alternated again with the others. When she felt the baby moving inside, she went to a midwife, informed the biological father, and began to prepare for delivery. Because of the weight gain and the changes they observed in the body, which they interpreted as the result of bulimic attacks, some alters became very anxious. They began to suffer from panic attacks. One alter did not want any contact with the others and went to another therapist. They were altogether so convincing in confabulating the bulimia, that the therapist accepted this as the cause of the bodily changes he could also observe.

As the end of the pregnancy approached, many alters, still unaware of the facts, became more and more agitated. The patient began to suffer from panic attacks. One alter started to use cocaine, another began to self-mutilate, and another, until then thought to be an inner self helper, bought tickets for a flight to another continent in order to search for her imagined parents.

Delivery

At forty weeks of pregnancy, a complicated delivery took place. The membranes broke, but the baby did not descend. Instead of a planned home delivery, the delivery had to take place in the hospital. With a syntocin infusion, external expression, (the amniotic fluid was meconium-stained), and an episiotomy, the delivery was facilitated. Because of the breaking of the membranes and subsequent events, and the general lack of support from her friend, the patient, i.e., the 'mother alter,' entered a panic state and felt she was dying. Everything became black around her, and she felt she was being sucked into a dark tunnel. During this experience, she impressed the attending medical personnel with lowered consciousness, and with disorientation in time and space. Suddenly this darkness "closed" and the child had been delivered. She became anxious when she did not hear the baby or anything else. When the gynecologist subsequently told her that everything was all right with the baby, a girl, and she could hold her in her arms, she experienced great joy.

Follow-up

Once home, all the other alters continued to be amnesic for the pregnancy and the delivery. The "mother" alter continued to take care of the baby and breast feed her for six months. Some of the other alters ignored the baby or just acknowledged its existence ("a small child came to live with us"). The child alters were happy with her: "We like to play with the baby." One alter, the former inner self helper, wanted to give up her function and sever all ties with the

others as a reaction.

At the same time, another alter began to abuse the baby, i.e., by letting her almost drown in the bath. Fortunately, around this time the therapist learned (from somebody in the patient's neighborhood) about the existence of the baby. He made inquiries with the patient and was informed in an "internal group session" by the 'mother' alter about the baby. She was ashamed that she had not informed the therapist before, and explained the reason for it: She feared being contaminated by the other alters' "craziness" and thus less able to protect the baby, if she would commit herself to treatment.

Together with the "mother" alter and other adult alters, the therapist was initially able to deal successfully with the abuse of the baby. He found out that the baby's crying was the trigger to the abuse: It evoked the traumatic memories of her own crying while being abused by her own mother, to which she responded by taking over, with panic and anger. All this triggered other abused alters, among them alters who had experienced rape. These alters then took a bath—in an attempt to cleanse themselves of the rape—together with the baby. The abusing alter then pushed the crying baby's head under the water. The ensuing *silence* triggered the "mother" alter to take over again, save the baby and comfort her—something which the other alters had never experienced themselves. The therapist was able to make stringent agreements with the adult alters to cooperate in order to prevent recurrence of the abuse; he guided the patient in creating a strong social support system around her with regard to care and protection of the baby, and he was effective in involving a pediatrician for frequent check-ups of the baby. In spite of all these agreements and precautions, at the time of this writing, the situation around the baby was still precarious. Apart from the "mother" alter, the adult alters involved still feared responsibility. They cooperated for the baby's physical safety, but refused to deal emotionally with the baby in a safe and consistent way.

M.

The following case report describes a patient with MPD whose amnesia regarding sexuality and pregnancy led to catastrophic problems, particularly the serious obstetric complication of stillbirth.

M., a black, unmarried mother of two, diagnosed as MPD at age eighteen, was twenty-three years old and at term with her fourth pregnancy when stillbirth was diagnosed.

History

M.'s own prior child abuse had included physical abuse by her father (beating with extension cords and chairs) and mother (slapping in the face), and violent sexual abuse by one uncle and three brothers (insertion of objects, penetration of all orifices). Family violence has continued to be perpetrated by all her abusers; her daughter has already been sexually abused by one of these men. One abuser was chronically grossly schizophrenic. One of M.'s siblings had died due to neglect.

M.'s first pregnancy had been recognized at six months

by her mother, and an abortion was performed. M. delayed going in for follow-up after the abortion, and by the time she did, she was told that she was seven months pregnant with the first of her two living children. She is still trying to piece together the paternity of both these children. She does not recall with whom she was having intercourse at the time of their conception.

Different alter personalities have different opinions about who the father or fathers may be. The alter that had the intercourse believes herself to be sterile. The intellectual alter that visits doctors handles the pregnancies and repeatedly requests birth control. However, since she has no awareness either of intercourse or menstrual periods, she is unable to follow through effectively with prescribed contraceptive methods. The sexual alter has been unaware of the pregnancies and has continued to use a variety of drugs, especially amphetamines, during pregnancy. This alter hates "getting fat," and by using stimulants and self-induced vomiting, has managed to lose weight during the last two pregnancies. With treatment, however, the sexual alter has become more interested in parenting. She has previously been impatient and physically abusive with the children.

Delivery of Stillbirth

In the last trimester of her fourth pregnancy, stillbirth was diagnosed in the presence of the intellectual alter. The sexual alter took over and, not knowing about the stillbirth, failed her appointment for labor induction. The therapist was contacted to take M. to the hospital. The intellectual alter went in, went through the induction with support, and held the dead baby with sadness and tearfulness. Then the boyfriend came in. At this point, the sexual alter came out. She had never been present at a delivery before and did not realize anything was wrong. When the boyfriend left, a frightened child alter came out, disconnected the intravenous lines and ran away to hide in a closet.

Follow-up

During the following weeks, while the intellectual alter was grieving, the sexual alter would wander from doctor's office to doctor's office asking if one of her treatment team members had her baby. She thought that the therapists distrusted her parenting abilities and had arranged with the intellectual alter to keep the baby from her. She made plans to kill the intellectual alter, which resulted in two suicide attempts.

DISCUSSION

Amnesia versus Denial

Janet (1909) observed that patients suffering from hysteria—the broad class of dissociative disorders to which MPD belongs—rarely have a precise notion of what is the matter with them. Very often they have dissociative symptoms, Janet said, which they themselves ignore, and which are only discovered through examination by the physician. As described in this paper, in some MPD patients, pregnancy may be an example. It seems only natural that those alter personalities which have been unaware that sexual intercourse has taken

place do not immediately interpret the signs and symptoms of pregnancy as such. However, it is a curious fact that it took them so long to discover it. Madame de B first believed she suffered from a strange disease, and only when the pregnancy was well advanced did she become aware of it. Félicité X thought that the illness she believed she had was worsening because her belly became bigger and she vomited each morning. She only began to realize what was the matter with her when she was told so quite brutally by a neighbor. In Els' case, the other alters found out about the baby only after the delivery.

It seems that in all these cases something more had been going on. Following Janet (1901, 1907, 1909), we may say that the ignorance was not only based on amnesia for intercourse but also on a dissociation of the function of sexuality and reproduction, which belonged to only one or a few alters. Those alter personalities ignorant of the pregnancy have dissociated the function and related notions of sexuality and reproduction. In other words, they are characterized by an amnesia not only for the pregnancy but for the whole realm of sexuality and reproduction. As this dimension does not exist for them, bodily changes such as amenorrhea, enlargement of the abdomen, growth of breasts and hyperemesis gravidarum simply cannot be interpreted as such.

Janet (1909) adds another aspect to this. Patients suffering from hysteria, he observed, are also characterized by a narrowing of the field of consciousness. This not only implies that the mind—of an alter personality—can deal with only a limited number of psychological phenomena, but also that their ability to critically assess, and reflect on, a given situation is limited (Janet, 1920). This does not mean that they cannot be critical, but rather that they view the world automatically from a limited point of view. They are severely hampered in their ability to take more options into consideration. This characteristic may foster an *unawareness* of being pregnant, but it also may enhance its *denial*. There exists a subtle but important difference between the two phenomena. In order to deny an experience or fact, Janet (1935) said, one has to realize its existence to some degree before. When one is fully aware of something (e.g., an event or state of affairs) and its implications for one's own life, *realization* has taken place. The opposite of this is not denial, but *non-realization* (Janet, 1935), the unawareness we were speaking of above. We believe that in the cases described so far, this was the initial phenomenon. It is theoretically possible (but not clear from the material so far) that alter personalities unaware of intercourse and pregnancy subsequently got some suspicions about being pregnant, and then—with the help of the tendency towards the narrowing of the field of consciousness and non-reflective assessment—denied this possibility. In general, in our experience, many MPD patients are able to have some initial awareness of something (a large, self-inflicted wound, for instance), and subsequently ignore its existence. In the case of the pregnant MPD patients described above, either they take the attitude of *la belle indifférence d'une hystérique*, as was the case with Els, or they fix their mind on the idea of an illness for which they want treatment (Madame de B, Félicité X).

Immediate Post-Partum Reaction/Partus Stress Reaction

Delivery as a traumatic event is seldom reported in the literature (cf. Goodwin & Jamarillo, 1981; Moleman, van der Hart & van der Kolk, unpublished). In two of the four cases described so far, the mother experienced the delivery as traumatic. In one case, a frightened child alter came out shortly after the delivery, and panicked.

In Els, it was the special "mother" alter who alone had been aware of the conception and pregnancy, and it was she who delivered the baby. She had the feeling of dying, and she experienced severe pains during labor, to which she responded with lowered consciousness and disorientation of time and space. This dissociative experience seems to be related with the *partus stress reaction* (PSR) which Moleman et al. observed in the first deliveries of three women, for whom the delivery overwhelmed existing coping mechanisms and was experienced as intolerable danger, pain, or anxiety. They responded to this acute trauma with panic, followed by dissociative symptoms such as depersonalization (in the sense of dissociating their personal consciousness from the physical and emotional experience of labor), derealization, and amnesia for aspects of the delivery. In all three women described by Moleman et al., this PSR seemed to be related to a history of infertility and complicated pregnancies. All three perceived childbirth as a severe threat, because they feared they might lose the baby.

However, one of them—an incest survivor—also reported that she feared that her abdomen would rupture. Although this was not explored, it is possible that this experience is due to traumatic memories about childhood sexual abuse, during which the fear of rupture in the abdominal region is often experienced by the abused child. If this is the case, labor triggered traumatic memories of childhood sexual abuse, in particular, rape. We wonder if the subjective experience of dying by the "mother" alter of Els was also a re-enactment of a previous trauma.

Psychotic Reaction to Delivery

One of the three patients reported, Madame de B, responded with a severe psychosis when labor started. She had to be admitted to a mental hospital. In fact, she became psychotic when she realized in her habitual state that she was pregnant. During this psychosis she believed in spirits, in spells which had been cast on her, in visits from the devil during the night. After the birth of her child, she believed she was being persecuted by demons.

It is not difficult to hypothesize that these delusions stem from the patient's own interpretations, made in her habitual state, of the origins of her pregnancy. Following Janet (1894/1895), who described a case ("Achille" of possession and persecution by demons in terms of a hysterical psychosis, van der Hart, Witztum and Friedman (1991) argue that psychoses as described above are dissociative in nature. We believe that the same is the case with Madame de B. According to Janet, this is apparent in the alteration of different states of consciousness, the existence of subconscious phenomena and high hypnotizability. However, while Madame de B was highly hypnotizable before her psychotic episodes, she could not be hypnotized during her psychosis—just like Janet's

own patient Achille. Janet showed that this was because his patient was so absorbed in his delusions and hallucinations, that only through an indirect hypnotic technique could hypnosis be induced. It seems not unlikely that the same could have occurred with Madame de B.

The practical reason for stressing the possible dissociative nature of Madame de B's psychosis is that patients with an hysterical psychosis seem to respond badly to antipsychotic medication (Spiegel & Fink, 1979; Steingard & Frankel, 1985; van der Hart, et al., 1991); something which is all too familiar in the treatment of MPD patients (Barkin, Braun, & Kluft, 1986; Putnam, 1989). Psychotherapy, particularly with the use of hypnosis, seems to be the treatment of choice. It might be possible that the same applies to postpartum psychosis in some cases (cf. Goodwin & Jamarillo, 1981), in particular, in women previously suffering from a dissociative disorder. This is a subject in need of further study.

Protecting Sexually Traumatized Child Alters from Experiencing Labor

This paper dealt with MPD patients in whom pregnancy was not realized by one or more adult and child alters. It is important to distinguish this from those situations in which adult alters (e.g., the host personality) consciously decide to become pregnant, while traumatized child alters are unaware of it.

As was hinted before, sexually abused child or adolescent alters run the risk that the delivery triggers their traumatic memories of sexual abuse such as rape or of enforced deliveries in the context of prior histories of satanic cult abuse—thus making labor into an overwhelming, traumatic insult. In the case of M., a frightened child alter came out shortly after the delivery of the stillbirth. She disconnected the intravenous lines and ran away to hide in a closet. Boon and van der Hart (1991) report the example of an MPD patient who, during treatment, purposefully became pregnant and then met with opposition from many alters, especially those who had experienced traumatic abortions. After internal discussions, it was decided to go ahead with the pregnancy, and with the help of the therapist, preparations were made for an emotionally safe delivery, especially for those child alters whose traumatic experiences of frequent rapes by an uncle were not yet assimilated and integrated. For this purpose, a kind of temporary pseudo-integration was established between all alters. Nevertheless, the delivery became a disaster for the patient. Instead of her trusted female doctor, a male obstetrician on duty and unknown to her guided the delivery. The patient felt threatened by him, she panicked, and the pseudo-integration dissolved. Later she said, "I have never switched so much as during the delivery. I had no control anymore. I could not stay anymore. The children were there. It was terrible. It was as if they were again raped for hours. They panicked and were afraid to push. They also believed that the baby would die or be mutilated because of the pushing. I wish that somebody would have attended who knew what was going on and would have said, 'Stay here.' Then, perhaps, I could have stayed and things wouldn't have

gone so wrong."

From these and other examples, we have learned to anticipate the risk that a woman suffering from MPD may experience labor as a traumatic insult. She should be guided in explaining to the child alters about her pregnancy and by training them to withdraw in an imaginary safe space during labor. We also instruct the partner—who, in The Netherlands is almost always expected to attend the delivery—to be aware of signs of emerging child alters and to take care of them in an appropriate and previously agreed upon manner; e.g., by orienting them to the present situation (instead of re-experiencing the past) and to allow them to withdraw again into their safe space. It is also important to inform the attending obstetrician and nurses about the psychological complications which may arise from the trauma history of the woman and to advise them to explain to her all things done during the delivery, as much as possible respectfully involving her as a participant in the process—also during emergency procedures.

Special complications during pregnancy and labor may arise in women who give histories of having been victimized as so-called breeders in satanic cults. In them, pregnancy may trigger traumatic memories in child or adolescent alters regarding previous pregnancies and resulting forced deliveries and "offering" of the babies. Apart from the limited possibilities of assimilating and integrating such memories while the patient is pregnant, explaining to these traumatized alters the differences between "now" and "then," teaching them everything which helps them to withdraw into a safe place or stay put in the present, and instructing the partner and medical personnel is most important.

In conclusion: Clinicians treating pregnant MPD patients should be aware that the process of childbirth may trigger traumatic memories of childhood sexual abuse of many varieties. They should guide the patient and her partner in the preparation for an emotionally safe delivery and invite the help in this regard from the attending obstetrician and attending nursing personnel.

Sexual Abuse by the Therapist

In the light of recent findings on MPD patients and, more general, survivors of incest who have been sexually abused (DeYoung, 1981; Kluft, 1989, 1990; Pope & Bouhoutsos, 1986), it is probably significant that in Bellanger's 1854 case of Madame de B, it was the therapist (Dr. X) who fathered the child. This is the first reported case of sexual exploitation and impregnation by a therapist, and thus has historical importance. However, it is not known if she had experienced sexual abuse before. Also significant is that in the recent case of Els, the patient had been raped by a previous therapist. This case, as well as others we are familiar with, confirm observations such as that made by Kluft (1989, 1990), that previously sexually abused MPD patients run the risk of repetition from their therapist or other health professional.

Double Personality versus Multiple Personality Disorder

We would finally like to make a few last remarks about

the fact that the 19th Century cases of Madame de B and Félicité X were seen as double personalities, while modern cases, also in this paper, usually have many more. Although 19th Century literature reported also a few cases with more alters, such as Louis Vivet (cf. Bourru & Burot, 1888), the dominating view on MPD was to regard it in terms of double personality. Thus, Azam (1887) spoke of *double conscience*, while his patient Félicité X showed at least three personalities, one of whom was probably a traumatized child alter.

The historical emphasis on double personality was accompanied by an ignorance of the childhood trauma, such as sexual and physical abuse, underlying the disorder. Although it was recognized that upsetting or traumatic experiences could, via vehement emotions, evoke dissociative reactions (Janet, 1889, 1898; cf. van der Kolk & van der Hart, 1989), there was insufficient awareness that the disorder should be traced back to such trauma. Thus, while we know about the upsetting event which triggered Madame de B's (then Mademoiselle de L) illness, we know nothing about previous trauma. And in Félicité X's case, her difficult infancy and the "strong emotions" she experienced during puberty were not explored in detail or related to her multiplicity. ■

REFERENCES

- American Psychiatric Association (1987). *DSM-III-R*. Washington, DC: Author.
- Azam, E. (1887). *Hypnotisme, double conscience et altérations de la personnalité*. Paris: J. B. Baillière et Fils.
- Barkin, R., Braun, B. G., & Kluft, R. P. (1986). The dilemma of drug therapy for multiple personality disorder. In B. G. Braun (Ed.), *Treatment of multiple personality disorder* (pp. 107-132). Washington, DC: American Psychiatric Press.
- Bellanger, A. (1854). Histoire d'une somnambule douée d'une double existence intellectuelle et morale. In Bellanger, *Le magnétisme: Vérités et chimères de cette science occulte* (pp. 207-290). Paris: Guilhermet.
- Boon, S., & van der Hart, O. (1991). De behandeling van de multiple persoonlijkheidsstoornis [Treatment of multiple personality disorder]. In O. van der Hart (Ed.), *Trauma, dissociatie en hypnose* [Trauma, dissociation and hypnosis] (pp. 157-187). Amsterdam: Swets & Zeitlinger.
- Bourru, H., & Burot, P. (1888). *Les variations de la personnalité*. Paris: J. B. Baillière et Fils.
- De la Tourette, G. (1887). *L'hypnotisme et les états analogues au point de vue médico-légal*. Paris: E. Plon, Nourrit et Cie.
- DeYoung, M. (1981). The sexual exploitation of incest victims by health professionals. *Victimology*, 6, 92-101.
- Goodwin, J., & Jarmillo, J. (1981). Post-partum psychosis in an artist. *Bulletin of Birth Psychology*, 2, 1-10.
- Janet, P. (1909). *Les névroses*. Paris: Ernest Flammarion.
- Janet, P. (1935). Réalisation et interprétation. *Annales Médico-Psychologiques*, 93, (II), 349-366.
- Janet, P. (1965). Introduction. In P. Janet, *The major symptoms of hysteria*. (2nd ed.), with new matter. Hafner: New York. (Original work published 1929, London and New York: Macmillan)
- Janet, P. (1973). *L'automatisme psychologique*. Société Pierre Janet, Paris. (Original work published 1889, Paris: Félix Alcan)
- Janet, P. (1977). *The mental state of hystericals*. University Publications of America, Washington, DC. (Original work published 1901, New York: G. P. Putnam's Sons)
- Janet, P. (1983). *L'état mental des hystériques*. (2nd. ed.). Lafitte Reprints: Marseille. (Original work published 1911, Paris: Félix Alcan)
- Janet, P. (1985). *The major symptoms of hysteria*. Hafner: New York, 1965. (Original work published 1929, London and New York: Macmillan)
- Janet, P. (1990). *Névroses et idées fixes*, Vol. 1. Paris: Société Pierre Janet. (Original work published 1898, Paris: Félix Alcan)
- Kluft, R. P. (1989). Treating the patient who has been sexually exploited by a previous therapist. *Psychiatric Clinics of North America*, 12, 483-500.
- Kluft, R. P. (1990). Incest and subsequent revictimization: The case of therapist-patient sexual exploitation, with a description of the sitting duck syndrome. In R. P. Kluft (Ed.), *Incest-related syndromes of adult pathology* (pp. 263-288). Washington, DC: American Psychiatric Press.
- Laurent, L. (1892). *Des états seconds: Variations pathologiques du champ de la conscience*. Bordeaux: V. Cadoret; Paris: O. Doin.
- Legrand du Saulle (1883). *Les hystériques: Etat physique et état mental*. Paris: J. B. Baillière et Fils.
- Miller, L. J. (1990). Psychotic denial of pregnancy: Phenomenology and clinical management. *Hospital and Community Psychiatry*, 41 (11), 1233-1237.
- Moleman, N., van der Hart, O., & van der Kolk, B. A. (1991). *The partus stress reaction: A neglected etiological factor in post partum psychiatric disorders*. Manuscript submitted for publication.
- Pitres, A. (1891). *Leçons cliniques sur l'hystérie* (2 vol.). Paris: Octave Doin.
- Pope, K. S., & Bouhoutsos, J. C. (1986). *Sexual intimacy between therapists and patients*. New York: Praeger.
- Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: Guilford Press.
- Ribot, Th. (1883). *Les maladies de la mémoire*, (2nd. ed.). Paris: Germer Baillière et Cie.
- Ross, C. (1989). *Multiple personality disorder: Diagnosis, clinical features, and treatment*. New York: John Wiley & Sons.
- Silverblatt, H., & Goodwin, J. (1983). Denial of pregnancy. *Bulletin of Birth Psychology*, 4, 13-25.
- Spiegel, D., & Fink, R. (1979). Hysterical psychosis and hypnotizability. *American Journal of Psychiatry*, 136, 777-781.
- Steingard, S., & Frankel, F. H. (1985). Dissociation and psychotic symptoms. *American Journal of Psychiatry*, 142, 953-955.

van der Hart, O., Witztum, E., & Friedman, B. G. (1991). Trauma-induced hysterical psychosis. Paper submitted for publication.

van der Kolk, B. A., & van der Hart, O. (1989). Pierre Janet and the breakdown of adaptation in psychological trauma. *American Journal of Psychiatry*, 146, 1530-1540.