DISSOCIATIVE DISORDERS AND DISSOCIATIVE SYMPTOMS AT A COMMUNITY MENTAL HEALTH CENTER

Stuart M. Graves, M.D.

Dr. Graves practices psychiatry at the Howard Mental Health Center in Burlington, Vermont.

For reprints write Stuart M. Graves, M.D., Howard Mental Health Center, 300 Flynn Ave., Burlington, Vermont 05401.

ABSTRACT

This paper presents the author's experience with dissociative disorders and dissociative symptoms among 125 patients seen for ongoing pharmacologic treatment at a community mental health center. Eleven were found to have a diagnosable dissociative disorder, and 16 others to have marked dissociative symptoms. The nature of the dissociative symptoms is discussed, as are the implications of these findings, should they prove replicable.

INTRODUCTION

Dissociation is a term believed to be originated by Janet. He used it to designate different streams of consciousness that do not seem to influence one another (Frischolz, 1985). The dissociative disorders has become a classification category utilized in DSM-III (American Psychiatric Association, 1980) and III-R (American Psychiatric Association, 1987), where it includes disorders characterized by "a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness" (American Psychiatric Association, 1987, p. 269). The influence of the idea of dissociation upon psychological and physiological thought has fluctuated from the 1800s through the early 1900s to the present (Ellenberger, 1970; Kluft, 1987a; Coons, 1988). This paper reports on experience with outpatients at a community mental health center in the light of the contemporary body of knowledge about such conditions. It is hoped that this report will increase awareness of unavoidable diagnostic dilemmas regarding "chronic mental patients" (as well as patients new to the mental health system), and encourage diagnostic caution.

METHOD

Between July 1, 1986 and July 1, 1988, the author saw 125 people in the "psychiatric disabilities" section of a community mental health center located in the largest population center of a rural state. This composition of this caseload of 125 resulted from a serendipitous match between the days the author consulted at the center and the days case managers of particular patients were able to accompany them to these interviews. There are no systematic factors that would prevent this group of people from representing the whole psychiatric disabilities population at this center, but this group was not acquired in a random or a scientifically organized manner. This sample includes all patients seen by the author during the above time span. In the interests of being conservative about prevalence of dissociative symptoms, no one was excluded from the sample, even if his or her contact with the agency was only fleeting. As a rule, the author met with these people for twenty to thirty minutes every two to four months if their clinical course was stable. However, if clues to a dissociative process emerged, the author would try to meet them more often and for longer periods to assess them in more detail as patient compliance and the author's time allowed. For example, meetings might be every four to six weeks for 45 minutes. This is fleeting contact by usual outpatient therapeutic standards, but when patients are seen in this manner many symptoms that had seemingly been previously ignored lay easily at hand. For example, patient #1 reported blackouts with his drinking, a fact known for several years before the following simple questions were asked:

Author:	*Were you ever sober?*
Patient:	Yes, for a year.
Author:	*What happened to the blackouts?*
Patient	Still had them.
Author:	*When do you remember starting to have them?*
Patient	At age nine.
Author:	*When did you start drinking?*
Patient	At around age 13

This patient had a normal EEG and neurologic workup, he had ample documented evidence by childhood therapists of severe abuse during his childhood, his chart from childhood was replete with such statements as "seems like a different boy in sessions," and yet the thought that these blackouts might represent a dissociative process had never been entertained.

Corroborating interviews by other clinicians were not logistically possible. To the authors knowledge, the nearest clinician with significant experience in dissociative disorders was 250 miles away. Even assuming resources were available for another clinician, considerations of time and patient compliance would present further obstacles. Almost all interviews, however, were witnessed by case managers, and none took exception with the author's questions or conclusions.

Systematic dissociative questionnaires (Bernstein & Putnam, 1986; Dyck & Gillette, 1987; Heber, Ross, Norton, Anderson, Anderson, & Barchet, 1987; Reager & Morelli, 1987; Ross, Norton, & Anderson, 1988a; Sanders, 1986) were not used, for the author believed them to be in various stages of development and not yet validated for diverse populations.

Nor was hypnosis used. This was not for fear of false positives (Braun, 1984a, 1984b; Kluft, 1982); rather it was felt that within the framework of short, infrequent visits, ostensibly for regulation of medications, hypnosis would introduce an investigative factor that would disrupt rather than build alliances (Horewitz, 1983).

The author had worked with most of these patients for a period of two to four years before he began to talk with them about dissociative symptoms. Thus, for some patients, a good deal of trust had been established, which probably helped in uncovering dissociative symptoms as areas were explored that the patients may have worried the author would find unbelievable (Goodwin, 1985).

It has been suggested by some reviewers that the author had an "axe to grind" in conducting these interviews. In fact, the author, in parallel process to his patients, found himself an unwilling participant. There was no original intention to systematically look for dissociative symptoms (it was the author himself who, for a period of two years, overlooked the blackouts in patient #1 as a possible dissociative symptom). It was only as his experience with MPD patients grew that he gradually became less able to deny his senses or refuse his intellect the next logical question. It was with concern and alarm that he compiled and counted the first rough list of patients that finally led him to systematize his experience in this paper.

FINDINGS

Information about 27 patients with dissociative disorders or symptoms is summarized in Table One. It is impossible in the space of this paper to give full clinical histories for all 27 patients. Thus the author has chosen to give no details on those patients with multiple personality disorder (MPD), since DSM-III-R criteria are quite specific, and were clearly met by the patients diagnosed as MPD. For the "in between" cases of dissociative disorder not otherwise specified (DDNOS), some detailed clinical description is given in the body of the paper. The remaining patients with dissociative symptoms have their major symptoms listed in the table. Many of these symptoms clearly point toward an MPD or DDNOS diagnosis, but no dissociative disorder diagnoses that were not firmly established were enumerated as present.

Column two of table one indicated those patients who met DSM-III-R criteria for multiple personality disorder or dissociative disorder not otherwise specified. Column three summarizes the dissociative symptoms present in the remainder of the patients. Column four indicated their time in the mental health "system." By this is meant the time from first psychiatric evaluation or institutionalization (state mental hospital, residential children's center, or state institution for the mentally retarded) to the present. Contact with social services or foster care was not considered as entering the mental health system. In those instances in which the patient was first evaluated as a child, the modifier "as a child" is inserted. Column five lists diagnoses used prior to the dissociative diagnosis, concurrent diagnoses, or current and past diagnoses if there is no diagnosis of dissociative disorder.

From column two, three patients meet DSM-III-R criteria for MPD, giving a prevalence among the 125 of 2.4%. Eight met criteria for dissociative disorder not otherwise specified. Seven of the eight fall into the category given by example 2 in DSM-III-R, " . . . cases in which a second personality never assumes complete executive control" (American Psychiatric Association, 1987, p. 277). These seven people have acknowledged the presence of others within, and have agreed to this as a major concern of therapy. Thus they are not entirely denying or resisting the diagnosis. One of the eight, #24, had chronic, mild dissociative symptoms, but under stress developed short-lived dramatic symptoms consistent with "a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness" (American Psychiatric Press, 1987, p. 277). Each of these eight people will be described briefly.

Patient #3 has many named "imaginary friends." In all her years as a patient, she has never told anybody about them before, although she and a ward aide once did share the "secret" that there could be "good" hallucinations. She has amnestic episodes; she states she has allowed me to visit with one of her friends during which time (about five minutes) her "involuntary" tongue movements (diagnosed as tardive dyskinesia) disappeared and then reappeared when the "visit" was over. It was hard for me to observe a switch other than the loss of her motions, and since this has occurred only once, I have left the diagnosis as NOS for the present. She is gradually beginning to talk about childhood abuse, but this occasions paroxysms of religious guilt and is accompanied by some self-mutilation.

Patient #4 reports first hearing a male inner voice asking her about a dream she had at age five. For most of her life she considered this to be the voice of Jesus, but recently has acknowledged him as a personality and they have agreed upon a different name. "It was quite a demotion for him." He will "turn his back" on her to discuss her actions with others she can't "see or hear." She experiences amnestic periods after which she can deduce some of the actions he has taken, and inquire about the others. He is "homosexual," religious, and shy, and has not yet spoken directly to the patient's therapist. He has taken executive control only to the extent of ideomotor activity in our presence. Thus, though it can be deduced that switches of control take place frequently, the diagnosis has been left as DDNOS rather than MPD, since they have not yet been observed.

Patient #9, after discussion of her symptoms and past abuse, has begun to speak openly of others inside her, their influence upon her, and of amnestic episodes. After a discussion of an issue in these terms she often says, "we thank you." An intense anger which she attributes to the "other her" quickly comes and goes in her eyes while she remains, in the rest of her demeanor, affable.

TABLE 1
Summary of Information on 27 Patients with Dissociative Disorders or Symptoms

Patient Number	*DX	*SX	Time in System	Other Dx's	*HX of Abuse	Age	Sex
1		amnestic episodes since age 9	as child, 25 yrs	schizophrenia	*+	34	M
2	MPD		as child, 29 yrs	borderline	emerging	37	F
3	NOS		as child, 40 yrs	mental retardation, schizophrenia	emerging	44	F
4	NOS		15 yrs	borderline, bipolar affective	emerging	50	F
5	MPD		11 yrs	borderline	emerging	36	F
6		+ and - visual hallucinations amnestic episodes; polio age 9	31 yrs	catatonia, bipolar, schizophrenia	+	45	F
7		childhood visual and auditor; controlled by demons; somatic senstions of being beaten by women; rapid changes in mental status	as child, 24 yrs	maladjusted child, schizophrenia	emerging	39	M
8		hallucinations in every sensory modality; multiple distinct male and female voices conversing with each other	26 yrs	schizophrenia	foster homes	61	M
9	NOS		3 yrs	mental retardation, obsessive emerging compulsive disorder, cerebral palsy, atypical psychosis, schizophrenia		29	F
10		amnestic episodes; marked differences in voice, dress and demeanor observed by others, does not recognize her own mirror reflection at times	20 yrs	bipolar, schizo-affective	emerging	41	F
11	NOS		15 yrs	schizophrenia	emerging	49	F
12	NOS		35 yrs	schizophrenia	emerging	58	F
13		auditory and visual hallucinations since childhood; states he creates personalities; observed rapid changes in mental state	9 yrs	schizophrenia	emerging	37	M
14		amnestic episodes; refers to self in third person, e.g. "That child should keep him busy;" somatic illusions, e.g." I feel half my size"	as child, 26 yrs	bipolar	+, ricketts as child	36	M

Table 1 continued on next page.

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Patient Number	*DX	*SX	Time in System	Other Dx's	*HX of Abuse	Age	Sex
15		anesthetic to burns; distinctnamed people conversing in his mind	10 yrs	schizophrenia	negative	36	M
16		amnestic episodes; helpful voices at times of loneliness	17 yrs	schizophrenia	emerging	50	M
17		observed by family member to become "another person"; voice, behavior, personality change and believes is living in past; auditory hallucinations of deceased family members	26 yrs	schizophrenia	+	49	F
18		amnestic for attacks on mother; anesthetic to self mutilation; sensation of passive influence with cutting self, hitting self	6 yrs	mental retardation, adjustment disorder, dysthymic, borderline, grand mal epilepsy	+	31	F
19		finds changes in apartment with no memory of doing them; sudden "frustrating" changes of interest/motivation	22 yrs	atypical psychosis	negative	40	M
20	NOS		24 yrs	schizophrenia	emerging	58	F
21	NOS		as child, 30 yrs	mental retardation, bipolar, schizophrenia and explosive personality	+, ricketts as child	35	F
22		amnestic episodes, internal voices discussing everyday events, cursing saints	23 yrs	bipolar, schizophrenia, borderline	emerging	44	F
23		amnestic episodes since young boy; internal conversing voices with names	27 yrs	schizophrenia	emerging	50	M
24	NOS		22 yrs	bipolar	emerging	45	M
25	MPD		as child, > 19 yrs	schizophrenia	+	34	F
26		visual hallucinations as child; amnestic for attacks on father; voices urging actions, e.g. "Go next door and evangelize"; sensations of passive influence with self mutilation	12 yrs	schizophrenia	emerging	34	M
27		+ and - visual hallucinations; amnestic episodes; named internal voices; sensations of passive influence, e.g. "They keep my medicine from me, tell me what to write, hit me"; suddenly could speak a whole imaginary language; asked to be exorcized	32 yrs	schizophrenia	emerging	55	M

* DX = Diagnosis; HX = history; SX = symptoms; + = present (positive)

Patient #11 has been walking into clinics for the past 15 years stating there is another woman living in the left side of her body. This person is more intelligent, and communicates with the patient (the presumed alter speaking to me) through a "silent beeper," though the patient is "not allowed" to communicate back. The patient lives a life of grotesque promiscuity "to get a husband." There are intimations of others, and of past abuse (in addition to current). As these issues were made a focus of therapy, for the first time in years she has attended appointments regularly.

Patient #12, after years of ignoring and denying her inner voices, using neuroleptics to suppress them, and insisting she was possessed, finally revealed the following in a letter. "I had just finished a dinner of jelly sandwiches when one of the voices pleaded for an egg salad sandwich. I was not hungry, but relented and made one. The voice wept at the act of kindness and said we needed more protein." She has many experiences of passive influence ("they made me carry the suitcase farther than was good for my arthritis"), amnestic episodes, and has told me it has been helpful to consider the possibility of past abuse.

Patient #20 speaks of a young boy that she can see and hear who comes around to play tag with her (she bats the air describing this), and an "old gentlemen" who says "I'm doing the best I can," and tells the others "to leave me alone." The "others" have written a note to me through the patient wondering what possible hope or "use" there is for the patient, who was abandoned as a child. Lately she has taken to bringing child-like drawings to the interviews that she has "forgotten" to sign.

Patient #21 keeps her room like a little child's, speaks of two named children inside her and their parents, has amnestic episodes, and experiences of passive influence. For example:

Author: *How did your arm get cut?*
Patient: I was depressed.
Author: *So you cut it?*
Patient: I felt like it.
Author: *But did you cut it?*
Patient: No.
Author: *Who did?*
Patient: A man. An angry man.
Author: *Inside you?*
Patient: Yes.

Patient #24 has never been able to clearly remember the events surrounding his father's death, for which there are two family stories. As we gradually explored this, it developed that there are many periods of missing memory in his life, from the remote past to the present. As the possibility of traumatic events in his childhood was raised, he become more agitated and paranoid with fears for his safety. He voiced suspicions with respect to the KGB and CIA. He came to a crisis appointment and did not recognize me, despite our relationship of five years. He was calm, had no current worries about the KGB, and recollected none. Instead he had a set of concerns about a girl he had met in the waiting room whom he had known several years earlier. During this general period of time he also produced a tape for his case manager in which there were several changes in tone of voice, verb tense about events, and perspective on events and living situations. Shortly after this he once again become paranoid, did not remember the tape he had made, and talked about his sister abusing him following his father's death. He was hospitalized because of threats to his mother. On return to the clinic he did not remember most of the above, but he did state that he had decided to "pretend" not to recognize me, though he doesn't know why.

The remaining 16 patients have their dissociative symptoms briefly listed in column three. These people do not acknowledge others within, and have not specifically entered therapy for their symptoms. At present, they have weaker therapeutic alliances, so symptoms are presented more inconsistently, or contact is temporarily lost as gentle exploration or confrontation around them begins. Some could possibly be said to have a diagnosis DDNOS, but it seems preferable to withhold the diagnosis for the present and wait until resistance is overcome, and both patient and therapist can agree on the presence of and the need to explore the symptoms more thoroughly.

Column four shows that for the eleven patients in the MPD and NOS group the average number of years in the system is 21 years. If the four people who entered the mental health system as children are not countered, the average changes slightly to 18 years. The average age for this subgroup is 43. For the entire group of 27 patients, the average time in the mental health system is also 21 years, and the average age is 41 years. These numbers are considerably higher than those found by Putnam, Guroff, Silberman, Barban, and Post (1986), among a presumably non-community mental health population, though there were seven patients who had never worked and fifteen unemployed in their sample of 100.

For the eleven patients with MPD and DDNOS, column five shows seven diagnoses of schizophrenia, three of mental retardation, one of obsessive compulsive disorder, three of borderline, two personality disorder of bipolar disorder, and a smattering of others. The remaining 16 patients show 12 diagnoses of schizophrenia, four of bipolar illness, two of borderline personality disorder, and one of mental retardation.

All but three of the 27 patients have a history of abuse that is self reported or reported by others. The three without a reported history of abuse are in the early stages of exploring their dissociative symptoms. It should be noted that many of these patients have only emerging histories. Their abuse was unknown to them and their therapist until therapy had progressed. Two, or 7% of the 27, had rickets as a child; a high percentage for our day.

For the 27 patients the ratio of male to female is 4 to 5. This is higher than previously reported (Putnam, et. al, 1986; American Psychiatric Press, 1987), although Bliss, Larson, & Nakashima (1983) reported a nearly 1:1 ratio in patients under hypnosis whose auditory hallucinations could be attributed to "personalities." However, in the 11 diagnosed MPD and DDNOS patients the ratio is 1 to 10; a finding more in accord with others.

DISCUSSION

Prevalence

The three cases meeting DSM-III-R criteria represent a lower limit of prevalence (about 2%) for MPD in this population of 125. The 11 MPD and DDNOS patients represent a possible prevalence for MPD of 9%. This is a figure in line with other estimates (Bliss & Jeppsen, 1985). All 27 patients together represent a possible upper limit to prevalence of MPD of 22%. There are many factors that cast doubt on this upper limit figure. First, it would seem unusual if all 27 patients turned out to have MPD, and thus the upper limit is probably less than 22%. However, each and every one of the patients with MPD or DDNOS originally came to attention because of dissociative symptoms only. In addition, there may be many patients among the 125 who have not yet revealed their dissociative symptoms. MPD is often a secretive illness; Kluft (1985) estimates that 94% present in this fashion, and that it is often denied (by some alters) when confronted. This author has experienced having patients, who clearly have MPD, look him squarely in the eye and say, "I'd rather be schizophrenic." Still others, with grace and ease, have denied or repressed the seemingly overwhelming evidence of multiple eyeglasses or hearing aids, being called different names by people they don't know, or lost time and amnesia for various parts of an interview. Finally, Kluft (1985), in his description of the natural history of MPD, is clear that only at certain intermittent points in a lifelong process does the "classic," clearly recognizable picture of MPD given by DSM-III-R emerge. The problem of prevalence must depend upon where a line is drawn demarcating MPD in a presumed spectrum of dissociative pathology, whether or not people can move back and forth in this spectrum (experience with treatment indicates they can), and the intermittent presentation of symptoms which represent a location on the dissociative spectrum.

Male to female ratio

The high ratio of male to female patients in this group of 27 patients could be an indicator that, in fact, many of these patients do not have MPD. On the other hand, it could be a clue that case identification and thus epidemiology has been skewed by unknown factors in previous samples. It may be that if abuse of sufficient barbarity to produce MPD is present in the environment, male children are as likely to be its victims as female children.

Dissociative symptoms

For those not familiar with the protean symptoms of a patient or patients with MPD, then the question of what constitutes a dissociative symptom can be a major stumbling block to understanding and recognition. It is of little help to say that dissociative symptoms are those resulting from a dissociative process. The abstraction of "dissociation" was created to knit together varied and confusing experiences with patients.

Further, a "symptom" is, by definition, not guaranteed to be a manifestation of one particular illness, physiologic process, or pathologic process, but rather a clue to its presence. Thus an experienced practitioner may find himself in the position of being able to recognize a symptom, but not a dissociative process. For instance, the experience of being unusually stuck in a mood of sadness, lowered energy, and lack of enjoyment that we clinically call depression, may (among many possibilities) be a symptom of bipolar illness, or it may represent the influence various alternate personalities reliving the harsh realities of past experience. The clinician may easily recognize that depression is present, but not that a dissociative process may be in operation.

There have been several different approaches taken to facilitate understanding that a symptom which is quite familiar may represent something quite unfamiliar, e.g. dissociation.

Putnam, et. al (1986) took the approach of listing the symptoms present in people diagnosed as having MPD. In a review of 100 cases, not many symptoms known to medicine were left unmentioned. By listing the prevalence of the symptoms among the 100 cases, some idea of sensitivity was gained, but none of predictive value. Interestingly, conversion symptoms, themselves the subject of some debate, are among those listed by Putnam and his colleagues. Perhaps anticipating the rising interest in dissociation, but having to use the common terms of his day, McKegney (1967) drew attention to the fact that conversion might involve the special senses as well, e.g. auditory sensations (sight was already partially accepted through the "hysterical" symptom of tunnel vision). Braun (1988) took a more conceptual approach in the BASK model. This provides a graphic and explicit presentation of the possibilities inherent in the idea of dissociation. It is an intermediate step between the abstraction of dissociation and the particular experiences of people, that again helps us to knit these experiences together. Bliss (1986) emphasizes the centuries of experience with hypnotic phenomena as an avenue to understanding which experiences could be dissociative symptoms. Coons (1984) took the approach of discussing the "differential diagnosis of MPD," by which it seems he means the entities who presentation could be mistaken for MPD. Thus, presumably, the symptoms of those entities raise the possibility of dissociation.

In the face of this large skein of possible symptoms, the author has tried to be conservative. The dissociative symptoms listed for the 16 patients in column three are not those with large and diffuse differential diagnoses, for example depression, but, in the author's opinion, are those which have a greater predictive value (individually or taken together) for a dissociative process. For example, the "blackouts" or amnestic episodes of patient #1, in the context of his past history, neurologic examination, and drinking history, raise the possibility of dissociation as strongly as they suggest alcoholic blackouts. As another example, Schneiderian first-rank symptoms are well-known as symptoms of MPD in general (Kluft, 1987b), and of MPD patients previously mistaken for cases of schizophrenia (Ross & Norton, 1988). Of all patients in the 125 who experienced auditory hallucinations, only a few are among the 16 listed in column 3. Complexity, conversational nature, the sense of a recognizable person ("his name is . . . ," "my father," etc.), the ascribing of special qualities recognizable over time (a man,

a child, a woman, a "patriotic salesman," etc.), and visualizing the person speaking, are among the factors that led to their selection as being more likely to represent a dissociative process. Other first-rank symptoms (e.g. made impulses) were considered more likely to be representative of a many primary dissociative process when found in the context of still more dissociative symptoms; e.g., amnestic episodes as in patient #23.

No use was made of the subtle signs of dissociation that an experienced clinician might note (Franklin, 1988).

This list of symptoms could be criticized for confusing any sense of "being out of control" in a patient with dissociation. One could see two common uses for this phrase. The first might be illustrated by a driver who loses control of his car on an icy road. Though the car is still perfectly in the control of the laws of physics, the driver's experience is one of not being able to determine his destination. This would seem to be roughly comparable to the experiences of delirium and head injury; the brain's owner has surrendered control to the laws of chemistry and tissue damage. The second common usage of loss of control is illustrated when a passenger in the car grabs hold of the steering wheel or otherwise coerces or misleads the driver. In this case, the driver again perceives partial or complete loss of control, but he also becomes aware of an intention not in accord with his own. Overtime, the driver may also become aware that in similar situations this particular passenger is prone to create characteristic difficulties. To an observer outside the car, both the skid on an icy road and the fight over the steering wheel result in roughly comparable results. The 27 patients presented in table one are those whose subjective experience relates more closely to that of a struggle for control of the steering wheel.

Time in the mental health system

The length of time the 11 patients with MPD and DDNOS have been in the mental health system compared to the Putnam et. al. (1986) findings is alarming. This could be the result of several different factors: lower quality of care available to the poor, more severe pathology leading to an overall more chaotic presentation (the struggle over the steering wheel is desperate and frequent enough so that the car has frequent interspersed skids), a group of patients with low motivation, an accepted and hope-depriving explanation for internal experiences ("I have chronic mental illness," "I'm just stupid," etc.), or the presence of concomitant mental illnesses which complicate the picture.

IMPLICATIONS

If the findings reported here are at all replicable, there are several implications for our health care system, its funding, the training of practitioners, the hazards of psychotherapy, and for our scientific understanding of the dissociative disorders.

For the health care system

There could be a significant number of people whose behavior, as a result of inhumane treatment during childhood, is being inadvertently "managed" but not treated by our health system. These cases require complex, prolonged, psychological (Braun, 1986; Kluft, 1984) and pharmacological interventions (Barkin, Braun, & Kluft, 1986; van der Kolk, & Greenberg, 1987). Yet they are sometimes left to the most routine pharmacological interventions, and to the least well paid, most overworked, and sometimes least experienced members of the mental health system. Agencies find themselves caught between patient needs and societal mandates, e.g. "We don't have the resources to provide intensive psychotherapy, we're supposed to provide case management." The overwork and low pay insures high turnover of therapists rather than stability. All this serves to reinforce the distrust, secretiveness, and thus the pathology of people suffering from dissociative disorders.

For funding

The increasing "privatization" (Schlesinger & Dorwart, 1984) of mental health care, and the incessant search by government or industry for "cost containment" does not bode well for the treatment needed by these people.

For training

How can any patients be adequately assessed and treated unless practitioners have a working knowledge of dissociative disorders and the various forms of abuse or trauma that lead to them?

It is important to have some sense of the knowing structures or vocabulary people may use to describe their internal dissociative experiences. For example, the substance abuser and "blackouts," the fundamentalist and "spiritual warfare" or "possession," the hypochondriac and "side effects" from medicine (e.g. amnesia from benzodiazepines), the chronic mental patient and "hallucinations" or "delusions," the sociopath and "I'm bad, not crazy," the new age spiritualist and "spirit guides" or "past lives," etc.

It is important to know of the extreme effects of ritual abuse. In the face of such an onslaught on the psyche and body, it is not surprising to meet disembodied alters who identify themselves as God, Jesus, angels, spirits, demons, the devil, or perhaps more modestly, a hallucination. These are internal identifications that lead the unsuspecting physician to discover various forms of grandiose and religious delusions, or hallucinations. As an example, if one were unaware of war and its traumatic impact, then the "flashbacks," "intrusive memories," withdrawal, agitation, sleep disturbances, etc. of a veteran with post-traumatic stress disorder (PTSD) could easily be taken for the hallucinations, delusions, flattened affect and other stigmata of psychosis.

It is important to realize that if restraint is to be exercised in arriving at the diagnosis of dissociative disorder, then for the same reasons, the same maxim must be applied in arriving at the conclusion of schizophreia, or bipolar disorder, or borderline, or mental retardation, etc. "Schizophrenia," as proposed by Bleuler, is in itself a concept that easily blurs with MPD (Rosenbaum, 1981). Prolonged periods of suspended judgement may be necessary for the comprehensive assessment of a particular patient as clues to dissociative

processes are explored and trust is developed.

For hazards to the therapist, DSM-III-R includes the witnessing of traumatic events as causal for post traumatic stress disorder. Surely therapy with these people, and awareness of their plight in our health care system is such a witnessing.

For scientific understanding

This study suggests that our knowledge of schizophrenia, bipolar affective disorder, and borderline personality disorder could be confounded by the uncontrolled (unrecognized) variable of dissociative disorders. Apparent mental retardation and obsessive-compulsive disorder are also represented in this population by diagnosis. The study of Putnam et al. (1986) would suggest that many other disorders (e.g., affective, sleep, eating, and substance abuse) could also be affected. We have made only a small beginning in understanding the prevalence of these problems in populations with dissociative disorders (Horewitz & Braun, 1984; Kluft, 1982). We have no understanding at all of the prevalence of dissociative disorders in populations who appear to suffer these other problems (e.g., schizophrenia, depression, borderline, etc.). We do not know if the intersection of obsessive compulsive disorder, sleep and eating disorders, affective and schizophrenic disorders, substance abuse disorders, and personality disorders with the dissociative disorders represents that of two independent variables in a population, or if there may be pathologic connections.

SUMMARY

An awareness and application of the body of scientific knowledge currently available, and some professional experience with dissociative disorders, coupled with the straight forward interviewing of 125 psychiatrically disabled people, has led to finding marked dissociative symptoms in 27. Among those 27, three people (or about 2%) meet DSM-III-R criteria for MPD, and another eight meet criteria for DDNOS. A dissociative disorder diagnosis had never before been formally in question for any of these 27 people, and yet, in at least 11 of the 27, or 9% of the 125, a major dissociative disorder had been unsuspectingly missed. Dissociative symptoms should be routinely and persistently looked for and inquired after. If they are found, diagnostic restraint should be exercised for as long as necessary to clarify the situation.

In addition, these findings, if reliable, may confound current scientific descriptions and understandings of certain mental illnesses, and point to needed changes in health care delivery and funding, and in the training of mental health practitioners.

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