EDITORIAL:

DISSOCIATION IN AN INTERNATIONAL PERSPECTIVE: THE 1995 AMSTERDAM PAPERS – I

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In 1995 the Fifth ISSD Annual Spring Conference was held in Amsterdam. The first thing that comes to my mind when I remember this conference was its international character. Compared to the conferences I had attended in the United States more European speakers and participants were present – an encouraging experience for European and American clinicians and researchers alike. This international character is reflected in the papers you will find in this issue. Three articles come from North America, two are from Turkey, one is from Italy, and two are from the Netherlands.

Although some continue to suggest that dissociative disorders are a North American disease caused by iatrogenesis, and, due to contamination, spread only to Holland, the papers in this journal prove they are not. The precise descriptions of the clinical phenomenology of these disorders in different countries will give readers the opportunity to verify for themselves whether a Turkish child suffering from dissociative symptoms matches its American counterpart. And, in the elaborate description of the symptoms, behaviors and treatment of a Dutch homicidal delinquent suffering from DID, one can recognize the similarity of this individual to similar cases described in North America.

Reading the papers in this journal brings back the atmosphere of the conference, an atmosphere of enthusiasm, curiosity, exploration, and – strange to say – innocence. The field was not as attacked and torn apart as it is now, even though difficult and controversial topics were described at the conference, including memory and dissociation, factitious disorder, and the limitations of and contraindications for trauma treatment in DID. You will find these discussed in this journal and another issue soon to be published. As co-editors of the 1995 Amsterdam papers, Onno van der Hart, Ph.D., Suzette Boon, Ph.D., and I are very proud to present to you this first selections of presentations from this conference.

Three articles focus on trauma and memory. Elizabeth Bowman, M.D., gives us a thoughtful overview of the empirical data on forgetting, remembering, and corroborating trauma. Factors associated with amnesia for trauma were the age of the patient at the onset of the abuse (the younger the patient, the more forgetting), threats or intense emotions, and more than one type of abuse. Data are inconclusive on the impact of multiple perpetrators, the use of violence, the duration of the abuse over time, and whether incest was involved. The return of delayed memories of abuse is not solely due to psychotherapy. Dr. Bowman questions whether laboratory studies of eyewitness memories are applicable to trauma memories.

In a second article, Dr. Bowman reviews research relevant to understanding the reliability and suggestibility of delayed memories of child abuse. Actually, research has not shed much light on the general accuracy or inaccuracy of these memories, Dr. Bowman finds, nor has it told us how to distinguish accurate from inaccurate memories. In both articles Dr. Bowman offers valuable recommendations for clinicians.

Albach, Moorman, and Bermond present rich and interesting data on the recovery of memories of childhood abuse. They compare sexually-abused women with non-abused matched controls. Amnesia for the abuse was quite common among the abused women, whereas amnesia for negative life events was uncommon among the controls. Psychotherapy did not play a significant role in memory recovery. Contrary to the findings in Bowman's reviews, early age and violence were not predictive of abuse-related amnesia. The importance of the authors' observations for the so-called false memory debate is striking.

Still, I think that the most productive stance or approach (both clinically and scientifically) to overcome the current "either-or" debates (the memories are either fantasy or reality; either a skeptical or believing stance is appropriate) is to take an "and-and" position: false memories do occur and are a real problem to consider, and factitious DID may be encountered, and recovered or delayed memories of real events to occur, and naturalistically-occurring DID exists. The major problem is how to differentiate between these alternatives in a given case.

Two Turkish papers address the clinical phenomenology of DID in adults and in children respectively. Tutkun,

Yargic, and Sar present four adult patients who were referred to their clinic as suffering hysterical psychoses and were diagnosed by the authors as having concurrent DID after the hysterical psychoses had subsided. Apparently, hysterical psychosis is frequently diagnosed in Turkey, and the authors strongly recommend that such patients be evaluated for DID. They consider hysterical psychosis as "one of the starting points for the recognition of DID in countries where professionals are more familiar with more traditional categories of mental disorders."

Zoroglu, Yargic, Tutkun, Ozturk, and Sar present five cases of DID in Turkish children between five and eleven years of age. The congruence of the clinical presentations of these patients with those reported from North America support the transcultural validity of DID in children.

Grave, Oliosi, Todisco, and Bartocci compared eating disorder patients with normal controls and schizophrenics on childhood trauma and scores on a self-report measure of dissociation. Although no significant differences in childhood trauma were found, eating disorder patients differed from schizophrenics in self-reported identity confusion and in loss of control and absorption, but not in amnesia. The only dissociative features which seem to link trauma, dissociation and eating disorders are identity confusion and loss of control, since absorption is not sensitive to the presence or absence of trauma. The authors conclude that this study does not permit the inference of any causal connection among trauma, dissociation, and eating disorder symptomatology.

In a fine article, Nijenhuis demonstrates that the long-term failure to diagnose DID in a forensic patient permitted the continued existence of highly aggressive dissociative identity states, and near relapse into homicidal behavior.

Lazrove and Fine describe both the use of and contraindications to EMDR (Eye Movement Desensitization and Reprocessing) in the treatment of DID patients. This technique is an alternate method for managing the processing of trauma. It must be modified to conform to the principles of fractionated trauma work. Apparently such approaches are to be used only by clinicians highly-skilled in work with dissociative disorder patients who are also well-trained in EMDR.

In closing, I want to thank Dr. Richard Kluft for the opportunity to contribute this editorial.

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