

GUEST  
EDITORIAL:

INTRODUCTION  
TO THE  
AMSTERDAM PAPERS

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On May 21-23, 1992, the International Conference on Multiple Personality Disorder & Dissociative States (i.e., the 2nd ISSMP&D Annual Spring Conference) was held in Amsterdam, the Netherlands. Since this was the first international conference on multiple personality disorder and dissociation held outside North America, it was a major event in the history of the ISSMP&D. The attendance of 465 attendants, many of them European clinicians treating one or more Multiple Personality Disorder (MPD) patients, was one of the signs that MPD is certainly not a North American culture-bound phenomenon, as some British clinicians would like us to believe. Since this conference, and partially because of it, developments in the field are rapidly taking place in a number of European countries, in particular in the Netherlands. That is why the 1995 ISSMP&D Annual Spring Conference again will take place in Amsterdam.

This special issue contains the *Amsterdam Papers*. They are a sampler of the general, theoretical, clinical and workshop presentations at the 1992 Amsterdam conference. There exists a need for regular reviews and overviews of different aspects of diagnosis and treatment of MPD. Based on his keynote lecture in Amsterdam, Putnam presents a highly readable and informative overview with regard to diagnosis and clinical phenomenology. Although Putnam reports on relevant findings and developments in North America, I am sorry that he chose to speak about "the current North America model of MPD" and call his approach "a North American Perspective." Indeed, Putnam describes an approach to diagnostic and related issues of MPD which was developed mainly by North American authorities in the field. But their observations, formulations and techniques have been validated by numerous other clinicians, both in North America and other parts of the world. Actually, there is no other viable approach. The fact that there are clinicians in Britain, for instance, who object to the mainstream approach to MPD which Putnam ascribes, does not mean that there exists a "British model of MPD" or a "European model of MPD." And finally, there exist also in North America critics of the perspective Putnam puts forward. In fact, in his article Putnam is responding to the arguments made by some of them. At the end of his article he discusses the issue of credibility of patient's reports of childhood abuse. Current developments in the field indicate that this issue is probably the most important challenge of the 1990s for all of us.

The other keynote presentation in Amsterdam was given by Kluft. Based on that presentation, his article is a comprehensive overview of treatment issues with dissocia-

tive disorder patients. Kluft answers questions such as, Where do we come from with regard to treatment? Based on the clinical experiences and research studies of our predecessors and ourselves, what do we know about good therapy? Kluft deals with a number of basic issues which clinicians encounter in each and every therapy. He often emphasizes the uncertainties that still surround a number of these issues. However, since his observations and recommendations are based on many years of excellence in clinical practice and teaching, readers are well advised to take his lessons most seriously.

That something of interest in the field of MPD is going on in Europe, in particular in the Netherlands and Belgium, is shown in van der Hart's impressionistic overview of the state of the art in that part of the world. This overview, in part presented as a plenary lecture in Amsterdam, shows that the opinion that MPD is a North American culture-bound phenomenon is a myth. One hypothesis about the maintenance of this myth is that it is based in part on cultivated ignorance in clinicians and researchers who feel narcissistically injured by the rise of clinical and research studies on an important clinical phenomenon that they were unable to detect.

There is a growing recognition that the study and treatment of dissociative disorders in children and adolescents should become a main thrust in the field. After all, by the time adult patients or clients with MPD or dissociative disorder not otherwise specified are diagnosed and treated, as such they have already suffered from trauma-induced disorder for most of their lives. If they had already been in therapy as children or adolescents, not only had they most likely received the wrong kind of treatment based on the wrong diagnosis, but often the traumatization (to which their dissociative disorder developed as a survival strategy) continued. Hornstein's contribution, a plenary presentation in Amsterdam, was based on the recognition and differential diagnosis of dissociative disorders in children and adolescents and is therefore a very welcome addition to the growing number of publications in this important area.

Where do MPD patients usually present their complaints and symptoms first? According to my observations in the Netherlands, they turn to the family physician. Sometimes the family physician becomes the therapist of last resort. For example, when the official mental health agencies are unable or unwilling to provide adequate treatment to some Dutch MPD patients, the general practitioner may become the sole provider of mental health care to the MPD patient.

As Hunter points out in her unique contribution on MPD and the family physician, there is generally very little attention paid to the role the family physician (as the primary health care professional) can play in dealing with the dissociative symptomatology—very often also encompassing somatic manifestations—of MPD patients. This was the reason why the organizing committee of the Amsterdam Conference was very eager to have Dr. Hunter present a special workshop on MPD for family physicians. Her contribution to this issue hopefully will inspire other clinicians in the field to take the role of the family physician in the treatment of MPD more seriously in actual clinical practice as well as in their publications.

Critics of what I, in reaction to Putnam's article, propose to call the "mainstream treatment model of MPD," often charge that once the diagnosis of MPD has been made, therapists rush to the discovery and exploration of traumatic memories of childhood abuse. The "snake in the grass" of this type of criticism is of course that these clinicians are allegedly so enthusiastic in their search for this childhood abuse, that they often suggest the material they are looking for to the patient. Although we cannot claim that there exist no uneducated or misguided therapists who will fall into such treatment traps, Kluft's important contribution on the initial stages of psychotherapy with MPD patients—based on a workshop in Amsterdam—shows that good clinical practice is completely different from what is implied by these critics' allegations. This article should be required reading material in all courses on the treatment of MPD. In my personal opinion, each therapist beginning the treatment of his or her first MPD patient should be required to quote/cite major parts of this work by heart.

In his article, based on both a plenary presentation and a workshop in Amsterdam, Fraser discussing treatment techniques to access the inner personality system of MPD patients and offers some beautiful examples of how to work with the system of alter personalities during these initial stages of treatment. His "dissociative table technique," for instance, should be a very welcome addition to the repertoire of all clinicians in the field.

As Frye and Gannon note, many MPD patients draw or use expressive outlets either spontaneously or with the minimal encouragement. Thus, psychotherapists of MPD patients may be easily inclined to use the medium of the expressive arts in their therapies. They should realize, however, that art therapy is a specific clinical profession with its own body of knowledge and techniques. From their respective perspectives, as an inpatient occupational therapist and an outpatient clinical social worker, Frye and Gannon show how psychotherapists can still make use of art without becoming poor imitations of art therapists. This contribution is based on a workshop Frye presented in Amsterdam.

As part of their important series of research studies on the diagnosis and differential diagnosis of MPD in the Netherlands, Boon and Draijer's contribution—presented at a workshop in Amsterdam—is about the differential diagnosis of MPD and DDNOS from borderline personality disorder (BPD) and other Cluster B personality disorders. In

the Netherlands, dissociative disorder patients are often diagnosed as BPD or a related personality disorder. Boon and Draijer's comparisons between these different groups of patients on a number of dimensions will probably be highly welcomed and valued by North American specialists. Especially when childhood traumatization is involved, the differentiation between a dissociative disorder and a Cluster B personality disorder with dissociative symptoms can be most difficult. This contribution, incidentally, is an indication that the input from North American authorities in the field in the Netherlands has been very fruitful and is leading towards mutually stimulating developments/production.

In October 1992, a freight-carrying aeroplane fell on a densely populated suburb of Amsterdam, the Netherlands, causing the death of the crew and more than 60 civilians. In a television interview one of the survivors in the stricken neighborhood remarked that, when looking out of her window at the sight of the disaster, she could not believe that the disaster had actually taken place. However, when she saw pictures of the scene on television, she did realize that it had indeed happened. I am reminded of this remarkable self-observation when reading Goodwin's important contribution on sadistic abuse. Clinicians in the field of the dissociative disorders are, probably more than any other mental health specialty, confronted with patients' reports of extreme violence. There are indications that not only these patients but also some of their therapists tend to more strongly dissociate and deny such extreme violent abuse than the less violent variations. I believe that this phenomenon is one of the underexposed factors affecting the current debate on the validity of satanic ritual abuse allegations (with another factor, i.e., knowledge about some cases in which such allegations have been proven to be untrue, being highlighted). Goodwin points, in a powerful manner, to the necessity for our field to come to terms with the fact that we are confronted with reports of extreme violence, not only on television but also in the privacy of our therapy rooms. Relating to such malevolent acts as torture, confinement, extreme threat and domination, overlapping physical and sexual abuse, and multiple victim or multiple perpetrator patterns of abuse, the term "sadistic abuse" should be part and parcel of our professional idiom. Its usage should help to "de-cathex" and de-escalate the current heated debate on satanic ritual abuse, which has reduced the phenomenon of extreme sadism merely to an issue of credibility.

In the spring of 1995, the next International Conference on Multiple Personality Disorder & Dissociative States (or The Fifth ISSMP&D Annual Spring Conference) will return to Amsterdam, the Netherlands. I hope and anticipate that the conference will be a reflection of an ever increasing cooperation between North American and European clinicians and researchers.

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