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A Phenomenological Study of Dissociative Identity Disorder

By

Yvonne Lorraine Marie Legris

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Education

Department of Educational Psychology

in

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The undersigned certify they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled A PHENOMENOLOGICAL STUDY OF DISSOCIATIVE IDENTITY DISORDER submitted by Yvonne Legris in partial fulfillment of the requirements for the degree of MASTER OF EDUCATION in COUNSELLING PSYCHOLOGY.

Dr. D. Shannon-Brady- Supervisor

Dr. R. Sobsey

Dr. B. Sinha

Date: Oct 2/95

DEDICATION

To the participants of this study who gave
so much of their time and energy so
that their stories might be told.

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ABSTRACT

The goal of the study was to explore and describe the phenomenon of dissociation and the experiences of people with Dissociative Identity Disorder (DID). The phenomenological approach was used to describe five participants' experiences. A total of eleven common themes emerged: experiences of severe trauma, recognition of something being wrong, escape from pain, disturbances in time, experiencing isolation, cooperation between alter personalities, experiences of fear, suicidal experiences, and a desire for understanding and acceptance. Eight important themes, but not common to all participants, also emerged and they were: hearing voices, being a high achiever, difficulty in being properly diagnosed, physical symptoms associated with DID, looking for control, feelings of anger, feelings of shame, feeling worthless. The people in this study described the importance of cooperation between alter personalities and discussed their protective role in helping them to escape painful memories or events. Evident for all participants was their varying levels of awareness or meta-cognition. Overall, protection emerged as a pervasive essence. All participants were actively involved in protecting the self.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE
INTRODUCTION

Dissociation had been defined by the Diagnostics and Statistics Manual (DSM-IV), (American Psychiatric Association) as, "a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic" (p. 477). Dissociative disorders (hereafter referred to as DD) were among the first pathological disorders to be scientifically investigated and their discovery played a key historical function in the molding of modern psychiatry (Putnam, 1991). The term "dissociation" was implemented in the late eighteenth century by Pierre Janet who began exhaustive research in the area. An interlude of several decades was to pass before a resurgence of interest in dissociative phenomena peaked in the late nineteen seventies. This renewed interest resulted in an increase in scientific discussion surrounding DD with many professionals becoming increasingly aware of its occurrence (Kluft, 1988; Ross, 1990). Concurrently, a dramatic increase in reported cases of DD appeared (Chu, 1994; Sachs, Fishholz & Wood, 1988; Putnam & Loewenstein, 1993; Saxe, van der Kolk, Berkowitz, Chinman, Hall, Lieberg & Schwartz, 1993). The prevalency rate for DD was recently reported as approximately ten percent of the general population, with Dissociative Identity Disorder (DID), being known to affect approximately one percent of the North American population (Loewenstein, 1994).

Dissociative Identity Disorder and Multiple Personality Disorder

DID was previously known as Multiple Personality Disorder (MPD) and has been described as a specialized or extreme form of dissociation that is often linked with a history of sexual abuse (Anderson, Yaskenik, & Ross, 1992; DiTomasso & Routh, 1992; Kirby, Chu & Dill, 1993; Sheary, 1994). Researchers have portrayed the dissociative action as an adaptive effort or a way of coping with traumatic events; however, dissociation that is characterized by severe, chronic, and pathological manifestations

more frequently leads to a diagnosis of DID (van der Kolk & van der Hart, 1989; Allen & Smith, 1993; Irwin, 1994).

The DSM-IV describes DID as "characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behavior accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness." (American Psychiatric Association, 1994, p.477). There are also a number of other dissociative disorders such as, Dissociative Amnesia, Dissociative Fugue, Depersonalization Disorder, and Dissociative Disorder Not Otherwise Specified, although the focus of this thesis will remain on dissociation and DID.

Issues in Research on Dissociation

Much of the recent literature on dissociation has focused on its clinical description with an effort made at categorizing specific symptomatology (Ellenberger, 1970; Putnam, Guroff, Silberman, Barban & Post, 1986). Experimentation and formulation of new research designs has occurred as a result of the increase of interest into the area of dissociation and had produced innovative research methods (Armstrong & Loewenstein, 1990; Putnam, 1991). In addition, assessment and screening techniques such as, the Dissociative Experiences Scale (DES), have been developed to assist in increasing overall diagnostic accuracy (Bernstein & Putnam, 1986; Stick & Wilcoxon, 1991; Boon & Draijer, 1993; Saxe, et. al., 1993). The treatment of DID has spanned the gamut from psychopharmacology, occupational, expressive, family and marital therapies to hypnosis and spiritualistic approaches (Krippner, 1985; Kluft, 1988; Sachs et. al., 1988, Putnam & Loewenstein, 1993; Chu, 1994; Zechner Richert & Bergland, 1991).

Although extensive research regarding DID had been produced in the last two decades, the study of dissociative disorders remains embued in controversy. Some critics (Merskey, 1992) would deny its existence outright by describing DID as a disorder fabricated through the use of hypnosis and clinical expectations. Others (Aldridge-Morris, 1989) claim that DID lacks a pure descriptive characterization and therefore does not merit its own diagnostic category. Rather these dissociative behaviors conform to

existing diagnostic categories such as, borderline personality disorder, schizophrenia, or post-traumatic stress disorder.

Purpose of the Research

As yet research that focuses on characterizing the actual experiences of dissociation or what the essence of such a phenomena might be, and the experiences of people who have DID remain relatively untapped. Information regarding the commonalties existent in people with DID most often appears in the form of case studies (Braun & Sachs, 1985: Kluft, 1988) or clinical and anecdotal experiences as relayed by clinicians working with a DID population (Ross, 1990; Kluft, 1988a; Kluft, 1990; Kluft, 1991; Loewenstein, 1991).

To further our understanding of DID a methodological approach that is capable of investigating the common aspects of DID may provide valuable insights. A phenomenological approach where the emphasis is placed on people's experiences of dissociation as opposed to pure clinical assessment may yield better understanding of the perplexing phenomena of DID. A phenomenological method will provide the framework used for detecting what are the common lived experiences of people diagnosed with DID. Therefore, the aim of this study will be to explore and discover the stucture and themes in the experiences of people who have lived through incidences of extreme dissociation typical of DID. The research question is therefore, "What are the common and important experiences of people who have DID?".

Overview of the Thesis

In chapter two, a detailed historical review of the concept and an overview of the relevant literature on dissociation will be presented with a particular emphasis placed on DID. The epidemiology or prevalency of DID will be discussed and a review of existing research theories will be examined in terms of their ability to assist in deciphering an etiology of DID. The literature review will also provide an overview of the diagnosis of DID, mainly, because the ability to accurately diagnosis DID has been a difficult process. Additionally, the treatment of DID will be investigated.

Chapter three will outline the philosophy of the phenomenological methodology that was used in this study and chapter four will follow with a presentation of the method, or research steps taken in this study and the steps used in the interpretation and analysis of the in-depth interviews. Chapter five will include an elaboration on results of the study. Chapter six is the final chapter that will include a discussion of the results, limitations of the study, and ideas for future research.

Both the DID and MPD acronyms are used interchangeably in the thesis depending on which was reported in the referenced material or used in the interviews by the participants.

CHAPTER TWO
LITERATURE REVIEW

A detailed historical review of the concept of dissociation as well as an overview of the relevant literature on dissociation and DID is presented. The historical background of dissociation, etiology, assessment, epidemiology, diagnosis, and treatment of DID will then be discussed.

Historical background of Dissociation

The area of dissociation has undergone many variations throughout history. As stated by Herzog (1984), "For the past 150 years, the diagnosis of multiple personality has withstood the vagaries of psychiatric nomenclature and has undergone many credibility crises" (p. 210). Therefore, a brief foray into the history of dissociative phenomena should help to establish a historical context for the evolving concept of dissociation. Dissociative Disorders (DD) were among the first pathological disorders to be scientifically investigated with their discovery playing a key historical function in the molding of modern psychiatry (Putnam, 1991). Interest in the phenomena of dissociation appears to have varied considerably in the last two hundred years. Chronicled cases of multiple personalities have alternately appeared in large numbers or sporadically throughout this period of time. (Herzog, 1984). Gruenewald (1984) states that the continual evolution of multiple personality disorder seems to reflect societal and intellectual trends, as "prevailing styles of thought influence not only manifest pathology but also the manner in which it is understood and treated" (p.170).

Written accounts of dissociation appeared between 1775-1900 during the "first dynamic psychiatry" as described by Ellenberger (1970). This movement incorporated the first scientific accounts of the investigation of a realm of mental illness and the workings of the unconscious mind. It spanned investigation into and development of the areas of mesmerism, spiritualism, hypnosis, and multiple personality. The bulk of psychological investigations taking place in the eighteenth and nineteenth centuries

consisted of inquiry into these areas with the concept of dissociation arising directly from them.

The Mesmerists

Franz Anton Mesmer (1734-1815) unleashed speculation and investigation into unconscious processes of the mind in 1775 through his doctrine of mesmerism. Mesmer recognized the psychological aspect of healing and stumbled upon the area of psychosomatic medicine. Unfortunately, his beliefs and methods of treatment were eventually rejected. Mesmer believed that he possessed a large quantity of fluid called "animal magnetism" that could heal other peoples' ailments. In his view, this fluid physically embodied each person and formed a connection between humans and the universe. A disequilibrium or a lack of this fluid would result in a diseased state that could be rectified by eliciting a state of crisis that would re-distribute or increase the person's fluid level. Restoring the equilibrium would result in an ameliorated physical state for the person.

The debated doctrine of mesmerism nonetheless provoked much dialogue about the work of the mesmerists and their exploration into "nonconscious determinants of experience, thought, and action" (Kihlstrom, Tataryn, & Hoyt, 1993, p. 204). The mesmerists' investigations into these nonconscious determinants provided the momentum for exploration into the area of dissociation and multiple personalities by Jean-Martin Charcot and Pierre Janet.

Hypnosis

Armand-Marie-Jacques Puysegur (1751-1825), a student of Mesmer's, successfully replaced his mentor's pseudo-physical theory of animal magnetism and ushered in the psychological groundwork of mesmerizing and "magnetic sleep", a precursor to the present day hypnosis (Ellenberger, 1970). Any change in the patient was attributed to the magnetizer's will to effect change through the induction of magnetic sleep rather than through the effects of animal magnetism by the magnetizer. The move toward effectively using and understanding hypnosis was historically important. The connection between the use of hypnosis and the presentation of multiple personalities

was well documented in the nineteenth century (Braun, 1984; Gruenewald, 1984). In addition, more cases of multiple personalities were reported in the literature during the later half of the nineteenth century when hypnosis was at a peak (Herzog, 1984). Coons (1980) comments about how questions were raised regarding the production of multiple personalities as an artifact of hypnosis. In their study, Putnam, Guroff, Silberman, Barban, & Post (1986) discovered that their DID patient profiles were similar in their presentation of symptoms regardless of whether their therapists had used hypnosis in their treatment or not. Implications of multiple personalities developing as a result of the use of hypnosis have been refuted only in the last decade (Horevitz & Braun, 1984). As Gruenewald (1984) states, "Although injudicious use of hypnosis may have a variety of untoward effects, causation *de novo* of multiple personality does not seem to be one of them" (p.175).

Duality of the Mind

Emerging from the practices of mesmerism and hypnosis, was the experimental investigation into the study of association of thoughts, emotions, and actions. As stated by Ellenberger (1970), the extensive study and intrigue surrounding the practice of mesmerism and hypnosis led to theories regarding the composition and characteristics of the human mind. According to Ellenberger (1970), divided personalities were the most commonly discussed topic among psychiatrists and psychologists in the 1880's. Researchers were curious about the ability of early mesmerists, or hypnotists, to reveal hidden personalities in patients and to cure their hysterical reactions. Hilgard (1977) states that the idea of a duality of the mind and a division of consciousness was of keen interest to researchers during this time. This duality was also proclaimed as a prominent epistemological view that spanned the whole nineteenth century (Kihlstrom et al., 1993). As a result of this curiosity and intrigue into unconscious processes, explanations were offered to account for them. The Dipsychism theory, for example, arose during this time with the explanation that a state of duality of the mind existed. The German psychologist Max Dessoir upheld this view in his book, The Double Ego (Dessoir, 1890) which described a dual nature of the mind. Specifically, two avenues of mental activity , the

upper and lower consciousness, were said to co-occur. Each layer consisted of independent links of associations that would operate either during the waking (upper consciousness) or sleeping (under or lower consciousness) state. Duality arose during a conflict in which both forms of consciousness vied for dominance. In addition, it was the model from which Janet drew his theory of the subconscious mind and dissociation (Ellenberger, 1970).

At the heart of the duality of mind idea is the presupposition of a unified, singular consciousness for each person. Hilgard (1977) proclaimed that a unitary consciousness is illusory because people are able to carry on various functions simultaneously while attending to other stimuli. In contrast, Laing, (1960) held that the key to reflective awareness is achieved only through personal unity.

Janet and "Dissociation"

Pierre Janet (1859-1947), a philosopher, clinician and psychiatrist, first coined the term "dissociation" and began exhaustive research in the area. The term dissociation evolved from the doctrine of association of ideas (Hilgard, 1977). This doctrine held that memories were brought into conscious awareness through their association with particular ideas. If a memory was not available for association and subsequent conscious awareness it was said to be dissociated. Janet believed that all material passed through the mind and was retained on some level.

Under the tutelage of Charcot, the famous neurophysiologist of the Salpetriere in France, Janet completed his doctoral dissertation entitled, "Automatismes Psychologiques". His dissertation was unique in its exploration of the psychological processes through which traumatic experiences were transformed into psychopathology. Charcot's research also centered around how the psyche was affected by psychological trauma but was particularly focused on the organic etiology of hysterical symptoms of multiple personality.

In his dissertation, Janet explained mental activity as composed of a vast array of psychological automatisms (Janet, 1899). These psychological automatisms were rudimentary structures each embodying an admixture of perceptions and actions that

were easily adaptable to incoming information. Each automatism represented a complete repository in consciousness for everyday acts of cognition, emotion, and motivation (Kihlstrom, Taratyn, & Hoyt, 1993). These automatisms could be readily and automatically adjusted without the person's thought or awareness. Janet believed that each person held a repertoire of automatisms that, together, formed a person's consciousness (Khilstrom, Glisky, & Angiulo, 1994). In usual circumstances, a person's awareness of feelings, thoughts, sensations, and actions in regards to a specific experience were perceived and successfully integrated into the unitary stream of consciousness. However, the integration of material into consciousness hinged upon the cognitive assessment of the experience (van der Kolk & van der Hart, 1989). For instance, the memory and emotion associated with a particularly traumatic event could be split off from conscious awareness and assume subconscious and autonomous development. The individual would have, in this circumstance, viewed the event as overly traumatic and have split off the automatism into the subconscious. The circumstances for such a split or independent functioning of the automatisms stem from a traumatic or stressful events (Khilstrom, Glisky et al., 1994). Stressful experiences too disturbing to be integrated into existing automatisms were thus fragmented from conscious awareness only to later show up as pathological automatisms (van der Kolk, & van der Hart, 1989). These pathological automatisms might become expressed as unexplained physical problems such as, rashes or scars that were associated with a particular traumatic event. Thus, in the event that one of the automatisms became split off or began functioning independently of the others, a dissociation or using the French term, "desegregation" occurred (Janet, 1889). These dissociated automatisms continued to maintain their influence on the individual but did so at a subconscious level (i.e., they are not under voluntary control of the person).

Extensive dissociation would result in numerous non-integrated memories, experiences, and thoughts that developed into separate spheres of consciousness called "subconscious fixed ideas" (Ellenberger, 1970). Independent development of part of this material was believed to occur separate from the conscious mind resulting in a division

of personalities. These fixed ideas were said to hold the content of the traumatic experience, that is, they kept the perceptual elements of the experience buried in the subconscious (van der Kolk & van der Hart, 1989). Multiple personalities would result when subconscious fixed ideas emerged as independent, individual identities.

Janet also contended that some people, in particular hysterics, might be genetically predisposed to dissociate because of their lack of psychological strength in binding the psychological automatisms into a unified consciousness. This state of "weakened integrity of awareness and response" (Kelly, 1991, p. 35) would leave the person vulnerable to dissociation.

Dissociation and Repression

According to both Janet and Freud, unconscious mental processes existed and were psychologically important (Kihlstrom & Hoyt, in Singer, 1990). The ways in which certain mental processes were prevented from surfacing into consciousness defined their points of departure. Janet used the term "dissociation" while Freud developed and used the term "repression" (Kihlstrom, & Hoyt, 1990). Nemiah (1989) describes Janet's view of dissociation as a "passive falling away of mental contents from an ego that was too weak to retain them in consciousness" (p.1528) and defined Freud's view of repression as an " active repression of undesirable and emotionally painful mental contents by an ego that was strong enough to banish them from conscious awareness" (p.1528). Therefore, while Janet proposed that the mind was too weak to gather together all of its mental contents, Freud claimed that the ego was strong enough to actively plunge mental contents out of conscious awareness. These differences regarding the understanding of unconscious processes are important because the emergence of Freud's psychoanalysis with his emphasis on aggression and sexual impulses soon overshadowed Janet's concept of dissociation (Herzog, 1984; Putnam, 1991). Therefore interest in psychoanalysis and repression gained acceptance and prominence while Janet's theory of dissociation slipped into the background (Braun, 1988; Hilgard, 1977).

The Decline of Interest in Dissociation

Extensive study into the realm of DID occurred from about 1880-1920 and has been termed the classical period in the study of DID (Kihlstrom, et. al., 1993). The decline of interest in the area of dissociation, and with it the use of hypnosis, was partially led by the rejection of Janet's concept of dissociation and the acceptance of Freud's theory of psychoanalysis (Spiegel & Cardena, 1991). In addition, empirical proof in research was being sought in academic psychology at the turn of the century as a result of the behaviorists' influence. According to Kihlstrom et. al. (1993) the behaviorists revolution focused more on observable behaviors in the laboratory and rejected most research into the arena of mental states. Much of the early work of the dissociation theorists was described as vague with frequently flawed experimental and clinical studies (Kihlstrom, et.al., 1993).

The newest level of intrigue in clinical psychology was psychoanalysis which was swept into the spotlight as interest in multiple personalities receded. The decline in interest in the area of dissociation around the turn of the twentieth century was also due to the introduction and popularization of the term schizophrenia (Herzog, 1984). Ellenberger (1970) also explains how the theory of dissociation underwent a negative reaction of disbelief during the nineteen twenties. It was felt that investigators into the area of dissociation "had been duped by mythomaniac patients and that they had involuntarily shaped the manifestations they were observing" (p. 141). In addition, the psychiatrist Morton Prince, a contemporary of Janet's and authority on multiple personality in the United States, displayed an inability to effectively treat his most famed multiple personality client: Miss Beauchamp (Prince, 1957). This event was cited as unhelpful in furthering serious consideration of dissociative disorders (Greaves, 1980; Horevitz & Braun, 1984). The concept of dissociation underwent a period of disbelief and disinterest, but Hilgard (1977) witnessed that the disinterest in dissociation was only temporary: "New interests drain attention into new channels, and older topics are merely set aside" (p.12).

Renewed Interest in Dissociative Identity Disorder

Carl Jung (1959) later developed the concept of the individuation of consciousness. He formulated the term "archetypes" to describe individual symbolic representations of experiences instinctively known to all humans. He claimed that there is an intuitive and common understanding of wholeness and unity that the person is pulled towards. Dissociating parts of the self away from the center, or wholeness was a disruption to the individuation process and a block to growth.

The sixties and seventies gave rise to a revival of interest regarding perceptions of the self and becoming connected to a true internal self. The concept of multiple selves was also resurrected and eventually led to the return of study and research into the area of MPD. Khilstrom et al. (1993) reported that not only did the number of reported cases in the 1970's increase, but the number of alter personalities or alter egos also increased during this time. An underlying common theme to the explorations during this time was an interest in learning how the self could be damaged and fragmented resulting in an emotionally detached person. These explorations were often developed on traditional psychoanalytic foundations and then later reformulated according to the humanistic approach.

Assagioli (1956) described his conception of psychological life as an integration of the energies and drives of the personality into a unified whole which he termed the psychosynthesis of the personality. The goal of psychosynthesis was to develop a unity between the conscious self, or the self most people are aware of, and the higher self, or the self of which we generally have less awareness. He identified the existence of subpersonalities or the variable and unintegrated psychological traits exhibited by a person. The splitting of the personal self into subpersonalities and the potential ability to subsequently reintegrate was cited as evidence of a higher self that remained untouched throughout the splitting process. Therefore, with multiple personalities, a higher self existed but had become separated from the conscious self which has been divided into subpersonalities. The process of psychosynthesis was an acknowledgment of the need to unite the conscious self and the higher self toward a union or integration.

Lowen (1967), based on a psychodynamic perspective, described a schizoid disturbance where certain individuals dissociated their true selves or their image of themselves from reality. These people were different from schizophrenics in that they had not completely withdrawn from reality but they nonetheless exhibited a detachment from reality and the unity of the personality was in a vulnerable state. As schizoid, these people displayed a conflict between the ego (which had not been allowed to experience feelings) and the body. This conflict eventually resulted in a psychological split. Images, sensations and perceptions of the schizoid person became dissociated resulting in a loosening or detachment of the self.

Stone and Winkelman (1985) considered personality to be fragmented from the onset and consisting of subpersonalities that were displayed as energy patterns. The energy patterns were related to internal states such as, mental, emotional and spiritual states. Becoming aware of the parts of the selves was considered important and in particular, becoming aware of and embracing the "disowned selves" or the energy patterns that were rejected but still existing within the person was key to healthy self. They explored three levels of consciousness: that of awareness, the experiences of the different parts of the self (also called subpersonalities), and the ego. As with Lowen (1967) and Assagioli (1956) an emphasis was placed on embracing the various selves but unlike them, they envisioned the subpersonalities as relatively autonomous, though linked to an "aware ego" that is conscious of all the subpersonalities.

In the 1980's, a relative explosion of multiple personality disorder cases were reported in the world literature (Ross, Heber, Norton, Anderson, Anderson, & Barchet, 1989). An interlude of several decades passed before this resurgence of interest in dissociative phenomena, particularly Multiple Personality Disorder peaked in the late nineteen seventies (Herzog, 1984). More cases of MPD were reported at the beginning of the 1980s than in the preceding two centuries according to Putnam (1986). A number of explanations are offered to clarify the reasons for the fluctuations of reported cases of MPD. Some researchers believe that the paucity of reported cases of MPD between the 1930s and the 1970s were the result of patients in the United States with MPD being

misdiagnosed as schizophrenics (Herzog, 1984; Rosenbaum, 1993; Goff & Simms, 1993). Other possible explanations for the rise in diagnoses of MPD are the increase in therapists' index of suspicion regarding MPD clients and their ability to correctly make the MPD diagnosis (Spanos, Weekes, & Bertrand, 1985). From the sociocultural perspective Armstrong (1993) notes that the "self" is culturally defined and with the naming of the multiplicity of the self, follows the increase in defining and interpretion of the disorders of the self. In the 1980s, the increase in diagnoses of MPD coincided with the inclusion of Multiple Personality Disorder as a new diagnostic category in the Diagnostic and Statistical Manual, (DSM-III) (Goff & Simms, 1993). Ross (1991) reported an increase from 200 worldwide reported cases of MPD in the early part of the 1980s to 6000 reported cases in North America by the later portion of the 1980s. Thigpen and Cleckley (1984) suggested that the increase of diagnoses of MPD could be explained as reactions to the popularization of MPD. Thigpen and Cleckley were the therapists involved in the treatment of Eve, a person with MPD, and the authors of the book "The Three Faces of Eve", released in 1957.

Subsequent to the publication of their work with Eve, an array of media attention was focused on books, movies, and criminal trials that revolved around the subject of MPD. The movie Sybil (Schreiber, 1973), had been released. The following books were in print: The Five of Me (Hank-Sworth & Schwarz, 1977), and The Minds of Billy Milligan (Keyes, 1981). The case of "The Hillside Strangler" was gaining widespread attention across the United States (Spanos, et. al., 1985). Kenneth Bianchi, also known as "the hillside strangler," claimed to have multiple personalities, one of which was responsible for the murders of young women in the United States (Spanos et. al., 1985). Thigpen and Cleckley (1984) staunchly held that MPD was a very rare disorder. They believed that instances of partial dissociation occurred regularly for most people, but not to the extent necessary to warrant a diagnosis of MPD. Furthermore, they encouraged therapists to not underestimate the motive of secondary gain for most people professing to have MPD. In their words, "We urge that the diagnosis of Multiple Personality Disorder be reserved for those very few persons who are truly fragmented in the most

extreme manner" (Thigpen & Cleckley, 1984, p. 66). The renewed interest in dissociation resulted in an increase in scientific discussion surrounding the dissociative disorders (DD) with many professionals becoming increasingly aware of its occurrence (Kluft, 1988; Ross, 1990). Concurrently, a dramatic increase in reported cases of DD appeared (Chu, 1994; Sachs, Frishholz & Wood, 1988; Putnam & Loewenstein, 1993; Saxe, van der Kolk, Berkowitz, Chinman, Hall, Lieberg & Schwartz, 1993).

The Etiology of Dissociation

The most widely held etiological view of DID is a trauma-based view where DID is believed to develop as a result of early childhood sexual and physical abuse (Ross, 1990; Kluft 1985; Putnam, 1989; Coons, 1986). Early incestuous abuse has also been viewed as a critical precipitating factor in the development of dissociative symptoms (Stick & Wilcoxin, 1991). In his extensive report on DID prepared for the Clinton Administration in the United States, Loewenstein (1994) indicated that almost all systematic studies of people with DID revealed a history of early childhood traumatic experiences. However, the actual relationship between the occurrence of trauma and the development of DID remains unclear. As Spiegel and Cardena (1991) explain, "Whether trauma is a necessary and sufficient condition or a more incidental correlate of dissociative disorders is far from clear".

Janet's influence is clearly evident in Hilgard's (1977) theory of neodissociation that has been offered to explain the occurrence of DID. The theory is based on the assertion that consciousness is illusory and is in fact composed of a number of different and interacting levels that are vulnerable to disruptions. The neodissociation theory holds that the mind is an organized mental framework made up of structures that oversee the two levels of consciousness: of both the active, or rational, mode of thought and the receptive, or passive, mode of thought. These interdependent structures, similar to automatisms, control the differences in perception or sensation, and cognition. The whole system is under executive control of a central regulatory mechanism that can be disrupted resulting in these structures assuming individual control of the person's overall functioning (Hilgard, 1977: Khilstrom et. al., 1993).

In contrast, the autohypnotic theory was suggested to explain how DID resulted in a form of autohypnosis (Putnam, 1986). People who are highly hypnotizable were believed to have a high dissociative ability that made them more vulnerable to developing a DD. Bliss (1980) stated that DID's were excellent hypnotic subjects and used self-hypnosis as a way of coping, "the process of self-hypnosis allows the delegation of an experience or a function to an alter ego, henceforth relegated to unconsciousness by the amnesia of hypnosis" (p. 1395). Spiegel (1984) discovered that Vietnam vets with post traumatic stress disorder (PTSD) had similar high levels of hypnotizability as people with DID and therefore, hypnotizability might be a predisposing factor for the development of DID.

According to the diathesis stress model of dissociation some people might have an ability to dissociate as a defensive measure used during times of stress (Khilstrom et. al., 1994). High levels of absorption or fantasy-proneness have been suggested as additional risk factors in the formation of DID, but this hypothesis remains unproven (Khilstrom et. al., 1994).

Putnam (1986) further commented that in general, people have a predisposition toward developing DID, but usually succeed through normal developmental processes to amalgamate the roots of identity into an integrated sense of self. This developmental view of the formulation of DID holds that experiences of trauma are responsible for causing a disruption in the normal development of the self. This disruption starts the initiation of dissociative defenses that sequester traumatic memories away from entering into conscious awareness by initiating the origination of an alter self with a physical and psychological identity to contain those traumatic memories.

In a similar manner, Fink (1988) describes DID as a disturbance in the formulation of the core self which results in fragmentation and severe alterations of the child's sense of self. The dissociative defenses that are used separate the child who experienced the trauma from the child who did not. He calls these *not me* experiences: "The essence of pathological process operative in MPD [is] designed to satisfy the one injunction: That did not happen to me, it happened to another" (p. 43).

Contending that DID is primarily a disorder of childhood, Albini & Pease (1988) describe the development of DID in childhood as a failure of cohesion and the resultant establishment of a nuclear self. The nuclear self consists of a number of nuclei that coalesce to form the nuclear or core self of the child. These nuclei can become split from the core self and result in a diffusion of thoughts, sensations, actions, and behaviors into the split nuclei that would ordinarily combine to form the nuclear self. This idea of split nuclei is similar to Janet's automatisms (1899) and Hilgard's structures of control (1977) which become segregated and develop independently while still exerting their influence on the person. This theoretical view of DID as occurring primarily in childhood is differentiated from other theoretical views in terms of regarding DID more as a preassociative than a dissociative disorder. This reconceptualization constitutes a paradigm shift in the consideration of DID. The question shifts from, "why does a child dissociate?" to "what are the mechanics that inhibit cohesion?".

In describing the mental content that is dissociated from awareness in people with DID, Sands (1994) concurs that abusive memories and sensations are dissociated from conscious awareness, but also contends that relational needs are similarly dissociated from consciousness. She defines relational needs as early developmental needs that are usually acquired through interactions with others and are necessary for normal development. When relational needs are unmet, they become dissociated and submerged as unmet need states. Sands characterizes DID as a relational disorder stemming from abandonment and a lack of relational attachment. Irwin (1994) has indicated the importance of investigating the impact of neglect, separation, and loss of parental influence as contributing to the overall etiology of DID. Thus while abusive antecedents may spur the development of DID (Kluft, 1985; Coons, 1986; Putnam, 1989; Ross, 1990) the contributing traumatic antecedents of loss and neglect appear to be pervasive in their impact on the person with DID.

Malmer's (1991) psychoanalytic perspective of DID views it as a syndrome of defense. Defenses and elaborated fantasies describe the methods used by DID patients to survive extensive trauma. His tripartite etiological view regarding the formulation of

DID involves the existence of trauma in the life of the patient, the internal conflicts and tensions inherent in the individual that affect the clinical course of the disorder, and the deficiencies intrinsic to the patient, such as the inability to soothe oneself in the face of hardship. In his view, the DID patient has set in motion an elaborate system of defense as a result of traumatic antecedents. In fact, some of the unusual behaviors displayed by a DID patient can be attributed to personified intrapsychic conflicts (Putnam, 1989). Uncovering and becoming familiar with the defensive structure and dynamic organization of the individual with DID can assist the clinician in recognizing therapeutic needs for ongoing treatment (Malmer, 1991).

The Phenomena of Dissociation and Dissociative Identity Disorder

Ross (1989) stated that dissociative experiences are common in the general population and are not necessarily pathological in nature. Dissociation has been described as a normal process in children linked with imaginative play and fantasy (Putnam, 1991). Furthermore, dissociative experiences appear to exist on a continuum with low levels of dissociation common in most people (Anderson, Yasenik, & Ross, (1993) and declining with age (Ross, 1989). An example of low levels of dissociation is undergoing episodes of absorption, such as daydreaming. The level of dissociation experienced by a person is important and as Ross (1990) explained, the difference for people with DID is that their level of dissociation is extreme and results in periods of amnesia for parts of their lives and additional experiences of not being themselves or feeling that their own actions belong to somebody else. While agreeing that people have differing aspects of personality and sometimes display different behaviors in different situations, he maintains that DID is a complex dissociative disorder that can be viewed as an extreme variant of normal dissociation. Features said to be associated with MPD include the ability to sustain a high degree of dissociation and character pathology arising out of a low level of ego strength (Herzog, 1984). Others (Armstrong, 1993; Coons, 1980) however, view the production of multiple personalities as an exhibition of coping and strength, "an active adaptation to a chaotically violent environment that allows the

child to achieve an unusual flexibility of coping, relatedness, and self-protection (Armstrong, 1993, p.601).

The essence of dissociation has been described as a disruption in conscious awareness (Tataryn, et al. 1993) and MPD as "a temporary alteration in awareness of one's identity" (Braun & Sachs, 1985). In addressing the occurrence of dissociation, Braun (1985) proposes two major predisposing factors in the ability to dissociate: experiences of severe trauma, and a natural, inborn ability to dissociate. Both factors are described as necessary for the formulation of DID. Additional features concurrent with dissociative ability are a superior working memory that is necessary to keep all of the alters' autobiographical information intact, above average intelligence, and creativity (Braun & Sachs, 1985). Standardized IQ tests yield unreliable scores for DID's because the scores can vary from 40 to 50 points on separate testing occasions, dependent upon which alter is in executive control. Consonant with Binet and Wechsler's interpretation of intelligence as adaptive ability, this rating of intelligence is ranked quite high for DID's. High-functioning multiples have also been noted in the medical profession (Kluft, 1986) and in psychiatry residents and graduate students of psychology (Kluft, 1990). The intricate processes involved in the formulation of DID speak to the high level of creativity of DID.

DID has been characterized as a pathological form of dissociation. It often entails a major personality or a number of major personalities that take charge of life events. Personality fragments also exist and assume minor or lesser functions (Anderson, et. al., (1993). The different personalities represent the person's adaptational and defensive modes of survival. Kluft (1988) prefers the term "alter" to "personality" because not all personalities are completely and distinctly defined or characterized as complete opposites of other personalities, but instead can be viewed as "different adaptational solutions to difficult circumstance, only some of which take the form of being opposites" (p.57). Isomorphic alters are near-duplicate alters that are similar yet remain autonomous in their patterns of perception, sensation, cognition, and identity with alters having originated to serve in a particular role at a particular time or to perform a specific task or action.

Extremely complex DID consists of DID's with an unusually extensive number of alters ranging from twenty-six alters to over four thousand five hundred (Kluft, 1988). The number of alters may be related to the number of different traumas endured (Kluft, 1988; Fink, 1988) and therefore, if a person with DID had undergone years of severe abuse and defensive tactics were activated to formulate alters on an ongoing basis to deal with particular incidences of trauma, one can see how a large number of alters might ensue.

Kluft (1988) suggests a paradigm shift in understanding this extensive multiplicity. Rather than maintaining the use of paradigms of dividedness and splitting, particularly in attempting to understand extremely complex DID, a paradigmatic conception of multiplicity is offered. This new paradigm is advanced to explain how the mind works at multiplying itself into the form of various alters rather than of dividing itself into increasingly large numbers of alters.

The principal feature of DID is the presence of "two or more distinct identities or personality states that recurrently take control of behavior" (DSM-IV, p. 484). In their landmark study, Putnam et. al. (1986) reported important information from clinicians regarding these alter personalities, such as the number of alter personalities encountered by clinicians (mean=13.3; median=9; mode=3). Child alters were among the most common type of alter personality with half the cases reporting opposite gender alters. Amnesia, an additional necessary criteria for the diagnosis of DID, was common among the personalities with 68% of cases unaware of the existence of other alters. Suicidal behaviors, self-mutilation, outward-directed violence, and substance abuse were all reported as common results of the psychopathology expressed by the conflicting interactions among the alters. Observations of frequent switching from one alter to another were reported by 87% of clinicians who also indicated that the speed of the switch ranged from seconds to five minutes.

The shifts from one alter to another are explained as shifts in autobiographical memory and affect and a corresponding shift in identity (Khilstrom et. al., 1994). Shifts occur back and forth between alters with a continuous autobiographical memory developing within each alter but disconnected across them. Amnesiac barriers keep the

alters separate and it is these barriers that become weakened and permeable during integrative therapies.

A number of psychophysiological aspects of DID were reported by Coons (1988). They include headaches, conversion symptoms, differences in visual perception, changes in voice, changes in handedness, analgesias, (or a insensitivity to pain), seizure-like occurrences, gastrointestinal disturbances, skin conditions, and sexual and eating dysfunctions. These results confirm that "MPD is not only a polysymptomatic disorder, but that a wide variety of defense mechanism may underlie the production of these symptoms" (Coons, 1988, p. 51)

The Assessment of Dissociation

The accurate assessment of dissociative disorders had previously relied on a retrospective review of reported cases of MPD in the literature or reported cases by select clinicians (Kluft, 1988; Putnam, et. al, 1986). Recently, assessment instruments have been developed and used to determine levels of dissociation and dissociative disorders. These assessment instruments serve an important role in defining more precisely the nature and prevalency rates for dissociative disorders. While there are a number of assessment tools presently being used to assess dissociation, only the most reliable and valid will be reviewed.

By far the most efficient and widely used screening technique for detecting dissociation is the Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986; Stick, & Wilcoxon, 1991; Boon, & Draijer, 1993; Allen & Smith, 1993; Saxe, et al., 1993;). The DES is a short questionnaire used to establish dissociative traits (not states) along a continuum of dissociation. It is an attempt to quantify the number dissociative experiences encountered by the person on a daily basis. Bernstein & Putnam (1986) describe the DES as the first reliable and valid instrument devised to accurately quantify dissociation (test-retest reliability of 0.84) and with high inter-rater reliability for the scoring of the DES (Bernstein Carlson, Putnam, Ross, Torem, Coons, Dill, Loewenstein, & Braun, 1993). In terms of construct validity, the expectation is that people predicted to score higher (i.e., people with dissociative disorders, or associated disorders like post

traumatic stress disorder) earn higher scores than people who do not have a dissociative disorder. Overall, the DES scale has been extensively researched and has been established as a reliable and valid measure of dissociative disorders (Ellason et al., 1994; Carlson Bernstein et al., 1993; Stick, & Wilcoxon, 1991).

A second version of this scale (DES II) has since been developed. In a recent study (Ellason, Ross, Mayran & Sainton, 1994), three samples of participants: college students, inpatients with Dissociative Identity Disorder, and inpatients with a chemical dependency, were compared for the degree of convergent validity in their responses to both forms of the DES. There were no significant differences of the mean scores between any of the groups when comparing between the DES and the DES II. Therefore, the inpatient group scored highest on both forms of the DES and the other two groups scored lower on both versions of the DES. Convergent validity was demonstrated for the DES II among all of the subjects combined ($r = .96$, $p = .0001$) with correlation coefficients ranging from .85 ($p = .0001$) for the chemical dependency group to .95 ($p = .0001$) for the Dissociative Identity Disorder group.

Determining appropriate cut-off scores for the DES has been a topic of much research and debate. Scores on the DES range from a minimum of 0 to a maximum of 100. Steinberg, Rounsaville, & Cicchetti (1991) suggest using a cutoff score of 15-20 to yield excellent sensitivity (ability to correctly identify true positives, or subjects who have dissociative disorders) and specificity (ability to correctly identify true negatives, or subjects who do not have dissociative disorders). Ross, Anderson, Fleisher, & Norton (1991) used a cutoff score of 20 or above which they thought would appropriately depict people who have dissociative disorders. However, Steinberg et al. (1991) suggest that using cutoff scores of above 20 increases the risk of including false negative cases since some subjects may be unaware or may deny having dissociative symptoms and will therefore not score very high.

From the beginning, Bernstein Carlson et al., (1986) have emphasized that the DES only be used as a screening tool and not as a diagnostic instrument. The DES does not have the capability to accurately diagnose dissociative disorders, although it is used

as a preliminary screener whose results may warrant further inquiry into the possible existence of a dissociative disorder. As Allen and Smith (1993) explain, "The DES indicates when to look further [and]...can be an excellent entree into the diagnostic process." (p. 333). Although the DES is helpful in screening dissociative tendencies, combining it with a diagnostic interview has been suggested as a means for ensuring accurate detection of DID and other dissociative disorders (Steinberg, Rounsavill, & Cicchetti, 1993).

A number of interview schedules or guides were also developed. Ross, Heber, Norton, Anderson, Anderson, and Barchet (1989) developed the Dissociative Disorder Interview Schedule (DDIS) to provide more accurate information regarding diagnosis of dissociative and related symptoms. These related symptoms are characteristic of somatization disorder, borderline personality disorder, and major depressive episode, all of which are often concurrently diagnosed with the dissociative disorders (Ross et al., 1989). The DDIS is a structured interview with a total of 131 questions. The questions cover a wide range of information including a history of physical and sexual abuse.

The validity was examined by having patients who were diagnosed as having multiple personality disorder according to the DSM III, re-diagnosed by a psychiatrist who was diagnostically blind to their condition. The results indicated excellent validity in that the psychiatrist accurately diagnosed the patients using the DDIS. Because, at the time, no other structured interview of this sort existed, the results of the DDIS were compared to the results of the DES. DES scores for patients accurately diagnosed as having multiple personality disorder were above 30 indicating that the DDIS is a valid instrument. These preliminary results indicate the reliability and validity of the DDIS are promising, but await subsequent replication studies (Ross, Anderson, Fleisher, & Norton, 1991).

The Structured Clinical Interview for Dissociative Disorders (SCID-D) assesses dissociative symptoms according to the DSM-IV criteria and yields diagnoses that agree with the DSM-IV . It was initially developed by Marlene Steinberg (1985) and appears to have become a standard assessment tool and has been described as, "the most refined

method for assessing dissociation" (Allen & Smith, 1993, p. 334). One hundred and fifty-eight initial, non-intrusive questions are included in the interview with one-hundred follow-up questions that can be used at the clinician's discretion to begin to elicit more specific information about a patient's particular background and history of dissociative experiences (Hall, & Steinberg, 1994). The focus of this particular semi-structured interview is more specific than that of the DDIS. The SCID-D shares the goal of assessing dissociative symptoms with the DDIS but is applied more specifically to determining whether core dissociative symptoms are experienced by patients. Thus, questions are restricted to ascertaining the amount of experience patients have had with amnesia, depersonalization, derealization, identity confusion, and identity disturbance (Hall, & Steinberg, 1994). While the DDIS is helpful is uncovering associated symptoms, such as the somatization symptom of extreme nausea unrelated to any physical cause, or possible traumatic antecedents such as physical and sexual abuse, the SCID-D focuses specifically on dissociative symptomotology. Some researchers (Allen & Smith, 1993) would argue that an indication of traumatic history is important enough to warrant the inclusion of a checklist or questionnaire developed to determine traumatic history into the overall assessment using a checklist such as the Traumatic Antecedents Questionnaire (Herman & van der Kolk 1992). Hall and Steinberg (1994) describe how a history of trauma was often volunteered by patients in field testing of the SCID-D, and they further claim that " the SCID-D's ability to elicit a spontaneous history of traumata makes it particularly useful to clinicians concerned about asking leading questions." (p. 112). Preference for one or the other interview might be based on a clinician's requirement for either a breadth of broad and somewhat diverse information or a depth of distinct and explicit information.

Good to excellent reliability and discriminant validity have been found for this structured interview (Allen & Smith, 1993; Boon, & Draijer, 1993; Hall & Steinberg, 1994) and in particular for its use as a diagnostic instrument and as a tool to decipher dissociative symptoms in clients who have disorders other than dissociative disorders (Steinberg et al., 1991). It has also been commended for its high degree of inter-rater

reliability (Kihlstrom et al., 1993). The SCID-D has a level of precision that ensures that a standardized format is followed to achieve a precise and similar diagnosis from a wide range of clinicians and further attests to its reliability. A cross-national study aimed at describing the characteristics of Dutch patients with DID using the SCID-D (Boon & Draijer, 1993) revealed striking similarities between Dutch and North American patients, indicating "a consistent set of the symptoms throughout North America as well as in The Netherlands" (Boon & Draijer, 1993, p. 491). Dutch patients exhibited somatic symptoms, suicide attempts, sexual and physical abuse, some form of amnesia, and several other characteristics that corresponded well with North American populations.

A more recent and shorter version of the SCID-D entitled the Mini SCID-D (M-SCID-D) has been developed and can be administered by a clinician or self-administered (Kihlstrom et. al., 1994). This shorter version can provide only a tentative diagnosis which can then be verified by using the more complete SCID-D.

The SCID-D has been translated into Dutch and the DES has been translated into a host of other languages: French, Italian, Spanish, Japanese, Cambodian, Hebrew, Czech, Swedish, Norwegian, German, and Hindi (Carlson & Putnam, 1993).

The Prevalence of Dissociation

The prevalency rate for Dissociative Disorders (DD) is based upon the use of assessment instruments like the DES, DDIS, and SCID-D. The benefit of using these standardized instruments is the production of concordant findings among studies despite the variability in methodologies and samples used by individual researchers (Loewenstein, 1994).

In many instances, prevalency rates for DD are also based upon the level of trauma experienced by a population. For example, Ross (1991) linked the prevalence rates for DD's to the high incidence of trauma, specifically sexual abuse, in the general population. His rationale for deciphering a prevalency rate for DD's was based on the vulnerability of children for having DD's. He explained that a relatively high rate of hypnotizability was noted for children and therefore their dissociative capacity was similarly likely to be high. By comparing the high level of dissociative capability of

children to the 5-10% rate of sexual abuse in a general population, Ross proposed that children were at risk of developing a dissociative disorder. Therefore, Ross believes that it is conceivable that DD's are common in North America.

Ross, Joshi, and Currie (1990) completed one of the first studies to widely use the DES to determine the prevalency of dissociative experiences in the general population. They administered the DES to a large stratified random sample in Winnipeg, Manitoba and discovered that at least 5% of the 1,055 respondents scored above 30 on the DES, 8.4% scored above 25, and 12.8% scored above 20 (all scores warrant further investigation into the possibility of a dissociative disorder). Their findings suggest that non-pathological dissociative experiences are common in the general population. These researchers suggested a tentative prevalency rate for dissociative disorders set at between 5-10% of the general population. However, because the DES is only a screening tool and not a diagnostic instrument, these researchers conducted a second phase of this study where follow-up interviews using the DDIS were conducted with as many of the original respondents as possible. Of the 454 interviews conducted, 11.2% received a diagnosis of DD and 3.1% received a diagnosis of DID Ross (1991).

Ross, Anderson, Fleisher, and Norton (1991) conducted a study to determine prevalency rates of DD's for psychiatric inpatients. This was a two year study in which consecutively admitted psychiatric inpatients were administered the DES. The patients who scored higher than 20 (30.1% of patients) were then interviewed with the DDIS. Of the 80 patients who completed both the DES and the DDIS, 20.7% of the patients warranted a diagnosis of DD and 5.4% received a diagnosis of DID (according to the DSM-III-R).

In their study of dissociative disorders of psychiatric inpatients, Saxe, van der Kolk, Berkowitz, Chinman, Hall, Lieberg, and Schwartz (1993) found that of the 110 patients who completed the DES, 15% scored above 25 (these patients were also interviewed with the DDIS)and were compared to a group of patients who scored below 5 on the DES. Overall, results indicated that 15% met the criteria for a DD and at least 4% met the criteria for DID.

A similar study by Horen, Leichner, and Lawson (1995) found that of the 48 psychiatric inpatients who completed the DES, 29% scored above 25 with 17% of patients meeting the criteria for a DD and 6% receiving a diagnosis of DID. These findings are consistent with previous results in both Ross. et. al (1991) and Saxe et. al. (1993).

Anderson, Yasenik, and Ross (1993) found very high rates of dissociative symptoms among female sexual abuse survivors. In their sample of 51 women who completed the DES and the DDIS, 88.2% met the criteria for a DD and 54.9% were diagnosed as having DID. However, the sample size (N= 51) was relatively small, and the participants were not clinically assessed and therefore may have better met the diagnosis of Dissociative Disorder Not Otherwise Specified and not DID specifically. Research has also been conducted into the level of dissociation experienced by United States veterans with substance abuse problems. Results indicated that 41.5% of patients scored at 15 or higher on the DES which suggests that dissociative experiences are not uncommon in this population (Dunn, Paolo, Ryan, & Van Fleet, 1993). Although published data indicate that people are being diagnosed with DD and DID, determining prevalency rates remains a difficulty. Dunn (1992) lists problems with the criteria for diagnosis, the issue of selectivity in choosing participants for the studies, and the problems with generalizing results as barriers to accurate identification of prevalency rates. Therefore, Dunn (1992) contends that speculations can be advanced only regarding prevalency rates for given subpopulations.

Nonetheless, Loewenstein (1994), in his recent report to the Clinton Administration, summarized the current literature and data on the dissociative disorders and reported prevalency rates. The results of his report indicated that approximately one percent of the North American population met the criteria for a DID diagnosis and an overall ten percent prevalency rate existed for people with DD's in the general population.

The diagnosis of Dissociative Identity Disorder

Dissociative Identity Disorder (DID) was once considered as a form of hysteria (Janet, 1899) and since that time, has undergone many definitional changes and classifications (Ellenberger, 1970). DID was previously classified as a psychoneurotic disorder in the first Diagnostic and Statistical Manual (DSM); as a hysterical neuroses in DSM-II; Multiple Personality Disorder (MPD) in DSM-III; and Dissociative Identity Disorder in DSM-IV (Kihlstrom, Tataryn & Hoyt, 1993).

Kluft (1991) describes the presentation of DID as a paradox. A florid presentation of striking and unusual behaviors is the classical or stereotypical view of people presenting with DID. In contrast, clinical experience and research findings generally report that DID is often a hidden or covert disorder that is difficult to detect which accounts for the complications involved in making an accurate diagnosis. The extensive symptomatology associated with DID often blurs a clear and straightforward diagnosis; much of the symptomatology involves physiological changes and disturbances in addition to psychological changes (Miller & Triggiano, 1992). In addition, the skepticism surrounding the existence of DID has resulted in reluctance on the part of some clinicians to make a diagnosis of this disorder (Coons, 1980; Kluft, 1988). As a result, lengthy time intervals occur between the presentation of the disorder and the receipt of a correct diagnosis (Kluft, 1991).

Some professionals are skeptical of applying the diagnosis of DID. This skepticism has been described as a contributing factor in the difficulty of accurately diagnosing DID. A recent study by Hayes and Mitchell (1994) obtained results from a US National survey of mental health professionals to support the hypothesis that skepticism and knowledge about Dissociative Identity Disorder (DID) are inversely related, with moderate to extreme skepticism being expressed by 24% of the sample. They also found that inaccurate diagnoses of DID were common and that its misdiagnosis could be predicted by the skepticism about DID. In an editorial (1993) in the *Dissociation* Journal, Dr. Kluft acknowledges and comments on the skepticism that greets many of the professionals involved in this area and suggests that these

professionals strive " to learn and develop a credibility for our field that is based on an increasingly solid foundation of basic and clinical research, and a time-tested body of clinical wisdom" (p. 80).

Putnam (1991) states that the construct validity of the MPD diagnosis is most strongly supported by the large number of independent studies that have uniformly proposed a similar clinical picture. Describing MPD as a disorder in its own right, Ross et. al., (1989) say it is distinct from both Axis I and Axis II disorders. However, the symptomatic overlap between the diagnosis of MPD and other diagnoses, such as borderline personality disorder (BPD), schizophrenia, and posttraumatic stress disorder (PTSD), has been demonstrated (Fink, 1991; Horevitz & Braun, 1984; Saxe et. al., 1993; Loewenstein, 1994).

Clinicians and researchers have come to realize that part of the difficulty in ascribing a correct diagnosis of DID has stemmed from the fluctuating clinical picture that is presented when different alters take executive control, "leading the casual observer to misperceive the functioning of one overt personality as the totality of the personality" (Spiegel, 1986). Therefore, the person with DID is also frequently given other diagnoses or co-morbid diagnoses.

According to Blank (1994), most authors would concur that approximately 80% of MPD patients also meet the criteria for PTSD at the time of diagnosis and the remaining 20% meet the criteria during treatment. He further proposed that patients who present with MPD have a high likelihood of fitting the criteria for PTSD. In fact, 80% of patients with MPD also qualify for a co-morbid diagnosis of PTSD, according to DSM-III-R (Armstrong & Loewenstein, 1990; Boon & Draijer, 1993). It is claimed that MPD be understood as a, "complex form of developmental post-traumatic dissociative disorder" related to early childhood trauma (Loewenstein, 1994, p.5).

In addition, patients with MPD have also been frequently diagnosed with BPD, "on the basis of symptoms related to manifestations of the individual alters" (Fink, 1991, p. 557). Clinicians are urged to exhibit caution in making the dual diagnoses in order to ensure that a complete assessment of the total personality is undertaken to avoid

erroneous diagnoses of an alter personality or subsystem of the total personality (Greaves, 1980). In their sample of patients, Horevitz and Braun (1984) concluded that 70% of patients with MPD commanded a concomitant diagnosis of BPD. However, these authors described the diagnosis of BPD in multiple personality patients as related to their overall level of dysfunction and not as the original diagnosis. Fink (1991) concurs with this view by stating that the borderline traits might be similar, but the experiences associated with the borderline symptoms were qualitatively different. According to Ross (1991) the overlap between BPD and MPD makes sense considering that both disorders arise as a result of the consequences of childhood trauma. Nonetheless, Fink (1991) maintains that "many MPD patients present with an apparent mixed personality profile consisting of an array of avoidant, compulsive, borderline, narcissistic, dependent, and passive-aggressive feature" (p. 564). In terms of the broader category of dissociative disorders in general (e.g.; Dissociative Fugue, Dissociative Amnesia, Depersonalization Disorder, and Dissociative Disorder Not Otherwise Specified) 75% of patients with dissociative disorders met the criteria for BPD, PTSD, and major depression at some point during their lives (Saxe et. al., 1993).

Schizophrenia is another psychiatric disorder with which MPD patients are frequently misdiagnosed (Ross, et. al, 1989). The Scheneiderian symptoms expected to be pathognomic to schizophrenia are frequently seen in patients with MPD (Ross, 1991). Scheneiderian symptoms include disturbances in thought (delusions), perception (hallucinations) and behavioral manifestations (agitation) (Gabbard, 1990) However, researchers compared three groups of patients to MPD patients (schizophrenics, panic disorders, and eating disorder patients) using the DDIS and observed that, "overall, MPD is a disorder with distinct clinical features that can be differentiated from other psychotic and nonpsychotic conditions" (Ross, et. al., 1989, p. 489). MPD was differentiated from the other disorders by a number of unique features: dissociative, substance abuse, child sexual abuse, and extrasensory experiences.

The Treatment of Dissociative Identity Disorder

Treatment techniques used for people with DID were most often based on the clinical experience and case studies of clinicians who had learned how to treat people with DID through their own clinical judgment and observation (Dunn, 1992). Most often, clinicians encountering a client with DID became overwhelmed and sought guidance from the few specialists who had treated clients with DID (Kluft, 1988).

It appears that the availability of treatments has increased. In a recent study, 305 clinicians working with DID patients were asked to rate the most useful and efficient types of treatment used with DID patients (Putnam & Loewenstein, 1993). The results indicated that psychotherapy and hypnotherapy were respectively rated as the most preferred treatments. Differences in professional specialty resulted in different responses for the third most preferred treatment: psychiatrists and social workers chose pharmacology as the third most important form of treatment while psychologists and other therapists rated art therapy and group therapy as the best third treatment option.

Other treatment choices have become available and include: behavior therapy, cognitive therapy, abreactions, and integrative techniques (Dunn, 1992) In addition, journal writing and audio/video visual recordings have also been suggested (Coons, 1986). Rehabilitative techniques like movement therapy have additionally been offered as important forms of treatment because, "the modalities used by movement and recreational therapists help release the tensions brought on by the intense psychotherapeutic experience of uncovering emotionally laden memories"(Zechner Reichert & Bergland, 1992).

Guidelines for treatment have been offered by therapists. Sachs, Frishholz, & Wood (1988) have determined five major phases for the successful treatment of DID. First, the diagnosis is confirmed and the client is educated about the diagnosis. In the second phase, the functions and purposes of the personality states and fragments are identified in order to be recognized and understood. The third phase involves having the client share traumatic experiences and in the fourth phase, the personality states are integrated so that "there will be little or no difference between personality states, thus no

need for separateness" (p. 252). In the final or fifth stage, new coping techniques are taught and learned by the clients so that the need to cope using dissociation is averted. Spiegel (1986) offers similar guidelines but adds that it is important for the client to retain a sense of control throughout therapy, particularly in relation to accessing memories. Some additional suggestions have been offered to enhance treatment such as working towards co-consciousness which is a term developed by Prince (1957). The phenomenon of co-consciousness occurs when at least one personality is aware of all other personalities that might be functioning at the time. Enhancing and maximizing co-consciousness is a desirable step in therapy, particularly with DID clients who demonstrate extreme complexity (Kluft, 1988).

One of the therapy techniques advanced by Braun (1986) involves encouraging the person with DID to ascribe one personality the role of internal therapist charged with assisting the therapist and eliciting internal communication or co-consciousness with the other personalities. Braun describes the goal of therapy as the achievement of integration by all of the personalities. Integration is defined as "the process by which thought and physiological processes are mixed and solidified" (Braun, 1986, p. 16).

A common difficulty encountered with DID clients includes their incredible sense of denial that is often transformed into what Kluft (1986) had termed "hiddenness". Spiegel (1986) defines this hiddeneness as form of incompleteness of the person that is not readily recognized "leading the casual observer to misperceive the functioning of one personality as the totality of the personality". This "hiddenness" occurs when clients try to obscure information or stop therapy in order to avoid a diagnosis of DID because avoiding, denying, and evaded a diagnosis of DID is a reflection of the person's desire to avoid confronting painful stimuli that are at the root of the disorder (Kluft, 1986). As Chu (1994) explains, the seemingly irreconcilable conflicts within the person are responsible for the fragmentation of that person into alternate personalities who deal with the emotionally-laden material in their separate ways. Therefore, he contends that communication between these alter personalities and the eventual integration of them necessarily produces intense anxiety and denial in the person. Nonetheless, integration is

defined by all clinicians as the ultimate goal in treatment for people with DID (Braun & Sachs, 1985; Braun, 1986; Kluft, 1988; Chu, 1994).

Treatment is therefore based on viewing the person with DID as a system of personalities and not a group of independent and autonomous individuals (Chu, 1994). Kluft (1988) also suggests treating the person with DID in totality, and not according to separate alter personalities. He states, "One must be vigilant to focus on the overall human being and avoid becoming entranced by the panoply of psychopathology" (p. 53). Coons (1986) warns therapists against viewing people with DID in the "special patient" role. People with DID must be treated as any other person with a mental disorder and therapists should not allow the unusualness of the disorder to affect the way the person is treated. He also comments that using this "special role" treatment encourages secondary gain.

The treatment of DID is still subject of individual case studies and independent observations made by a handful of clinicians. Putnam (1986) calls for increased systematic studies into the treatment of DID by suggesting the use of more objective research in furthering our understanding of treatment techniques. Clinicians with the scientist-practitioner model background are therefore perhaps best suited for furthering this area of investigation.

CHAPTER THREE
PHILOSOPHY OF METHOD

In this chapter, approaches to research will be discussed with an elaboration on the phenomenological approach. Issues related to a phenomenological method of research will then be examined.

Approaches to Research

Natural Scientific Paradigm

Natural scientific research can be described as the study of natural objects and natural events with the purpose of providing explanations and causes regarding the behavior of those objects and events. Adherents of the natural scientific attitude in psychology borrow from the scientific method of natural science and impose those methodological tenets on the study of human behavior. This process is carried out following the three assumptions that underlie the natural scientific approach to research; the phenomenon must be observable, measurable or quantifiable, and its existence and characteristics must be agreed upon by others to exist (Valle & King, 1978). A study of the relationship between the occurrence of a particular phenomenon and its results is undertaken using prediction and probability rules while controlling the variables under study. Basic to this idea is that the variable in question must be operationalized or defined in terms of a behavior that can be measured. Giorgi (1978) states that measurement of variables is of paramount importance from the viewpoint of the natural scientific paradigm, with measurement becoming " the giant filter through which all phenomena must pass if they are to be psychologically relevant" (p. 65).

This approach also rests on maintaining objectivity through the inclusion of distance between researcher and the object of research. While appropriate in some instances, the natural scientific paradigm of research exempts aspects of human behavior from such scientific inquiry. In particular, some research surrounding peoples' experiences and the meanings they attach to those experiences can lose their qualitative power using the natural scientific approach.

Human Science Paradigm

Human science is a paradigm of research that involves the study of the meanings and consciousness of humans with the purpose of interpreting and understanding those meanings (Van Manen, 1990). Phenomena such as purpose, experience, and consciousness are not open to natural scientific methods of investigation but are nonetheless human expressions and are therefore psychologically relevant (Giorgi, 1970). Researching such phenomena requires adopting a different paradigm of research that is reflected in the human science paradigm of research. The human science approach focuses on the connection between humans and their experiences which are inseparable from the world they inhabit. Therefore, elucidating meaning as derived from individuals' accounts is sought in preference to maintaining distance and observing participants, also known as objectivity in natural scientific inquiry (Giorgi, 1978). The human science paradigm focuses on purposeful selection of participants for the purpose of significant exchanges of information between the researcher and the participant. It does not purport to uphold the foundational tenets of objectivity, control of variables, and predictions of outcomes inherent in the natural scientific paradigm.

Existential Phenomenology

Existential phenomenology forms the basis of an approach that seeks to understand how people encounter the world around them and thereby place meaning on their experiences. Based on existential philosophy, phenomenological psychology seeks to uncover the essence or structure of human experience and behavior. (Valle & King, 1978). An essence can be understood as the elemental meaning that is commonly understood from a phenomenon that is mutually experienced by a number of people (Patton, 1990).

Phenomenological Methodology

Phenomenologists are most interested in understanding peoples' consciousness and awareness in relation to a particular experience. A phenomenological methodology is discovery oriented because it seeks to find the common meanings of how a particular phenomenon is experienced (Van Manen, 1990). The focus of a phenomenological

research is on the inner perspective of the person, spanning a range of human awareness including memory and imagination (Polkinghorne, 1979). Phenomenological research is therefore descriptive in the sense that it describes participants' experience of meaning with an aim to "produce clear and accurate descriptions of a particular aspect of human experience" (Polkinghorne, 1979, p. 44). The particular descriptive qualitative method, in this case phenomenology, must be amenable to providing sufficient reliability and validity of the study (Colaizzi, 1978).

Unfortunately, there is no one phenomenological method and therefore, no uniform or direct tests for reliability and validity (Patton, 1990). Therefore, establishing rigor is described as an ongoing process with a minimal a priori criteria to be adhered to; the methods for achieving rigor and trustworthiness emerge throughout the inquiry (Giorgi, 1985). Basic principles of phenomenology include co-constitutionality and the idea of the life-world. Both are helpful in guiding phenomenological study and are addressed below.

Co-Constitutionality

A basic principle of phenomenology is that people and their experiences are inextricably wound together with the world. Experiences do not exist inside of the person as a form of internal state but rather are propelled into the world and experienced there (Colaizzi, 1978). Rather than regarding people as solitary objects placed in the world and viewed as separate and distinct from it, people exist in undivided unison with the world. Thus a person and her world are said to co-constitute one another; the removal of one leaves the other devoid of meaning, "it is via the world that the very meaning of the person's existence emerges" (Wagner, 1979, p.8). Therefore, our existence is embedded in the world, contextualized, and cannot be separated from it. The world impinges on the person and the person similarly impacts the world. An investigation into the personal experiences of dissociation is best studied using a methodology that can accommodate and keep intact the co-constitutionality of the participant and her world of meaning.

Life-world

Life as lived by a person encompasses a pre-reflective or rudimentary, natural way of living referred to as the life-world of the person. Phenomenology seeks to discover the experiences of people within their life-world. According to Husserl (in Giorgi, 1970), it is an examination into the direct experiences of people after peeling away the layers of language and individual interpretation and thereby attempting to see the person's experience in its simplest form. It is a matter of returning to a basic or phenomenal level to allow for a rediscovery of how the world appears to the person (Giorgi, 1970). By viewing the phenomenon under investigation within its context, within its life-world one remains faithful to the person's co-constitutionality.

The Researcher as Instrument

The phenomenological method embodies a different paradigm of research than the natural scientific paradigm and therefore issues of reliability, validity, and generalizability are viewed from a phenomenological perspective.

Reliability

Reliability, as explained from a quantitative perspective, refers to "the consistency, stability, and dependability of a test or testing procedure" (Sandelowski, 1986). The consistency of the test or testing procedure is established when data yield the same results after being subjected more than once to a particular testing procedure. A different approach is taken in phenomenological research where commonality of meaning, auditability, accuracy, and reduction as opposed to replication of results is the goal (Wertz, 1984). Reliability in qualitative research is depicted in terms of the researcher's ability to accurately gather, document, and code the information from participants and ensure that consistency is maintained in the interpretation of the information. Reliability is attained by sifting through the variable information from participants' accounts and retrieving those aspects that retain similar and consistent aspects across participants. The similarities or commonalties arising from the experiences provide the consistency (reliability) of results. A resultant uniformity of the elements of the experience ensues and provides the essential meaning of the phenomena.

Therefore, an in-depth inquiry into the experiences of individuals, in the form of interviews for this study, cannot be tested for consistency in a similar quantitative manner because the context in which this research is conducted is unique and unrepeatable (Sandelowski, 1986). Thus, an interview with a participant is an example of a one time, unrepeatable occurrence that is not open to the quantitative dictate of repeatability and thus, reliability. Each participant will have an individual account of their experience. In fact, multiple perspectives of the phenomenon under study will emanate from the participants of the phenomenological interviews. These perspectives provide a wide range of views, beliefs, thoughts and understandings for each participant regarding the phenomena.

Auditability

If another researcher is able to follow the data analysis process set out by the original researcher and concur with the results, reliability in the form of the criterion of rigor called "auditability" is said to have been established. This criterion involves "certifying that data exist to support every interpretation and that the interpretations have been made in ways consistent with the available data" (Guba & Lincoln, 1981, p. 88). Additionally, if the researcher can reduce personal biases and ideas about the phenomenon under study and remain true or adhere closely to the data, particular results will ensue. Comparable results should be obtained by another researcher reviewing the same analysis and interpretation provided that the researcher has also delineated personal biases. As Sardello (1978) points out, facts can transcend the biases and, " the facts [of the research] can be understood within the limitations of the bias" (p. 138).

In addition, it is helpful if the researcher explains how decisions are made regarding the analysis and interpretation of the data. This has been defined as a "decision trail" and ensures that other researchers are able to track the decisions made by the researcher (Lincoln & Guba, 1985).

Accuracy

Phenomenological inquiry involves the researcher as the primary instrument who conducts the interviews, analyzes the data, and reports the results. A human being as a

research tool will, by her very nature be inconsistent and error-prone (Guba, 1981; McCraken, 1988). Characteristics that can affect the human research tool include: fatigue, evolving insights, and changing perspectives. Therefore, the researcher continually checks the level of consistency in results ensuring accurate and e[illegible]ent handling of the data (Patton, 1990).

Reduction

In phenomenological research, an attempt is made to transcend what is known in the natural world in favor of becoming open to the life-world of research participants. The known world of the researcher is stripped as much as possible from preconceived ideas, opinions, beliefs, and biases and becomes reduced to the phenomenal realm in an effort to understand the basic meaning of the phenomenon (Valle & King, 1978). The process of reduction is an active one that is carried out through the use of such techniques as bracketing (Patton, 1990). Bracketing is a way to suspend or bracket personal beliefs by making them explicit lest they unconsciously influence our interpretations of the phenomenon (Van Manen, 1990). Bracketing involves filtering out any biases or presuppositions that the researcher might have in order to view the phenomenon under investigation from a fresh perspective that disallows the researcher's personal imposition of meaning (Patton, 1990). Colaizzi (1978) originally described the Individual Phenomenological Reflection (IPR) procedure where biases and predetermined ideas are brought to awareness and, once recognized, are sloughed off so that their influence on the research process or results is reduced. In effect, bracketing helps to focus the researcher into seeing the original appearance of the phenomena, stripped of conventional definitions, and is often called a purification procedure (Polkinghorne, 1979).

Because phenomenological research ideally strives to "abstain from any preconceptions of hypothetical ideas and instead secure knowledge based solely on empirical expressions of the phenomena" (Wertz, 1990, p.30), bracketing occurs consistently throughout a study in order to achieve this ideal. However, most phenomenologists believe that achieving a pure, unbiased position is an ideal objective

that can never be fully attained because we remain culturally-bound (Polkinghorne, 1979; Valle & King, 1978).

Validity

The phenomenological researcher works at increasing the trustworthiness of the study by ensuring that a credible research process is followed and that the results of this process accurately reflect the participants' experiences. Therefore, depicting the life world of the participants in a truthful and accurate manner is a key factor in achieving a valid phenomenological study. The truth value of a study, in terms of quantitative research, relies on how confident a researcher is in stating that the results of the study accurately depict and reflect the characteristics of the variables or the phenomena under study (Sandelowski, 1986). Deciphering the level of confidence a qualitative researcher can hope to attain regarding the truth value of her research depends upon the credibility of the research process and results and is not determined beforehand according to a priori theories and hypotheses (Polkinghorne, 1982; Guba,1981). Validity in phenomenological research can be determined in a number of ways, such as validity checks, pragmatic and empathic validation, transferability, and juridical validity.

Validity Checks

A credible or valid qualitative study is one that maintains the research context and "preserves the holistic situation" (Guba, p.84). The results of the research must be firmly rooted in the experiences of the participants and remain true to their experiences. Participants are asked to review the information obtained by the researcher to ensure that it is truthful and accurately follows their accounts (Sandelowski, 1986). The validity of this "member check" is described as the "single most important action inquirers can take, for it goes to the heart of the credibility criterion" (Guba, 1981, p. 85).

Pragmatic and Empathic Validity

A researcher must be scrupulous in recording descriptions and carrying on interpretations regarding human experience to the extent that "people having that experience would immediately recognize it from those descriptions or interpretations as their own" (Sandelowski, 1986, p.30). If others who have experienced the phenomena

under investigation, but were not a part of the study, agree with the results, then empathic generalizability is achieved.

Transferability

External validity, from the quantitative perspective, relies on the ability of the researcher to generalize the results from the study sample to a specific population (Nachimias, 1976). However, because the purpose of the qualitative inquiry is to illuminate and not replicate results for the purpose of generalizability, the criterion of transferability or "fittingness" is used (Sandelowski, 1986). If the researcher has made a clear and accurate description of the results, other researchers may judge whether or not the results can be transferred to fit other situations or contexts (Patton, 1990). Ultimately, qualitative inquiry regards each research situation as unique with a particular researcher interacting with a particular participant both embedded in a particular context (Sandelowski, 1986; Guba 1981).

Juridical Validity

In presenting the results of the study, the researcher must provide a rationale for having made her interpretation in the manner that she did and be able to defend her decisions. This type of validity is called juridical validity (Salner, 1986). The researcher should be prepared to defend the results of the study against the scrutiny of others and provide explanations regarding the manner in which the results were arrived at.

CHAPTER FOUR
METHOD

In this chapter the procedures for the study such as ethical considerations, participant selection, the interview process and guide will be discussed. In addition, the process of bracketing undergone by the researcher will be presented. The interpretation and analysis of the data will also be explained.

Ethical Considerations

Ethical approval for this study was obtained from two different sources. A proposal for this study was submitted to the Department of Educational Psychology Ethics Review Committee at the University of Alberta. The committee accepted the proposal on March 30, 1995 indicating that appropriate steps had been taken toward ensuring acceptable ethical practices. A suitable site for conducting this research was the Grey Nuns Hospital. The researcher had previously been involved in an epidemiological study of Dissociation Disorders with clinicians at the Grey Nuns Hospital and potential participants for this study could be obtained at this site. Therefore, the proposal was also submitted to the review board responsible for reviewing research proposals for the Grey Nuns Hospital: The Caritas Health Group Research Steering Committee. After a short presentation made by the researcher to this committee the study was deemed ethically appropriate subject to certain conditions and was approved on April 18, 1995. See Appendix A and B for Ethical forms.

Participant Selection

An investigation aimed at uncovering, understanding, and describing characteristics of dissociative experiences necessitated interviewing participants who had undergone dissociative experiences and were able to articulate them to the researcher. A purposeful sampling technique was therefore used to select people who had experienced incidences of dissociation and could verbalize their accounts. Purposeful sampling allows the researcher to deliberately choose participants who can reveal an in-depth knowledge and insight into the phenomenon under investigation. The particular strategy

of extreme case sampling was used to selectively choose the information-rich cases of people who had experienced the extreme levels of dissociation that characterize Dissociative Identity Disorder.

The head of the Dissociation Disorders Program at the Grey Nuns Hospital in Edmonton assisted the researcher in recruiting participants who fit the criteria of an extreme sample. The selection of participants included the following three criteria:

1) All participants must have previously received a diagnosis of Dissociative Identity Disorder and be currently under the care of a psychiatrist.

2) All participants must have completed the Dissociation Experiences Scale (DES II) and obtained a score of 20 or more, which has been described as suggestive of a DID disorder.

3) All participants must have undergone experiences of extreme dissociation and be able to articulate those experiences to the researcher.

Sample of Participants

In total, five participants were selected. All participants were female with a mean age of 44 years, range = 36-60 years. Each is presently under the care of a psychiatrist. All participants were given pseudonyms to protect their identity and ensure confidentiality. More information about the sample of participants will be provided in chapter six.

Interview Process

The head of the dissociative disorders program at the Grey Nuns Hospital assisted in supervising this study by providing suggestions regarding the interview process: she described ways of introducing the study to the participants and comments regarding the manner in which questions might be asked to elicit comprehensive information. She also briefed the researcher on techniques used to deal with crises should participants react when being interviewed. The researcher expected that the material being discussed by the participants in the interviews would be of a sensitive nature, and therefore a number of strategies were developed to ensure participant's confidentiality and safety. Initially, a preliminary interview was planned in order to allow the participants to become familiar with the researcher and ask any questions about

the study. However, rather than a preliminary interview, participants were introduced to the study by either the director of the program or a psychiatric nurse. These professionals were both familiar with the potential participants and provided them with a brief description about the study and the researcher. After these potential participants agreed to be contacted by the researcher, the researcher phoned them and further elaborated on the purpose of the study and their possible involvement while also answering any of their questions. An interview was then arranged with each participant. All interviews took place at th Grey Nuns Hospital with a psychiatric nurse on call and available to the researcher and her participant in the event of a crisis situation in which assistance was required. Prior to the beginning of the interview, each participant was given a patient information sheet that contained a detailed description of the research and each signed a consent form. See Appendix B for the patient information sheet and the consent form.

In the interest of obtaining a complete and comprehensive understanding of participant's experiences, an intensive, in-depth interviewing strategy was adopted. The aim of this strategy was to allow the researcher a more comprehensive and detailed exploration into participant's perspectives, beliefs, opinions, and experiences. The interviews ranged in length from an hour to two hours. All interviews were audiotaped and later transcribed by the researcher.

Validity Check Meetings

After the researcher had made a preliminary analysis of the data a validity check meeting was arranged with the participants. In this meeting, the participants were asked to review their interview transcripts and the preliminary analysis made by the researcher in order to verify initial results for accuracy and validity. They were also instructed to make corrections and alterations as they deemed necessary. Some minor wording corrections were made. On occasion, the researcher and the participant discussed the descriptive power of a few assigned labels and made alterations to those labels so that they might better fit the participant's experience.

When the researcher had delineated the common and important themes, a second validity check meeting was arranged. The researcher described the common and

important themes that had emerged overall from all participants. All participants agreed that these common themes accurately represented their experiences. The important themes, those which were common to some, but not to all participants, were also mentioned and were accepted. The validity checks of this study were essential in allowing participants the opportunity to reaffirm their ideas and beliefs while also adding information that they had not previously divulged. The validity checks also ensured that the researcher had received and interpreted their information in an accurate and truthful manner. It is important to note that the researcher documented and reported the perceptions and accounts of the participants' experiences as the participants described them; however, it is possible that these perceptions and accounts may not be accurate representations of the real events as they took place.

Bracketing

The important on-going procedure of "bracketing" of personal and culturally-determined biases and assumptions was a continuous and necessary procedure that occurred throughout the research process. Recognizing my own biases and assumptions and their potential influence on the study was an important step toward ensuring that a truthful account of participants' experiences would be made evident. The following is a list of preliminary assumptions and biases that were apparent from the inception of this research project:

1) What influenced my choice in selecting the topic of dissociation?

- A personal counseling experience with a woman who described her experiences of dissociation that piqued my curiosity.
- A short presentation made by a co-worker on the topic of Multiple Personality Disorder.

2) What are my assumptions/expectations about dissociation?

- I assume that dissociation exists on a continuum ranging from mild experiences of dissociation to extreme experiences of dissociation.

- Minor forms of dissociation are common. Most people will have already experienced minor forms of dissociation, such as being heavily absorbed in an activity (e.g., reading a book).

- Dissociation could be considered as a survival technique for people who have undergone severe trauma.

3) What are my assumptions/expectations of people with Dissociative Identity Disorder?

- They will probably have a history of sexual abuse or at least some history of physical or emotional abuse. Generally, I believe that they will have lived through a life filled with trauma and upheaval.

-They will have been depressed at some point in their lives and most likely will have been clinically depressed. May also have received other diagnoses such as: post-traumatic stress, borderline, obsessive-compulsive, manic depressive, or anxiety disorders.

- They will probably have had many encounters with mental health care practitioners (e.g., psychologists, psychiatrists, social workers...) and have been institutionalized at some point in their lives.

- They are likely to have few close friends or intimate relationships. These relationships are likely to be transitory in nature due to the pervasive effects of having DID.

- They are unlikely to have attained more than a high school education because of a lack of structured support to encourage advancement, or even attendance at school.

- They are likely to have either a strong or a nonexistent sense of spirituality.

4) What are my personal fears about studying Dissociative Identity Disorder?

-That participants might switch identities periodically throughout the interview making me nervous and the interviews difficult.

-That participants with DID may not be willing or emotionally able to be involved in the research process.

- That the information received from participants will be so far removed from my experience that I won't be able to understand or interpret it accurately.

Some of the implications of these biases and pre-judgments are as follows:

1) I fear that people who do not conform to my pre-fabricated image of what a person with Dissociative Identity Disorder should be, may invalidate my previous research and my personal experience.

Implication: By overly-emphasizing what I expect to see, I may deny the reality of the participants and disavow their unique experiences. Also, I may question the reliability and validity of my methods and data if I don't encounter the type of experience or information that I had expected to.

2) I have a very strong belief, stemming from my background and my research to date, that my participants will have undergone some form of abuse, particularly sexual abuse.

Implication: If my participants do not describe having undergone abuse, I may be inclined to believe that they have suppressed the memory. I will therefore not be keeping an open perspective to the possibility that Dissociative Identity Disorder can occur without the precursor of abuse (especially sexual abuse).

3) I have predetermined ideas of the types of life experiences and coping strategies that my participants will have encountered.

Implication: If I have already imposed personal categories of experiences and strategies used on my participants, then I enter into the interviews with a mental checklist that is exclusive rather than inclusive. By maintaining a narrow focus, I risk losing the personal context of my participants' stories.

The Interview Guide

An interview guide was created to serve as a basic checklist of questions to ask each participant. The interview guide provided a structure to the interviews by ensuring that particular questions would not be omitted. It also allowed the researcher a certain freedom to veer from the path of pre-determined questions and follow a line of questioning if it proved fruitful in eliciting salient information. Therefore, while the questions were standardized to the extent that the answers would be forthcoming at some

point during the interviews, the flexibility in questioning was important in allowing an exploration into the lived experience of the participant.

A member of the Dissociative Disorders Program at the Grey Nuns Hospital declined to be interviewed for the study but assisted the researcher in formulating the questionnaire. She made comments regarding questions she believed might be considered intrusive and offered suggestions about additional areas that might be important to question. With her assistance a final comprehensive interview guide was formulated.

A particular objective for using the interview guide was an attempt to establish the participant's own description of the term "dissociation". Therefore, many of the questions in the guide were aimed specifically toward deciphering the participant's own language and understanding of the term dissociation. See Appendix C for the interview guide used in the in-depth interviews.

Interpretation and Analysis

A phenomenological research method was used to uncover the structure of the experience of dissociation using the procedure of hierarchical thematic analysis. A schematic view of the analysis follows:

Schematic View of the Hierarchical Thematic Analysis

1. First Level of Individual Analysis:

Interview Transcript→ search for meaning units→ paraphrase of meaning units→ label assigned → First validity check with participants

2. Second Level of Individual Analysis:

Clustering of labels from each participant→ emergence of themes for each participant

3. Between Participant Analysis:

All Participant's themes compared→ emergence of common and important themes → Second validity check with participants.

The following is a list of the procedural steps that were adhered to:

1. This first step involved becoming familiar with the content of the interviews in order to get a sense of them. This step was carried out by listening to the

audiotaped interviews as they were being transcribed, and then reading the interview transcripts, or protocols, a number of times to become familiar with their content.

2. The second step involved a return to the protocols for the purpose of extracting statements that appeared significant in terms of understanding dissociation and Dissociative Identity Disorder. These statements are also referred to as "meaning units" because they convey a particularly important unit of meaning and potentially, will offer insight into the meaning of dissociation.

3. The third step involved translating the meaning units into a paraphrase to ensure the meaning unit was understood in its context. Remaining faithful to the experience and context of the participant meant adhering to their words in the paraphrase as much as possible.

4. The fourth step involved assigning labels to the meaning units and their paraphrases. This step involved the use of insight on the part of the researcher in order to make the leap from what the participants said to what they meant. This insight is important for uncovering and illuminating meaning by ensuring that the assigned label truly was derived from the intended meaning of the participant. Therefore, after a label had been assigned to the lifted unit of meaning, the researcher arranged a first validity check meeting with each participant. The purpose of this meeting was to check that the first level of individual analysis (i.e.: pulling out meaning units, forming paraphrases and ascribing labels) corresponded faithfully to their experiences.

5. In step five the second level of individual analysis occurred. Each participants' labels were organized into more comprehensive themes for the sake of clarity and ease of analysis. The themes were validated by a return to each of the original protocols to ensure that all of the participants' information was accounted for.

6. The final level of analysis involved a between-participant analysis where all of the participant's themes were compared for common and important themes. A

final number of common and important themes resulted. A final validity check was made with participants to ensure that the obtained common themes corresponded to their experiences. The participants were also shown important themes, or themes that were not common to all participants to ensure that all of the information they had given had been considered.

The results of the analysis are discussed in Chapter Five.

CHAPTER FIVE
RESULTS

In this chapter, the three levels of thematic hierarchical analysis for all participants will be presented along with the common and important themes that arise from them. Following the presentation of these results, is a discussion of the common and important themes that emerged from the study.

Hierarchical Thematic Analysis

Composition of Labels

The purpose of thematic analysis is to provide a method of organizing a large amount of data into meaningful themes that can illuminate the phenomenon under study. In assigning labels to meaning units in the first level of individual analysis, it became apparent to the researcher that a number of labels were qualitatively similar and could be included under a broader label for later discussion. For example, the broader label of "Personal Level of Awareness" became an inclusive label for the individual instances of awareness that were evident for all participants.

In the first level of individual analysis for Kate, the label "Personal Level of Awareness" had initially encompassed various types and levels of awareness such as: Initial level of Awareness, Present recognition of past unawareness, Having an enhanced level of awareness, Desire for an increase in awareness, Awareness of alters, Lack of awareness of alters, Split awareness of alters.

In addition, the levels of personal awareness were variable for all participants. The mass of labels that resulted led the researcher to include these levels of awareness under the inclusive label of "Personal Level of Awareness" with the understanding that these various levels of awareness would be compared across participants and later discussed.

Other labels such as "Disclosure, Description of Parts, Suicide, Healing, and Alter Role" were also considered inclusive labels. For example, some participants disclosed

their experiences of abuse to someone, others did not; however, theses experiences were all included under the label of "Disclosure" for ease of organization and were later elaborated in the discussion section.

The method of phenomenology does not include specific rules for analyzing data, but rather provides guidelines. The researcher followed the guidelines and then took independent organizational steps to synthesize the large amount of information into a format that could be more easily interpreted.

An example of the first level of thematic analysis that includes the meaning units, paraphrase and labels from the interviews is presented:

Meaning Unit	Paraphrase	Label
1. I started to remember just about two and a half years ago now and I didn't know what was going on.	Started remembering the abuse about two and a half years ago and was not aware of the what was going on.	-Personal Level of Awareness

An extended example is presented in Appendix D. (Note: The researcher can provide a complete copy to those interested).

In the tables that follow, the three levels of analysis are presented in the succeeding order:

1) A grouping of the meaning units and their labels into the first level of individual analysis.

2) The labels are then grouped into themes for the second level of individual analysis.

3) The common and important themes from all participants are then grouped together for the between participants' analysis.

The information regarding each participant will be presented in the follwoing order: Kate, Roseanne, Ida, Tammy, and Bonnie

Table 1.

First Level of Individual Analysis
Kate

Label	Meaning Unit Number(s)
Abandonment by God	73, 74, 75
Dealing with Multiple Personality Disorder	69
Denial	10
Description of Parts	16, 39, 40, 56
Origination of Parts	62, 63, 64, 65
Diagnosis	26
Disclosure	11
Dissociation As A Gift	82, 84, 85
Dissociation As A Struggle	19, 20
Dissociation As A Survival Tool	73a
Dissociation As Being Taken Away	24a, 37
Dissociation As Being Far Off	21a
Dissociation As Fading Out	15, 18
Dissociation As Sudden	14, 17
Emotional Abuse	32, 33, 54
Fear	29, 52, 57
Fearful of God	72, 77
Awareness of Being Different	2, 4, 5, 29, 30, 87, 88
Healing	46, 49, 86, 90, 92
Hearing Voices	60
High Achiever	28
Impact of Trauma	91, 93, 94
Integration	43, 47, 50, 51, 52, 55
Isolation	70
Losing Time	3, 23, 24, 58
Memory	36, 45
Out of Body Experiences	46a
Parts Frozen	41, 42, 44, 45, 53,
Personal Level of Awareness	1, 3, 6, 8, 22, 23, 25, 29, 30, 38, 41, 42, 43, 48, 49 50, 53, 59, 61, 67, 79, 80, 87
Personal Relationships	12
Physical Abuse	31
Role of Parts	57, 66
Sexual Abuse	7, 31, 34, 54, 55
Shift	78
Spiritual Strength	71, 76
Splitting	35, 37

Table 2.

Second Level of Individual Analysis
Kate

Labels	Theme
Denial, Diagnosis	1. Difficulty In Accepting the Diagnosis of MPD
Healing, Shift	2. Aspects of Healing
Awareness of Being Different	3. Awareness of Being Different
Losing Time	4. Awareness of Losing Time
Dealing with Multiple Personality Disorder, Disclosure, Isolation, Personal Relationships	5. Being Alone in Dealing With MPD
High Achiever	6. Being A High Achiever
Parts Frozen, Description of Parts, Origination of Parts, Role of Parts, Trigger	7. Description of the Parts of the Self
Dissociation As Being Taken Away, Dissociation As Being Far Off, Splitting	8. Dissociation As Being Away
Fear, Fearful of God	9. Feeling Fearful
Hearing Voices	10. Hearing Voices
Impact of Trauma	11. Impact of Trauma
Integration of The Parts of The Self	12. Integration of the Parts of the Self
Out of Body Experience	13. Out of Body Experience
Personal Level of Awareness, Switching, Stress in Childhood, Verbalizing	14. Personal Awareness of Multiple Personality Disorder
Understanding of Dissociation, Dissociation as A Gift, Dissociation As A Survival Tool, Understanding of Multiple Personality Disorder	15. Personal Understanding of Multiple Personality Disorder
Abandonment by God, Fearful of God, Spiritual	16. Relationship With God

Strength	
Memory Emotional Abuse, Physical Abuse, Sexual Abuse	17. Retrieval of Memories 18. Trauma Experiences
Dissociation as Fading Out, Dissociation As A Struggle, Dissociation As Sudden, Tunnel, Variability of Dissociation	19. Variability of Dissociation
Handedness, Physical Appearance	20. Physical Symptoms Associated With MPD

Table 3.

First Level of Individual Analysis

Roseanne

Label	Meaning Unit Number(s)
Absorption	44, 45
Behavior	21, 54
Co-Consciousness	8, 53, 55
Commonality	63, 69
Control	5, 16, 17, 26
Dealing with Multiple Personality Disorder	6, 67, 68
Denial	30, 32, 34
Depression	12, 13
Description of Parts	20, 25, 35, 48, 56
Diagnosis	2, 10, 11, 12, 67a, 73
Disclosure	19, 61, 65, 73, 84
Dissociation As A Spacey Feeling	39
Dissociation As Automatic	42
Dissociation As Escape	41
Dissociation As Numbness	40
Fear	37, 48, 49, 81
Feeling Different	64, 66
Flashbacks	38
Guilt	17
Healing	70, 81
Hearing Voices	51, 71
Integration	59
Intellectually Accepting Diagnosis	33, 36, 37
Internal Communication	24
Isolation	60, 64, 69
Knowledge of Multiple Personality Disorder	10
Losing Time	7
Memory	9, 27, 31, 38a, 57, 80
Parts Blended	53, 58
Parts Hidden	19, 60, 61, 65, 67
Personal Level of Awareness	4, 23, 26, 43, 46, 55, 58, 66
Personal Relationships	72, 79, 82, 83, 84
Physical Changes	46, 85
Self-Abuse	76
Sexual Abuse	38a
Spirituality	77, 78
Suicide	14, 75
Switching	46, 47, 48, 50, 85

Table 4.

Second Level of Individual Analysis
Roseanne

Labels	Themes
Denial, Intellectually Accepting of Multiple Personality Disorder	1. Difficulty In Accepting the Diagnosis of Multiple Personality Disorder
Self-Abuse, Spirituality, Therapeutic	2. Aspects of Healing
Depression, Diagnosis,	3. Being Correctly Diagnosed
Behavior, Description of the Parts, Switching	4. Description of the Parts of the Self
Absorption, Dissociation As An Escape	5. Dissociation As An Escape
Dissociation As Numbness, Dissociation As A Spacey Feeling	6. Dissociation As Numbness
Dissociation As Automatic	7. Dissociation As Occurring Automatically
Fear	8. Feelings of Fear
Feeling Different	9. Feeling Different From Others
Dealing with MPD, Disclosure, Guilt, Isolation, Parts Hidden	10. Feeling Unknown By Others
Hearing Voices	11. Hearing Voices
Co-Consciousness, Internal Communication, Integration, Parts Blended	12. Integration of the Parts of the Self
Control	13. Loss of Control
Suicide	14. No Longer Suicidal
Personal Level of Awareness, Knowledge of MPD	15. Personal Awareness of Multiple Personality Disorder
Flashbacks, Losing Time, Memory, Trigger	16. Retrieving Memories

Commonality, Personal Relationships	17. Support From Others
Physical Symptoms	18. Physical Symptoms associated with MPD
Sexual Abuse	19. Traumatic Experiences

Table 5.

First Level of Individual Analysis

Ida

Label	Meaning Unit Number(s)
Alter Description	4, 31, 32, 33, 39, 49, 55, 68, 79,81, 94, 109, 141, 142
Alter Role	46, 81, 88, 94
Alters As Unique Identities	107, 108, 109
Alters Frozen	38, 80
Anger	19
Anxiety	25, 46
Commonality	102, 123, 124
Confusion	52
Control	51, 73
Counting	13, 14, 16, 34, 57, 146
Crisis	86, 72, 92
Depression	139
Origination of Alters	29, 36, 45, 75, 81, 105, 109
Diagnoses	136, 138
Disclosure	5, 35
Dissociation As Beginning Early	98
Dissociation As Freedom	145
Dissociation As a Release	146
Dissociation As an Escape	7, 10, 123
Dissociation As Creative	104
Dissociation As Letting Mind Go	9, 12, 16
Dissociation As Necessity	101
Domination	58
Emotional Abuse	25, 26
Fear	6, 8, 22, 26, 27, 50, 77
Flashbacks	71, 76
Fragmented	42, 119
Guilt	40
Harmony	90, 93, 95, 96, 97
Integration	108, 110
Internal Communication	63, 82, 83
Healing	112, 129
High Achiever	67
Humiliation	69, 125
Isolation	99
Knowledge of Multiple Personality Disorder	120, 122
Losing Time	60, 62

Table 6.

Second Level of Individual Analysis

Ida

Labels	Themes
Personal Level Of Awareness	1. Awareness of Alter Personalities
Healing, Medications, No Satanic Abuse, Safety, Spirituality, Therapeutic	2. Aspects of Healing
High Achiever	3. Being A High Achiever
Alters As Unique Identities, Harmony, Integration	4. Creating Harmony Between Alter Personalities
Alter Role, Internal Communication, Alter Description, Alters Frozen, Origination of Alters, Splitting	5. Description of Alter Personalities
Depression, Diagnosis	6. Difficulty in Being Diagnosed Correctly
Counting, Dissociation As An Escape, Dissociation As Freedom, Dissociation As A Necessity, Dissociation As A Release, Dissociation As Beginning Early	7. Dissociation As An Escape
Dissociation As Creative,	8. Dissociation As Creative
Dissociation As Letting Mind Go	9. Dissociation As Letting Mind Go
Disclosure, Isolation, Personal Relationships, Secrets	10. Feeling Alone With Multiple Personality Disorder
Anger	11. Feeling Angry
Fear	12. Feeling fearful
Fragmented	13. Feeling Fragmented
Confusion, Guilt, Humiliation, Self-Blame, Shame, Valueless	14. Feelings of Shame

Commonality	15. Feeling Validated
Crisis, Domination, Self-Abuse, Anxiety, Fragmented	16. Impact of Trauma
Losing Time	17. Losing Time
Out Of Body Experiences, Tunnel	18. Mental Tunnel Image As An Escape
Control, Flashbacks, Memory, Repression	19. Repressing Memories
Sexual Abuse, Emotional Abuse	20. Trauma Experiences
Suicide	21. Suicide
Understanding of MPD, Knowledge of MPD, MPD As Creative	22. Awareness and Understanding of MPD

Table 7.

First Level of Individual Analysis

Tammy

Label	Meaning Unit Number(s)
Accepting Multiple Personality Disorder	8, 10, 14, 43, 44, 67
Alter Description	15, 40, 44, 53, 56, 83
Alter Role	16, 18, 49, 50, 55, 60, 61, 68, 111
Alter Stuck	52, 54
Anger	75, 96
Co-Consciousness	38, 70
Communication	41, 42, 86, 111
Control	5a, 73, 107
Dealing with Multiple Personality Disorder	31
Denial	7, 43
Depression	5
Diagnoses	4
Disclosure	31, 32
Dissociation As Survival	16, 17
Dissociation Not a Conscious Thing	19
Emotional Abuse	51
Fear	34
Frustration	99, 104, 105, 108,
Grounding	58, 76, 110, 112
Healing	34, 62, 64, 68, 69, 72, 82, 89, 114, 115
Hearing Voices	3, 84, 85
Hypnosis	24, 35
Integration	63, 70, 71
Isolation	29, 91
Knowledge of Multiple Personality Disorder	6, 12, 87, 93
Memory	24, 26, 27, 36, 39, 61, 89, 90
Out of Body Experiences	20, 21, 22, 25
Personal Level of Awareness	2, 3, 13, 21, 22, 30, 33, 37, 57, 59, 66, 72, 79, 80, 84, 97,
Personal Relationships	94, 95
Physical Symptoms	88, 89, 90
Secret	46, 102
Sexual Abuse	51
Shame	11
Spirituality	91, 92
Splitting	23
Suicide	46, 47, 48, 81
Switching	107

Table 8.

Second Level of Individual Analysis

Tammy

Labels	Themes
Accepting Multiple Personality Disorder, Denial, Diagnoses, Shame, Trust	1. Difficulty In Accepting the Diagnosis of MPD
Communication, Grounding, Healing, Hypnosis, Personal Relationships Spirituality, Therapeutic	2. Aspects of Healing
Control, Switching	3. Being In Control
Suicide	4. Being Suicidal
Alter Description, Alter Stuck	5. Description of Alter Personalities
Dissociation Not A Conscious Thing, Out of Body Experiences, Splitting	6. Dissociation As An Out of Body Experience
Anger, Depression	7. Feelings of Anger
Hearing Voices	8. Hearing Voices And Believing Others Could Too
Co-Consciousness, Fear, Integration, Wholeness	9. Integration of the Parts of the Self
Dealing with Multiple Personality Disorder, Disclosure, Isolation, Secrets	10. Isolation As Protection
Knowledge of Multiple Personality Disorder, Personal Level of Awareness,	11. Personal Awareness and Understanding of Multiple Personality Disorder
Physical Symptoms	12. Physical Symptoms Associated with Multiple Personality Disorder
Frustration, Others Understanding of Multiple Personality Disorder	13. Professional and Others Understanding of Multiple Personality Disorder
Alter Role, Dissociation As Survival	14. Protective Role of Alter Personalities

Memory, Triggers	3'. Retrieving Memories
Emotional Abuse, Sexual Abuse	4). Trauma Experiences

Table 9.

First Level of Individual Analysis
Bonnie

Label	Meaning Unit Number(s)
Anger	40, 41
Behavior	68
Control	28, 45
Denial	14, 18, 123
Depression	15, 45, 78
Description of Parts	29, 50, 57, 59, 60, 62, 63, 64, 66
Disclosure	16, 41, 43, 111, 119
Dissociation As a Natural Phenomenon	4, 7, 8, 26, 101, 102, 115
Dissociation As a Survival Tool	5, 31, 103
Dissociation As Another Sphere	10
Dissociation As Automatic	10, 96
Dissociation As Comfortable	94
Dissociation As Coping	37
Dissociation As Floating	97
Dissociation As Going Away	6, 11, 70, 95
Dissociation As Harmful	13, 104
Dissociation As Helpful	107
Emotional Abuse	38
Healing	18, 24, 41, 54, 55, 72, 76, 83, 90, 93, 105, 108, 124
Hearing Voices	83
High Achiever	75, 82
Hypnosis	116, 117, 118
Impact of Trauma	39, 42
Integration	19, 29, 30, 47, 65
Isolation	34, 77
Knowledge of Multiple Personality Disorder	106, 122, 123
Losing Time	12, 27, 70
Memory	21, 23, 44, 46, 52, 53, 110, 112, 113, 121
Origination of Parts	62
Out of Body Experiences	99, 100
Parts As Unique Identities	58, 67
Personal Level of Awareness	9, 17, 22, 23, 28, 48, 49, 80, 83a, 92
Personal Relationships	33, 56, 69, 71, 72, 79
Physical Abuse	109
Physical Symptoms	25, 83a
Professional Understanding of Multiple	2, 3

Table 10.

Second Level of Individual Analysis
Bonnie

Labels	Themes
Healing, Spirituality, Therapeutic	1. Aspects of Healing
Impact of Trauma, Knowledge of Multiple Personality Disorder, Personal Level of Awareness, Understanding of Multiple Personality Disorder, Shift, Verbalizing	2. Awareness And Understanding of Multiple Personality Disorder
High Achiever	3. Being A High Achiever
Disclosure, Isolation, Secrets, Trust	4. Dealing With Multiple Personality Disorder Alone
Denial	5. Difficulty In Accepting Diagnosis of MPD
Control	6. Having No Control
Depression	7. Depression
Description of Parts, Origination of Parts, Parts as Unique Identities, Splitting	8. Description of the Parts of the Self
Integration, Personal Responsibility	9. Difficulty With Integrating the Selves
Dissociation As Automatic, Dissociation As Another Sphere	10. Dissociation As Automatic
Dissociation As A Natural Phenomenon, Understanding of Dissociation	11. Dissociation As A Natural Phenomenon
Dissociation As A Survival Tool, Dissociation As Coping	12. Dissociation As A Survival Tool
Hypnosis	13. Dissociation As Different from

Out of Body Experiences	Hypnosis 14. Dissociation As Different From Out of Body Experiences
Dissociation As Going Away, Dissociation as Floating, Dissociation As Comfortable, Dissociation As Helpful, Dissociation As Harmful	15. Dissociation As Going Away
Anger	16. Feeling Angry
Suicide	17. Experiences of Suicide
Valueless	18. Feeling Valueless
Hearing Voices	19. Hearing Voices
Personal Relationships	20. Impact of Multiple Personality Disorder on Personal Relationships
Behavior, Physical Symptoms	21. Physical Symptoms Associated with Multiple Personality Disorder
Professional Understanding of Multiple Personality Disorder	22. Professional and Other's Understanding of Multiple Personality Disorder
Memory, Losing Time	23. Retrieving Memories
Emotional Abuse, Physical Abuse, Sexual Abuse	24. Trauma Experienced

The common and important themes from all participants are now presented.

Table 11.

Common Themes
Between Participant Analysis

Common Themes	Participant	Cluster of Themes
1. Experiences of Severe Trauma	Kate	Impact of Trauma (11)
		Trauma Experiences (18)
	Roseanne	Trauma Experiences (19)
	Ida	Impact of Trauma (16)
		Trauma Experiences (20)
	Tammy	Trauma Experiences (16)
	Bonnie	Trauma Experiences (24)
2. Recognition of Something Being Wrong	Kate	Awareness of Being Different (3)
		Personal Awareness of Multiple Personality Disorder (14)
		Out of Body Experiences (13)
		Variability of Dissociation (19)
	Roseanne	Feeling Different From Others (9)
	Ida	Feeling Fragmented (13)
	Tammy	Personal Awareness and Understanding of Multiple Personality Disorder (12)
		Dissociation As An Out of Body Experience (6)
	Bonnie	Awareness and Understanding of Multiple Personality Disorder (2)
		Dissociation As A Natural Phenomena (11)
3. Escape from Pain	Kate	Dissociation As Being Away (8)
		Personal Understanding of Multiple Personality Disorder (15)
		Variability of Dissociation (19)
	Roseanne	Dissociation As An Escape (5)
		Dissociation As Numbness (6)
		Dissociation As Occurring Automatically (7)
	Ida	Dissociation As An Escape (7)
		Dissociation As Creative (8)
		Dissociation As Letting Mind Go (9)
		Mental Tunnel Image As An Escape (13)
	Tammy	Personal Awareness and Understanding of Multiple Personality Disorder (12)

	Bonnie	Dissociation As Automatic (10) Dissociation As A Survival Tool (12) Dissociation As Going Away (15)
4. Disruptions in Time:	Kate	Awareness of Losing Time (4) Retrieval of Memories (17) Personal Awareness of MPD (14)
	Roseanne	Retrieving Memories (16)
	Ida	Losing Time (17) Repressing Memories (19)
	Tammy	Retrieving Memories (15)
	Bonnie	Retrieving Memories (23)
5. Experiencing Isolation	Kate	Being Alone in Dealing with Multiple Personality Disorder (5)
	Roseanne	Feeling Unknown by Others (10) Support From Others (17)
	Ida	Feeling Alone with Multiple Personality Disorder (10)
	Tammy	Isolation as Protection (10) Aspects of Healing (2)
	Bonnie	Dealing with Multiple Personality Disorder alone (4) Impact of MPD on Personal Relationships (20)
6. Cooperation Between Alter Personalities	Kate	Integration of the Parts of the Self (12)
	Roseanne	Integration of the Parts of the Self (12)
	Ida	Creating Harmony Between Alter Personalities (4)
	Tammy	Integration of the Parts of the Self (9)
	Bonnie	Difficulty with Integrating the Selves (9)
7. The Importance of Healing	Kate	Difficulty in Accepting the diagnosis of Multiple Personality Disorder (1) Aspects of Healing (2)
	Roseanne	Difficulty in Accepting the diagnosis of Multiple Personality Disorder (1) Aspects of Healing (2)
	Ida	Aspects of Healing (2)
	Tammy	Difficulty in Accepting the diagnosis of Multiple Personality Disorder (1) Aspects of Healing (2)

	Bonnie	Aspects of Healing (2) Feeling Validated (15)
8. The Roles of Alter Personalities	Kate	Description of the Parts of the Self (7)
	Roseanne	Description of the Parts of the Self (4)
	Ida	Awareness of Alter Personalities (1) Description of Alter Personalities (5)
	Tammy	Description of Alter Personalities (5) Protective Role of Alter Personalities (14)
	Bonnie	Description of the Parts of the Self (8)
9. Experienc of fear	Kate	Feeling Fearful (9) Relationship With God (16)
	Roseanne	Feelings of Fear (8))
	Ida	Feeling Fearful (12)
	Tammy	Integration of the Parts of the Self (19)
	Bonnie	(Personal Communication)
10. Suicidal Experiences	Kate	(Personal Communication)
	Roseanne	No Longer Suicidal (14)
	Ida	Experiences of Suicide (21)
	Tammy	No Longer Suicidal (4)
	Bonnie	Experiences of Suicide (17)
11. Desire for Understanding and Acceptance	Kate	Personal Understanding of MPD (15)
	Roseanne	Support From Others (17)
	Ida	Awareness and Understanding of MPD (22)
	Tammy	Professional and Others Understanding of MPD (13)
	Bonnie	Professional and Others Understanding of MPD (22) Aspects of Healing (1) Awareness and Understanding of MPD (2)

Table 12.

Important Themes
Between Participant Analysis

Important Themes	Participant	Cluster of Themes
1. Hearing Voices	Kate	Hearing Voices (10)
	Roseanne	Hearing Voices (11)
	Tammy	Hearing Voices and Believing Others Could Too (8)
	Bonnie	Hearing Voices (19)
2. Being a High Achiever	Kate	Being A High Achiever (6)
	Ida	Being A High Achiever (3)
	Bonnie	Being A High Achiever (3)
3. Difficulty in Being Properly Diagnosed	Ida	Difficulty in Being Properly Diagnosed (6)
	Roseanne	Being Diagnosed Correctly (3)
4. Physical Symptoms Associated With MPD	Roseanne	Physical Symptoms Associated With MPD (18)
	Kate	(Personal Communication)
	Tammy	Physical Symptoms Associated With MPD (12)
	Bonnie	Physical Symptoms Associated With MPD (21)
5. Looking for Control	Roseanne	Loss of Control (13)
	Tammy	Being in Control (3)
	Bonnie	Having no Control (6)
6. Feelings of Anger	Ida	Feeling Angry (11)
	Tammy	Feelings of Anger (7)
	Bonnie	Feeling Angry (16)
7. Feelings of Shame	Ida	Feelings of Shame (14)
	Tammy	Difficulty in Accepting the Diagnosis of MPD (1)
8. Feeling Worthless	Ida	Feelings of Shame (14)
	Bonnie	Feeling Valueless (18)

Table 13.

Emergent Themes

Common Themes	Important Themes
1. Experiences of severe trauma	1. Hearing voices
2. Recognition of something being wrong	2. Being a high achiever
3. Escape from pain	3. Difficulty in being properly diagnosed
4. Disturbances in time	4. Physical symptoms associated with DID
5. Experiencing isolation	5. Looking for Control
6. Cooperation between alter personalities	6. Feelings of Anger
7. The importance of healing	7. Feelings of Shame
8. The roles of alter personalities	8. Feeling Worthless
9. Experiences of fear	
10. Suicidal Experiences	
11. Desire for understanding and acceptance	

Results of the Analysis

In this study understanding the phenomenology of dissociation has meant understanding the pre-reflective experiences and elemental meanings that characterize dissociation. Participants' experiences were analyzed through a process of hierarchical thematic analysis. Thematic analysis refers to "the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the work" (Van Manen, 1990, p. 78). The thematic analysis is an attempt at deciphering the meaning of dissociation for the purpose of illustrating and clarifying the structure of the phenomena.

The individual manner of both the participant who describes the phenomena and the researcher who analyses the information are important points to consider when determining the structure of experience. Each of the participants revealed their experiences of dissociation to the researcher in a particular way. In turn, the researcher perceived and analyzed the information from a distinct vantage point. The structure of experience is therefore somewhat variable dependent upon how it is elicited and analzed. Valle and King (1978) describe the variability of the phenomena under study as analogous to an ever-changing crystal. A crystal will reveal an assortment of colors and intensities of light depending upon the amount of light reflected on it, the clarity of the surroundings, and the angle from which the light strikes the crystal. However, as well as variability, a consistent structure to experience may emerge. For instance, a consistency in the crystal's appearance or its structure can become known after repeated observations of its varied appearances. As Van Manen (1990) indicates, phenomenological themes may be best understood as structures of experience that, in combination, reveal the content of the phenomena. Just as the structure of the crystal can become known, the structures of experience that make up dissociation can also become known and be revealed through the process of thematic analysis. An attempt is therefore made to capture the lived experience of dissociation by uncovering the structures that make up the experience of that phenomenon and presenting the structures in thematic form.

There will always be varying, yet compatible themes that can arise from other researcher's accounts of the structures of the experiences under study (Wagner, 1983). This occurrence is not unexpected and rather serves to further illuminate the phenomena. An attempt was made to capture the common lived experiences of the participants in relation to the phenomena of dissociation. Therefore, the common themes should reflect the information provided by the participants and illuminate the nature of dissociation.

The thematic analysis consisted of a number of steps. Each participant's interview was transcribed verbatim by the researcher. They were then analyzed with three levels of individual analysis taking place. A between participant analysis was subsequently undertaken to reach eleven common themes and eight important themes for all participants.

Common Themes

1. Experiences of severe trauma
2. Recognition of something being wrong
3. Escape from pain
4. Disturbances in time
5. Experiencing isolation
6. Cooperation between alter personalities
7. The importance of healing
8. The roles of alter personalities
9. Experiences of fear
10. Suicidal Experiences
11. Desire for understanding and acceptance

Biographical Description of Participants

Roseanne

Roseanne is a forty-three year old woman who is married and has two twin daughters. She has seen psychiatrists and therapists since she was seventeen years old. She was diagnosed with Dissociative Identity Disorder three years ago. Her previous diagnosis was most often depression and she is presently on anti-depressant medication.

She has been in therapy for ten months. She is a voracious reader and had read *The Three Faces of Eve* prior to being diagnosed. She was aware of Dissociative Identity Disorder before being diagnosed and was not surprised at being given the diagnosis. Intellectually, she accepts the diagnosis, but emotionally, she realizes the difficulty of the therapy and denies the diagnosis to a certain extent. She is not taking any medications. She is presently unemployed.

Ida

Ida is a sixty-year old woman who is married and has three sons. She is a retired school teacher. Over the years she has received many different diagnoses spanning from depression, epilepsy, to brain tumors. She was given the wrong medications and was hospitalized for these erroneous illnesses. She received the diagnosis of Dissociative Identity Disorder two years ago and has been undergoing therapy with her psychiatrist and a therapist since that time. The information that she has read about Dissociative Identity Disorder was information given to her by her therapist. Prior to reading this information, she had no knowledge of Dissociative Identity Disorder. She is presently on a number of medications including an anti-depressant, anti-anxiety, blood pressure medication, and premerin for her hysterectomy.

Kate

Kate is a thirty-six year old woman who is married with two children. She is presently five months pregnant. She was diagnosed with DID two years ago and began reading extensively about the disorder when she was diagnosed but found the information overwhelming and stopped reading. She experienced a lot of denial and struggled with having DID. She does not speak to many people about DID and very few people know that she has DID. She has been previously hospitalized. She has previously been on medications for DID, but does not like using medications. Presently, she is not on any medications. Kate is a family physician.

Tammy

Tammy is a forty-one year old woman who is twice divorced and presently in a common-law relationship. She has had many diagnoses over the years, the most common

being that of depression. She has two children. She was diagnosed with Dissociative Identity Disorder five years ago and has been in therapy since that time. She has been previously hospitalized. Her previous knowledge of Dissociative Identity Disorder includes the movie *Sybil* and other popular media shows on Multiple Personality Disorder. She had great difficulty in accepting her diagnosis. She occasionally still finds the diagnosis difficult to accept but now speaks freely about the diagnosis and the implications it has had on her life. She is presently unemployed.

Bonnie

Bonnie is a forty-four year woman who is married and has two daughters. She has received many diagnoses over the years and although she was not aware of the names of the given diagnoses, most often she was told that she was depressed. She has been previously hospitalized. She was given her diagnosis approximately five years ago and she still sees her psychiatrist on a quarterly basis. She is using asthmatic and pancreatic medication. She speaks openly about her diagnosis and her family is aware of it. However, at first she completely denied the diagnosis of Dissociative Identity Disorder and spent a number of years overcoming the denial and learning to accept the diagnosis. She is a voracious reader and knew about the books on Multiple Personality Disorder prior to her diagnosis, but felt unable to read them. She is now able to read this information because she has completed her therapy. She is a health care worker who is presently employed.

Composition of the Themes

Each one of these common themes is discussed in relation to the contribution of experiences made from each participant. Together, these experiences are merged to reveal a commonality of experience for all participants. The common themes are individually presented and explained using the comments made by the participants. Different themes are also discussed. These important themes include experiences that were not common to all participants but nonetheless are of importance in shedding light on the overall understanding of the phenomena of dissociation.

Common Themes

1. Experiences of severe trauma

All participants had undergone experiences of severe trauma. Tammy explained that she definitely experienced emotional abuse and had also experienced body memories related to physical abuse, "So at times, memories of an event will trigger aching in my teeth. I've had numbness in my face, my arms, my legs, but that comes from beating." However, in regards to sexual abuse she states, " I have no memory of any sexual abuse as of yet. I mean it could possibly be there, I don't know." In a similar manner, Roseanne had amnesia for periods of her childhood and adolescence. She is also still in the process of uncovering past memories of suspected abuse. As Roseanne states, "We do know that my oldest sister was sexually abused by various people...just knowing that she remembers makes it seem more reasonable that I do have memories like that I just don't let them out." Therefore, despite lack of recall for past incidences of severe trauma, the participant believes that such incidences did in fact occur.

Ida, Bonnie, and Kate had all been subjected to severe incidences of abuse. The severity of the abuse was based upon 1) the age of onset when the abuse occurred, which in this case was either prior to or at the age of two years old 2) the number of abusers (more than one in some instances), and 3) the descriptions of the cruelty involved. As Kate described one of her abuser's, "he seemed to take a lot of pleasure in just being mean for the sake of being mean." Often this abuse included sexual abuse.

2. Recognition of something being wrong

The underlying common experience of something not being right was originally discovered through the differences in participants personal levels of awareness about dissociation. Discovering a common theme of experience for the participants by wading through their differences in personal experience appears paradoxical; however, despite the differences in personal experiences of dissociation, a previously unspoken feeling of something being amiss was apparent from each participant. Arriving at this theme entailed following the separate and different understandings of each participant. For example, three of the five participants initially believed that all people dissociated. They

had no realization that their level of dissociation was unusual or different from others. In discussing dissociation, Kate stated, "you just don't realize other people aren't like that...it's how you grow up and who you are and it's not, you don't see it as different." In a similar manner Tammy explained, "I didn't realize that things that were happening to me didn't happen to everybody." Bonnie's experience of dissociating was similar, "I just thought everybody could do it." These three participants assumed that their experiences of dissociation were similar to other people and did not, at that time, question their own extreme levels of dissociation.

In contrast, Ida and Roseanne both recognized that their experiences of dissociation indicated something was different with them. Roseanne stated, "I just knew I was different" and Ida similarly explained, " I had no knowledge of anybody else doing this." However, for all participants, there was a mutual recognition at some point in time and at some level, that something was wrong. Whether or not they recognized that they were experiencing an unusual or different level of dissociation from others, this ubiquitous feeling of something not being right pervaded all participants experiences.

3. Escape from pain

Dissociation was described by all participants as a method of escape. Each participant described the actual process of dissociation in similar, though distinctive manner. At times, the dissociative process of escaping was the avenue through which other parts or alter personalities would be allowed access to emerge thereby escaping from experiencing the underlying trauma. Sometimes the escape through dissociation occurred automatically and sometimes it occurred slowly. Despite the variability of manner of dissociation, it was apparent that dissociation was an avenue of escape from pain for the participants.

Roseanne stated that dissociation was, "It's like an escape when you can't escape, you have to be there, so I just go." In Roseanne's experience, dissociation occurs automatically, "It's generally when I've reached kind of an overload point. It just happens, it's not something that I do deliberately." She further describes dissociation as, "I'll feel myself close off, you know, my ears get kind of muffled, unfocused on the wall,

something like that, it's kind of a spacey feeling" and " I'm still there but I'm not listening, I'm not taking in anything...It's kind of like slipping into numbness."

Ida explained that dissociation was an escape that she used during abusive episodes, " So, when my Granddad's games really were hurting then I could just let my body go. My mind and each body part didn't hurt." Ida developed a mental tunnel that she could slip into when undergoing periods of severe trauma, "I developed a mental tunnel...a place to hide." She further describes, " I learned to count, as I counted my body would rise out the tunnel and then I could be hiding in the tunnel....I counted, the counting got me into that state where I could dissociate." In describing the idea of the tunnel as an image for escaping, she explains,

> ...the tunnel was not an impossibility, it seemed to be an O.K. escape within the realm of possibility of my thinking. And then it just was so comfortable and reassuring that it never changed even though now I'm an intelligent person who knows that this is impossible, but it's not impossible?

For Ida, dissociation meant being able to completely escape so that her body would no longer feel any pain. Dissociation was viewed as a feeling of freedom, " It's a euphoric feeling of free. You have a sense of pain...it dissipates." Ida also explains how helpful and necessary dissociation was for her, "And it was just an appropriate necessity because of the trauma that I was experiencing" and " It was a very creative necessity which has served me well."

Kate, Tammy, and Bonnie all felt that if they hadn't dissociated they might not be alive today. Kate stated, " If I couldn't have dissociated I probably would have died in the midst of it." Bonnie stated, "If I hadn't had that I probably wouldn't have made it out of childhood, so it was a good tool for me. A survival tool." Tammy explains how dissociating and having another person take the pain helped her to survive, " I know within myself that if it wasn't for me creating these personalities, that I'm sure I would be dead."

Through the protection of her alter personalities, Tammy further describes how she escaped her trauma, "they have protected me, they've taken the pain, they've taken the agony, they've taken the hurt." In elaborating on the process of dissociation, Tammy describes an incident of automatically escaping a traumatic time, "I was up in the corner of the ceiling watching myself and my daughter having this huge massive argument and I was up there in the corner, but there was nothing I could do. And so it's like an out of body experience." In a similar manner to Tammy, as a child Kate also escaped trauma by removing herself from it. Kate metaphorically described how she was taken away by an angel while an alter took her place and underwent the abuse. From a child's viewpoint, Kate describes how she was removed from the abusive situation by an angel, "when it happened, it was just like flying away, like letting an angel come and take the part that remembered...and then afterwards, the angel would bring the little girl who remembered back." By leaving or escaping from the trauma through dissociation, she escaped from any memory of it, "I [illegible] that I had been away, like I'd dissociated." Similar to Ida's tunnel experience, Kate also explained that she returned from dissociation through a tunnel experience, "Its' like being at the end of the tunnel and I want to get to the other end of the tunnel to come back."

Echoing both Roseanne and Tammy's accounts of dissociation as automatic, Kate described the protective mechanism of dissociation as either a quick retreat from pain, or a gradual feeling of fading away, "Sometimes it's just like someone turning the light on and the light off, it just happens quick" and "Other times, it's almost, you can feel it coming along like a wave and you can feel yourself sort of almost fading out." For Kate, the time lapses involved in dissociating depended upon the part that was emerging,

> Parts that are much stronger can do the light switch thing and very suddenly making things disappear...Ones that are younger aren't as powerful or tend to, I feel more it coming on a wave kind of thing, just sort of fading, fading out.

Bonnie also found the experience of dissociation as an automatic escape from pain, "I do it automatically if I start to have pain. It's almost like a turning of the head

and you're in another sphere and you carry on." Similar to others' experiences she states, "I just go away. I think of it just as being somewhere else." In agreement with Ida, Bonnie also experienced the comfort of escaping through dissociation , "It's a nice feeling, it's very comforting, it's comfortable...so it's a nice feeling of floating almost."

4. Disturbances in time

All participants had experienced some form of disruption in time. This disruption was diversifly characterized by participants as memory lapses, gaps in time, periods of amnesia, total blackouts, and a lack of recall for childhood and/or adolescent memories. These time disturbances were further described by participants as having occurred either long ago in the past, more recently, or in the present.

Both Roseanne and Bonnie initially explained that they had not experienced any recent losses in time. Roseanne stated, " Even when I'm not in control, I don't have days where you don't have any memory or I don't find myself in places that I don't know how I got there." Bonnie also stated, " I don't lose any time, I just lose that part of my body that hurts." However, an uncertainty over whether or not periods of time had been missed emerged gradually through the interactions with the participants. In a third meeting with Roseanne, she conceded that recently she may have been missing short bursts of time, a matter of minutes here and there. Bonnie also displayed some uncertainty about disruptions in time by stating, " I don't think I'm missing any time...I don't think I've lost any time in a year." Becoming aware of personal disruptions in time is difficult because one has to be aware of not being aware. Ida explained, " I didn't know that I didn't know...I didn't realize." One has to be aware of disruptions in time before knows that one has been subjected to those disruptions.

Roseanne described an incident where a disruption of time occurred because an alter personality had assumed control, "I don't know when I come back to myself after she's been out. I don't remember what I said or what I did. It's very fuzzy, blurry, I know I was there, I know I scratched and kicked, hit, bit, swore and all that, but I don't know, I can't get a sense of details."

Ida also discussed the necessity of protecting the self through periods of amnesia and as a result would lose the painful memories, " I totally forgot, see it became necessary. And I still have amnesia, although I'm regaining some of this stuff." She also describes how she has presently become aware of losing time, "I knew I was losing time. I didn't know what happened. I'm still like that. Not as badly." For Ida, disruptions of time also meant that certain personalities would remember events while she remained unaware of them, "I couldn't really handle it so I just forgot it. I was able to leave it with, the memories with Janet. Janet stored all the memories of it, and I didn't remember any of it." At the present time, Ida is unaware of what one of her alter personalities, Janet, does, "when Janet comes out now, I can't remember what she does at all. I have no memory at all of her behavior."

Kate found loss of time to be a matter of awareness as well, "But I think the main thing with losing time is that you're not aware of it. Like I wasn't aware of how much time I was losing." Gaps in time are also apparent, " But there are times, like with journaling or different things that like, afterwards there's absolutely no recollection of what's been written or whatever." Losing time was also seen as a way to evade painful memories, " I mean at times, it is easier when you just lose time, you know, you come back versus you working hard to explain things."

Tammy described her memory loss as, "Initially there was nothing, it was like I had gone to sleep and I woke up, so there was the memory loss." One of Tammy's alter personality's protects her from painful memories, " He doesn't want her to remember all of the traumas that she's had, he wants her just a happy little girl." She also mentions experiencing a blackout, "But I've had an experience in April where, total blackout." Becoming aware of the disruptions in time, Tammy has been, on occasion, triggered to past memories by sensations in her body, "So at times, memories or an event will trigger aching in my teeth." Memories emerge in other forms as well, "...memories come to me like pictures, like movies in my head and that's how I usually get a memory."

In a similar manner to Ida, Bonnie explains how her awareness for certain memories of events were dependent upon which personalities were present for the

events, "I used to miss a lot of stuff I guess, or parts of me had it and parts of me didn't" she continues, "And when you can't remember things or you lose space...you have no idea." For Bonnie, the retrieval of memories is also dependent on the age in which the memory was encoded, "...my first memory picture was sepia colors. Some now are coming back in black and white, so it's funny how the colors in the memories are all different, must be what I captured at the time."

5. Feeling isolated and alone

As a result of having DID and experiencing incidences of dissociation, all participants have additionally experienced some form of isolation. The form of isolation differs among participants but is usually extensive. The circumstances of isolation range from feeling alone in one's knowledge of having DID, dealing with the effects of the disorder by oneself, or ensuring that one remains isolated as a form of protection.

Roseanne's isolation involved keeping the parts of herself a secret in order to avoid rejection,

> I felt isolated before I found out I had DID because I knew I was different...I knew that there were parts of me I had to hide...It's kind of like you've got to keep parts hidden or be an outcast.

She further described how she became adept at hiding the parts, "one thing we've discussed in group is how good we get at hiding it. Hide the parts that are not acceptable." Because of Roseanne's fear of rejection and her need to hide parts of herself, she felt unknown by others, "...you feel like nobody ever really knows you because if anybody does know you, it's only a part of you, they don't know the rest." Therefore, Roseanne expressed relief upon realizing that she was not alone with DID, "It was reassuring though to see, to meet other people with the same diagnosis, you know, to realize that they look as normal as you do."

Ida described experiencing isolation in terms of secrecy, "I had these secrets from myself and from my husband, my kids, my community." Ida also felt alone in dealing with DID because she did not know anybody else suffered as she did. Only until fairly recently did Ida become aware of others similarly afflicted with DID. She began therapy,

joined a group for people with Dissociative Identity Disorder, and read information about the disorder, " It's very reassuring to find yourself in print because you suddenly don't feel so isolated, such an oddball...And it's reassuring because we feel weird."

Tammy also viewed isolation and secrecy as forms of protection, " ...this whole thing about all this protection in here, that nobody should ever find out, especially me, especially the host." She describes how she withdrew, " I completely withdrew...I just completely hid from the world". She further described how she then became proficient in hiding the disorder, " And you become adept at covering it up...I could hide it." More recently, Tammy has had the support of her family which helps in easing the pain of isolation by dealing with DID alone.

Kate had not discussed her disorder with many people, "I really don't talk with anybody about this...I don't talk about it." Although, as with Tammy, she has also become skilled at hiding the disorder, "I've gotten better at just sort of fast footing...I think I've become a bit more adept at doing that and I can fake it." Overall, Kate has been alone in dealing with the disorder although, "I've gotten to know a couple of people and they had a group that they ran for multiples and I went to that for awhile."

In contrast, Bonnie has spoken to many people quite freely about the disorder, "I talk quite freely about it because I think people need to hear more" although, similar to Roseanne, she remains isolated by protecting herself from becoming completely known, "Nobody knows the whole story about me and I think that's a protector process I go through." Unlike the other participants who are members of a group for people with DID, Bonnie had not met anyone else with the same disorder, "I've not met another Multiple Personality Disorder, maybe through work, but no, I don't know anybody else." In terms of family support, her father has shown concern, but her husband, "...hasn't got much knowledge of what went on with me because he didn't want to know, he just wanted me to get better". Overall, Bonnie has felt isolated in having the disorder and in healing from it, "I have totally felt alone through all of the process."

6. The process of integration as cooperative

Discussions regarding integration involved participants describing how the alternate personalities or parts were perceived by them and how these parts reacted to the idea of integration. All participants held a particular view on the idea of integrating their alter personalities dependent upon their view of the separateness of their parts. Overall, a sense of cooperation between alter personalities, not complete integration into one total and complete personality, prevailed and was viewed as an ideal goal.

Roseanne describes her different parts as, "They're all kind of blended...I don't have different parts with different names that don't know each other" and "So I may find at some point that there are different parts of me with different names, but at this stage I've kind of labeled the part but I don't feel like it's a separate part." Therefore, Roseanne finds that her parts are not separate and distinct from herself and yet the type of parts that are Roseanne are quite varied and affect the integration process, "...it's kind of hard to integrate one that has no morals with on that's a saint. I mean hopefully it will meet somewhere in the middle where I'm not either totally rigid nor without values."

In describing her alter personalities, Ida states, "...they are all clearly defined. They are total identities in themselves. They are not just fragments...I can't visualize losing these alters." For Ida, the idea of becoming one total personality is not desirable, instead she describes herself as a system of parts that are melded together, "...this shows the system sort of getting it together, we're getting more melded." However, this melding of the alter personalities is different than integration, "See, I don't expect us to be amalgamated into, integrated. Like I don't believe it will happen for us because we've been separate so long. And I'm quite comfortable with our separateness." Ida instead considers achieving harmony between the parts as her goal, "If we could just have harmony, that's my goal. Not integration, but harmony."

Tammy describes a process of her individual parts becoming whole resulting in herself becoming whole,

> Because I'm becoming aware more and more everyday of how these personalities are actually a part of me...so that each one of these

> personalities will become whole and will become better because that's the only way I'm going to become whole and better is to help them. And so when each of these personalities no longer has trauma, or if we're co-conscious, then I think integration will be there.

However, Tammy expresses some doubt about integrating her alter personalities, "I'm not sure integration will ever happen. I don't know if everything that each one of these personalities has is going to come out." Despite her doubt, she describes the ultimate goal in therapy, "is to have everybody inside happy and content."

Kate believed that an increase in awareness between the different parts might occur naturally on its own, "I think that we could all become more aware of each other, probably just on their own someday." In regards to the process of integration, Kate was quite fearful,

> For me, the word integration means the other part doesn't exist anymore. Like they disappear or whatever...See, integrated is sort of a scare, a scary word I think for people with MPD, cause it's like parts, it's like everybody has to be wiped out or destroyed or lost or something.

Instead, Kate describes a type of cooperation as the goal, "I think for me, I think it's more that if everybody can sort of help everybody out and nobody was scared to be outside, not to come out."

Bonnie has completed the bulk of her therapy and with the help of her therapist, has undergone a process of integration. She describes her initial reaction to integration,

> I really fought for a long time integration, I do not want to integrate...At the time I was, Oh God, I don't want to do this and I would say that over and over again and then finally parts would give in and start the process.

She also described the various difficulties she encountered while working through integration, such as grief, loss, and an ability to trust in the process,

> It's a grieving process, you're giving up a way of life, a loss like a family, it was a family that kept you alive. So, you have to kind of, you're giving up something to get something and you don't know what you're getting.

Working through integration also meant that Bonnie had to deal with her trauma, "The problem was if you were apart, you could get rid of the stuff you didn't really like and not I have to deal with it all." As a result of integration, Bonnie now describes how she has had to become responsible, "I have to lead a new lifestyle. We've responsibility, that's the hard part. Just one person responsible for everything." Bonnie describes how the process of integration feels, "I get very uncomfortable in my skin is how I put it, when integration occurs, because it's not normal? It doesn't feel right, it doesn't fit." She is still somewhat doubtful and unsure of the integration process, "I'm still not really happy that this is a thing that I need to do, at some level because having many parts is a lot easier than having one, if you've lived like that all of your life."

7. The importance of healing

All participants were actively attempting to heal. For some, becoming aware of having DID and learning to accept the diagnosis marked the beginning of their healing. For others, a number of healing strategies had been actively used for some time. Overall, the importance of healing was commonly upheld as not only possible, but necessary.

For Roseanne, accepting the implications of the diagnosis was a big hurdle to come to terms with before the process of healing could be initiated,

> I don't have the memories from childhood. I still have to go back and dig those up...there's a large part of me that doesn't want to do that. I'm finding now that I can make it from day to day, why bother digging any deeper? But at the same time I want to be cured, if that's the right word, so I know I have to go through that...There's times when I wonder if the diagnosis is right...Intellectually, I've accepted the diagnosis, but emotionally I don't want to go through what has to be gone through.

A number of healing strategies have worked for Roseanne, including marriage counseling and journaling. She has also signed a contract with her therapist agreeing to adhere to a number of rules stipulated by her and her therapist, such as not drinking, "The biggest difference that I've found since being in treatment here is that not drinking has kind of eliminated one personality that use to cause me a lot of grief." In sum, Roseanne has just

begun her healing process and describes the focus of her healing as, "the major part of therapy is reliving the memories and then putting them to bed...So, I would say that I'm barely started."

Ida has used a number of therapeutic strategies and has been quite actively involved in her healing. She began writing as a way of keeping track of the alter personalities and has also mapped her personalities. This mapping involves plotting out the personalities to get a picture of them and to become more aware of them. She has used contracting to manage the alter personalities and work for the benefit of the whole, " ..we have to contract to not allow them to emerge Also, we had to contract not to develop any more alters." Ida has made an album depicting her story with poetry, sketches, and paintings. Other helpful healing techniques she uses include, "We have affirmations that we recite daily... I don't just leave this to circumstance, I'm working on this all the time." She describes the impact of the help that she's received, "I think this is a wonderful program...I'm touched by the caring and the respect and the dignity that is given to us because it's a rotten thing to have happen to you." In agreement with other participants, Ida has a strong spirituality that has been her stronghold, "It's the only thing that got me through this, was my spirituality."

Kate also experienced a struggle in accepting the diagnosis of Dissociative Identity Disorder and in dealing with its implications. She spoke about the acceptance of the disorder as the hallmark to her initiation of healing. She recounted how her first therapist told her that she had trouble accepting the diagnosis, "She talked about how I struggled with it once she started talking about dissociation and stuff with me and how I really really resisted the concept." Increasing her awareness and acceptance of the disorder helped Kate and her child alter personalities,

> And that's been really nice in that there is now an awareness on the part of some of the little kids, that there is a world outside and that, they can come out and see it and they don't have to be scared, that it can be different.

Kate also struggled with her spirituality; she found it difficult to understand how God could have let her endure so much trauma, "God being all powerful and all knowing and all, you know, how can he just watch? I really struggled with that incredibly...why didn't God intervene?" Although she questioned God, her sense of spirituality became the foundation from which her healing occurred, "Its' always been a real source of strength for me and a really really important part of my life." Having this source of strength was necessary for Kate, "Cause even now, as an adult, it's incredibly hard dealing with this stuff. I never could have done this as a kid." Kate has also done a fair amount of reading to increase her knowledge of DID. In sum, for Kate, to heal is, "to undo the dysfunction and often you have to build a healthy foundation and then on top of that start building your life. But there's always that underlying sort of bit of quicksand."

Tammy initially experienced difficulty in finding professional help and as with other participants, Tammy experienced difficulty in accepting the diagnosis of Dissociative Identity Disorder,

> So when she diagnosed me, it was the most terrible thing that she could ever, it was like, no way, I'm not like one of those kind of people...totally denying that it was really happening. I was having a difficult time really really accepting. And it's still hard to accept, even though you know you have to, there are still aspects of some of these personalities that are still very tough for me to accept.

Tammy has used a number of healing strategies including journaling, "the journaling really helped me to understand where they were coming from, what my personalities were all about." She also contracted with her therapist and made use of grounding techniques. Grounding techniques are used to help the person stay in the present rather than dissociating, "...that's been my savior, grounding." Tammy has also had tremendous support from her family which has helped her in her healing process.

Bonnie also found it difficult to find a professional to help her, "I think the biggest struggle was finding help and then I didn't trust the help after awhile and that was frightening." After she did find help, she completely denied the diagnosis, "I was so busy

denying it that I wasn't getting well. It took me probably two or three years of therapy to maybe even think that that was a possible diagnosis, and to think that it was attached to myself." Upon accepting the diagnosis, what helped most with her healing was reading books,

> One thing that really really helped me to survive was the book *The Courage to Heal*...so I did have a support group, but it was a book and books have always been my savior. I can't imagine not being able to read. So that is still what I turn to when I'm upset or distressed.

Like Kate, her strong sense of spirituality has helped her to heal. She had considered writing down her experiences as a therapeutic endeavor but has not done this as of yet. She described how taking care of herself helps in the healing process, "And if I start to feel kind of shattered, a good rest makes a big difference." Bonnie describes the healing as hard work but beneficial, "I have a lot of explanations for a lot of reactions to things in my life. So, it's kind of nice to fill in the pieces. I have finally learned some peace, some internal peace in the last year."

8. The roles of the different parts of the self

All participants were able to describe the various parts of their personalities or alters. These descriptions were similar in many ways such as the ages of the alters (many participants described child alters) and their behaviors (many participants had a deviant alter) however, the common theme for all of these alters was that they served a role. Each alter incorporated a function, that is, each alter originated for some purpose. When describing the alters, participants also mentioned or described the process of one alter receding and another alter becoming dominant: this process is known as "switching". Another term frequently used to describe alters is "splitting" which occurs when a new alter comes into being.

> Roseanne had been working on identifying and naming the alters that she was aware of, There's the party girl, the bitch, the slut, the wolverine, there's the supermom, there's the one that works. I think we've only identified about six at this point and I don't seem to have any

> child parts coming out yet. The one that parties I call a slut, there's the bitch, the wolverine is another bad one.

Roseanne's alters were quite distinct with each having its own sets of values and behaviors, "My experience is different behavior, different sets of behavior for different sets of personalities." These alters accommodated Roseanne by surfacing when she required them, "I can go from numbed out and slip into the bitch if whatever I'm trying to escape from doesn't quit." Roseanne described the process of switching as one where a certain alter becomes dominant if the situation warrants it, "The bitch will go away and if the bitch doesn't end up handling the situation, especially if there's extra baiting or jabbing going on, the bitch can turn into the wolverine." She explained that she was unaware of when she was undergoing a switch, but noticed the result, "...I notice after I've switched just because of the language, and the attitude and the posture is different...I act differently...my whole appearance changes."

Ida described five alters in total with each one completely unique and developed. The first alter to develop was Janet who assisted her during abusive events, "I had to get somebody to help me and so my first alter was named Janet and she's tough...Janet could be any size she needed to be to do what she had to do...Janet could be larger if she had to be, she could be mature." As Ida matured, Janet took on a deviant role and would act out inappropriate behaviors, "Part of me was promiscuous and I didn't know what to do. Janet was shoplifting...and Janet would come out and be seductive." Ida then developed a second alter who is still frozen in time, "I developed a third alter named Spoofy and she stayed little, she's the little person. She hardly ever comes out, just at night when it's safe because she's really traumatized, and she's fixated, like she's frozen in time at the age of four." Even though the alter Spoofy remains frozen and reclusive she is, "totally developed within her own limitations, she's totally developed...she can speak and she can't read yet, but she's very able to, she's her own person." She then developed a third alter who had a particular role to assume, "to take my Uncle's abuse and her name was Katie. I had Katie take care of the anxiety. She was born when I was about nine, ten in there and she stayed frozen in time between that age." A fourth alter was developed at the

time of her Uncle's death who assumed the role of a persecuting alter, " And then Judas was developed as a mature adult persecuting alter when I was fifty-five." This alter changed his abusive role after therapy was started, "And Judas is changed again in his role to be more caring and fatherly type." Overall, Ida describes her system of alters as,

> My alters are all, there's not many of them for one thing, they are all clearly defined. They are total identities in themselves. They're not just fragments they're beings in their own right that can negotiate and function individually from the host.

Kate described herself as, "the one who functions more outside. You know, who talks to you or just socializing or being with friends, or going to group, it's me that goes." Her alters developed spontaneously as they were needed and did not develop or grow as a person would, "We were just inside, you're just born and you start, you're not born as the baby." She further described Anna, her first alter as being, "born at that moment, at the time when she first came in, that's when her life started." Katie, a six year old alter was also developed , "but with Katie...like when you talk about being three or something, then oh no, that's Anna, I was never three." She also described other child parts as serving a function during an abusive event and sometimes being given a name,

> Some of the little girls do have names and then others are just sort of more workers in one event...there's not a specific name. But if it happened more than once in one occasion, then generally there is a name attached.

Kate describes the alters who underwent the abuse as frozen in time,

> I have this feeling that they're sort of huddled in me in some dark corner and they're just sort of frozen in time and space and if there's ever one that comes out or whatever and like she becomes unfrozen.

She was unsure of how many frozen alters there were, "I don't know how many little ones there are, the ones that are frozen in time...cause I'm not aware." and further explained that they were still frozen and as a result, have not aged, "Nobody's gotten older, in that sense. Anna's still little and Anna's still Anna. I mean she was frozen at the start of when I started to remember."

Tammy has a number of distinct personalities with particular roles where, "Different situations would call for a different personality." She describes one of her personalities as an addictive personality and "One of my personalities committed a fraud." and "I have a personality that's very religious only it's not healthy religion, it's old time religion." Like Bonnie, she describes an alter of particular importance, "There's a native that always tells me that he's getting older, so I suspect that he has aged as I have aged." She further describes him and his role,

> He's a very big native man and he protects me, that's his role, he protects the little girl...he's looked after and protected this little girl for many many years. I think he's where I've gotten my parenting skills from because he's a very good parent.

Like Kate, Tammy has alters that are frozen in time, or stuck, "I had a personality that's seven and that personality is stuck there. I have a young child and then I have a woman in her early twenties that have not moved. They're stuck...they haven't moved anywhere." In describing the role of all of her alters, Tammy concludes, "They've always had a role and that role has been to protect me from whatever it may be...I mean that's their role, to protect me."

Bonnie describes her parts as unique and completely developed, "But to me they're very distinct people, very distinct. I guess they just are who they are." In particular she mentions an alter named Joe,

> Joe, I don't remember life without him because when my first memory came Joe was there and I don't know if the memory came or if Joe, the incident happened and Joe split from me or what happened. It's just like having a twin.

Bonnie continues to explain that, "They're not just a name. There's a whole, when I say Joe, an image comes." Bonnie suspects that she may have ten alter personalities in total although, "There may be more underneath." Bonnie describes her parts,

> There was ...the drinker, she had a wonderful time. There was no one that took the beating except for the angry one who got bigger all the time.

Some of them stayed as children and some of them grew, some of them are the same age as I am and some of them aren't."

Bonnie has completed her therapy, but is still concerned about the development of additional alters, "So, that's what I'm on guard for, is the splitting because I don't know if I might do it again and not be aware of it because I did it before and I didn't know I was doing it. To me, it would be very natural to happen again, but it hasn't, I don't think."

9. Experiences of fear

Experiences of fear emerged in different ways for each of the participants. For some participants, feelings of fear were candidly expressed. Others expressly denied having experienced fear, while others did not mention fear at all. By reviewing the transcripts and returning to question participants, it became clear that an underlying feeling of fear implicitly emanated from the transcripts and was validated as existing by participants who had not explicitly disclosed the feelings of fear. Overall, each participant illuminated the theme of "Fear" as a common, though disparately described theme.

Roseanne had previously described her fear of going through the process of healing which would be difficult. She further described being afraid of the actions of an alter, the wolverine, "I've broken my husband's ribs before and bit him so that he had to go to the emergency room and get stitches. It's really scary."

Ida described being frightened during the abuse, " My Uncle would threaten us at knifepoint...and it was very very horrific, it was frightening" and after the abuse, "I cried easily and often had screaming nightmares." As she grew older, her fears increased, "I knew I was going crazy. I knew I was out of it and I was very very frightened."

Retrospectively, Kate recognized the extent of her fearful feelings as a child, "I think at times when I would be really really fearful about things, it was like a panic would set in...I realize now the intensity to which it happened is probably different than other people." She has also become aware of her fear of God and has questioned this, "I think part of the abuse was of, I don't know if it was spiritual abuse...God will get you

and stuff like that and I think working that through more has generated a lot of fear inside about God."

Tammy's fears stemmed from discovering her alter personalities, "Initially, it was very, very scary. I mean, first you discover one and then another one and you think, Oh, my God, is this ever going to end?"

Bonnie did not make any mention of feelings of fear despite having undergone incredibly frightening experiences such as being held against her will at a psychiatric hospital. When questioned during the second validity check about whether she had experienced any feelings of fear, she explained that the instinct of fear had been pushed aside at an early age in favor of survival. She stated that her feelings of fear were only now becoming known to her.

10. Feeling Suicidal

Having made previous suicidal attempts and recognizing suicidal feelings were joint experiences for all participants. Most often suicide was viewed as a way to escape from the effects of the trauma. Not all participants were presently suicidal, but all had been suicidal at some point in their lives and had tried to commit suicide on at least one occasion.

Roseanne described herself as no longer suicidal, "...I'm not suicidal, something I use to have to contend with." For Roseanne, suicide was a controversy between her alter personalities, "The part that wants to commit suicide, there's another part that doesn't. We all keep me from doing it. The part that doesn't want to die is stronger than the part that does."

Ida had previously been suicidal and explained that, "I did very nearly commit suicide, so I am lucky. That was a sobering time."

During the interview, Kate did not mention any previous attempts at suicide or having suicidal feelings. However, during the second validity check she did mention that she had previously made two suicide attempts and that she was familiar with having suicidal feelings.

Tammy explained that she had always had suicidal thoughts, "...there have been those all my life, that tendency has been there." She described how, in the past, committing suicide would have protect her, "Early on I was very suicidal and I think that it was, again, a protection. We can't let all the secrets out. Finish it off, we can't let anybody know all these secrets." Presently, she is no longer suicidal, " I haven't had suicidal thoughts for a long time, which is really good, really really good."

Bonnie has a particular viewpoint on suicide, "Suicide is not a crime for me and I don't know why." In addition, she has had a history of being suicidal, "I had been hospitalized a couple times for being suicidal, but I managed to fool them all." She remained suicidal for a long period of time, " And I remember getting up and thinking, 'Well, it's a fine day to die' and I took every pill in the house thinking that that should do it, and it didn't." The repercussion for this event was the subsequent ease of committing further suicidal attempts, "Every time something went wrong for a long time afterwards, well, I'll just kill myself. Now I think, oh God, get a grip on reality, it's not the answer."

11. A desire to be accepted and understood

Being accepted and understood was important to all participants and represents the final common theme among them.

In discussing other people's acceptance of her diagnosis of MPD, Roseanne stated, "So I haven't had anyone really dispute the diagnosis, but at the same time, I don't tell very many people either...I haven't had any of my friends out and out tell me that I'm nuts, that it's not possible." Although, she explained that being accepted by her friends was important to her,

> ...they are really my friends because they know about me and they have not rejected me. Somehow telling them about it and accepting the diagnosis means quite a lot. I think it means they really do accept me and they don't judge me.

Therefore, Roseanne's acceptance by her friends was considered important to her and represented a need to be understood.

Ida described how other people have viewed multiples and indicates her own viewpoint, "you're considered crazy, this whole thing is crazy when you think, it's not crazy, it's creative." She explained how being understood is important to her, " I want people to understand, that I want to help with it." However, she acknowledged that helping others to understand is not a simple matter, " But it's hard for people to understand and as long as we remain silent, they never will understand. But it's difficult to bear your soul."

Kate expressed concern over other people's opinions about multiples, " I think for me, the whole thing dissociation or MPD, or whatever may go attached to it, is that I think a lot of people think of it as something really strange, like something bizarre or weird." She explains DID in a different way, "You know [DID], develops in childhood...if you don't go through that kind of trauma, you don't develop that kind of system to deal with everything." She further explained, that in her view, DID is more like a gift than a disorder, "...it is a real gift, and I resent almost the disorder part that's put on there...it's a disorder in one way, but it is a gift in a much more important way."

As with Ida and Kate, Tammy also pointed out how people misunderstand DID, "...most of the people when you say multiple think of the hillside strangler, Sybil, movies that they've seen on T.V...they have no perception of what MPD is all about." Tammy was not daunted by this misperception but instead stated, "I only wish people could understand...I want people to understand, I want to be a part of making people understand."

Tammy has experienced quite a lot of frustration in being believed by the medical profession, "I had a psychiatrist...tell me point blank that he thought this whole thing was totally crazy, that there was no such thing as MPD." She felt defeated as a result of not being understood, "It is very, very, extremely frustrating not to have people believe you, especially when they're in the medical profession." She was quite determined that others, including the medical profession, understand, accept, and believe that DID exists, "...one of my objectives, I'd like to see that more and more people, especially in this profession,

understand that when somebody walks in the door and says, 'I'm a multiple and I need help', they need it."

Bonnie has had similar difficulties in not being believed and understood by the medical profession, "...the problem is the profession doesn't agree on MPD or DID or whatever you want to call it. And I had to literally lie in one hospital that I didn't have that to get out." She further described her difficulties by stating that , "I think the biggest struggle was finding help and then I didn't trust the help after awhile and that was frightening."

Overall, being misunderstood was commonplace for Bonnie. About DID, she claims, "I still don't consider it abnormal." In fact, she has come to realize her own understanding of DID, "I suppose you can have MPD without being beaten and raped and almost killed and all that other stuff, but I don't think so, I think that the two go together."

A number of important themes also emerged from the analysis. These themes were not common to all participants but did provide additional information about the phenomenon of dissociation and understanding about DID. They are as follows:

Important Themes

1. Hearing voices
2. Being a high achiever
3. Difficulty in being properly diagnosed
4. Physical changes associated with DID
5. Looking for Control
6. Feelings of Anger
7. Feelings of Shame
8. Feeling Worthless

1. Hearing Voices

Roseanne described hearing voices in bed, "Then I'd be lying there in bed and have the voices going on in my head." The voices were not necessarily helpful, "The voices in my head are quite destructive to self-esteem." Kate described an incidence of

noticing the voices being distractive, "...that of course can be real distracting if you're driving along and all of the sudden you hear all of these voices." Tammy thought that everybody heard different voices in their head, "Originally, I didn't understand that you didn't hear voices the same as I do." She elaborates by stating, "But with me, it's not my voice I'm hearing. They seem to come from different places in my head. Different personalities will come from different places in my head." Before she went through therapy, Bonnie explained how "Sitting still and relaxing I would have started to hear voices."

2. Being a high achiever

Kate Ida and Bonnie all described themselves as being high achievers. Kate explains her achieving well in school, "I was doing well in school. I loved sports. I always got honors in school." Ida describes her success in the community, "I was a very successful, high-profile person in my community." Bonnie explained her achievement in terms of being a quick learner, "I could read before I went to school. I was probably very precocious. My sister taught me the alphabet one night after school."

3. Difficulty in being properly diagnosed.

Roseanne experienced a difficult time in finally being diagnosed with DID, "I had gone to see psychologists and therapists since I was 17, 18 years old and never getting cured, never finding satisfaction" and "My husband had been trying to get me some help for years and I was in therapy off and on dozens of times it seemed." Ida's experience was similar, "I've been everything. Well, doctors didn't pick up on it...I'd get medical attention and they thought I was epileptic or brain tumors or all kinds of things."

4. Physical symptoms associated with DID

A number of physical changes in appearance, behavior and attitude occurred most often as a result of switching from one alter to another. Roseanne described generally looking and feeling different after switching from one alter to another, " I don't notice the actual switch, but I notice after I've switched just because of the language and the attitude and the posture is different." Kate did not describe any physical symptoms in the interview, but explained physical changes during the last validity meeting. She explained

another alter was attempting to communicate, " if I've got a lot of aches and pains, or I've got numbness or whatever, I know, there's something going on. One of them has something to say". Bonnie explains how others noticed how she changed physically when she had switched to another alter, "My husband says that he could tell when something wasn't right...and I have a friend that says, yes, I walk differently, I talk differently, I behave differently".

5. Being in control

Roseanne stated that, at times, she would lose control and another alter would assume control, "I would know what I was doing, but I wasn't in control. The personality in control said screw it, I want to do it". For Tammy, control was very important, "But I think the main thing that I have earned is self-control - do not have blackouts, do not allow another personality to take control". Before going through therapy, Bonnie explained how she lacked control or awareness, "Before, I wasn't really in control of it, or I wasn't aware of it".

6. Feelings of Anger

Ida described feelings of anger arising from having to smother them as a child, "and the more I stifled my feelings, the greater the anger became". For Tammy, feelings in general were described as triggers, "..for me it's emotions, feelings. If I feel overly strong about something, overly angry, or overly compassionate, it's usually a sign that it's triggering one of my other personalities". Although, Tammy also described feeling very angry for present day difficulties, " I'm really angry, like I think I have every right in the world to be angry". Bonnie described still having a lot of anger, "I do have some anger attached, quite a bit yet".

7. Feelings of Shame

Both Ida and Tammy experienced feelings of shame. Tammy explained how she felt shameful for having DID, ...there's a certain amount of shame that goes with it...I have felt in the past very ashamed of who I am and why I am. I'm beginning to accept it

now that there's nothing to be ashamed of. absolutely nothing." Ida stated, "I just, I still feel a great deal of shame."

8. Feeling worthless

Both Ida and Bonnie explained feeling worthless. Ida stated, "And you feel so unworthy, so, so rotten." Bonnie attempted to achieve some sense of value by accomplishing much that she set out to do because as she stated, "You feel valueless." Both made attempts in compensating for the feelings of worthlessness that they explained resulted from the effects of having DID.

CHAPTER SIX
DISCUSSION

In this chapter the results of the study will be discussed in relation to past and present theoretical understandings. Participant characteristics will be discussed first followed by the discussion of the common and important themes. The decision trail for this study will be examined as will the limitations for this study, and implications for future research.

Participant Characteristics

Participant Profiles

Five participants, Roseanne, Ida, Kate, Tammy, and Bonnie were involved in this phenomenological study of Dissociative Identity Disorder. All participants were women with a mean age of 44.8 (range, 36-60 years). The DID patient sample in Putnam's Study of one hundred cases of DID (1986) and Kluft's study of 33 cases (1984) were similar with predominately female patients (mean= 92% female patients) aged between thirty and forty years old.

Except for Kate, all participants had received previous diagnoses before the diagnosis of DID had been made. Depression was reported as the most common previous diagnosis received. Putnam (1986) stated that 95% of patients had received one or more previous diagnoses prior to the diagnosis of DID and depression was cited as the most frequently acquired diagnosis representing 70% of the patients.

Putnam reported an average of 6.8 years (range, 0-23 years) from patients' first contact with the mental health system until a correct diagnosis of DID was received. Both Tammy and Roseanne had been to see doctors since the ages of 16 and 17 respectively, and Ida had been seeking medical treatment on and off throughout her life, therefore a direct calculated comparison with Putnam's study is not possible. Kluft (1991) explained that most often classic presentations of DID which are characterized as "overt and readily observable behavior" (p. 621) occur in people with DID during the late twenties to mid-30's and become known to clinicians at that time. In this study, memory

for the first incident of abuse occurred at a mean age of 41.6 years (range, 33.5-55 years). The participants in this study also reported being in therapy for DID for a mean of 3.4 years (range, 2-5 years). Bonnie has now completed her long-term therapy and visits her psychiatrist on a quarterly basis.

Except for Roseanne who is still in the process of recovering early childhood memories, the first episode of abuse occurred for participants at a mean age of 2.3 years (range, 1-3 years). Both Bonnie and Ida reported incidents of sexual abuse by doctors from whom they were seeking treatment (fondling and sexual intercourse respectively).

Alternate Personalities

Goff and Simms (1993) indicated that the mean number of alternate personalities had increased since the beginning of the twentieth century, but the most frequent number of personalities, or the mode, remains at two. The number of alternate personalities for the participants in this study averaged 10.4 (range, 4-25). The average number of reported personalities in Putnam's (1986) study was 13.3 and 13.9 for Kluft (1984).

All participants reported having at least one child alter. This result corresponds to the 85% of patients in Putnam's (1986) study who reported child alters. Both Bonnie and Kate described a group of child alters called "little ones" that were "frozen in time". Bonnie also had a group of "older ones" the same age as herself and Tammy had a native alter that is aging along with her. In discussing her alters, Roseanne stated, "I think we've only identified about six at this point and I don't seem to have any child parts coming out yet." The four participants who recalled having child alters explained that they originated when the participants were themselves very young children: Ida's "Janet", Bonnie's "Joe", Tammy's "young child", and Kate's "little ones" all originated when the participants were very young. Other researchers noted that the first subpersonalities discovered for people with DID were reported to have been created between the ages of four to six years old (Bliss, 1980; Herzog, 1984).

Some of the alters were named according to their characteristics. When Ida attempted to disclose her abuse to her mother by stating that she had a friend who helped

her, her mother replied that she was spoofing or joking. Hence, Spoofy became the name of an alter. Roseanne labeled all of her alters according to their characteristics.

The following comparisons were made with Putnam's study (1986): Both Ida and Roseanne had alters that were sexually promiscuous (in comparison with 50% of Putnam's patients); Tammy, Roseanne, Bonnie all had substance abuse alters (in comparison with 50% of Putnam's patients); Ida, Tammy, and Bonnie all had opposite sex alters (in comparison with 50% of Putnam's patients); Roseanne's "wolverine" alter is prone to violent behavior and Tammy has become violent when switching from one alter to another (in comparison with 50% of Putnam's patients).

DES II Results

All participants completed the Dissociative Experiences Scale Second Version (DES II). The average score was 27.5 (range, 12-52). Steinberg, Rounsaville, & Cicchetti (1991) suggested using a cut-off score between 15-20 to yield high sensitivity (true positives) and specificity (true negatives). All but one participant, Roseanne (score= 12) scored above a cutoff score of twenty. Roseanne told the researcher that the she may have even scored herself a little too high. The DES II result was not obtained from Roseanne until the second or final validity check.

Considering that the validity and reliability of the DES has been adequately established, these results are puzzling. Bernstein & Putnam (1986) have cautioned clinicians to refrain from using the DES as a diagnostic tool but instead to use it as an effective screening technique for dissociative experiences. Nonetheless, Roseanne appeared to have scored quite low compared to the usual scores of people with DID's. Most people with DID score at least above 20 on the DES (Steinberg et. al., 1991; Ross et. al., 1991). However, Ross. et. al. (1991) stated that 15% of clinically diagnosed patients with DID score below the cutoff score of twenty (a case of false negative).

A final explanation for this low score is the possibility that Roseanne's experience is not adequately covered in the DES II. For example, question #22 of the DES II asks whether people have they ever found themselves in one situation where they act differently compared to another situation to the extent that they feel as though they

were two different people. Roseanne scored 20 out of a possible 100 and yet she explained how the "party girl" would go out and have a great time, tell jokes, drink... behaviors that were very unlike the Roseanne I interviewed. Nonetheless, because of her apparent awareness at some level, her coconsciousness, she may recognize that she is not two different people even though they behave completely different. As Roseanne stated, " My experience is different sets of behavior for different sets of personalities."

The Common Themes

Some of the common themes will be discussed jointly because of the overlap with the research pertinent to those areas.

Experiences of Severe Trauma

Overwhelmingly, researchers have considered experiences of abuse as highly correlated with DID (Kluft, 1985; Coons, 1986; Putnam, 1985; Putnam, 1989; Ross, 1990; Braun & Sachs, 1985; Loewenstein, 1994; Marmer, 1991). In particular, Ross, et. al., (1991) contends that a vulnerable period for developing DID exists for individuals abused prior to age ten. All but one participant, Roseanne, had distinct memories of being abused. However, that she has experienced some form of traumatic experience in the past is not in question. Roseanne has begun to experience frightening flashbacks in the past couple of months. Flashbacks are described as, "recurrent and intrusive distressing recollections of the event including images, thought, or perceptions (DSM-IV, p. 428). It is therefore likely that Roseanne is experiencing a flashback of some traumatic experience. Roseanne has, like other participants in this study, formulated a complex set of defense mechanisms that led to her to a diagnosis of DID. Overall, it appears likely that Roseanne has experienced some form of severe distress in her childhood. The unknown variable appears to be the *type* of distressing event she has endured.

Recognition of Something Being Wrong

Participants held opposing views regarding whether they believed that other people experienced levels of dissociation similar to their own. Nonetheless, each experienced some indication of something being wrong, despite not being able to

articulate its exact origin. Wilbur (in Kluft, 1985) noted that patients with MPD held the self-knowledge that they were different in some way. Roseanne, Ida, and Tammy have been to see doctors and therapists over the years with varying levels of awareness of something being wrong with them. Roseanne would encounter mental health professionals for problems with the effects of DID only at particular times without realizing why, "Over the years that's generally been when I've gone to see someone, a counsellor or a therapist, is after a violent episode" Ida, "suddenly I had some clues...I came to realize that there was more to me." Tammy, " I had no idea, it just felt totally out of control. I didn't know what was going on." Kate received messages from her mother that something was wrong with her when she would frequently keep her home from school "and just say that I was stressed out or I was getting to nervous or I was dealing with different things."

Escape from Pain/ The Role of Alter Personalities

All participants described the act of dissociating as a method of internal escape from distressing and painful events. By implication, physically escaping by leaving or going away was not possible. To overcome the problem of needing to escape and not being able to physically escape, Ida explained, "So I learned to let my mind go up in the air." The act of dissociating provided participants with an avenue of intrinsic avoidance that they still employ today in a variety of situations as a method of escaping pain. Bonnie explained such a situation, "I was in the dentist chair and the freezing didn't work for some reason and I just went away."

Because all participants had the ability to dissociate and were attempting to flee some distressing event, they fit Braun & Sachs' predisposing factors for developing DID (Braun & Sachs, 1985). The ongoing use of dissociative escape created dissociative states that, over time, became molded and structured and eventually became fragmented from the person. The dissociative states enclose affective, sensory, and cognitive information that is overwhelming to the person and therefore becomes split off. This split off, encapsulated information becomes separated from the individual who cannot acknowledge or integrate it and thereby sets up defensive measures against experiencing

it. Therefore the information becomes subsumed under the domain of the alters who emerge "when a series of fragmented but defensively related episodes, linked by a common affective state, take on an identity of their own" (Kluft, 1988, p. 49). Ida's "Katie" took on the feelings of anxiety that overwhelmed Ida, just as Bonnie's "angry one" took on the anger, "there was no one that took the beating except for the angry one who got bigger all the time" and Roseanne's "wolverine" became responsible for encapsulating feelings of intense anger and rage. As Coons (1980) stated, the alter or secondary personalities helped "enable the individual to act out impulses unacceptable to the primary personality" (p. 332).

Both Janet's (1899) diathesis stress model of automatisms becoming split off and assuming individual existences, Freud's mechanism of repression of unwanted mental content, (1990), Hilgard's neodissociation theory (1977) of dissociated subunits, and Albini and Pease's (1988) split nuclei, all touch some element of truth regarding the processes undergone by the participants. They differ in many aspects, in particular, whether dissociation into alter personalities occurs primarily as an adult manifestation or as a developmental defensive strategy in childhood. Nonetheless, they all shed meaning and understanding on the processes undergone by the participants of this study. Some form of splitting off of affective-laden information into a new structure is evident in all participants. In commenting about the neodissociation theory Spiegel (1986) stated that it "provides a model for understanding unconscious interaction among dissociated subunits, a model that fits at least some clinical cases of dissociation" (p. 126). The exact mechanisms used to describe the splitting off of emotional content as evidenced in people with DID is still under speculation, but that this type of event occurs for people with DID is evident in this study.

The defensive purpose of escape as defined by the psychoanalytic literature on DID, emphasized the role of infantile fantasies in the development of alter personalities (Putnam, 1991; Marmer, 1991; Spiegel, 1986). In an effort to control the traumatic events that they were experiencing, they fantasized control of their lives by developing the defense of escape or dissociation that took over the course of development and

repeated trauma, eventually resulting in a formation of alter personalities. These personalities were also charged with protecting the individual by assuming the unacceptable affect, sensation, and cognition. These findings lead us to the "not me" experiences described by Fink (1988) where the individual is not able to assimilate traumatic experiences and therefore splits internally allowing another to deal with the content of experience. Bonnie described how she didn't do something and that it must have been the other person who did do it.

The person with DID adapts to a hostile environment by fragmenting the core self into an unintegrated series of selves (Albini & Pease, 1993; Marmer, 1991). Thus the escape experienced by participants through dissociation is a defensive and adaptational process where alter personalities assume the responsibility or role of keeping the person divided though intact. This appeared to be the experience of the participants of this study.

Disturbances in Time

Roseanne had not experienced periods of amnesia, although she has not recalled her early childhood memories. Kluft (1991) described a version of MPD called "Coconscious MPD" that is characterized by an absence of time loss (amnesia) except for events in the far past, and an apparent lack of alternating personalities (1991). Roseanne did tell the researcher that her therapist had discussed with her the concept of coconsciousness where she does alternate between alters but has always " got conconsicousness which means at some level in there I always know what's going on". Therefore, according to Ross (1991) people who conform to "Coconscious MPD" will have fulfilled the criteria for Dissociative Disorder Not Otherwise Specified in the DSM-IV. The possibility exists that Roseanne has this form of DD. Nevertheless, a disturbance of time was noted for Roseanne and the other participants.

Disturbances in time occur during dissociation. All participants described being able to dissociate and come back at a later time indicating that a disturbance of time had occurred. Time disturbances might also occur when alter personalities alternate in emerging. Secrecy and denial of the disorder will sometimes result in a cooperative effort among the alters in keeping the losses of time secret. The person might become

adept at covering up lapses in time and memory. In such an event "neither amnesia nor overt differences may be readily apparent" (Kluft, 1991, p. 613). Such instances occurred with the participants of this study: All participants described being good at covering up the disruptions in time created by the act of dissociating or the emergence of an alter.

Experiencing Isolation/ Desire for Understanding and Acceptance

People with DID who disclose their symptoms or disorder have often been disbelieved. Professionals have expressed doubt about the disorder and discounted patients who have attempt to gain assistance in understanding the effects of DID (Kluft, 1988). Their diagnosis has been ridiculed by professionals or they have been told that they are so unusual that they have developed a rare disorder (Cleckley & Thigpen, 1977). These experiences were recounted by participants in this study. As a result, in accordance with Saxe et al., (1993), these participants often hid their symptoms or had covered them up. Other researchers have documented this "hiddenness" of DID (Kluft, 1985) or have termed the high incidence of denial and hiddenness as "pathology of hiddenness" (Gutheil, in Kluft, 1985).

Based on the historical background of disbelief and doubt exhibited by professionals (Merskey, 1990) and lay people alike regarding the existence of DID, it appears reasonable to assume that the reason for this pervasive hiddenness observed in people with DID lies in their fear of rejection. The participants in this study described feelings of anger at not being believed that reflected societal and professional doubt of DID. All participants expressed a desire for others to understand and accept their personal experiences of DID as truthful accounts of what occurs in people with DID. They hoped that others similarly afflicted would not have endure the oppressive disbelief and doubt that they had endured.

Suicidal Experiences/ Experiences of Fear

All participants had attempted suicide at some point in their lives and had experienced suicidal feelings. Suicidal experiences in people with DID were also common in other studies (Anderson et. al., 1993; Coons, 1980, Marmer, 1991). The

suicidal feelings expressed by the participants of the study often ensued from particular alters who demanded that the secrets be kept and suicide was a way to ensure that the secrets remained undetected. Kluft (1991) explained the role of the persecuting alter which in Ida's case, attempted to eliminate her and her other alters. The persecuting alter, Judas, was created to identify with the original aggressor and upon the death of that original aggressor, attempted to destroy the constitution of alters. Such occurrences were common for the other participants who had alters who wanted to die.

All participants implicitly felt sensations of fear, but most often this fear was deferred by conferring those unacceptable feelings onto another alter personality. Feelings of fear were usually described in childhood as related to abusive episodes. Later on, fear was experienced when the participants would discover that alters were emerging, as stated by Tammy, "Initially it was very scary, I mean, first you discover one and then another one and you think, oh my God, is this ever going to end?"

The Importance of Healing/Cooperation Between Alter Personalities

The importance of healing was unanimous among the participants. They all believed that healing was possible and all had been actively using a variety of therapeutic or healing techniques. The processes involved in healing corresponded to commonly held professional therapeutic techniques such as, journaling and mapping the personality system (Braun, 1986; Chu, 1994). However, the therapeutic goal for most therapists was integration. The idea of integration was rejected by participants in favor of some cooperative process whereby the alters could understand and appreciate each other while yielding control of their appearance and behavior to the host personality. Some of the participants held that their alters were too distinct to be integrated while others stated doubt about having radically opposing alters merged into one. Braun (1986) had briefly addressed the issue of separateness or distinctiveness of alters but firmly maintained that the resolution of the patients' problems could only be achieved through the process of integration. In agreement with Braun, Kluft (1988) explained that the formulation of the alters was an important adaptational and defensive measure taken by the individual with DID in order to survive but that the alters must be integrated into one totality for ultimate

healing. Marmer (1991) described this fear of integration as a desire for alters to maintain their self-preservation by stating that, "Some alters believe that the entire system would collapse if their separate functions were not kept sacrosanct" (p. 682). He stated that during therapy, the defensive structures and organization of the person with DID become manifest and the rationale for the formulation of the alters becomes understood. Throughout therapy, the need for the alters to maintain their separateness lessens and the person's ability to function better without the alters becomes enhanced. While these explanations of integration are helpful, and the understanding of the resistance toward integration has been noted by some therapists (Braun, 1986; Kluft, 1988; Marmer, 1991), the overwhelming desire to not integrate was a common feeling among participants.

The Important Themes

The different themes will be discussed briefly

Hearing Voices

Some participants heard voices in their head which they described as not being their own voices. The occurrence of hearing voices, or auditory hallucinations has been documented and often causes confusion in assigning a correct diagnosis in people with DID. (Bliss, 1980).

Being a High Achiever

Ida, Kate, and Bonnie described themselves as being high achievers. This has been noted for some people with DID (Horevitz & Braun, 1984; Kluft, 1986; Kluft, 1990).

Difficulty in Being Properly Diagnosed

This difficulty was encountered by most participants except Kate. The difficulties for people with DID in being properly diagnosed are well documented (Kihlstrom, Tataryn, & Hoyt, 1993; Hayes & Mitchell, 1994).

Physical Symptoms Associated with DID

Not all participants described physical symptoms associated with DID, although some mentioned that their appearance changed or as with Kate, her handedness changed

from one alter to another. Such instances have been documented and the subject of interesting research (Coons, 1988; Miller & Triggiano, 1992).

Looking for Control

Many participants described feeling out of control of the alter personalities. Some had described themselves of having reached an ability to satisfactorily control the alter personalities. Some researchers explain that it is important to ensure that patients maintain a sense of control with their alters (Chu, 1994).

Feelings of Anger/Feelings of Shame/Feeling Worthless

All of these feelings were variously described by most participants as feelings they had experienced at some point. Explanations for understanding and dealing with the emotion of anger have been documented in the literature (Chu, 1994; Braun & Sachs, 1985); however, the researcher did not discover literature dealing with feelings of shame and worthlessness in people with DID.

Conclusions

Eleven common themes and eight important themes emerged from this phenomenological study of DID. In revisiting the themes that emerged from this study, three types of experiences pervaded the participants' accounts of having DID. These experiences can be classified in terms of three higher order themes:

1) Cooperation:

A sense of cooperation existed at some level for the person with DID within the system of alter personalities. Although the alters reported that on occasion internal disagreements or conflicts arose between the alters, some basic cooperative mechanism was eventually in place for these participants that allowed them to secure a safe, functional, and cooperative system. Therefore, for the participants in this study, the continued cooperation and collaboration within the system was viewed as a desirable goal for healing. According to the literature, cooperation between alters is a necessary factor for eventual healing in the form of integration (Braun & Sachs, 1985; Braun, 1986; Chu, 1994; Kluft, 1988; Kihlstrom, et al., 1993). However, Stone and Winkelman (1985) proposed an interactive form of healing where an autonomous connection between the

different subpersonalities to an "aware ego" was favored in place of complete integration. Thus, the merging or integrating of subpersonalities was not ultimately sought. The participants of this study appeared to agree with this view, held by Stone and Winkelman, of an eventual cooperative effort among alters to co-exist in harmony rather than to become intermixed and integrated. Wholeness was the ideal for the participants, but a more cooperative form of wholeness rather than a directive streamline of integration was pursued.

2) Meta-cognition:

The complexity of the defensive safety structure that was in place for these participants necessitated a high level of perception and awareness that I have termed "meta-cognition". The emergence of different alter personalities affected the overall level of awareness for participants of their behaviors and actions while the other personalities were in control. Therefore, all participants experienced varying levels of awareness at different times of their lives. This variability is reflected in the memories of the participants and the amnesiac barriers that prevented them from realizing a complete and unitary level of awareness (Khilstrom et al., 1993). The varying levels of awareness were also reflected in the number of different diagnoses given to participants and the length of time before their condition was known. Therapists and clinicians should be cognizant of the fact that people with DID operate within various levels of awareness that affects their overt presentation in clinical and other settings.

3) Protection:

A pervasive sense of protection emerged from all participants during both the recounting of their experiences and in the common and important themes that resulted. All participants needed to be protected to such an extent that they formulated an elaborate defensive structure to ensure a high level of protection. Janet (1899) first elaborated on the incapability of people with DID to integrate frightening experiences resulting from traumatic events into the existing stream of consciousness and were therefore split off into subconscious fixed ideas or new sphere of consciousness surrounding the conscious memory. Ultimately, dissociation is viewed by most

researchers as a defensive structure to protect the self (Coons, 1986; Kluft, 1985; Putnam, 1989; Ross, 1990). For the participants in this study, dissociation was used and continues to be used as a form of defense and ultimately as a form of protection for the self. Therefore, a pervasive sense of protection of the self emerges as the essence of dissociation that is characteristic of dissociative identity disorder.

Decision Trail

Upon reviewing the personal biases, fears and assumptions, previously stated and understood at the inception of this study, I have begun to realize that many of these fears were unfounded and the assumptions and biases altered as a result of conducting the interviews and proceeding with the analysis. For example, I expected that the participants would be difficult to interview or that I might not be sufficiently able to understand their experience. Instead, I found the participants to be extremely cooperative and verbal in recounting their experiences to the extent that I felt that I could truly, as much as is possible, understand their experiences. I also expected extreme forms of behavior such as, switching of alters during the interview (this did not occur according to the participants) and participants with strong beliefs and extreme views, such as, having a very strong sense of spirituality. Instead I found that while some of the participants had a strong spiritual base, it was not common to all. In terms of extreme views, I had origianlly expected to encounter people with very set ideas about the structure of their world and their beliefs about the world. Instead, I found the participants to be very open-minded and thoughtful during the interview.

Throughout the research process I have made an effort to be aware of my biases and have attempted to counter their effects by remaining as truthful to the research process as possible. Between interviewing the participants, I noticed that I occasionally began looking for similar experiences within the participants rather than letting the individual experiences of the participants emerge. I kept a field journal during the progression of this study and noted these biases as they emerged and was able to become aware of them and filter out their influences when necessary.

A number of decisions were made during the research process and will be briefly presented in an effort to demonstrate how consistency in analysis was ensured. During the analysis of the data, the researcher amalgamated several meaning units under an "inclusive label" to better organize and makes sense of the large amount of data. The researcher also arranged a second validity check with participants to ensure that the common and important themes that emerged during the analysis corresponded to their experiences. I noticed an absence of any mention of feelings of fear for two of the participants. During this second validity check, all participants were generally asked about whether they had feelings of fear and as a result of the post hoc affirmative response, this theme emerged despite the fact that some participants had not previously mentioned feelings of fear in the interview.

A number of observations were noted while conducting the interviews. The participants were forthcoming with their information, articulate in their responses, and represented a favorable group with which to work in uncovering information about DID. Peculiar though it may seem, I found it difficult to recall the physical appearance of the participants from one meeting to the next. Their facial appearance remained a blur after each meeting. This observation may reflect their body's ability to appear frozen or neutral at certain times particularly when conversing with someone they do not know well. This would be an interesting area of further investigation.

Overall, my observation was that the participants did not find the interviews unusually difficult and I feel confident in stating that the participants appeared to gain some benefit from having been involved in the study.

Limitations for the study

Five participants were interviewed in this phenomenological study. If this study had been a quantitative study, five participants would have represented a severe limitation in the generalizability of results. However, as stated by Polkinghorne (1979), "The purpose of phenomenological research is to increase the understanding of a functioning experiential concept, not to generalize statistical findings to a specific population"(p. 19). Therefore, variability among the participants is sought. In

qualitative research, the greater the variety of participants in the study, the more complete and encompassing the results. Unfortunately, the variability of participants was lacking in regards to the inclusion of male participants. Male participants were not included in this study and although their input may not have differed qualitatively from that of the females of the study, it is possible that the obtained results might have been different had they been included. In addition, only participants that had the verbal ability to articulate their experiences to the researcher were interviewed for this study. People with DID who were in a vulnerable or unstable state in their therapy were not interviewed. This represents a delimitation of the study. Their exclusion is unfortunate, it also represents a limitation for this study because these people's experiences were not included.

It would have been interesting to have had the DES results both at the time of the original diagnosis of DID was made for the participants in order to compare them to the DES results obtained during this study; however, these results were not available to the researcher.

Future Research

The areas of research that have been presented and discussed in this study attest to the wide range of different levels of research that are presently being investigated in the field of dissociation. The future will undoubtedly continue to hold new and relevant theories regarding the occurrence of dissociation, most notably in the area of childhood and adolescent dissociation. Research into this area of childhood/adolescent development of dissociation holds the probability of a better understanding of the formulation of dissociation and the reasons for its occurrence.

It would be interesting to discover the cognitive and physiological conditions involved in the act of dissociation. Ernest Rossi has described state dependent learning where memories, sensations, and perceptions can be encoded and recalled according to state dependent theory. Applying this theory to the mechanics of dissociation and DID promises to be an avenue of intriguing research.

Studies using a phenomenological methodology in the future will hopefully provide more information regarding the experiences of people with dissociation. A replication of this study using men might yield different results from this study and would make for an interesting comparison.

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Appendix A
Patient Information Sheet

This information sheet and consent form, copies of which have been given to you, is only part of the process of informed consent. This information should give you a basic idea of what the research project is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please feel free to ask the psychologist or psychiatrist giving you this information or you may want to call the researcher (Yvonne Legris at 492-5245). Please take time to read this carefully and to understand any accompanying information.

The purpose of this study is to understand what the experience of dissociation is like for people who have been diagnosed with Dissociative Identity Disorder (also known as Multiple Personality Disorder). You are being asked to participate in this study so that you might provide information about what the experience of dissociation is like for you. Your contribution of answering questions and describing the experience of dissociation is important because you will be providing information that will help myself and other researchers know more about dissociation.

The study will focus on your answers to some questions that I will ask you. You will be asked to take part in three interviews. The first interview will last about a half hour and will provide you with the chance to ask any questions that you might have about the study. The researcher will also briefly ask some preliminary questions about your age, birthplace, education, and mental health history. In the second interview, the researcher will ask some basic questions about dissociation and you will be asked to talk about the times you have experienced dissociation. This second interview should take about an hour to a maximum of two hours long. In the final interview, which should last about a half an hour, you will be asked to verify the information collected by the researcher. The interviews will be audiotaped. At the end of the study, you will receive a summary of the study and the results.

Dr. Fogarty has recommended you as a suitable candidate for this study based upon her assessment and my selection criteria. Your participation in this study is voluntary. You may stop at any time. If you decide to withdraw from the study your therapeutic care will not be affected. If you decide to withdraw from the study, you should call the researcher as soon as possible to inform her. The researcher and doctors involved may stop your participation in the study at any time if they decide that it is in your best interest.

This study has gone through the necessary ethical steps to ensure that your well-being will be protected although, there are possible risks and benefits involved in participating in this study. During the interviews, it is possible that you may begin to be aware of thoughts, emotions, or feelings that are unpleasant or disturbing. A psychologist or psychiatrist will be available to assist you in the event of this occurrence. It is also possible that you may feel pleased or satisfied in being able to talk about your experiences of dissociation.

If you agree to participate, all information provided by you will be kept confidential. You will not be identified by name on any publications resulting from this study. The audiotapes used during the interview(s) will be erased at the completion of the study. Only the researcher and the researcher's supervisor will have access to the taped material.

If you have any questions about this study, the following people may be contacted:

Yvonne Legris 492-5245
(Principal Investigator)

Dr. D. Shannon-Brady 492-1163
(Co-Investigator)

Appendix B
A Phenomenological Study of Dissociation: Understanding Dissociative Identity Disorder
Consent Form for Patients

I acknowledge that the research project described in the preceding information sheet has been explained to me and that any pertinent questions have been answered to my satisfaction.

I understand that Yvonne Legris at 492-5245 or Dr. D. Shannon-Brady at 492-1163 will answer any additional questions that I have about the research project.

I have been informed that I may discontinue my participation in this study at any time without any adverse consequences. I have also been informed about all the known possible risks and discomforts involved in participating in this study.

I agree to allow the researcher to audiotape the interviews and I understand that only the researcher and the researcher's supervisor will have access to the audiotapes which will be erased at the completion of this study.

I understand that I will receive a copy of the information sheets and this signed consent form, but I will not be identified. I have been assured that my confidentiality will be respected. I consent to participate in this study.

_____ _____

Name of Participant (please print) Signature of Participant

_____ _____

Name of Witness (please print) Signature of Witness

_____ _____

Name of Investigator (please print) Signature of Investigator

_____

Date

Appendix C
Interview Guide

The interview guide permits some structure and direction for the interview and ensures that certain information is asked of each participant. The interview guide also serves as a schedule of listed prompts so that the investigator does not have to rely on memory alone. The word "dissociation" and "MPD" were used in this interview guide, but the researcher will use whatever terms the participant offers to account for these experiences.

Preliminary Portion of the Date Gathering Interview
* Brief introduction. Ensure that the setting is comfortable.
* Brief summary about the study: purpose and requirements made of the participants. Hand out patient information sheet and consent form. Ensure that he participant knows that she can refuse to answer any questions.
Do you have any questions about the forms that you've signed?
Do you have any questions about the study? about myself?
I will be asking some general questions about your background information and about what your experiences are like.

1) Background Information:
- Name
- Age
- Birthplace: Where were you born? Have you lived there all your life?
- Marital Status: Are you married? Have you ever been married? In a serious relationship?

2) Mental Health History:
- Are you an outpatient at this hospital?
- Can you tell me how long you've been seeing Dr. X?
- Have you ever been involved in any therapy groups? self-help groups?

3) Participant's understanding of the term "dissociation" and "MPD/DID"
Grand tour/General questions regarding the present understanding of MPD/DID (an attempt will be made to ascertain the native terminology used for dissociation, MPD/DID).
* Start with the first question, but can use the other two if necessary.
- How did you come to know Dr. X? How did you come to be at the Grey Nuns Hospital?
- What led you to be a patient at the Grey Nuns Hospital?
- Have you ever been hospitalized?
- Do you understand what I mean by dissociation? Is that the word you use, dissociation?

4) Previous understanding of MPD/DID
- Did you understand before what MPD/DID was?
- Had you ever heard of MPD/DID before?
- Did you realize that you had MPD/DID?

5) Present understanding of MPD/DID
- Overall, how much would you say you now know about MPD/DID?
- Have you read any books or seen any movies about MPD/DID, dissociation?
- Have you ever done any research on MPD/DID?

Second Portion of the Date Gathering Interview
More detailed information about the experience of dissociating and having multiple personalities.
- If you think back, do you remember when you first became aware of dissociating?
- Do you remember the first time you dissociated?
- Can you describe what dissociation was like for you?
- Were you ever given a different diagnosis? Told that you have a different disorder? (Can you name it/them?)

1) Most recent dissociative experience
- Can you recall the last time that you dissociated?
- Would you be able to describe what it was like?
- Are you more aware now of when you dissociate?

2) Multiple personalities
- How many different parts (alter personalities) do you think you have?
- Would you be able to describe what the different parts are like? (e.g.: How are they different, the same?)

3) Coping
- How do you cope with everyday life?

4) Spirituality
- Do you have a sense of spirituality?
- Do you consider yourself to be a spiritual person?
- If yes to previous question, how important is your faith/spirituality to you?

5) Social Contact
- Have your experiences of dissociation affected your personal relationships? professional relationships?
- Have your experiences of dissociation affected the extent to which you socialize with others?
- Have you ever been in contact with other people who dissociate?
- Do many people know that you have MPD/DID?

Appendix D
First Level of Analysis: Kate

Meaning Units	Paraphrase	Label
1. I started to remember just about two and a half years ago now and I didn't know what was going on.	Started remembering the abuse about two and a half years ago and was not aware of what was going on.	- Personal Level of Awareness
2. somewhere along the line she mentioned about dissociation or something but, it was just me being me, I mean I didn't know other people weren't like that, I thought just that everybody was like that.	The idea of dissociation was mentioned to her, but she thought that everybody dissociated. She thought everybody could dissociated.	- Awareness of Being Different
3. I started losing a lot of time, I became aware that was happening. Before I didn't have an awareness of that.	She started losing a lot of time. She became aware of losing time but hadn't previously been aware of it.	- Losing Time - Personal Level of Awareness
4. But is was hard to realize that not everybody was like that, that there was a problem, something more going on.	It was hard for her to realize that not everybody dissociated and that it was a problem.	- Awareness of Being Different
5. if you just grow up that way or that's just who you are you don't realize other people aren't like that. So, I guess I just never thought that other people were different than I was different.	She didn't realize that other people weren't like her. She didn't realize that she was different.	- Awareness of Being Different
6. Of course, now I'm much more aware of, it is something that happens.	She is more aware of it as something that happens.	- Personal Level of Awareness
7. You know, develops in childhood...if you don't go through that kind of trauma, you don't develop that kind of system to deal with everything.	mpd develops in childhood. If a certain level of trauma is not undergone by the child, that type of system will not develop.	- Understanding of Multiple Personality Disorder

that it really happened.	notice that she was dissociating.	Awareness