The Improvised Social Solution Model:

A Reconceptualisation of

Dissociative Identity Disorder

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Doctor of Philosophy in Psychology

by

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In the last few decades, the incidence of Dissociative Identity Disorder (DID) has risen significantly. Most research into the aetiology of DID suggests that among other factors, a genetic propensity to pathologically dissociate is present in the development of the disorder. This thesis rejects the “innate predisposition” model of DID and aims to reconceptualise the disorder as an improvised social solution that is activated when external support structures are eroded. Insecure attachment, interrupted identity development and the acquisition of protective mechanisms are all identified as critical factors that, in the presence of trauma, lead to susceptibility to dissociate. The model put forth in this thesis postulates that DID is activated as an autodefault solution in the event of complete systemic psychological collapse. The improvised social solution is multifunctional, providing the illusion of order, the facility for conflict resolution and the provision of an internalised support structure.
The legitimacy of Dissociative Identity Disorder (DID) (formerly Multiple Personality Disorder (MPD)) continues to be debated among psychological theorists. This pathological dissociative disorder has waxed and waned in popularity both in research and in clinical practice for decades. Research in the area reveals there is huge inconsistency about the prevalence of the disorder. Some estimate the number of cases is as high as one or two per cent of the population (Ross, 1989). Despite the persistent claims among some that DID is merely artefactual (e.g., Spanos & Burgess, 1994; Kampman, 1976), there is ample evidence that DID is a valid disorder (e.g., Kluft, 1984; Sutcliffe & Jones, 1962; Taylor & Martin, 1944).

Dissociative Identity Disorder (DID) is a social problem on the rise (Boor, 1982; Greaves, 1980), fueled by a cultural environment that is quickly eroding social structures and relationships (Berman, 1983; Capps & Fenn, 1992). This thesis argues that the protection provided by these social structures is a core element in protection from DID.
The rise in the diagnosis of DID in the last few decades is nearly exponential. Braun (1986) estimates that 500 cases of DID world-wide were known in 1979. This number grew to one thousand in 1984, and to five times that number only two years later.

Prior to 1980, DID was thought to be extremely rare. At the time of the publication of *The Three Faces of Eve* in 1957, Eve White was thought to be the only case of the disorder (Ross, 1989). The first international conference on Multiple Personality/ Dissociative States in 1984, found that the 92 presenters had seen 667 cases of DID in the previous decade (Frischholz, 1985). Spira (1996) considers DID sufficiently rare that most psychotherapists will never confront a case. Ross (1989), however pegs the incidence of DID in Winnipeg where his research took place, at somewhere near one case per 1500 people in the general population. This is a far cry from the situation decades earlier when the cases could be counted individually.

The burgeoning incidence of DID is closely related to culture. More specifically, this psychopathology relates to detachment from culture (Dorahy, 2001). While such detachment may occur through physical displacement, it is keenly present as a cultural phenomenon throughout the western world (e.g., Fornäs & Bolin, 1995; Inkeles, 1983; Putnam, 1995; Frosh, 1992). The cultural shift had its roots in modernism beginning
shortly after the turn of the century. Half a century later, postmodernism took hold, and along with it grew the seeds of a new culture-based psychopathology.

**Postmodernity, culture and DID**

The surge in the diagnosis of DID corresponds to a burgeoning cultural movement that has widespread implications on the development of psychopathology. The industrial revolution and the dawn of the age of modernity brought with them widespread changes in lifestyle and culture (Frosh, 1992; Berger, Berger & Kellner, 1973). But in terms of profound psychosocial consequences, modernity could not compare with what followed (Featherstone, 1995). The increase in dissociative disorders has also been attributed to the social effects of modernity and to their resultant lack of cultural 'psychological defense' (Schumaker, 2001).

Postmodernity shook the very foundations of culture, and with it, the anchor upon which we built our identity. In less than a generation, centuries-old, and once-thought stable, institutions like the church, the family and community have crumbled. Although in Western society each still exists, they do so with little cultural imperative. Individualism, the child of postmodernism, has created a culture both at liberty to, and encouraged to seek what fulfills on a personal level (Capps & Fenn, 1992). One might
attend church as one's parents had. One might marry and have children. One might invest energy in developing community relations. But one might not. The structure upon which previous generations based their communities and their identities is no longer.

What has been coined an “MPD epidemic” (Boor, 1982) is, in fact, representative of an epidemic of psychopathology. Rates of depression have increased dramatically since the 1950s (Seligman, 1990; Hagnell, Lanke, Rorsman & Oejesjoe, 1982). Diagnoses of borderline personality have also been on the rise in western cultures (Millon & Davis, 1995; Paris, 1993; Paris, 2001). The radical transition in western culture resulting from postmodernism has interfered with the social structures and support mechanisms present among traditional and non-westernised societies. The structures are protective factors against psychopathology in general, and specifically, DID.

Social structures still present and well defined in traditional cultures are disappearing in modern western society. The implications of postmodernism extend from the broad cultural context to the intimate relations of a family. The effect of postmodernism on westernised culture is profound. Individualism is a hallmark of postmodernism (Capps & Fenn, 1992). Cultural icons and institutions are being regarded as relics of the past, museum pieces packed with nostalgic value but without the staying power to ground individuals with solid cultural identity (Berman, 1983; Inkeles, 1983).
Counter cultures and subcultures are as valid as an individual’s decision to abdicate both. Since individualism is primarily driven by the will to satisfy one’s personal needs, desires and tastes, the foundations of cultural structures are no longer being maintained. Weakening cultural identity is implicitly problematic for people experiencing trauma. One’s culture represents a sphere of belonging, and thus identity and strength. Furthermore, culture dictates the roles of community and family, both of which are ideally vital areas of support.

Contrasting markedly with the solidity of community in the premodern times and in non-western cultures, the postmodern notion of community is much more transient. Communities whose membership was based on geography and cultural affinity have been greatly supplanted by interest-based membership in a range of communities. Such communities may have their basis in professional affiliations or leisure activities. Increasingly, virtual communities are replacing those requiring physical contact. This transition emphasises the cultural thrust on communities. But membership in a range of single-issue communities with little cross-over and limited depth or commitment may not provide solid support upon which to lean in times of adversity. The reality for the postmodern member of the community(ies) may be a myriad of largely superficial relationships that do not provide the requisite support when the need arises. Indeed, the
realisation that one’s community relationships do not stand the test of time and need may
heighten one’s sense of isolation and vulnerability in times of crisis.

The most basic expression of community, that of family, has not escaped the
damaging effects of postmodernism. The inclination of parents and children to engage in
their own pursuits (coupled with the disappearance of community-based family activities,
like church services and community gatherings) has the effect of turning the family unit
into a pit-stop for rest and meals. Any erosion of the family’s ability to provide stability,
support and strength of identity has huge implications for psychological health,
particularly when it is threatened by abuse or trauma. Schumaker (2001) notes that
marital and family relations represent one area that could have benefited from the social
and financial freedom in the age of consumerism. Men and women, freed from the past
constraints of economic hardship and liberated from bothersome social relations, might
have faced the possibility of engaging in the ‘pure relationship’. But the conditions of
postmodernity are not favourable for the development of the pure relationship. According
to Schumaker, factors that formerly contributed to marital cohesion, like children, may
now be considered nuisances. Similarly, the former emphasis on commitment, trust and
mutuality have given way to self interest and personal fulfillment. With this development,
any notion of the pure relationship recedes and more western marriages may fail than
endure.
The individualistic nature of postmodern society, while offering myriad possibilities and myriad opportunities, comes at great cost. On a cultural level, the nomadic inhabitants of postmodernity have the world at their fingertips, but no community to call home. This lack of cultural stability poses serious risk to psychological resilience. What results is a two-fold vulnerability. The cultural fluidity, the lack of family adherence to cultural institutions, promotes weak sense of identity. In the absence of effective role models and structures, young people struggle to forge an identity (Paris, 2001). Additionally, in the event of adversity, the practical manifestations of community are not available. Support structures may be few or absent, or supportive relationships may be superficial, a result of little investment in supportive infrastructure.

**A new conceptualisation of DID**

This thesis is concerned with the implications of eroded support structures and their effect on children who are subjected to sustained trauma. The fact that postmodernism represents a climate of psychological risk is not central to the model of DID presented in this thesis. It does, however, provide a context for the surge in the number of diagnoses, and an indication of the urgency of a new conceptualisation of DID. The model of DID presented in this thesis is based on the understanding of the
place of our social roles in our psychological health and stability. This thesis builds a progressive argument identifying the various factors and their interplay in the development of the disorder.

Chapter 2 provides the context for this thesis and explains the need for a novel approach to adequately account for the manifestation of DID. This chapter discusses the nature of DID, its aetiology and some of the pervading perspectives and theories in the clinical and research arenas. It is here that it becomes apparent that DID is strongly linked to the social structures and circumstances of its victims. While trauma is a necessary component in the development of the disorder, on its own it is not predictive. The absence of various levels of social structure appear to be a key ingredient for the development of the disorder.

Chapter 3 investigates early childhood attachment to caregivers. The chapter identifies several styles of attachment and their psychological consequences. It is here that the role of attachment in the development of psychopathology is argued. Insecure attachment sets the foundation for the hindrance or interruption of the acquisition of protective mechanisms and consequential psychological resilience. This chapter also seeks to establish the relationship between attachment and identity formation. It postulates that the psychological foundation provided by secure early attachment plays an
integral role in establishing a strong sense of identity. Early attachment serves as the cornerstone of psychological development. On its own, insecure attachment can be identified as a risk factor for the development of DID. The reality, however, is that poor attachment is likely not an isolated risk factor. Instead, as psychological strength is built on early secure attachment, so too are risk factors compounded, domino like, in the presence of insecure attachment.

Chapter 4 explores identity formation on several levels. The chapter juxtaposes the effects of traditional premodern or non-western culture on identity formation with that of postmodernism in the West. This chapter illuminates how postmodernism and individualism have contributed to a climate that does not provide adequate bedrock on which to anchor developing identity. Membership in erstwhile important cultural institutions like the church, the family and the community has been supplanted by participation in fragmented, special interest activities. This movement has contributed to the destruction of a framework upon which children have based elements of their identity like community and sex roles. The dissolution of cultural identity has perhaps placed an even greater onus on the family to provide a base within which to develop personal identity. Where this is particularly important is in the context of familial abuse (often linked to DID), when there is limited cultural identification and support to ward off pathological dissociation.
Following from the assertion in Chapter 4 that strong identity formation is a protective factor in the face of psychological trauma, Chapter 5 identifies protective factors that contribute to psychological resilience. The chapter indicates that the development of protective factors begins with strong attachment and identity formation. Attainment of others occurs, to some degree, as a consequence of the solid early psychological foundations. Protective factors include the generation of social support upon which the individual may rely in times of adversity. This supportive structure also provides a social role and identity within this community. From the context of this secure social base (which includes, but is not limited to family) the individual may expand the social network within a progressively diverse range of activities, and develop both the sense of self and conception of self worth. As much as the presence of protective factors is argued to be instrumental in fending off pathological dissociation, the absence is illustrated to be a significant risk factor for DID in the face of trauma.

The preceding chapters set the context, culturally and individually, for the surge in incidence of DID. What they also do is help to establish the connection between the level of available support and the risk of developing psychopathology in times of trauma. The identification of the cultural and individual issues surrounding the development of
DID contribute greatly to the perception of the disorder as a consequence of social issues, and not subject to genetic predisposition or the type or severity of abuse.

Based on this new understanding of DID, Chapter 6 puts forth a model of the disorder as an improvised 'social solution' to a largely social problem. The lack of protective support experienced by DID sufferers is a result of the absence of specific supportive roles. This chapter presents DID as an improvised social solution to account for this critical absence. The chapter illustrates how alterpersonalities are not a random selection of characters, but rather the personification of a purposeful combination of roles designed to support the host while facilitating conflict resolution. Across cases, researchers have discovered a remarkable consistency in the presentation of alterpersonalities, or *alters* (Ross, 1989; Putnam, 1989). Although there is a huge range in the number of alters manifested among DID sufferers, they tend to fit into a number of established categories. These categories, it will become clear, are significant in the provision of types of support absent to the victim in the external world. Similarly, the number and roles of presenting alters correspond to specific voids in the DID victim’s external support structure. Although essentially maladaptive, the improvised social solution provides an outlet or stage for conflict resolution and protects the host from having to confront realities and memories beyond their ability to cope.
This thesis argues that this social solution is an autodefault mechanism, activated when all other protective mechanisms fail. DID is ultimately a means for the psyche to impose control. Control over support. Control over self expression. Control over social dynamics. The control made possible through DID, it is important to note, is control not possible otherwise. An important factor in the establishment of control over several facets is the establishment of order. Conditions favourable to the development of DID often create disordered reality. A fundamental capability of DID (and one which accommodates the supportive functions of the disorder) is DID’s establishment and maintenance of order. One such example is the maintenance of logic and consistency in the day-to-day life of the DID sufferer.

The improvised social solution model of DID provides an opportunity for a reconceptualisation for the disorder. This model also has important research and therapeutic implications for the future.
Chapter Two

DISSOCIATIVE IDENTITY DISORDER

THEORIES IN PERSPECTIVE

Several strands of thought are currently being played out in the theoretical realm of dissociation. Since the mechanisms of dissociation are still largely unknown and subject to debate, the domain remains entirely theoretical. One might argue dissociation will forever be nebulous. Researchers have attempted to provide scientific explanations for DID, however it seems that dissociation is as much the stuff of fog and fancy as neurophysiology. No argument based on physiology seems to adequately account for the occurrence of dissociation. This is certainly not for lack of trying. DID has been linked to temporal lobe epilepsy (e.g., Benson, Miller & Signer, 1986; Schenk & Bear, 1981) and genetic predisposition (e.g., Kluft, 1993; Whalen & Nash, 1996). This is not to say there lacks consensus on its regular and increasing occurrence (Boor, 1982). This chapter will introduce and juxtapose models of dissociation that have maintained some prominence since the birth of dissociation as a psychiatric condition in the 1800s. This exercise will
attempt to contextualise my model of Dissociative Identity Disorder as a factor of early attachment and identity formation.

DID, formerly Multiple Personality Disorder (MPD), is as much a subject of debate as the broader realm of dissociation. The controversy surrounding DID includes whether in fact it exists, let alone its manifestations. The schools of thought represented in this paper approach the topic of DID from sometimes different theoretical camps. The similarities in their findings are perhaps more telling than the differences and provide fertile soil from which to grow a more expansive theory. A starting point for this discussion is a definition of DID provided by the *Diagnostic and Statistical Manual Fourth Edition* (DSM IV) (American Psychiatric Association, 1994) which states:

a) The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

b) At least two of these identities or personality states recurrently take control of the person's behaviour.
c) Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

d) The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behaviour during alcohol intoxication) or a general medical condition (e.g. complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play (p.230).

A brief history of dissociation and DID

Dissociation was a large area of study in the 19th and early 20th centuries. Among the key figures involved in the study were Pierre Janet in France and Morton Prince and William James in the United States (Putnam & Loewenstein, 1989). Janet’s approach to dissociation has been very influential in the contemporary conceptualisation of DID. He viewed dissociation as stemming from an inability to “associate” memories, particularly of a traumatic nature. Janet (1976) elaborated the notion that the conscious mind can split in a manner different from merely “forgetting”. According to Janet, people dissociated because of a biological predisposition. He referred to this innate propensity as mental “désaggregation”. Research on hypnosis, automatic writing and fugues was popular in the late 19th century and diagnoses of Multiple Personality Disorder (MPD) began to be
reported with some regularity (Ross, 1989). Janet considered dissociation as the principal mechanism behind both hypnosis and hysteria (including fugues) and amnesia and MPD. In 1890, with the publication of *Principles of Psychology* by James, MPD received a serious boost in credibility. James, a highly recognised psychological theorist to this day, devoted a full chapter to MPD, contributing significantly to the acceptance of the disorder in the psychological community. Also piquing the imagination of the scientific and broader community at that time was Ribot’s 1856 publication of *The Strange Case of Dr Jekyll and Mr Hyde* (McKellar, 1979).

With the publication of *The Dissociation of a Personality* with Christine Beauchamp, Prince (1969) established himself as the leading authority of MPD in North America during the first half of the twentieth century (Greaves, 1980). Prince and Janet became particularly noteworthy in their polar approaches to the treatment of MPD. While Janet sought to integrate alter personalities, Prince attempted to reinforce “good” alters to dispel unfavourable ones. Despite the increased stature of the disorder, its incidence in diagnosis oscillated markedly. This occurred for several reasons, the most notable of which may have been the work of Sigmund Freud. Formerly a strong advocate of the theory of dissociation, Freud abandoned his work in this area in favour of repression. Freud was extremely influential and had many followers, so his change of
cant involved a significant shift in psychology away from MPD (Ellenberger, 1970; Kluft, 1993).

From 1901 to 1944, 33 cases of MPD appeared in the literature, and in 1910, 'dementia praecox', the umbrella diagnosis for the hysterias (including MPD), was replaced with schizophrenia (Rosenbaum, 1980). When Freud's colleague, Bleuler, introduced the term schizophrenia, he stated "it is not alone in hysteria that one finds an arrangement of different personalities, one succeeding the other: through similar mechanism, schizophrenia produces different personalities existing side by side" (Rosenbaum, 1980, p.1384). Consequently, with the presence of overlapping symptomatology, the incidence of MPD diagnoses plummeted corresponding to a surge in the diagnosis of schizophrenia (Braun & Sachs, 1985).

So unpopular became the diagnosis of MPD that during the course of Thigpen and Cleckley's (1957) treatment of their soon to be famous patient "Eve" from 1945 to 1954, "so little had transpired in the field that Eve was believed to be the only living person with multiple personality" (Greaves, 1980, p.578). The next 25-year period yielded only 14 cases of the disorder (Rosenbaum, 1980). But this period was followed by an upsurge of MPD cases. In the 1970's, the literature indicates some 50 cases of MPD world-wide (Greaves, 1980). Thus, the waxing and waning of DID diagnoses throughout the 19th and
20th centuries occurred for several reasons. First, Freud had great clout in the psychiatric community and was better positioned politically than Janet (Putnam & Loewenstein, 1989; Ellenberger, 1970). “Interest in dissociative disorders declined during the 1920s as the Freudian theory, with its rejection of hypnosis and child sexual abuse and its substitution of repression for dissociation in clinical formulations, gained disciples” (Putnam, 1993, p.2). Ross (1989) notes that Freud “effectively banned a large area of psychic reality from serious study, and that included dissociation” (p.37).

Another significant factor in the waning recognition and diagnosis of MPD was the burgeoning behaviourist movement championed by John B. Watson in the United States in the 1920s (McKellar, 1979). Watson led a movement that shifted psychological emphasis away from subjective experiential models to the objective and measurable study of behaviour. In so doing, psychology was, in effect, embraced by science. Behaviourism took off, and the biological and physiological area of psychological study became relevant and important under the scientific ideological umbrella.

It is important to emphasise the unassailably artefactual nature of the fluctuations in the frequency of MPD diagnosis. Significant increases in dissociative symptoms were seen in traumatized soldiers during every war of the 20th century (Putnam, 1989; Foa & Hearst-Ikeda, 1996). Despite these reported increases in fugues, amnesias and conversion
disorders, “these observations tended to be forgotten by the psychiatric community, as the wars themselves faded from memory” (Putnam & Loewenstein, 1989, p.3).

The 1980s heralded the return of MPD research in full force with the decline of behaviourism. As evidence of the enduring prevalence of multiple personality during these times of diagnostic fluctuation, during that decade about 40 per cent of schizophrenics were rediagnosed as suffering from Multiple Personality Disorder (Ross, 1989). Although DID is once again regaining credibility within the psychological community, it continues to be met with skepticism. There has been some suggestion that DID is largely iatrogenic, that it results from a combination of a naïve, enthusiastic (or suggestive) therapist and a histrionic patient (Spanos, 1996).

**Epidemiology of DID**

From the outset, it must be stated that the epidemiology of DID is shaky at best. Putnam (1997) bemoans the failure of epidemiologists to include measures of pathological dissociation in recent studies, and that “dissociative disorder researchers have little expertise in epidemiology” (p.95). Nonetheless, several studies have been conducted to identify the prevalence of DID. In his study of the incidence of dissociation in the normal population of Winnipeg, Canada, Ross estimates the incidence in that
community to be around 1.3 per cent (Ross, 1989). An independent analysis of the same data using the “Dissociative Experiences Scale” (DES) found an incidence of 3.3 per cent (Putnam & Loewenstein, 1989). Ross estimated the incidence of DID could realistically reach five percent (Ross, 1989). His research joins “a considerable amount of work that has been done on the epidemiology of dissociation within clinical populations and a lesser amount among college students” (p.4).

Putnam and Loewenstein (1989) have found the incidence of DID among psychiatric inpatients to range between six and 20 per cent. These findings hail from Russia, the United States, Canada, Turkey, and Western Europe. They also reported gender differences ranging from equal numbers of female and male diagnoses in early childhood increasing steadily for women to the ratio of eight to one by late adolescence. As Putnam (1997) notes, the discrepancy in diagnoses among men and women may result from the fact that males are more frequently perpetrators of sexual abuse, and females more often victims, suggesting the possibility of environmental rather than sex-linked determinants of the disorder.
Abuse and Trauma

The relationship between trauma and DID is widely accepted among contemporary dissociation theorists. In fact, Janet (1965) described dissociation as a way for the mind to disconnect stressful events from memory and conscious awareness. This view underlies the general understanding of trauma's role in the disorder. While mechanisms and rationale continue to be subjects of active discussion, in broad terms it is believed that in the face of overwhelming trauma, the subject must separate the memories of the traumatic events from conscious awareness to continue functioning (e.g., Ludwig, 1983; Speigel, 1993; Putnam, 1997; Ross, 1996). Speigel (1993) explains the function of dissociation in the face of trauma: “Dissociative defenses, which allow individuals to compartmentalise perceptions and memories seem to perform a dual function. They help victims separate themselves from the full impact of physical trauma while it is occurring, and, by the same token, they may delay the necessary working through and putting into perspective of these traumatic experiences after they have occurred” (p.117). While trauma appears to be a nearly universal component in DID (Braun & Sachs, 1985; Braun, 1984; Brenner, 1999), on its own, trauma is not causal. Identifying the other factors in the development of DID is currently the area of most active research.
An Innate Predisposition To DID?

There is some question as to whether dissociative capacity is innate or acquired. The fact is, the bulk of theorists contend dissociation relates in some way to genetic predisposition. Genetically determined mitigating factors in the research on DID appear in several forms. Principally, they include ‘predisposition to dissociate’ (Kluft, 1984; Spiegel & Spiegel, 1978; Frischholz, 1985; Beahrs, 1983), ‘hypnotisability’ (Bliss, 1983), ‘intelligence’, or ‘creativity’ (Braun & Sachs, 1985). Only one principal theorist, Putnam (1997), argues against the position that genetically predisposed factors affect the incidence of DID among individuals. He holds that all people are born with an innate dissociative ability, thus the ability to dissociate is universal. His position is fully elaborated further in the chapter. Others, such as Spanos (1996), deny an innate pathological dissociative ability but they venture further to challenge the validity of the diagnosis. For Spanos, manifestation of DID is a result of histrionics on the part of the attention-seeking patient, reinforced by therapists keen to validate DID diagnoses. Contributing to the arguments against the validity of the disorder are several factors. The use of hypnosis in the diagnosis of DID has raised criticism because of the spectre of hypnotic suggestion (Spanos & Burgess, 1994). Furthermore, there is concern that histrionic patients may fake symptomatology (Merskey, 1992; Aldridge-Morris, 1989; Piper, 1996). Fuelling skepticism is the belief that the majority of DID diagnoses emanate
from clinical procedures using suggestive techniques designed to identify alter personalities. Critics argue that this technique does not uncover, but rather constructs alter identities (Spanos & Burgess, 1994; Spanos, Weekes, Menary & Bertrand, 1986).

Janet viewed dissociation as a manifestation of an innate physiological "weakness" which prevents the integration of some traumatic psychological experiences into consciousness (Ellenberger, 1970). Contemporary theorists who endorse the Janetian view of the mechanics of dissociation refer to this phenomenon as an innate predisposition to dissociate. Proponents of this perspective claim innate differences between those who can manifest dissociative responses from those who do not. Goodwin and Sachs (1996) found that the most likely explanation for the variation in dissociative response to child abuse was "wide constitutional differences in the ability to dissociate" (p.94). In combination with innate capacity, proponents of the 'constitutional factors' argument find that the presence of trauma greatly increases the likelihood of generating a dissociative response (e.g., Ellenberger, 1970; Whalen & Nash, 1996).

The predominance of the 'innate versus acquired' discussion is to some degree contrived. There has been pressure from within the field of psychology and from outside to scientifically validate the existence of DID (e.g., Spanos, 1996; Bliss, 1988; Blizard, 1997). The issue has been hijacked by a series of phenomena which have affected the
traditional evolution of psychological theory. As indicated earlier, DID has achieved waves of popularity, beginning in the 1800s (Kluft, 1993; Ellenberger, 1970). In keeping with the modern trends, DID almost vanished from the field; it was removed from the diagnostic manuals and generally considered a hoax (Ross, 1989; Rosenbaum, 1980; Blizard, 1997).

Theorists have been unable to establish a causal relationship between trauma and manifestation of DID. So, lacking concrete experiential determinants, some have turned to what I believe is the default mechanism and the last resort: genetic predisposition. Exploration into the transgenerational incidence of DID became a likely indicator for a genetic link for DID (Braun, 1985). I will argue in the following chapters that despite elevated incidence of DID within families, genetics are likely not a causal factor. This thesis seeks to clarify the environmental determinants of the disorder, that social and behavioural factors leading to the development of DID are not tied to genetic predisposition. The following chapters will illustrate the complex causal relationship between trauma and DID.
**Factors Affecting “Dissociativity”**

Dissociativity is broadly defined as the proclivity of subjects to dissociate. In this context, the implication of dissociativity is the ability to pathologically dissociate. Dissociativity is a particularly important concept for theorists who argue that tendency to dissociate is a necessary component in the development of DID. Dissociativity is a description affected by many factors, predominately, hypnotisability (Frischolz, 1985), age and fantasy proneness (Putnam, 1997) and tempermental traits (Beere & Pica, 1995).

Spiegel (1993) and Putnam (1997) both find that age is correlated with dissociative capacity, with dissociative ability peaking at nine or ten years of age, then beginning to decline. Putnam argues that childhood abuse combined with higher dissociative ability in childhood helps to explain pathological dissociation. “Taken together with evidence that innate dissociative capacity appears to peak during childhood, these findings have suggested to several investigators that childhood trauma acts to enhance or preserve into adulthood the child’s normatively elevated dissociativity” (p.5).
Hypnosis and DID

The autohypnotic model of DID has been particularly compelling to clinicians working with DID patients. The model suggests that pathological dissociation is a form of self- or auto-hypnosis which is adapted in the immediate context of trauma or abuse, later becoming elaborated into alter personalities (Bliss, 1984; Putnam & Loewenstein, 1989). Proponents of this school of thought note similarities between the phenomenology of deep trance states and some of the phenomenology seen in DID. In terms of the aetiology of DID, supporters of the hypnotic model point to DID patients having the highest hypnotisability compared to normal controls and patients with other affective disorders (Putnam & Loewenstein, 1989; Ross, 1989). The proposed link between hypnotic and dissociative ability works broadly like this:

- *DID sufferers are highly hypnotisable.*
- *High hypnotisability is positively correlated with dissociative capacity.*
- *Variations in hypnotisability are innate.*
- *Therefore, DID too, is a factor of innate predisposition.*

The above lines clearly represent several leaps in logic. Perhaps the most serious is the chicken and egg argument of whether hypnotisability precedes or is a consequence
of dissociative ability. Ross (1989) describes this logic as equivalent to stating that “pneumonia is caused by fever” (p.65). It is also important to note that dissociation in the hypnotic context does not necessarily equate with pathological dissociation.

**Neodissociation Theory**

Ernest Hilgard’s theory of “neodissociation” also recalls similar phenomena among dissociative and hypnotic subjects. He introduces the concept of the psychic “hidden observer” who remembers events the subject does not recall because of an amnesic barrier which exists between states (Hilgard, 1994). His theory articulates some mechanisms at the root of the correlation between hypnotisability and dissociation.

For Hilgard, dissociation is the manifestation of innate weakness. He likens dissociation to poor “executive control” which results in the poor consolidation of memories and mood states. The critical message of Hilgard’s theory is that those with weak executive cognitive control (and who exhibit the hidden observer under hypnosis) display an innate cognitive weakness and are more likely to display pathological dissociation.
Despite the correlation between hypnotisability and dissociative capacity, and not withstanding questionable causal relationships, there may be a much more robust explanation for incidence of DID. When conducting his experiments on hypnotisability and the hidden observer, Hilgard does not appear to have adequately accounted for his subjects’ histories, allowing for the likelihood that high hypnotisability and dissociative capacity may both result from a psychological defense against trauma. Notwithstanding Hilgard’s affinity for the hypnosis model, the hidden observer phenomenon introduced in his neodissociation theory has been crucial to conceptualising the mechanisms of DID. In this model, the hidden observer illustrates the ability of different identities to function, often without the other identities’ knowledge. Even though Hilgard’s theories are based on experiments of hypnosis and can’t easily be generalised to the mechanisms of DID, they nonetheless provide fodder for the investigation of the disorder.

**Archetype Alters**

The presentation of DID is significant to this thesis as I will indicate in Chapter 6. DID alter personalities are not a random or completely individualistic selection of personalities. Rather, alters tend to reflect several archetypes which represent important areas of social influence. It is important to note here that the term ‘archetype’ is not used in a Jungian context, but rather the more pedestrian ‘1. a very typical example of a
certain person or thing, or 2. an original which has been imitated" (Pearsall, 1998, p.86). Fine (1999) likens the development of alters to a child's use of imaginary friends to cushion the blow in times of adversity, serve as a protector or merely share the experiences in friendship. Fine's analogy, though simplistic in relation to the development of the disorder, is remarkably apt in terms of the roles alters play in the psychic dynamic of DID. Ross notes three basic personality types among alters, and within those types more than one personality may be present (Ross, 1989). His three main types are: Child personalities, protector personalities and persecutor personalities. These characters may appear as the opposite sex, and in a variety of guises. The presence of these archetype alters reflects the significant conflict experienced by the DID sufferer. Saltman and Soloman (1982) found that DID may be interpreted as a defensive state. In their investigation of the disorder (in particular to the disorder's relationship to neurosis), Lichtenberg and Slap (1973) found that splitting as a defense is not "confined to any specific diagnostic category" (p.773). The place of conflict, and emotional ambivalence in the aetiology of DID is well expressed by Greaves (1980) in his meta-analysis of the early literature. These areas of conflict frequently surround the themes of religion and sexuality (Bowers, Brecher-Marer, & Newton, 1971), and abound in environments where polarity is fostered and side-taking encouraged (Allison, 1974). The seeming universality of conflict in the lives of DID sufferers does not, in its own right, explain the role of the alters in this conflict, however. This thesis will argue that an integral function of DID is,
firstly, the facilitation of functioning in the presence of conflict, and secondly, providing a stage to allow for the safe expression of this conflict. The alters provide the facility for both of these requirements. The elucidation of this dynamic takes place in Chapter 6 following the identification and analysis of the factors that contribute to the aetiology of the disorder.

**The Alters’ function in the social solution**

The presence of the alter or alters provides an internal “social solution” to the presence of conflict. It will be argued more expansively elsewhere that particular alter personalities may help to provide a coping mechanism to allow the DID sufferer to contend with the presence of irreconcilable conflict (for example, a parent alternately delivering love and torture). The alters internally ‘play out’ troublesome external dynamics. This internal solution develops in response to a lack of external support or to the physical or emotional absence of key social figures.

This thesis will illustrate that the alter personalities observed in DID recreate dynamics which have led to trauma or abuse, but with the necessary modifications allowing the subject a greater degree of control, the kind of control simply unavailable in their external lives. While “protectors” may have been externally unavailable to a child in
an abusive situation, the creation of an internal protector may play a necessary mental function. Ross (1989) states that child personalities often present themselves as frightened and untrusting, while protector/observer alters share a common goal, to protect the host from abuse. Persecutor alters are usually self-destructive (in that they bully and threaten the other alters). These are often responsible for suicide attempts among DID sufferers.

Kluft (1993) articulates the alter types differently, contributing detail to Ross’ three archetypes, but the nature of the personalities remains that of antagonists and defenders. He states: “the often dramatic differences among the personalities are more an arresting epiphenomenon than the core of the condition. Characterological factors, cultural influences, imagination, intelligence, and creativity make powerful contributions to the form taken by the personalities” (p.22). According to Kluft, most MPD patients are rather muted in comparison to the well-documented cases assumed to epitomise the condition. The adaptational patterns and strategies enacted by the personalities are developed to promote defense and survival. Those personalities frequently encountered, he notes, include childlike personalities, protectors, helper-advisors and inner self-helpers. Others include personalities with distinct affective states, guardians of memories and secrets, inner persecutors, anesthetic personalities and expressers of forbidden impulses. Avengers, defenders or apologists for the abusers, very specialised
personalities and those who preserve the idealised potential for happiness, growth and the healthy expression of feelings are also present in the customary range of alters.

Despite their variation, most of the roles identified by Kluft assume the role of aggressor or defender. This is not to say DID sufferers do not manifest exotic alters. For example, Ross (1989) classifies as less common types of alters: demon alters, alters of a different race, dead relative alters, other living person alters. Although these personalities are less common and are largely dependent on their significance to the host, generally, they still fall into an archetypal category. Supernatural alters are relatively common among Judeo-Christians because of this group’s culturally strong presence of personified evil. Demon and deistic personalities may represent a different category of dissociation, that of the socially sanctioned (and consequently not pathological) dissociation.

**Culturally Sanctioned Dissociation**

In the context of clinical practice and psychological theory, DID assumes a pathological quality. With a change of context, however, very similar symptomatology becomes, in many cultures, normal and, arguably, necessary. This thesis is concerned with pathological dissociation as it relates to early childhood attachment and identity formation. The determinants of "culturally sanctioned" dissociation appear to be quite
distinct from the aetiology indicated here. Culturally sanctioned dissociation appears almost universally religious. Common examples include shamanic transfiguration, trance and possession states (McKellar, 1979; Ross, 1989). Even in the context of the westernised world, reports of possession persist. While those exhibiting culturally sanctioned forms of dissociation might, under different circumstances, be diagnosed with a dissociative disorder, the aetiology of the religious or culturally relevant dissociation may differ from that of the growing incidence of DID in westernised culture. There are practical limitations to researching the aetiology of culturally sanctioned dissociation. While the condition may stem from dynamics similar to those explored later, reality for these dissociators differs markedly from their westernised counterparts. Not marginalised with diagnosis and treatment (and not present in the scientific literature to facilitate study), these culturally sanctioned dissociators may fulfill important societal roles.

The existence of reported spirit possession in all cultures, some researchers argue, precludes the suggestion that DID is merely iatrogenic (Ross, 1989). In fact, Krippner (1994) argues that possession is universal (and cited among the World Health Organisation's list of known illnesses) while DID is a little-known cultural construct, seen primarily in the United States. The cultural implications of the symptomatology of the dissociation, whether DID or culturally sanctioned, are important in distinguishing between the two, however. Bourguignon (1977) cited two similar subjects as examples,
one in New York City and the other in Sao Paulo, Brazil. The alter present in the New York case caused the patient embarrassment, while her Brazilian counterpart welcomed her “spirit possession” which was also welcomed by her community. Schumaker (1995) contends the route to dissociation is both natural and compelling for both the individual and society. He describes humans as hypnotic beings “who by nature seek pathways to dissociation, [and] this was meant to operate at the collective level” (p.153). He states that many anthropologists and cross-cultural psychologists believe cultures to be always religious at some level because religion represents a style of coping, for both individuals and the whole society. Religion, he argues, is a type of psychopathology, both cognitive and ritualistic, that evades formal diagnosis because of its socially sanctioned status. Schumaker has found that many non-western societies display virtually no neurotic symptoms as we know them in the West. This situation worsens once they come under the influence of western culture. “By stark contrast to intact non-Western cultures, we in the West now make frequent reference to the mental health crisis that seems to have befallen us” (p.174). He states that psychopathological symptoms as we understand them present only when cultural dissociative outlets such as religion have deteriorated to the point that private symptoms become necessary.

The private expression of dissociative symptomatology that otherwise, in non-western cultures, is culturally and socially acceptable, maintains an important social
component. I will argue that through the elaboration of alterpersonalities, the DID sufferer constructs a dynamic internal social environment within which to relate. This improvised social solution, upon I will elaborate in Chapter 6, is a burgeoning response to an innate drive to dissociate in an cultural environment that provides few opportunities for the expression of dissociation in a collective context.

Dissociation displayed in non-Western cultures seems mostly limited to trance and possession states (Bourguignon, 1977; Kokoszka, 1993). Examples of socially sanctioned dissociation seemingly do not require full, detailed elaboration of alters, replete with histories and identities. Kluft (1993) acknowledges that there exist similarities in the phenomenology of DID and possession syndromes. In societies where possession states remain a powerful and sanctioned means of expressing experience and conflicts, "the psychopathologic niche that MPD occupies elsewhere is already filled and MPD will be quite uncommon" (p.17). Kluft points to the existence of spiritually important phenomenology that helps to preclude the manifestation of DID, I will argue that perhaps equally important in staving off DID in non-western cultures is the keen sense that maintaining social connection is critical to the health of the community and its members.
Braun (1995) notes that in early West African cultures, each person was expected to play his or her part in maintaining kinship relations and community networks. Harmonious relationships within the community were a sign of health, while strained relations were deemed a major cause of sickness. The same must be said to be true in the postmodern westernised world. I will argue in this thesis that strong community is critical to identity formation, the foundation protective factor against DID. Furthermore, in the case of serious abuse or neglect by the primary caregiver, strong community ties provide a safety net of support upon which abuse victims may rely, staving off the onset of mental illness.

**Environmental Determinants**

The innate predisposition perspective enjoys a large share of support among theorists, but there exists another camp that views dissociation as solely dependent on environmental conditions. Several indicators point to the importance of environmental factors. Unpredictable, repetitive, abuse are among the strongest indicators in triggering dissociation (Putnam, 1985). Another critical environmental factor in the development of DID is the age of onset of abuse. According to Putnam (1997), DID is much more likely to develop in response to trauma sustained in childhood, during which time “dissociativity” is at its highest and identity has yet to be consolidated.
Putnam is the principal detractor from the 'innate predisposition' perspective on the development of DID. Everyone, he states, is innately capable of dissociation. This capacity is actuated in the presence of traumatic environmental stimuli, particularly in early childhood. With his 'discrete behavioural states model' (DBS), Putnam (1997) accounts for the manifestation and the elaboration of alter personalities in DID. The DBS model suggests that the alter personalities seen in MPD reflect the creation of a set of complex, enduring, identity-based, discrete dissociative states that evolve during childhood and adolescence. Drawing on research on infant consciousness, Putnam (1997) claims that infants are born with a discrete set of behavioural states, with the switches between states in infancy resembling alter personality switches in DID. In very young infants, he says, there exist few discrete states that shift dramatically without continuity; crying, active awareness and sleep states appear to shift without warning. As children develop, they acquire progressively more behavioural states, and the transitions between them become smooth. He postulates the smoothing of these transitions relates to the consolidation of self and identity across behavioural states. Similarly, the switching between alter personalities in DID recalls the 'switching' across states in infancy. He postulates that maltreated children may create emotional states that help to distance them from the fear and shame of abuse.
Putnam argues the trauma creates a disruption in normal neurological pathway functions. A child who is repeatedly traumatised enters a specific state, he says. Repetitive traumatic episodes elicit a return to pre-established alter states. "Other states may be activated in the aftermath of maltreatment as the child struggles to reconstitute him or herself after physical or emotional intrusions. Internally focused, reality-altering states of deep fantasy located in magical mental worlds are a common restitutive response of tormented children" (p.167).

It is clear that abuse does not cause DID. As I will explain in chapter five, the disorder more likely results from a system of environmental factors which threatens emotional and psychological health while removing societal and familial protective barriers to illness. This perspective is expanded further in the thesis. A recent study of victims of severe abuse has illustrated the significance of familial dynamics in the incidence of DID. Investigating the generally pathogenic environments of sexual abuse victims, Nash, Hulsey, Sexton, Harralson & Lambert (1993) found that abused subjects were more dissociative than controls, but when looking at family environment as a covariate, researchers found the effect of early trauma was insignificant in the prevalence of dissociative responses.
Putnam (1997) notes that in healthy families, the primary care giver is capable of understanding and predicting the child's progression of behavioural states. By virtue of that knowledge, caregivers have the capacity to stave off unpleasurable moods. At the formative level, and even in the absence of abuse or trauma, indications of lack of support and sympathy from the caregiver pave the way for insecurity and the encouragement of dissociative responses. In addition to the problems associated with the lack of supportive environment, he ventures that in some instances there exists a tyranny of mood from the adult caregiver overwhelming the child's moods and transitions with the dominant mood of the caregiver. This may impede the development of the child's transition of discrete moods. The implication, Putnam argues, is that the child's consolidation of the self, is not achieved, paving the way toward the manifestation of DID.

Kluft (1993) is representative of the middle ground among theorists who incorporate the "capacity to dissociate" among the determinants of DID. He describes the aetiology of the disorder according to the presence of four factors. His theory holds that several sequential stages must be passed in the development of DID. They include:

a) the capacity to dissociate (which becomes mobilised for defensive purposes)

b) life experiences that traumatically overwhelm the neodissociative defenses and adaptational capacities of the child's ego
c) shaping influences and available influences and available substrates will determine the form taken by the dissociative defenses in the process of alter formation

d) inadequate provision of stimulus barriers and restorative experiences by significant others (p.15).

A shift in thinking about dissociative capacity from an innate predisposition model to an emphasis on environmental systems represents an important shift in perception, prevention and treatment of DID. In many respects this shift in conceptualisation may breathe new relevance into the important work of early theorists.

**Evolutionary Product or Vestige**

What may be considered a minor issue of origin may, in fact, hold the key to understanding whether DID should be considered an illness or an appropriate response to trauma in the presence of specific conditions. Depending on the theorist, DID is either an evolutionary response to pain and disorder or a vestige of bicamerality. Consideration of the origins of dissociation is important to a later discussion of how DID becomes the ultimate defense or “autodefault” mechanism in the presence of chronic abuse or trauma. In this regard, Jaynes’ (1976) perspective is unique. In his work on the evolution of
consciousness, he documents what he coins “the breakdown of the bicameral mind”. Although Jaynes saw the implications of his own theory for understanding schizophrenia, it is at least as relevant in understanding the manifestation of DID. The bicamerality of which Jaynes speaks is a primordial cognitive duality that existed prior to the development of the modern integrated consciousness. In the bicameral mind, one side of the brain “spoke” to the other, often representing the directions and orders of divine authority. Jaynes argues that evolution eroded the barrier between the two “minds”, allowing the integral function. With the evolution of consciousness, there developed the subjective “I” whose experiences encompass both an historical continuum and a sense of wholeness and identity.

So, in the Jaynsian view, DID represents a reversion to bicamerality in the presence of severe stress or trauma. It is important to note that Jaynes documents the presence of several discrete identities in bicamerality, each representing a different authority figure depending on the situational requirement. This phenomenon preceded the development of the sense of free will, so the distinct voices of authority emerged to provide necessary direction. One must note the presence in DID of similarly distinct characters, or alters, who are typically present and, it is argued, emerging to contend with distinct situations to which they are perhaps uniquely well suited.
Jaynes' theories, while not widely supported, resonate with some of the key thinkers on dissociation. Jaynes attempts to explain the origin, and not merely the presence, of psychopathology. Both Janet (1965) and Hilgard (1986), for example, describe DID as an affliction suffered by a select few. For Hilgard it is a result of poor "executive cognitive functioning", while Janet speaks generally of "désagrégation", literally the disaggregation of the psyche. Neither explains the presence of the weakness.

Schumaker (1995), on the other hand, views dissociation not as an evolutionary vestige, but as a modern adaptation. He falls among those who consider DID to be a factor of environmental conditions, drawing on Lancelot Law White's contention that the human brain's primary goal is to achieve a sense of order. That order, he states, was once achieved through primary reality during which time the brain had not evolved to a point where contradictions were obvious. At this time, there was no need for religion or psychopathology to help to create order from disorder. Once our brains had evolved to a point where contradictions in the world became obvious and order was no longer achievable through primary reality, we developed a capacity to create artificial order, he states. He contends that religion and psychopathology presented us with ways of achieving this order. When the incoming information is problematic, when it conflicts with other beliefs, there is a need to create order from the ensuing chaos. The mechanism for so doing, he states, is dissociation. The chaos of which Schumaker refers, results, for
example, when a child experiences sadistic abuse from a caregiver who is otherwise loving. With pathological dissociation, the conflict is removed by separating the identities of the abuse victim and the loved child. The result is a continuity, an artificial consistency with which the child may function.

**Summary**

Since the birth of dissociation in the 19th Century, DID has been understood as a pathological disorder arising from a genetic ‘weakness’ or predisposition. This conceptualisation of DID has provided an explanation for the absence of DID in the presence of some trauma. Although the “genetic predisposition” perspective is useful in fending off criticism that not all trauma leads to DID, many theorists still erroneously consider it a legitimate explanation for the development of pathological dissociation. The individualistic nature of this explanation undermines the significance of social dynamics and determinants. Although most dissociation researchers acknowledge the essentially social nature of trauma in the aetiology of DID (and recognise the huge potential for psychological damage from the abuser), little attention has been given to the larger social context. With DID diagnoses soaring in the United States, and child abuse reaching epidemic proportions, it seems likely that aetiological explanations at the social or cultural level may prove more useful than default “predisposition”. In the next chapters, I
will describe how secure attachment and identity formation are critical in the acquisition of protective mechanisms.
Chapter Three

ATTACHMENT AND DISSOCIATION

Attachment theory holds that healthy psychological development starts with positive parent-child interaction (Bowlby, 1988). The father of attachment theory, Bowlby (1969) said each child develops an attachment to his or her primary caregiver(s). He argues attachment exerts an enormous influence on the child’s self conception throughout development. Beginning in infancy, children quickly learn that to have their needs met, they must communicate them strategically. During the first years of life, when the infant is helpless and heavily reliant on others to be fed, changed, cuddled and cared for, the caregiver’s responses determine the extent to which the child feels secure. For infants, the attachment figure becomes the focus of their world. Consequently, contact with the caregiver has a significant impact on the child’s early concept of self and other. Researchers argue that the quality of the relationships between children and their caregivers has a prolonged effect on the child’s emotional development (Howe, Brandon, Hinings & Schofield, 1999).

Attachment behaviour is the term that describes a child’s need to increase proximity to his or her caregiver in times of distress. Under such circumstances, contact
with the main caregiver provides the child with a sense of security and comfort, decreasing the level of stress (Bowlby, 1969; Sperling & Berman, 1994; Williams, 1972; Ainsworth, Bell & Stayton, 1971). By contrast, children, for whom the attachment figure is unavailable, can not relieve their insecurity. A child who is not comforted by the attachment figure is considered to be in a chronic state of distress (Howe et al., 1999). Although Bowlby’s (1944) initial observations concerned children who experienced loss as a consequence of physical separation from the caregiver, his theory seems equally applicable to children whose parents are also emotionally unavailable.

Attachment theory is developed from an ethological/evolutionary perspective and describes the attachment system as similar to other drive-behavioural systems like feeding and mating (Sperling & Berman, 1994, Bowlby, 1988; Ainsworth et al, 1971). Its central tenet is that humans possess an attachment behavioural system which places infants in close proximity to their parents or caregivers, especially in dangerous situations. Behaviours such as crying, touching or calling out are designed to increase proximity to the attachment figure. Once proximity is achieved, the attachment system is deactivated and the child may engage in other behaviours such as exploration. The attachment system consists of behaviours which have evolved to keep the child away from threat or danger. The system operates in a homeostatic fashion by trying to maintain a set goal for proximity to keep the infant within safe range of the caregiver. When
danger seems unlikely, the distance from the caregiver is allowed to increase as the attachment system fades into the background. This situation is ideal for exploration, a vital activity, which will acquaint the child with the ways of the world and help her develop social skills. A secure attachment relationship in infancy depends on the caregiver’s responsiveness and sensitivity to the child’s needs. It also depends on the child’s trust in the caregiver’s accessibility (Sroufe & Waters, 1977).

*Internal working models*

Internal working models of attachment are a consequence of repeated attachment behaviours (Bowlby, 1988). They include information about the self, attachment figures and attachment relationships. Internal working models are beliefs that help individuals make sense of the world, and help them predict behaviours and intentions of others. These models are flexible and malleable in early childhood, but repeated similar styles of interactions with a caregiver strengthen the emerging working models, making them more resistant to change.
**Attachment Styles**

Ainsworth is the originator of the ‘strange situation’ (SS), an empirical measure used to assess infant attachment behaviour at the ages of 12 to 18 months (Ainsworth, Blehar, Waters, & Wall, 1978). The SS procedure involves placing infants in a unusual environment and subjecting them to several conditions designed to evaluate attachment. During the SS, children exhibit three general patterns of attachment: avoidant (pattern A), secure (pattern B), and anxious-resistant (pattern C). More recent research by Main and Solomon (1986) suggests the existence of another pattern of attachment: disorganised/disoriented (pattern D). Main and Solomon claim that a minority of children do not exhibit behaviours which fall under patterns A, B or C. Children who fall into the D category are most often victims of child abuse, and thus, will be of particular relevance in this paper. Before describing the attachment styles, I will briefly describe the ‘strange situation’ procedure:

- Mother and child are together in a room. The child plays.
- A stranger enters the room and the chats with mother, then interacts with the child.
- The mother exits the room, leaving the child alone with the stranger. The stranger interacts with the child.
- Mother returns, and comforts the child. The stranger leaves.
• The mother exits again, leaving the child alone.

• The stranger comes back into the room and interacts with the child.

• Mother reenters and calms the child, and the stranger leaves.

Secure attachment (type B)

In the SS, infants who fall into the B category exhibit clear signs of distress when mother leaves the room. These children are easily comforted by her upon her return. Securely attached children have a positive outlook, possess good social skills, and are able to deal relatively effectively with distress (Howe et al., 1999). Mothers of secure children have been described as sensitive and available (Bretherton, 1985). The majority of people fall into the secure attachment category. The most recent research indicates that 55 per cent of infants across cultures are labelled “secure” (van IJzendoorn, 1995).

Insecure - Avoidant attachment (type A)

Children who display avoidant attachment show no signs of distress when mother leaves the room in the SS. Upon her return, these children actively avoid her. Avoidant attachment styles appear to be adopted as a response to a rejecting caregiver. In fact, Howe et al. (1999) claim that mothers of type A babies respond with distress to their
child's style of attachment behaviour (ie: seeking proximity to attachment figure). The
distress felt by mothers in response to their babies’ needs often makes them behave in a
rejecting, disaffirming manner. The type A child’s avoidant behaviour is considered an
attempt to maximise the availability of the caregiver. Since mother rejects the child’s
comfort-seeking, the child quickly learns to suppress attachment behaviour. An
estimated 23 per cent of people in normal populations fall into this category (van
Izendoorn, 1995).

**Insecure – Anxious-resistant attachment (type C)**

Children who fall into the C attachment category are highly distressed when
mother leaves the room, and are not easily comforted upon her return in the SS. Mothers
of these babies have been described as unpredictable in their responses to their child’s
needs for comfort. They often interfere with their child’s attempts at autonomy (Belsky &
Nezworski, 1988). People who fall into this category tend to have very low self-esteem
and may constantly question their personal value. They are characterised as very
dependent on others and are “clingy”. In normal populations, Howe et al. (1999) estimate
from eight to 12 per cent of people fall into this category.
**Insecure – Disorganised/disoriented (type D)**

The category of disorganised/disoriented attachment has recently been adopted to accommodate those children who exhibit attachment behaviour with no consistent pattern (Main & Morgan, 1996; Main & Hesse, 1990). Children in this category often behave as if they are confused. They may approach mother as if to seek comfort, but avert their gaze, or they may freeze in the presence of the caregiver. Disorganised/disorientated children are more likely to be the victims of abuse (Anderson & Alexander, 1996, Blizard, 1997) and are more likely to have mothers who are drug or alcohol abusers or suffer from some type of psychosis (Howe et al., 1999). Liotti (1992) states that children who have formed D attachments are more susceptible to developing dissociative identity disorder than children with other attachment styles. D-type children are said to have no “organised behavioural strategy for regulating their affect, achieving proximity or gaining care and protection” (Howe et al., 1999, p.122-123), and postulated that children adopt the D attachment style in response to a caregiver who is frightened of or frightening to the child. When the parent, who should be a source of comfort, is also threatening to the child, the child becomes confused and has difficulty responding to the parent (Liotti, 1992; Howe et al., 1999; Blizard, 1997). About 15 per cent of children in normal populations fall into this category.
Implications of secure attachment

Secure attachment has been described as an important start to healthy psychological development (Harwood, Miller & Irizarry, 1995; Bowlby, 1988; Heller, 1997). Although it is important to stress that secure attachment cannot predict a person’s later psychological condition, it can certainly enhance a person’s psychological and emotional competence. Secure attachment serves important functions in protecting a person from psychological damage. As Sroufe (1983) succinctly stated: “I view basic responsiveness and warmth (and consequent secure attachment) as representing a core substrate, from which develops the child’s inner sense of confidence, efficacy, and empathic regard for others” (p.25). The inner working models for secure infants develop into views of the world in which there exists a basic trust of others. This results from interacting with a sensitive caregiver who is responsive to the needs of the infant. The infant will feel security in his or her ability to communicate needs, and gains a sense of control over the immediate environment (Bowlby, 1969). Secure mothers are effective at limiting periods of distress in their infants (Howe et al., 1999). As described earlier, distress activates attachment behavioural responses. With the activation of attachment behaviour comes a rapid decrease in explorative behaviour. In other words, secure children have more time to explore their environment and to gain experience in the workings of the physical and social worlds. The existence of a harmonious relationship
between mother and infant help the infant develop a sense of how feelings and behaviour influence each other. According to Howe et al. (1999), interpersonal patterns begin to be perceived by infants and help them to interpret both their own and their caregiver’s behaviour. They state “the effect of such synchrony is to create a kind of interpersonal scaffolding that helps children to locate and support their growing understanding of their own and other peoples’ emotions, mental states, behaviours and interactional styles” (p.47).

Understanding the behavioural and emotional consequences of exchanges between people is critical to the acquisition of healthy social skills. The infants quickly generate the primitive understanding of social relations (for example, how others’ behaviour affects their feelings, and how their feelings and behaviour affect others). As a consequence, the child can adjust behaviour accordingly. This observation and response supports the development of empathy and sensitivity, both of which are key elements in intimate relationships (Main, Kaplan & Cassidy, 1985). Also, Hinde and Stevenson-Hinde (1991) discovered in intergenerational studies that parents who recall being treated warmly and lovingly exhibit similar traits with their own children.

Securely attached children spend a proportionately greater amount of time than their insecurely attached counterparts in the pursuit of exploration (Main, 1983). The
implications of exploration are huge as they relate to the acquisition of social support. The value of developing social relations and allegiance is argued more extensively in Chapter 5. However, from infancy to childhood, the consequences of secure attachment are apparent. School-aged children who were securely attached as infants exhibit more competence in peer relationships than do insecurely attached infants (Bradley, Caldwell & Rock, 1988; Zeanah, 1996). Their sense of autonomy affects the way in which peers and teachers relate to them. Teachers tend to leave secure kids to their own devices and count on them to seek help when required (Sroufe, 1989). When confronted with problems at school, secure children approach teachers in a constructive manner. He notes also that securely attached children are rated as being more competent with peers, more positive, more empathetic and more likely to develop friendships. In everyday family situations, securely attached children are also generally cooperative and can communicate effectively with their parents (Sroufe, 1983).

The competent regulation of affect by secure children resulting from their strongly developed emotional recognition (Saarni, 1990) enables precise labelling of their emotions. This development is important for children dealing with high levels of arousal or distress, providing the ability to manage emotional arousal by expressing themselves in a socially appropriate manner (Howe et al., 1999). Securely attached children also tend to respond appropriately emotionally (Saarni, 1990). Similarly, securely attached adults
are more likely to accurately recall both positive and negative events. By contrast, Pianta, Egeland and Adam (1996) describe insecurely attached children as frequently vague or unsure when describing past events, or may be prone to over dramatise some events. The relative lack of emotional distortion on the part of secure children is significant as it relates to psychological strength and potential future development of dissociative disorders. The tendency of secure children to relate to adversity directly makes the shift to dissociative coping mechanisms uncharacteristic and unlikely. Howe et al. (1999) found that insecurely attached children are prone to distort the cognitive-emotional relationship, suggesting a maladaptive coping strategy that, in the short term, at least, precludes the child having to deal with the full emotional impact of events. Repercussions of this behaviour may include poor development of healthy coping strategies and perhaps a progressive susceptibility to develop psychopathology. So, while secure children become more resilient as they deal with adversity (putting problems into the context of their daily lives), insecure children are less able to cope with adversity because of their tendency to distort the true nature of their experiences.

Researchers found the ability to establish positive peer relations in the school yard has important consequences for both the progressive development of supportive networks and later psychological health which is, in part, a consequence of the supportive infrastructure. Securely attached children of school age are less likely to victimize or
become victims of playmates (Bradley et al., 1988). In general, they have a positive affect, are popular with peers and have good conflict-resolution skills. The impression securely attached children leave is one of competence. Consequently, the positive social connections established by these children extends to their teachers who tend to treat them in a matter-of-fact way further inspiring confidence. Howe et al. (1999) argue that secure children can establish intimacy in relationships with relative ease. Such relationships become sources of support upon which they will draw in times of adversity.

Sroufe (1983) has established a strong connection between secure attachment and what he calls "ego strength". He notes that children have an ability to flexibly engage the environment and to recover following periods of stress. The resilience developed by secure children contributes considerably to their awareness of their place in society and to the formation of strong social bonds.

Research has found that secure children exhibit sensitivity and empathy (Howe et al., 1999). These qualities contribute to these children being seen as a valuable presence in their roles as students, peers, sons and daughters. An important extension of secure children's empathy is their conflict resolution ability. This ability enables these children to establish new alliances but it is essential in developing and deepening existing relationships. It is not only in the secure child's recognition and value of his or her
relationships that will ultimately preclude the onset of dissociation. This child’s ability to
assert him or herself will represent the backbone of many protective mechanisms that
secure attachment and strong identity development will engender. These will be
expanded at length in Chapter 5.

**General Implications of Insecure Attachment**

Although it is impossible to predict psychopathology from quality of attachment,
the evidence indicates that insecure attachment is a risk factor for future emotional and
psychological dysfunction (Belsky & Nezworski, 1988; Bowlby, 1969). Insecurely
attached children are likely to have low self-esteem and often question their self-worth
(Howe et al., 1999). When faced with trauma, these children may be more inclined to see
themselves as the cause of negative events or believe they deserve to have bad things
happen to them. Insecurely attached children are at greater risk for developing
psychopathology than securely attached infants (Allen, Hauser & Borman-Spurrell,
1996). While attachment over the first year of life is not an accurate predictor of later
psychopathology, insecure attachment is a determinant of a host of psychological
problems (Belsky & Nezworski, 1988; Howe et al., 1999). Not all types of insecure
attachment put a child at equal risk. It appears as though the most anxious types of
attachment pose the most serious risks for psychopathology, and disoriented/disorganised attachment style figures prominently among DID sufferers.

**Disorganised/Disoriented Patterns**

The disorganised/disoriented (type D) attachment category, recently identified by Main and Solomon (1990) is characterised by an absence of an organised behavioural strategy to increase their proximity to (and attention from) caregivers for the purpose of gaining protection. Type D attachment behaviour is often laden with contradictions, for example, running to greet a parent but freezing before reaching her, or looking for comfort but turning the head away from the caregiver. Main and Hesse (1990) suggest that infants in the disorganised/disoriented attachment category fail to adopt an organised defensive strategy. Other insecure attachment strategies include deactivating or hyperactivating attachment behaviours to maximise the availability of the caregiver (Lyons-Ruth, 1996). Infants' failure to develop an effective proximity-seeking strategy results from unpredictable frightening displays directed at the child by the caregiver (Anderson & Alexander, 1996). Children who perceive their parents' behaviour as frightening are confronted with an irresolvable paradox. Their fear makes them seek comfort from their caregivers who, themselves, are the source of the fear. It appears as though whatever attachment behaviours the child attempts, anxiety and distress continue
to rise and threaten to overwhelm the child with profound fear and helplessness (Howe et al., 1999). "The internal working model achieved by these children represents the self, others and relationships chaotically and incoherently. There appear to be no organised rules based on experience that are available to predict and guide attachment behaviour, achieve affect regulation and increase felt security (p. 123)."

Howe et al. (1999) argue that most frequently falling into this category are the victims of abuse or children whose caregivers suffer from various forms of psychosis. They estimate that 80 per cent of maltreated children fall into the Type D disorganised/disoriented attachment category. Liotti (1992) proposed that disorganised attachment is a risk factor for developing dissociative disorders. He suggested that to deal with frightening and or frightened behaviour of the parents, the child learns to escape into a hypnotic state, setting the stage for the development of dissociative disorders. In cases of abusive parents, children are often faced with the possibility of 'setting off' a parent when seeking comfort in times of distress. When a child is distressed, he or she may turn to the parent who may become unpredictably violent toward to child. Lyons-Ruth (1996) suggests that the frightening and unpredictable nature of the parent-child relationship reaches a breaking point at which the child decides to fight or flee the situation. He has postulated a connection between D-type attachment and aggression disorders such as oppositional defiant disorder (ODD) and conduct disorder (CD). Also, Howe et al. argue
that children who fall into the D category are more susceptible to developing obsessions, compulsion and hypochondria.

**The Relationship Between Attachment and Dissociation**

The relationship between attachment and dissociation is an area of current exploration in psychological research. Underlying the variations among prevailing hypotheses is a strong commonality in the understanding of the relationship between attachment and dissociative disorders. Some research goes so far as to label DID as an attachment disorder (Barach, 1991). Recently, researchers from the independent fields of attachment and dissociation have come together to articulate the links between these two domains and to test the relationships (e.g., Liotti, 1992; Putnam, 1997; Barach, 1991).

As indicated earlier, avoidant children typically avoid contact with their caretaker upon reunion and eschew her comfort in the strange situation scenario. It is important to note that this behaviour is in response to a parent’s rejection or absence. Barach (1991) postulates that children are traumatised by parents who fail to respond or who are emotionally absent. He suggests that the failure to respond, coupled with severe and prolonged physical or sexual abuse, cause the child to ‘detach’, manifesting incipient DID.
The results of a study by Anderson and Alexander (1996) indicate that attachment style is related to dissociation (measured by the dissociative experiences scale), particularly in terms of fearful avoidant attachment and consequent dissociative responses. It is interesting to note that Anderson and Alexander’s subjects were women survivors of incest who, they postulate, would have been classified disorganised/disorientated as abused children. Liotti (1992) suggests that contradictory behaviours exhibited by babies and children who fall into the disorganised/disoriented category of attachment closely resemble symptoms of DID. He states that episodes involving children who ‘freeze in their tracks’ upon reuniting with their caretakers are evocative of trance-like states. He suggests that this attachment style is most commonly associated with DID. He proposes that parents’ frightening behaviour confuses the child. Liotti believes children are overwhelmed by the conflict inherent in fearing the same person who represents an important source of support. He suggests that disorganised attachment precipitated by a frightened and/or frightening parent may result in a type of induced hypnosis which my develop into DID. Main & Hesse (1992) suggest that the type of disorientation in the attachment relationship typical of Type D children is suggestive of a disorder of consciousness.
Farber and Egeland (1987) studied the psychological effects of various types of abuse and neglect on children. What they found was heavily supportive of the position that attachment issues are strongly linked with later psychological health. Children of mothers who were psychologically unavailable exhibited the greatest degree of psychopathology over all other types of abuse. The researchers found that at various stages of assessment the development of these children became progressively maladaptive. The comparative study (which spanned the children’s first five years) included physical abuse, verbal abuse, neglect and psychological unavailability.

Insecure attachment is the first of many factors that contributes to the development of DID. It is intimately connected with difficulties relating to the acquisition of other critical protective factors. The literature clearly indicates that children with hyperactivating and deactivating attachment strategies are not as well equipped with social skills as are securely attached children (Fagot & Kavanaugh, 1990; Cole-Detke & Kobak, 1996; Allen et al., 1996), but the organisational nature of their defensive strategies appears to make them less likely to develop DID. One way to flee overwhelmingly frightening and unpredictable situations may be for children to create an inner structure or emotional framework to compensate for their lack of satisfactory external support system. This may be achieved through the manifestation of DID as an improvised internal support system. This theme will be elaborated in Chapter 6.
Although some researchers claim that certain behaviour observed in children is indistinguishable from dissociative symptomatology, I believe the relationship is mediated by several other factors. Insecure attachment alone does not account for the development of DID. Insecure attachment makes the child more susceptible to develop DID, but only in the presence of other factors. Significant risk factors include the lack of social support, negative outlook and poor sense of identity. Ironically, these risk factors are inextricably linked to attachment.

**Secure Attachment and Strong Identity Development**

Strong identity serves as a protective factor against DID for a number of reasons. As stated earlier, attachment theory holds that securely attached babies who are not feeling in danger, use their mothers as a secure base from which to explore the world (Ainsworth et al., 1978). Recalling the implications of attachment on exploratory behaviour, insecurely attached children are disadvantaged in that they spend less time exploring and more time fostering the attachment relationship, the focus of perpetual insecurity. The additional time secure babies have exploring the world provides them with more social experience and responses from which they will develop a sense of self. Secure children also have a more positive outlook than insecure children, and thus, are more likeable. In this context, a child is also more likely to make positive social
impressions, since she relates to those around her in a positive way. Securely attached children tend to be dealt with as valuable, lovable people. The inner working models of secure children reflect this. As a consequence, the child will start to see him or herself as worthy and likeable since these qualities are being mirrored back to the child in most social settings. These children have more social contacts, each reinforcing the message and helping them to form a solid sense of identity.

The consequence of supportive and encouraging parents, according to Bowlby (1982) is the development of a positive model on which to build future relationships and a sense of self worth. This encouraging early start provides children with an opportunity to explore the world, and from that exploration, develop a degree of confidence, competence and understanding of others. Given the continuity of family support, this model provides the basis for personality, style and resilience. Bowlby surmises that the absence of such a positive model may engender less resilient personalities.

As secure attachment facilitates the development of other protective mechanisms, risks associated with poor attachment are compounded by the dependant nature of other protective factors on strong attachment. Although this situation places insecurely attached children at serious disadvantage, it is not necessarily indicative of impending pathological dissociation in the presence of abuse or trauma. Through a variety of means and
relationships, insecurely attached children may build their arsenal of protective mechanisms to help them cope with adversity without resorting to a dissociative response. This approach may help to explain why not all children who sustain serious abuse and trauma develop DID, regardless of their style of attachment. The nature of protective mechanisms is further elaborated in chapter five.

**Summary**

Attachment theory identifies the implications of the quality of primary care. The quality of this care, in fact, fundamentally affects the subsequent development of the child. Varying parental styles have been found to elicit four distinguishable attachment categories: insecure avoidant, secure, insecure anxious resistant and insecure disorganised/disoriented. This last style of attachment has been implicated as the most likely platform upon which to develop pathological dissociation. Disorganised/disoriented individuals are described as having no survival or coping strategies. This differs from other insecure attachment styles in that these permit strategies (albeit maladaptive) for contending with social situations. The disorganised/disoriented individual, therefore, has little capacity to direct others to attend to their needs.
Systems of belief, called internal working models, help to mould subjective reality for the person. For those who are disorganised/disoriented, this model reflects an individual lacking self worth and confidence and with an inability to interpret social cues imperative for the establishment of social connection.

Strength and style of attachment are critically linked to the risk of pathological dissociation. This thesis examines the role of protective mechanisms in the internal dynamics precipitating DID. Strong early attachment is one such protective factor. Alone, it is critical in setting the stage for future psychological health and resilience against psychopathology. It is also the cornerstone in the establishment of further protective factors against the development of DID. As illustrated above, the likely consequences of secure early attachment are strong identity formation and the development of a broad supportive social network. By contrast, insecure attachment not only provides no protection in its own right, but hinders the development of other protective mechanisms that may stave off a pathological dissociative response in the presence of sustained sadistic abuse. It is likely that individuals who exhibit the disorganised/disoriented style of attachment are more prone to develop DID because the disorder provides an internal social structure that provides the necessary reinforcement and outlets largely unattainable in the external world for these people. The concept of DID as an internal social structure will be elaborated in detail in Chapter six.
Identity and Fragmentation

Despite its reliance on social influences, identity is nonetheless the encapsulation of the sense of self. Largely independent and self-expressing, it is both a consequence and a prerequisite of mental health. Identity is an important cohesive construct, and is a composite of diverse factors. It is more than the “sense of self”. It is larger than the narrative “I”. It is greatly influenced by experience and the social context of that experience, and it is reinforced by behaviour.

There exist at least two distinctive measures of identity: the subjective “sense of identity” and the much more concrete and objective experience of others’ identity. Both bear a great relevance in the increasing prevalence of DID. Succinctly, it is the limitations in the former and drive for the fantasy realm of the latter that so well typify the identity crisis of the postmodern era. In the context of this thesis, identity formation is a
consequence of secure attachment in early life and the subsequent formation of relationships that contribute to its solidification. Secure early attachment (as articulated in chapter 3) provides a positive emotional climate from which children may foray into new relationships. The support network that they develop from these relationships is paramount to the formation of strong identity.

This chapter examines identity formation from a socio-cultural and historical perspective in the westernised world. In particular, it chronicles the effects of the modern and postmodern movements on social institutions and the dramatic consequences they have had on identity development. The modern age is responsible for large-scale shifts in values which have had a dramatic impact on our social structures and launched the age of individualism. Postmodernity took this leap in individualism to new heights.

Further in the chapter, I will discuss why hindered identity formation is an important factor in the development of DID. In Chapter 5, I will elaborate the interdependent relationship among secure attachment, identity formation and the acquisition of protective factors against the development of psychopathology, specifically DID.
Factors Contributing to Strong Identity

The discussion of identity evokes thoughts of me-ness, the elusive qualities that differentiate us. But, this chapter will indicate that this essentially individual quality has as much to do with others, perhaps, as the self. Erikson (1968) has documented the continual identity formation process, emphasising the particular importance of adolescence. He viewed identity as the culmination of the period of identification. Even William James (1983), in an important precursor to social psychology which wouldn't emerge for several decades, viewed identity in terms of how we behave in relation to others in our lives.

The Role of Attachment in Identity Formation

We will find that it is not merely the presence of people in our lives, but the bonds that we establish that contribute to identity formation. Our relationships necessitate inhabiting a multitude of roles which define and stabilise identity. In some ways, multiple roles mean multiple selves. Traditionally, these roles have been quite well established: man, woman, family member, church member and member of the community.
The importance of secure attachment to identity formation is a principal concept here. Secure attachment equips a child with a sense of confidence and self esteem that enables him or her to have new experiences and to explore the world. The relationship between secure attachment and the child’s ability and desire to explore beyond the realm of family, is well articulated by Heller (1997): “Assured of comfort, infants come to believe that they can depend on people to come through when needed, that the world is benign and that they are worthy of support and comfort. Filled with basic trust, the basis of all secure relationships, children later form healthy human connections” (p.59). Carlson and Sroufe (1995) have found that children identified as secure in infancy exhibit greater ego resilience as well as greater competence in social and exploratory behaviours. Ego resilience, in this context, is synonymous with the robustness of the child’s sense of self, or identity.

So, the relationship between attachment and identity is primarily a factor of security. Children secure in the solidity of their attachment with their primary caregiver may venture progressively further afield. While venturing away from their base, these children may be less daunted by choices, expressions of opinion, and establishing relationships with surrounding people and objects. As discussed in the previous chapter, securely attached children approach the world in a more trusting manner than their insecure counterparts. As a result, they are more receptive to its opportunities. In terms of
identity formation, the securely attached child develops supportive relationships with more people who not only contribute to their protection, but also reinforce the child’s burgeoning identity. Relationships reinforce behaviours that are a product of identity, and the practical expressions of identity become solidified.

Consistency in all relationships, especially with the primary caregiver, is a reinforcement for the developing identity. The consistency with which an individual is treated is reciprocated in the establishment of behaviour patterns or responses, affirming the developing identity. As discussed in Chapter 3, an inconsistent relationship between the child and primary caregiver interferes with the attachment security and hence the process of identity formation.

**The Role of the Community and Culture**

While attachment emphasises the immediate social environment of the child, it is important to recognise that broader community and cultural environments also contribute to the formation of identity. Perhaps the role of community in the development of identity is most aptly illustrated with examples from the non-westernised world. The western world’s distinct abandonment of some cultural and social roles has greatly contributed to the ‘identity crisis’ of the modern era.
Barth (1997) studied the concepts of self in two distinctly different non-Western cultures: the Baktaman of New Guinea and Bhuddist Monks and laity in Bhutan. What he found was extreme examples of collectivity and individualism in how these peoples conceptualised their identities. The Baktaman, for example, had limited terminology for expressing views about their selfhood or that of others. Their social structure and supporting rituals were strongly aimed at reinforcing the notion of collectivity. The Bhutanese, however, expressed strong individualisation, almost to the exclusion of social contact, favouring the pursuit of their individual paths to spiritual enlightenment.

Although these two cultures appear poles apart, one sociocentric, the other egocentric, from the perspective of identity formation, they bear great similarity. Individuals in both groups are born into very well defined social roles which guide their behaviour and help to strengthen identity within the parameters of the community and culture. From a cultural perspective, the spiritual component of both the Baktaman and Bhutanese cultures provides a significant additional commitment to their social identities. For example, the path of the young Baktaman males from childhood to their mid-thirties is punctuated by secret sacred ritual, divinely sanctioning the passage from one developmental milestone to the next. Similarly, much of the Bhutanese identity is enfurled in the quest for spiritual enlightenment. Connection with fellow Bhuddist monks
and lay people is not emphasised, however the relationship between the monk or lay person and his religious or secular teacher are of paramount significance.

**Why Is Strong Identity Important?**

From the context of the development of DID, the formation of strong identity provides resilience against trauma. In the postmodern era during which many of society's social structures are losing authority (Fornäs & Bolin, 1995, Featherstone, 1995), strong identity provides an important front line defense. Perhaps the Eriksonian view of identity formation provides some clues to the nature of the resilience. If identity is the culmination of the period of identification, then it may be considered a solidification of one’s sense of being. This indicates the progression toward independent self-hood, as opposed to identification and the reliance on others for response cues. So, in the presence of trauma, those benefitting from strong identity may look inward for validation of self worth and confirmation of values relating to what is befalling them. Those who have hindered identity formation will seek their comfort and protection from around them. In the case of DID sufferers, such protection is frequently not to be found (Blizard, 1997; Putnam, 1997; Kluft, 1993).
Now more than ever in the West, strong identity is particularly valuable in staving off mental illness. It is conceivable that in cultures that have maintained strong social institutions (i.e. family, community, and religion), these institutions may provide a measure of protection for those who have failed to develop strong identity. Cross cultural research has pointed to a conspicuous absence of psychopathology in some cultures where social institutions are rigid and family and community remain the focus of everyday life (e.g., Schieffelin, 1985; Hollan, 1988). In the 21st century westernised world, however, places which may have provided strength and protection have themselves crumbled. In this environment, those without strong identity are greatly vulnerable to fragmentation in the face of significant trauma.

Highlighting the interdependent nature of attachment, identity and support, strong social connection not only contributes to identity formation as noted above, but itself reinforces and expands the social network. This interplay Jenkins (1996) refers to as the “internal-external dialectic”. He argues that identity, or “selfhood”, while individual, is thoroughly socially constructed. Although each person may be unique, all of that selfhood is defined by and expressed as our social identities, including gender, ethnicity, relationship choices, clothes or pets. “The self is, therefore, altogether individual and intrinsically social. It arises within social interaction... It depends for its on-going security upon the validation of others, in its initial emergence and in the dialect of continuing
social identification" (p.50). As we see in the aetiology of DID, trauma is almost invariably a component. In the case of trauma befalling one who has a strong sense of identity, he or she will have created and inherited a diverse support network within which he or she will find both protection and validation.

The consequences of modernism include the dissolution of many of the social institutions from which people created their social selves (Berger, Berger & Kellner, 1973). Many of the social institutions upon which identities were hinged are gone, replaced by transient pop culture icons and fads (Cushman, 1995). This transition presents some serious problems in the successful establishment of identity.

**Social Implications of modernity and postmodernity**

The social implications of the modern and postmodern eras are of fundamental significance to what appears to be burgeoning numbers of DID diagnosis. In Chapter 2, I discussed the increases and decreases in the prevalence of DID. This chapter emphasises the influence of the modern and postmodern eras in the incidence of DID. This thesis argues that DID occurs as a defense mechanism in the presence of overwhelming trauma, but it occurs as an improvised social solution to compensate for a lack of social support in the external world. This lack of external support is largely a consequence of a major shift
in Western values following modernity. What was once a culture driven by the Christian ethic (kindness, compassion, charity and honour, among others) has been replaced by one driven by economic success. Consumerism has created a culture in which those driven by success rather than positive social values, are deemed successful (Henry, 1965).

Braun (1995) describes modernity as a time when social roles were in flux, and social connection took a back seat to financial gain. “The development of self-control is largely for money-making purposes nowadays, not for citizenship or for relating to neighbours or for acts of compassion. In fact, economic markets have tended to displace what once might have been called markets of admiration for people with fine characters” (p.70). This is an important observation in the context of psychopathology and personal connection. The modernist economic and consumerist drive resulted in a wide scale abdication of membership in social institutions, and the consequences of this self-imposed alienation continue to be felt beyond postmodernism (Berger et al., 1973).

**Modernity**

Modernity had its roots in the industrialisation of the mid-1800s. The essence of the era is simple: It represented a new age of hope for the masses. Luxury and innovation were mass produced. Modernism represented an important shift from the age of
preindustrialisation (Conrad, 1998). As whole neighbourhoods realigned their priorities according to the consumerist goal-posts of automobile or television ownership, for example, the consequence was a dilution of the former value structure. The effects of modernity are wide sweeping. Modernity paved the way for ousting the church, family and nation from their solid perches. From a psychological perspective, its consequence was the wide-spread cultural orphaning of individuals throughout the western world who have voluntarily rejected connection with these institutions. Emotional and spiritual connection was supplanted by the material. Modernism, for the population of consumers, was mirrored by 'Fordism' on the part of the manufacturers, mass producing goods to fill the void left by broken societal connection.

Braun (1995) notes the irony of the West’s fixation on communication at a time when much of the community connection has been sacrificed to consumerism. He states that the aspects of life that allowed ancient communities to develop common cultures and moralities, and allowed them to function as communities are finding rough going in modern times. “(Communities), for all their economic achievements, are often not emotionally satisfying because they function more as associations than as communities” (p.71). Braun is not surprised by modern society’s increasing preoccupation with communication in the modern mass communication environment, as our common frame
of reference dwindles, as does our motivation to communicate, perhaps except as a passive audience.

In the wake of modernity and the essential crumbling of society's social and spiritual institutions, the mass media has taken on the role of custodian of society's values. Given that the emerging value structure has lost its historical and social context, adoptive values are prone to limited depth and constant change. According to Schumaker (2001) the consequence of the collapse of the West’s institutional and social structures is the disappearance of social roles, or what he refers to as socially sanctioned identity templates. The absence of set social roles in communities presents new challenges for identity development simply because the set roles with which individuals could identify and aspire are no longer. In their place is a new fluid structure, one that Schumaker describes as socialisation via the media.

With the dissolution of the physical community as the focal point of our collective identity, we have greatly empowered the media as a surrogate community. The media have become a ubiquitous constant in our lives, where other aspects and relationships are now fleeting. We have entrusted our collective identity with the media, tapping in regularly for our drip feed of culture, but what we witness is merely image, lacking depth. Perhaps in response to the paper-thin spectacle that passes for culture, our search
continues for something real. In response, the media provides change. An important consequence of our symbiotic relationship with the media, television and print dutifully provides us with an endless series of role models to which to aspire. These images, like all others produced for mass consumption by the media, are superficial. The presentation of celebrities as fantasy role models is problematic. An increasingly lost and fragmented society is hinging its identity on these (in effect identity-less) images with predictable results. Their value is limited to influencing the superficial, stopping short of providing any solid values and depth of character to which their audience may relate and consequently contribute to identity development. The fall-out is a dissatisfaction with the prevailing celebrity role models and an on-going hunger for something more. What society yearns for is depth and solidity. What the media can provide, however, is a steady train of reigning celebrities.

The ubiquitousness of the media and its role in modern collective identity is a symptom and not the cause of the identity crisis of the modern and postmodern eras. Many theorists credit modernism as the cause of the prevailing identity crisis (e.g., Braun, 1995; Berger et al., 1973; Cushman, 1995; Gergen, 1991, Inkeles, 1983). This is a crisis that results from the failed search for happiness that is hinged on the constant search for identification among changing social images and idols. Conrad (1998) describes modernity as a roller coaster, a voluntary ride that thrilled as it toyed with
disaster. "The dangers were optional, not predestined. They derived in a society which had rejected traditional guidance about who we are, from a revelation that identity is tenuous" (p.16).

Cushman (1995) relates to the 'empty self' as the assumed identity of the modern and postmodern eras. Following the Second World War, he argues, grew a period of meaninglessness, resulting in part by the losses of the church and the communal belief structures. What replaced these institutions, he said, was the mass media. Thus, advertising became a major cultural force, replacing community and social institutions. He contends that the advertising industry uses the substitution of one identity for another as a sales strategy; "Consumers are customers that buy lifestyle in a vain attempt to transform their lives because their lives are unsatisfying and without massive societal change, ultimately unfixable" (p.81). He describes the lifestyle solution, (appealing to the consumer by associating the product with a happy, stylish model) as the ultimate sales tool used by the advertising industry. In the time of the empty self, the consumer is particularly vulnerable to wanting to take on a new identity, to fill the void.

Consumerism stripped western society of traditional morals and values, which in the past gave people roles or goals to which to aspire. In modern times, consumerism has taken precedence over all the institutions that influenced people's lives and gave them a
sense of place. Communities, families, religion, all of which help to generate virtues of kindness and compassion, are in direct conflict with consumerism. According to Cushman (1995): “the concepts of meaningful reciprocal connections to another person or to other people and of contributory and honourable work are no longer simple givens in this society. If we live in a society that confounds our efforts at ethical, honest work, structural complications in these twin pillars of our personalities are likely to ensue” (p.149). The problems to which Cushman is referring include increased rates of addiction and psychopathology, which in an age of individualism are treated as individual problems. Prozac, Paxil and AA are all supposed solutions prescribed to humanity’s *defective machines* to help them function more effectively. This myopic approach denies the role of society in the creation of the problems.

**Postmodernity**

Many social researchers eschew the term “postmodern” viewing the current era as simply the necessary evolution of modernism in the information age (Conrad, 1998; Caputo & Scanlon, 1999). Regardless, postmodernity represents an explosion of the former constraints of modernity. The individualism and consumerism of modernity took an exponential leap with the advent of postmodernity in the mid-20th Century. The dawn of the information age and the consequent global shrinking resulting from pervasive mass
media spawned an era in which consumers begin to take the reins of production. Featherstone (1995) articulates the movement from the “production perspective” in the modern era to a “mode of consumption perspective” in the postmodern era. The implication of the perceived shift in control from the producer to the consumer is that even the fancies and potential of consumerism have taken a turn toward further individualism, and further alienation. The demise of the social structures upon which individuals have anchored their identity and place in society has opened a chasm of opportunity for producers (through mass media) to exploit in the name of modern marketing. No longer do advertisers promote the virtue of their products. In the postmodern era what they sell is identity (Cushman, 1995; Fornäs & Bolin, 1995). The incessant clamour to fill empty shopping baskets is allegoric. The drive to consume accompanies the unsatisfied need for identification and identity.

The “Marlborough Man” doesn’t sell cigarettes. The advertisers link their brand to the identity of the rugged cowboy, brave and compassionate who undoubtedly espouses the values society admires but no longer possesses. To smoke Marlborough cigarettes, the advertisement says, is to adopt a piece of the identity. Similarly, the Hanes pantyhose advertisements target the female market with the identity of the happy and attractive woman executive. Whether cigarettes or pantyhose, consumers do not buy products, they adopt identities. Clearly identities created by marketing departments do
not satisfy consumers' demand for wholeness. Cushman's concept of the empty self remains unsatisfied despite constant attempts at fulfillment through the purchase of corporately constructed and ever-changing market identities.

**Pluralisation of Modern and Postmodern Society**

A necessary consequence of modernity and postmodernity is the pluralisation that results from the lack of integration and cohesion of the diverse facets of individuals' lives. Where pre-modern identity encapsulated membership and expectation in firm social structure, moderns and postmoderns have been progressively specialised and individual in focus (Moghaddam, 1997; Berger et al., 1973). Pluralisation may be coined a host of selves, unrelated to each other and lacking unity. In the pre-modern West, or in some non-western societies, a woman in the community assumes several roles: mother, daughter, wife, church member, and worker. All of these roles overlap in the context of community. They are roles to which all of her contacts may relate and which contribute to her sense of wholeness of self. In modern or postmodern times, by contrast, the woman may commute to her career in another city, she may not go to church, she may be an Amway representative and belong to an international hobby collective. The modern woman and her neighbours (and her nuclear family) experience vastly different worlds with little opportunity for overlap. Pluralisation indicates increased individually driven
specialisation. Featherstone (1995) argues that time constraints and limited connection means that the pre-modern notion of community may not exist in tandem with the pluralisation that accompanies postmodernity.

Gergen (1991) likens pluralisation to the creation of multiple selves, as we increasingly possess many voices. Each self sings different melodies, different verses, and with different rhythms, with no concern for harmony. “At times they join together, at times they fail to listen one to another, and at times they create a jarring discord. But what are the consequences of the multiply populated self?” (p.3). To answer Gergen’s rhetorical question, the consequences of the multiply populated self are enormous as they relate to the health of community and to the incidence of DID.

Berger et al. (1973) discuss the impact of plurality of the life worlds of individuals in modern and postmodern societies. In modern society, they argue, personal and public spheres are distinct, contrasting greatly with pre-modern societies which were largely integrated. Different sectors of the everyday life force individuals to contend with greatly divergent worlds of meaning and experience. “Modern life is typically segmented to a very high degree, and it is important to understand that this segmentation (or, as we prefer to call it, pluralisation) is not only manifest on the level of observable social conduct but also has important manifestations on the level of consciousness” (p.64). The
recognition of the divergent coexisting worlds existing for residents of modern society has important implications in the development of DID.

**The Effects of Pluralisation on Identity**

The requirement of individuals in modern society to operate in a fragmented world makes it all the more important that they come from a secure base to ensure the development of a strong sense of identity (Berger et al., 1973). Pluralisation, they state, has become part of the process of primary socialisation. The outward, as opposed to internally focussed, early socialisation, highlights the critical value of secure early attachment in the development of identity. The plurality of modern societies has increased individuals' vulnerability in identity formation. This vulnerability relates to the "fragmentation" that occurs in communities, and of the self because of the lack of integration of individual roles. The ever-changing objects of identification in postmodern society (in the absence of former roles and role models) has created an insecure and ever-changing ideal identity to which members of society may aspire. This fluidity results from the lack of static cultural values and enduring roles for the purposes of identification. Both of these areas of fragmentation may interfere with identity formation. The dissolution of community undermines the stability of place for children with developing identities. The elimination of stable roles (and role models) greatly reduces
the benefit of "community". The largely integrated societies of pre-modern times offered an inherent safety net for children to develop a sense of place in communities if the family environment fell short.

The danger of postmodernism and the fragmented self to identity formation is ultimately about the lack of social structure and society's burgeoning individualism. Modern societies, by virtue of consumerism and the abandonment of old institutions, have become individualistic, in which the focus of the individual is to look after oneself. Moghaddam (1997) describes individualistic ideology as an ethos emphasising self-help, personal responsibility and, above all, getting ahead on one's own, in other words, 'making it' as an individual. The American rags to riches dream is characteristic of moderns' choice of individualistic freedom over community.

Where individualism is critical in the development of DID is in the corresponding decline in the strength and significance of social connections. Henry (1965) documents the effects of consumerism on the health of society. He states that modern society has likely created and traversed all of the paths to insanity, much more so than premodern societies. Our society is as adept in psychopathology as technology, he states, a telling reality since psychosis can be considered the consequence of cultural malaise. On a personal level, the cultural illness is transmitted through the parents to the children, and
the fluidity of cultural values means none but a non-modern outsider may recognise the folly.

**What Hinders Identity Formation in the Postmodern Age?**

The critical message in the above discussion of the nature of identity is to highlight its profoundly important social component, and the effects of the erosion of postmodern community on identity development. As noted earlier, secure attachment is perhaps the most significant determinant of identity formation. Beyond the realm of the nuclear family, modern and postmodern societies have a profound impact on identity formation. Pluralisation, individualisation and secularisation are the consequences of the postmodern age. Thus, its inhabitants endure poor community connection, isolation and a life devoid of faith. The weakening of the pillars of community and church mean identity roles to which young members of the community may have looked toward are gone. In their place they have found transient pop-cultural icons (Fornäs & Bolin, 1995). The manner in which this trend has endangered identity formation is that cultural values perpetually and arbitrarily change, so identification by moderns and postmoderns blows in the wind. As infatuation is to love, rather than solid identity development, we see superficial identification that is whimsical and groundless and ultimately may provide no strong or enduring identity formation.
How Does Identity Formation Relate To DID?

There is no causal relationship between hindered identity development and DID. There are many determinants of DID, the most common of which is trauma (see chapter 2), but not in isolation. Factors that appear to increase susceptibility include insecure attachment (in particular disorganised/disoriented attachment), and a dearth of social support. There is inherent resilience against DID in strong identity. It is difficult to separate the part played by the strong identity from the confounding secure attachment and extensive social support that almost always accompany strong identity formation. Perhaps the best way to approach the question of the value of strong identity is to examine the implications of interrupted identity formation.

Pursuing the model of identity development through identification (Erikson, 1968), we may conceive of the earlier period of identification as the internalisation of values from the surrounding community and role models. In the case of abuse by the primary caregivers (typical among DID sufferers), the internalised messages are detrimental to the emerging identity. Perhaps as important as the negative messages in the development of DID is the inconsistency with which they are delivered. Thus the child may be alternately fed messages of love and loathing by his or her model of primary
identification. As the child's consistent behaviours are met with dramatically inconsistent responses, nascent identity is hindered. According to Erikson (1968), the model for identity is developed through continuity and predictability of responses. As expressed through the internal-external dialectic, it is impossible to separate the internal self from the outside world from where continual feedback helps to shape and hone one's sense of self.

For those with strong identity formation, abusive behaviours are not so easily traumatic because victims may seek solace from their own familiar, predictable and entrenched values structure. Abusive behaviours won't so easily challenge already established strong identity and become internalised. Independent of the stable psychological make-up of strong identity formation, the extensive social network necessarily developed by those with strong identities provides a further barricade against harm. Those with poorly developed identity will not have ventured as far afield from primary caregivers to establish new social connections. In the face of adversity in the home, the poorly constructed identity and support network contribute to great vulnerability.

Hindered identity development means, in effect, there is no firm place for the individual, in the home or community. In the event of trouble when support is required,
not only may one not turn to an external support structure, but solace may not be found internally, either. DID provides the support that is not to be found externally. The DID is a creation of the psyche to provide a "social solution" to the mental onslaught to which the individual is being subjected. "Social solution" means alter personalities provide necessary support and connection to permit the self to continue to function.

**Summary**

In the midst of an era of change in the westernised world, identity is besieged by the crumbling social institutions of family, community and church. Where individuals formerly anchored their identities and values, firm in their belief of unquestioned stability and place, now they find change and instability. Residents of the postmodern world not only find no certainty in cultural values or objects of identification, these values are forever changing. In the void left by the dissolved social structure, mass media markets identities where it once marketed goods. From the perspective of soaring incidence of DID, the crumbling of social institutions means individuals are less able to develop strong identities. With the individualism that accompanies modernism and pluralisation, social connections are weakened. The legacy of modernism is individuals who lack strong identity and meaningful social connection. Thus, in the presence of trauma, they
are ill equipped to stave off mental illness. This point will be further elaborated in the following chapter on protective mechanisms.
Chapter Five

FAMILIAL AND SOCIAL SUPPORT IN THE DEVELOPMENT OF
DISSOCIATIVE IDENTITY DISORDER

Psychological texts and journals are replete with examples of trauma or sadistic abuse that result in the development of psychopathology (e.g., Browne and Finkelhor, 1986; Bagley & Ramsay, 1986; Russell, Schurmann, & Trocki, 1988). Such is the evidence that DID has been considered a consequence of abuse (e.g., Spira, 1996; Ross, 1989). In exploring the strength of the perceived causality, it seems often little emphasis is placed on those victims of abuse or trauma who emerge into adulthood psychologically unscathed. Chapter three illustrates how poor early childhood attachment to a primary caregiver increases susceptibility to psychological illness. Chapter four argues how interrupted identity development lays the groundwork for psychological illness in the presence of abuse. Poor attachment and weak identity formation are clearly provocative factors in the development of DID. While the identification of aggravating factors in the development of psychopathology is clearly beneficial in the construction of an explanatory model for DID, it is not enough. Investigation into the factors that create resilience against DID is equally important. This chapter explores the factors that contribute to children's resilience against
psychopathology. In doing so, this work will identify the protective mechanisms that come to play. They are the mechanics behind the resilience, and the identification of these factors will contribute to more predictive outcomes of abuse and trauma.

**Protective Mechanisms**

Garmezy & Rutter (1989) describe a protective factor as one that often in coexistence with the presence of risk factors is accompanied by a reduction in the probability that the disorder will develop. Researchers consider protective factors primarily in the context of risk. The exploration of protective factors or mechanisms is crucial to the identification of variables that may help those at risk. In the context of DID and childhood trauma, the identification of mediating variables affecting psychological outcome is important in targetting those elements that either stave off DID or increase its incidence. A Canadian study examining the prevalence and mental health sequelae of child sexual abuse (Bagley, 1995) made what the author described as a puzzling discovery. A 22 year old woman presented for an interview and recalled a childhood marked by emotional coldness, neglect, parental strife, and excessive physical punishment. Over a six-month period, from age 12 to 13, she had to submit to sexual intercourse by her father. Then her parents separated, then she lived with an aunt. She was raped at age 15 by a cousin, and again at age 17 by a boyfriend. She was a cheerful,
extraverted individual with many friends. She had excellent self esteem and no sign of depression or neurosis. "The only factor we could adduce in her survival was a chronically cheerful and extraverted personality, and her ability to make many friends. Yet this is a post hoc interpretation, and exactly why she has survived psychologically is ultimately a mystery" (Bagley, 1995, p. 117).

Another case, also described by Bagley, chronicled the plight of a woman who was forced on a single occasion, to fellate her neighbour. In marked contrast to the first example, the psychological consequences of this event were disastrous; she developed serious anorexia nervosa, chronic depression and suicidal ideation. Why, indeed, has the first woman displayed resilience to such remarkable abuse? Her scenario clearly confounds prognostic expectations, while the severity of the second case might also surprise. The accepted precursors to the development of psychological symptoms are generally considered duration and severity of abuse (Bagley, 1995; Putnam, 1997; Russell, 1986). In the above examples, it is the isolated incident that has incurred the more serious consequences.

The details missing from these case descriptions may provide the clues to unlock the ‘mystery’ confronting Bagley and his co-investigators. The need for investigation
into protective factors is beginning to yield results in the literature. Rutter (1985) identifies a series of protective factors in fostering resilience. They are:

- reduction of risk impact, including altering exposure to and interpretation of risks,
- reduction of negative chain reactions that exacerbate the effects of the risk
- the establishment and maintenance of self esteem and self efficacy and
- the opening up of opportunities, particularly in educational and occupational settings.

The emphasis of Rutter's protective factors is clearly on practical solutions to a potentially damaging environment. Protection from psychopathology, he would argue, lies in avoiding the negative environment and contextualising and depersonalising negative messages, while increasing exposure to positive, esteem-building environments and activities. Notwithstanding the intuitive validity of Rutter's protective factors in the context of an abusive home and family, their practical relevance is questionable. A child living in an environment where the same behaviour can elicit both abuse and expressions of love may not be able to predict and avoid risky situations. In fact, the very unpredictable and abusive nature of these children's home life is an integral risk factor for developing DID, as explained in earlier chapters. Each of Rutter's factors for resilience requires a level of confidence, self esteem and social skills which seems unlikely to be developed in the home of a DID sufferer.
In a study examining the compound effects of stressors, Rutter, Cox, Treppling, Berger & Yule (1975) looked at risk variables in 10-year-old children. The risk factors they included were: severe marital discord, low socioeconomic status, overcrowding, paternal criminality, maternal psychiatric disorder and foster home placement for the child. They found that the presence of a single risk factor did not increase the children’s rates of psychiatric disorder. Two factors increased the probability by four, while four or more factors increased the probability of psychiatric disorders by ten times. In the context of a young child returning home to encounter a drunken and abusive parent, Rutter’s model emphasises that the reduction of psychological impact lies in avoiding contact and perceiving the abuse as the parent’s problem. It seems the presence of a potentially damaging home life, the child’s psychological health depends on developing expertise and self esteem away from the home, most likely in scholastic or athletic arenas.

Garmezy (Rhodes and Brown, 1991) takes a different approach to protective factors. Rather than “mechanisms” he identifies protective “characteristics”, some of which are more predetermined or developed than behavioural. His emphasis on personality characteristics indicates that some protective factors are not adoptive but largely situational or developmental. Garmezy cites a child’s “personality factors” and high self-esteem as significant in the maintenance of psychological health because it
facilitates adaptation to high stress environments. A supportive family milieu and access to an external support system that encourages and reinforces the child’s coping are also important factors in staving off psychopathology, he states. A stable and cohesive family climate, particularly non-conflictual relations between the parents and good parent-child relationships, provide a particularly important protective function.

In her work on resilient personalities, Joseph (1994) identifies skills, attitudes and protective conditions typical of resilient children. She identifies proactive means of generating conditions of invulnerability, essentially a ‘how-to’ for the development and maintenance of psychological health. This includes a child’s development of skills (i.e. sports or music) which bring praise and recognition, interests and hobbies to act as stress buffers, social skills to solicit support from others when needed, responsibility to actively seek solutions to problems, and coping skills to minimise the negative impact of a stressor. Furthermore, she concurs with Garmezy that children require nurturing, structure and a good role model.

Although many of the skills Joseph identifies are unattainable in the context of a child enduring severe abuse and intrafamilial conflict, she makes a critical observation. In several cases she notes children developing resilience despite a high risk social environment largely with the adoption of a single role model. The special emphasis of
role models in Joseph's work is that a role model represents an unprecedented opportunity for some children to develop a solid relationship upon which they may develop confidence, self esteem and healthy coping mechanisms. The unfortunate reality is that children with poor social skills are markedly less likely to develop positive relationships with adults outside the family.

Peters, Wyatt & Finkelhor (1989) link the increased risk of sexual abuse to family characteristics. Breaking away from the assumption that sexual abuse, itself, is causal of psychopathology, they question whether the apparent long term consequences of sexual abuse are merely an artifact of underlying deficiencies in family relationships. They have found that lack of maternal warmth is the family characteristic most strongly associated with the occurrence and severity of contact abuse. The notion that deficient family and other social relations (and not the presence of abuse) are the more important determinants of DID presents a new way to conceptualise the disorder and its determinants. Keeping abuse as a constant, it appears the family environment may be a more robust predictor of psychopathology.

Despite the range of protective mechanisms identified by researchers, Peters et al. (1986) point to a fundamental question facing each of the dissociation theorists, one of artifact. The issue relates both to the incidence of abuse (as noted above) and to the
psychological consequences of that abuse. The potential artifactual nature of the determinants of vulnerability cited above is paramount to this thesis. Individual qualities identified in the previous section do not occur randomly. It is not merely coincidence that some children develop protective qualities while others develop psychopathology.

Bagley (1995) points to “an interesting but unresolved question... is why some individuals (about a third of all victims of long-term abuse) do not develop serious mental health problems, despite severe or multiple trauma in childhood” (p.116). The answer to Bagley’s query is that vulnerability to psychopathology requires the presence of other risk factors, notably (to begin with) the absence of secure early childhood attachment (Howe, 1994) and the sequelae to that attachment, as elaborated below. I will not reconstruct the dynamics associated with attachment and later development of DID articulated in Chapter three. In summary, however, children who are subject to insecure attachment, often a consequence of poor maternal responsiveness, (Liotti, 1992; Belsky & Nezworski, 1988; Sperling, & Berman, 1994) take their first steps on the path to psychological dysfunction. Insecure attachment is the first stage in the production of psychological (and physical) vulnerability in children. It is important to note that attachment is the foundation that sets the stage for the acquisition of additional protective mechanisms or risk factors (Howe et al., 1999). Poor attachment reduces the child’s development of social skills, exploration of the external world, his or her sense of place.
in it and sense of self (Sroufe, 1978; Belsky and Nezworski, 1988). Therefore, a child who is insecurely attached is less likely than his or her securely attached counterpart to possess the skills associated with the acquisition of other protective factors.

The work on maternal warmth by Rutter et al. (1975) is consistent with the assertion that secure attachment is an important factor in the psychological health of the child. Rutter and his colleagues investigated the protective effects of a positive, loving relationship with at least one parent in an otherwise high risk family environment. They found that the presence of a supportive, warm and loving parent significantly decreased a child’s risk of developing psychiatric disorder. They found that children who had no supportive relationship were three times more likely to suffer from psychiatric illness. While the notion of the positive psychological value of the child’s warm, loving relationship is relatively uncomplicated, what is the nature of its value? It is important to clarify the distinction between protective mechanisms and resilience against psychopathology. Protective mechanisms in this context are acquired as weapons or tools to draw upon in defense against DID. Resilience, however, while indeed protective, relates more to a systemic ‘invulnerability’, not so dependent on the presence of external support structures. The distinction is perhaps subtle. This thesis in fact argues that resilience is fostered from the onset with the acquisition of protective mechanisms like attachment, strong identity formation, and place in the social and cultural environment.
Consequently, it is possible for otherwise unresilient children to benefit from protective mechanisms (e.g., Garmezy, 1991).

Resilience and Vulnerability

Fine and Schwebel (1991) describe resilient children as “those who are able to maintain positive mental health despite facing stressful situations typically associated with increased risk for disorder” (p. 23). While their description of resilience appears valid, I question these researchers’ emphasis on resilience as opposed to vulnerability. Childhood vulnerability to psychopathology has as much to do with social conditioning as to the presence of trauma. Fine and Schwebel relate to stressful situations typically associated with increased risk for disorder. While they refer to trauma and abuse, it is evident that “increased risk for disorder” accompanies several factors primarily associated with socialisation.

In studies of childhood invulnerability to serious risk, researchers discovered that several factors played major roles in the protection against psychopathology. Wolff (1995) describes a child’s primary relationships as crucial to protecting children from psychiatric disorders. She also notes that a strong relationship with an adult outside the family also has a protective effect. Other factors emerging from her research include:
high intelligence and an easy temperament, qualities which she feels enable children to develop self esteem and satisfaction from achievements. In their study of well functioning children of disturbed parents, Fisher, Kokes, Cole, Perkins, & Wynne (1987) found that competence played a major role in protection against psychopathology.

Fine and Schwebel (1991) found that critical factors for resilience include: favourable personality characteristics (e.g. high self esteem and self control and internal locus of control, positive mood, social responsibility and flexibility); a supportive family milieu that encourages and facilitates coping efforts, and a warm, supportive social environment that encourages and reinforces coping attempts. Werner (1989) states that a positive mood, sociability, easy temperament and adaptability are vital factors in staving off psychopathology. From the wealth of research into resilience and protective factors, the connection between social factors acutely linked to attachment, identity development and the generation and maintenance of positive relationships and not developing psychopathology is well established. Further investigation into the nature of resilience and protection against DID reveals that in a climate of traumatic abuse, it is social factors alone that account for vulnerability or resilience to psychopathology.
Abuse and Resilience

In Russell’s (1986) analysis of the significance of the severity of abuse and the degree of psychological damage, she finds inconsistency. Her own study, involving 64 victims of incest, found a linear relationship between the severity of abuse and the degree of trauma experienced by the subjects. Other, larger studies found differing results, however. In a study of 796 college students, Browne and Finkelhor (1986) found no relationship between the severity of sexual activity and degree of trauma. Bagley and Ramsay (1986) found the child sexual abuse involving vaginal, oral or anal penetration was highly related to mental health problems in adulthood.

Russell (1986) notes that despite the inconsistencies that exist in the research, her intuitive response to the data insists that one occasion of genital fondling will not generate the same degree of psychological problems as repeated exposure to penetrative and physically painful sexual abuse. Browne and Finkelhor (1986) found that despite the inconsistencies present in the research, there are linear correlations between severity and duration of abuse and psychological outcome. They add that many clinicians take for granted that the longer the abuse persists, the more traumatic it is. Russell concludes that undocumented mediating factors exist to confound the research. “Intuitively, it seems likely that, other things being equal, the longer the duration of the incestuous abuse, the
more traumatic it is. However, because of the intricate and not yet fully understood interrelationships between this and other significant variables, the duration effect can be lost. This is a complicated way of saying that other things are rarely equal” (p. 147). The reasons for the inconsistencies in the research are indeed that “things are rarely equal”. And the thing of paramount importance to resilience and vulnerability is the presence of social support.

**Social support in the developmental years**

In cases where early attachment is hampered, insecure children are less likely to venture out to develop an extended social network (Howe et al., 1999). This hindered socialisation presents multiple problems with respect to resilience against psychopathology. It is unlikely that the poorly attached child, for example, will have the confidence to develop skills and expertise from which he or she could base self esteem. It is unlikely that the insecure child could develop a robust supportive social network because of his or her reticence to venture forth from the primary caregiver. Similarly, it is possible that other areas of achievement (i.e.: the classroom or sports field) might also not develop to their full potential because of the child’s insecurity and inferior social skills.
While, as noted above, there are serious and direct implications of insecure attachment on the psychological health of the child, these are but the beginning. The run-on effects will compound the risk of developing psychopathology in the event of trauma. Howe et al. (1999) observed that poorly attached children are at high risk of social maladaptation. They found that disorganised attached children are less likely to socially interact with or respond constructively to others. Furthermore, physically abused children are likely to be both verbally and physically aggressive with peers. Other maltreated children actively avoid their peers, while the least socially competent children are both aggressive and withdrawn.

As poor early attachment impinges on the development of peer relations, problems in relating with peers further engender serious problems in the acquisition of social support and competence, important preventative factors against psychopathology. Asher and Parker (1989) evaluated the impact of peer relations in childhood on social and emotional adjustment. They identified seven “friendship functions” that consistently appear in research on peer relationships. These are:

- Fostering the growth of social competence
- Serving as sources of ego support and self validation
- Providing emotional security in novel or potentially threatening situations
- Serving as sources of intimacy and affection
Ladd (1989) identified the significance of children’s behaviour in the school setting and their acceptance by peers. He found that antisocial children were more likely to be disliked and rejected, while well-adjusted children were better liked by their peers. Children who were rejected by their peers had greater difficulty finding consistent play companions and were deemed by their teachers to be less well adjusted at school. The importance of school in the development of resilience among children has been well documented by many researchers. In his research with economically disadvantaged children, Rutter (1979) found that the effects of a stressful home life were mitigated by a positive school environment. Furthermore, Zuckerman-Barlee (1982) discovered that among Israeli children who were frequently exposed to violent border conflicts, school enhanced flexibility in problem solving, and improved problem solving was linked to stress resistance. While the structure of the school setting and regime have been shown to be helpful for children in stressful home environments (Hetherington, Cox & Cox, 1982; Wallerstein & Kelly, 1980), contact with a supportive teacher has also been identified as a important source of resilience (Werner & Smith, 1982).
Up until now in this chapter I have been discussing the role of social support as it
relates to resilience and vulnerability to psychopathology in general. This section will
illustrate the link between these factors and DID in particular. What follows is simply an
indication that people with DID have lacked social support, and consequently have likely
not been resilient.

Empirical studies involving DID patients are few, however evidence about the
family dynamics of these patients seems consistent. The evidence paints a picture of an
abusive, unstable, discordant, and rigid family life. Boor (1982) found in his review of 29
reported cases of DID, that the subjects’ childhoods were marked by family discord. He
found that family environments were characterised by severe perfectionist standards.
Almost all of the cases involved histories of severe physical and/or sexual abuse. Parental
absence or rejection was also a common factor among Boor’s cases. His findings are
consistent with other work on the aetiology of the disorder (e.g., Greaves, 1980; Putnam,
1989). Atchison and McFarlane (1994) note that all similarly abused children do not
progress to develop psychiatric disorders. They suggest that an important mitigating
factor among those who develop dissociative disorders is family discord. According to
the authors, “it may be that children with the capacity to dissociate in the face of
inescapable suffering and who grow up in disordered families are those at risk of continuing to use dissociative defenses to a pathological extent in later life” (p. 594).

Kluft (1984) and Spiegel (1986) have both found that inconsistent parenting and families characterised as authoritarian and rigid are typical of DID patients. Alexander and Schaeffer (1994) found that people suffering from pathological dissociation had family environments in which was found severe violence, conflict, abuse and controlling parental behaviours. The consistent findings about the family histories of DID patients paint a relatively clear picture of their early family life. It has been argued that family discord and conflicting parental behaviours will erode resilience in children. That these qualities are almost universal among DID patients, coupled with pervasive physical, sexual and psychological abuse, presents a recipe not only for vulnerability but also for the trauma that will push them to dissociate. To further exacerbate the effects of abuse and an unsupportive family environment, children's inability to acquire social support in the form of peer or non-familial relations further increases their vulnerability to develop DID. Sroufe’s (1989) research on early childhood relationships indicates that insecurely attached children have fewer friends, have superficial relationships, and are poorly ranked socially. Joseph (1994) emphasised the potential protective value of relationships between children and non-familial adults, but according to Sroufe (1989) insecurely attached children are less likely to find those positive role models in the school setting.
He found that teachers showed less warmth, had lower expectations and were sometimes angry with insecure children. The fact that the poor social skills displayed by these children interferes with these relationships indicates that yet another source of protection is unavailable to poorly attached and socially maladaptive children.

Insecure attachment among children represents a risk factor on its own in that children lack the protective value of a solid connection with their primary caregiver. Furthermore, this primary risk factor produces domino-like effects as other sources of support vanish as a result of the manner in which these children relate and others relate to them, as indicated above.

While a history of abuse is characteristic of DID sufferers, it is not the determining factor. Serious abuse does not necessarily engender psychopathology, and research has also indicated that the duration and severity of abuse are not always indicative of the degree of psychological impact (Browne & Finkelhor, 1986). What is indicative of psychopathology, and common to DID sufferers, is a family history marked by abusive and unpredictable parenting. The early family socialisation represents the first in a series of domino-like maladaptive situations which generate psychological vulnerability in a child. Children with insecure early attachment lack the psychological protection afforded by a healthy and secure home life. Further, however, their insecurity
resulting from weak parental bonding, interferes with the acquisition of important social support structures, both inside and outside the family environment.

**Summary**

Resilience to psychopathology is the result of the acquisition of protective mechanisms. This process of acquisition is a consequence of a healthy early childhood and family life followed by the facile development of supportive environments, in the larger family setting, and in school and in the wider community. In the event of abuse or trauma, these children display resilience. With the support of those around them, they are unlikely to develop psychopathology. While severe physical, sexual and/or emotional abuse in an unpredictable, rigid and authoritarian home environment may trigger DID, the evidence indicates the abuse is not the causal factor. Studies of the aetiology of the disorder point to a very consistent profile of home life and socialisation of DID sufferers. An intrinsic part of this profile is insecure attachment, a determinant of later psychological disturbance. In this home environment, the insecurely attached child develops barriers to further socialisation. Consequently, he or she does not develop social skills and external support structures upon which to rely in times of adversity. Interrelated with the maladaptive social environment, poorly attached children present with psychological vulnerability that precludes healthy coping with or avoidance of
abusive situations. The evidence points to abusive situations that have not resulted in psychopathology. One may infer that victims of such abuse who remain psychologically unscathed, benefit from their resilience associated with healthy early attachment and/or their solid social support networks. DID sufferers, by contrast, are likely products of a difficult early life, frequently marked by abuse. Histories of poor social attachment make them less socially equipped, and consequently less able to fend off or cope with the abuse they encounter.
Chapter Six

THE SOCIAL SOLUTION MODEL OF DID

Introduction

Throughout this thesis, DID has been discussed as a disorder triggered by abuse and trauma in an environmental context lacking support. Previous chapters have articulated the relationship between DID and attachment, identity development and the role of protective mechanisms. Each of the above issues represents the existence and implications of external support systems. It is important to note that although external support is critical in protecting children against DID, the social support plays out another function, an internal one. The nature of the internal and external support is a complicated one, and I will elaborate at length later in the chapter. This chapter presents a model of DID as an improvised social solution. This solution responds to a social problem confronting DID sufferers. The social solution manifests itself in the presence of alters. This allows for the presence of characters and qualities that may or may not exist in the victim’s other reality. Various emotions and conflicts are personified in alters. This solution serves the function of creating internal order from external chaos.
The pathological dissociation represented in DID is triggered as an autodefault mechanism in the face of systemic psychological collapse. What this means is that DID is a primitive automatic response that occurs during overwhelming trauma in the absence of an effective support structure. This chapter will explain how DID is a universally available mechanism, and is not limited to those genetically predisposed to dissociate.

**A Social Problem in Need of Solution**

Until now, this thesis has been engaged in identifying the social dynamics contributing to susceptibility to DID. It has been postulated that poor early childhood attachment has a negative effect on identity formation and the development of positive reinforcing social structures. Conversely, the lack of positive social relationships appears to adversely affect identity formation. The intricate, co-dependent nature of attachment, identity and social relationships speaks to the profound and critical importance of social factors to our psychological well-being. Not only do they enhance general psychological health, but individually and collectively they act as a safety net in the event of serious trauma. The failure of one’s psychosocial requirements, however, does more than simply increase one’s vulnerability to abuse and trauma. In dire circumstances, such failure will require improvisation. In the event of overwhelming trauma, with nowhere to turn for
support, some victims create the support and coping mechanism unilaterally in the guise of DID.

Improvisation, in this instance, relates to the generation of alter personalities, or alters, characteristic of DID. Ross (1989) describes DID as “a little girl imagining that the abuse is happening to someone else” (p.55). For Ross, this projection is the essence of the disorder, and all other aspects are secondary. He says the dissociative experience for the abused child is sufficiently intense, compelling and adaptive, that he or she experiences parts of herself as external characters.

**The alter personality system**

The dissociative aspects of the little girl to which Ross refers are alter personalities that serve several well-defined functions. This hypothetical girl may display the presence of one or several “dissociated aspects of herself”. These distinctive alter personalities are not arbitrary, but play crucial roles in the psychodynamics of someone with DID. So consistent are some of the characters that they represent a host of distinct social roles. Kluft (1984) provides a solid description of an alter personality that this thesis uses as a definition: “An entity with a firm, persistent, and well-founded sense of self and a characteristic and consistent pattern of behaviour and feelings in response to
given stimuli. It must have a range of functions, a range of emotional responses, and a significant life history (of its own existence)” (p.20).

Ross (1989) suggests methods for clinicians to map the alter personality system. His interest is in forming a therapeentic alliance with the alters to allow future integration. While his focus is not on the social relevance of the alters, his methodology provides interesting clues to their existence. He advises clinicians to question their subjects (and their subjects’ alters) about their histories (including when the alter came into existence, and what the alter or alters have been doing since), their functions, and how much time an alter has been in executive control. He suggests using the perspective of one alter to gather information about others. While Ross’ methodology is designed to map out the alter personality system, this mechanism helps us realise that different alters serve different functions, and interrelate, as do any members of a social system. Their genesis may help to shed light on the specific purposes for which they were introduced.

A DID study of 236 cases reported that patients manifest, on average 15.7 alters. (Ross, Norton, & Wozney, 1989). Putnam, Guroff, Silberman, Barban & Post (1986) reported an average of 13.3 in his study of 100 cases. Researchers have documented the following list of common alter personalities. The literature appears to differ in the
specific manifestations the alters may bear, but there appears to be agreement concerning
the rather discrete list of roles they tend to inhabit:

<table>
<thead>
<tr>
<th>Child</th>
<th>Protector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal self helper</td>
<td>Memory trace personality</td>
</tr>
<tr>
<td>Persecutor</td>
<td>Suicidal</td>
</tr>
<tr>
<td>Cross gender personality</td>
<td>Promiscuous</td>
</tr>
<tr>
<td>Administrator</td>
<td>Obsessive compulsive</td>
</tr>
<tr>
<td>Substance abusers</td>
<td>Autistic and handicapped</td>
</tr>
<tr>
<td>Personalities with special talents or skills</td>
<td>Imitators and imposters</td>
</tr>
<tr>
<td>Anaesthetic or analgesic personalities</td>
<td>Demon</td>
</tr>
<tr>
<td>Different race</td>
<td>Different age</td>
</tr>
<tr>
<td>Opposite sex</td>
<td>Another living person</td>
</tr>
<tr>
<td>Dead relative</td>
<td></td>
</tr>
</tbody>
</table>

Many of these types of alters are seen consistently across DID patients (Ross, 1989; Putnam, 1989). A cursory glance reveals that this list of common alters incorporates nearly the full range of personalities society has to offer. The representation of a host of personality types provides the DID sufferer with the potential for internally

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contending with conflict and providing protection. This mechanism forms the basis of the social solution model of DID.

**Functions of the alter personality system**

The system of alters inherent in DID creates an opportunity for the affected individual to contend with three significant issues: the presence of unresolved conflict and the absence of order and support. The issues are interwoven, but the mechanisms for addressing them are distinct. It must be clearly stated that the premise for this thesis is that DID is a creative disorder resulting from overwhelming trauma and conflict. As a response, DID is clearly maladaptive, but nonetheless provides a means to contend with the issues in a "secure" psychological environment.

**Conflict Resolution**

Earlier in this chapter, I referred to DID as an improvised social solution to a social problem. With regard to the issue of conflict, the social problems facing DID sufferers involve reconciling conflicting behaviours and messages from close family and friends. I have argued the importance of the lack of social support in the development of DID. The abuse that precipitates the disorder may involve characters in the DID victim's
life who, in normal circumstances, would be protectors and supporters. Accounting for the high degree of trauma experienced by the victims, and of the seriousness and repetition of the abuse, the abusers are almost always close to the victim (Ross, 1989; Kluft, 1984). The most common form of abuse among victims of DID is incest, usually father-daughter or step-father-step-daughter (Putnam, 1989). This situation clearly illustrates the nature of the conflict present in the life of the DID victim. The perpetrator of the sexual abuse also theoretically inhabits the role of loving father, supporter, protector, and role model. The two realities do not easily co-exist. The abuse need not be sexual to engender this type of conflict. Nor does the abuser need to be the father.

Although the connection is not well established, it appears as though there is a greater likelihood of developing DID if both parents are involved in the abuse (Putnam, 1989). Thus, abuse at the hands of both parents merely increases the degree of conflict present. One might visualise a scenario in which mother and father both profess love, kindness and concern (altogether normal, expected and necessary responses) and then spontaneously behave abusively. Putnam et al. (1986) note that DID sufferers are frequently victims of sadistic abuse in which, according to his National Institute of Mental Health survey, three quarters were also subjected to beatings or torture. In some instances, the confused messages of love and loathing from their caretakers were
delivered simultaneously. He explained instances of ritualized abuse during which their abusers claimed the episode or attack was a form of “cleansing”, as though the child should interpret the abuse was a form of caring.

Braun (1985) cites elements of abuse that largely differentiate future DID sufferers from other victims of abuse. To promote the development of DID, the abuse “must be frequent, unpredictable, and inconsistent” (p.47). Braun discovered that child abuse victims who are unlikely to generate DID are more frequently subject to reactive aggression from their parents. Their DID counterparts, however, were prone to inconsistent abuse, with or without reactive aggression. As example, he notes the bizarre ritual endured by one male DID victim. The patient’s mother used to insert a pearl tied with thread into his penis with the help of a thermometer, and then pull it out. This behaviour and that of other similarly abused DID patients, is often inconsistent with the caregiver’s behaviour immediately preceding the aggression. In fact, sadistic abuse may easily follow expressions of endearment.

Barach (1991) has found that the subject of the conflict experienced by child victims of abuse need not be confined to the abuser. As discussed in Chapter 3, it is not only sadistic abuse that leads to the manifestation of dissociative responses in children.
Barach describes "parents failing to respond" as a form of trauma which is particularly important in the development of pathological dissociation. Failure to respond in this context may mean that a parent does not actively protect the child from abuse, or is not emotionally available or responsive to the child. A child in this environment is more prone to dissociate in the presence of both abuser and unsupportive parent. Barach's example of children traumatised by lack of involvement or empathy highlights the roles of both support and security in the development of detachment and pathological dissociation. It also helps to explain the potential roles of the alters and the requirement of the improvised social solution in the presence of DID.

The means by which alters alleviate the sense of conflict generated by those expressing abuse and love alternately is to separate the conflicting messages through the creation of distinct personae. Alters generally represent a core emotion or affect (Putnam, 1989). Despite the fact that manifestations of DID are infinitely complex, tailor-making solutions to every need and social history, the basic tenet appears quite simple: to break the conflicting social elements into core roles which often include variations of victim, abuser and supporter. The combination of alters present in any one case is a function as much of the present support structure as it is of the prevailing traumatic elements.
An illustrative example of DID as social solution

The detailed account of Cornelia Wilbur's psychoanalytic patient "Sybil Dorsett", provides an exceptional framework within which to review the role of the alters as a social solution in the management of psychological conflict. Schreiber (1973) relays the history and life of this American woman and of the 11 years of treatment. Wilbur documented the presence of Sybil's 16 alter personalities.

Sybil's family history as it unraveled through the course of her treatment revealed serious physical and emotional torture. Her mother, a rigidly religious woman, was schizophrenic, and subjected Sybil to abuse that was at times ritualistic and at times seemingly spontaneous and unpredictable. Outside the reach of mother, Sybil took comfort in her love for and support from her paternal grandmother. The abuse was inflicted on the little girl from the age of three. Each morning Sybil's mother hanged the child upside down, bound and gagged with tea towels, and used an enema bag to fill her bladder. In addition to the pain associated with the large amount of water inserted into her urethra, her mother forced her to hold her water, and then punished her when she wet. Similarly, the child was given milk of magnesia following a meal and was sent to her room, forbidden to use the toilet. When she invariably soiled, she was beaten. Other ritualised abuse by her mother included the insertion of sharp objects into her vagina,
notably bottle caps, a button hook and knives. The range of torturous abuse was creative, and always out of the presence of her father who remained oblivious to the abuse.

**The collapse of the social support structure**

While not directly implicated in her abuse, Sybil’s father seems to have seriously eroded his daughter’s trust when he tricked her into undergoing a tonsillectomy. Fanatically religious and preoccupied with the Armageddon, he was not emotionally available to his daughter, nor did he question her about her many accidental bruises and fractures. For Sybil, her father’s lack of emotional availability and genuine interest in his child’s welfare meant he was not someone on whom she could rely for support.

The onset of Sybil’s pathological dissociation appears to be correlated with her father’s deception at the time of her tonsillectomy. According to Schreiber (1973), Sybil remembers wishing the kind young doctor would rescue her. When the doctor refused her pleas, her first alter, Peggy, emerged. Until this point, her father was a source of potential love and support. Despite her father’s grave inability to provide a support against the backdrop of her mother’s savage abuse, it appears Sybil’s dissociation remained relatively inert until the death of her paternal grandmother about four years later. Her grandmother appears to have been her sole gatekeeper against active dissociation. It
seems Sybil trusted her and felt safe in her presence. When she died, the little girl was hurled into two years of steady dissociation as Peggy and Vicky lived her life. In the absence of grandmother’s support, Sybil developed a mechanism by which the traumatised child could contend with the sadistic abuse and neglect by her parents and play out conflicted dynamics. In his investigation into resilience and factors that are protective against psychopathology, Garmezy (1991) found that despite conditions of abject poverty, absence of parents or marked marital discord, the presence of a caring adult inside the home is a strong variable. Another is the presence of a source of external support.
**The presence of social conflict**

There are several strong sources of social conflict in Sybil’s experience. Her mother simultaneously told her she loved her as she tortured and beat her with unfathomable cruelty. From Sybil’s perspective, the expressions of love and loathing are impossibly reconciled. In the context of this difficult existence, her father, while generally beneficent, never rescued her. He was an unwitting accomplice, and abuser in absentia. The other main source of conflict was to be found in her own experience and reaction to it. For example, Sybil loved and needed her father, but she was furious with his complicity. Both are clearly healthy responses to the situation in which she found herself with her father, but the nature of her abuse precluded their expression. The parameters of DID, however, offered a fortuitous opportunity. Distinct personalities, secure in their place within the structure of alters, may express a range of appropriate responses. As the function of the alters relates to conflict, they contend with the irreconcilable nature of Sybil’s experience of those around her. Without a means for addressing the conflict, there persists a psychological tension that must become manifest. One might argue that the tension that results from irreconcilable conflict is the root of psychopathology. Nowhere has this thesis argued that DID is a healthy response to conflict, but it is successful in diffusing tension. One of the reasons it is maladaptive is
that conflict is not played out freely, but rather through the contrived cast of characters to which the host is normally amnesic.

**The role of alters in playing out conflict**

The investigation of the specific alter dynamics in the case of Sybil Dorsett shows how DID allows the expression of some of Sybil’s elements of conflict. The behaviour of Sybil’s waking self indicates disempowerment, submission, misery and need. The expression of her other legitimate emotions and characteristics was, for her, seldom possible in her dangerous familial climate. The alters, however, were not so fettered, and together represent a comprehensive range of emotions and behaviours appropriate to Sybil’s experience. The conflict generated by Sybil’s inability to express herself began to be alleviated with the arrival of Peggy, her first alter, and Victoria Antoinette Charleau, the memory trace. The arrival of Peggy meant the arrival of assertion, enthusiasm and anger; in many ways the antithesis of Sybil as it relates to her parents. She voices the powerful emotions that Sybil kept concealed. The onset of Marcia Lynn Dorsett, the hyper-emotional writer and painter allowed Sybil the facility to express her otherwise inexpressible emotions. Through Marcia she cried, where Sybil could not. Vanessa Gail Dorsett was dramatic, where Sybil was subdued. Marjorie Dorsett had a quick sense of humour and laughed easily. Sybil did not have this luxury. Through the male alters, Sid
and Mike, Sybil had the opportunity to express her desires not to be female. Much of her mother's abuse involved mutilating her vagina because "the men will do it to you anyway". Maleness, in light of her abuse, must have seemed a blessing.

**The creation of order in the resolution of conflict**

In the case of DID victims, part of their conflict involves the need to reconcile polar behaviour among their carers. This reconciliation results from the creation of order out of a situation which, in its manifestation of co-existing opposites, provides none. The way this is done is by creating alters that have a very limited range of behaviour and emotions, providing little risk of contradiction within the alter. Several significant aspects of living characters may be represented as distinct alters. As previously indicated, Sybil's mother was loving. She was also a brutal abuser, and these two realities do not easily co-exist in the mind of a child. In Sybil's case, the presence of Mary Dorsett and Clara Dorsett provides a barrier between negative and positive attributes. Mary Dorsett was maternal, accepting and loving. Clara, by contrast, was critical of Sybil and highly religious. While clearly all of the facets of Sybil's mother, Hattie, are not personified in these two alters, they may represent two aspects which, for Sybil, needed to be separate.
The discrete emotional, experiential and behaviour states achieved by alters is a clear indication of a propensity, or requirement, for order. The establishment of alters to represent a potential range of conflicting attributes provides not only order but control over situations which are outside one's sphere of control. Whether or not one relates to dissociation in terms of order, it is widely accepted that the nature of dissociation involves filtering from consciousness elements of reality that challenge order and heighten tension. The order created through dissociation, it is important to note, is artificial. The purpose and dynamics associated with the creation of this artificial order will be discussed in the section describing the social solution model of DID.

The third important factor associated with the development of DID is the creation of an artificial support structure. Earlier in this thesis, the role of external support as a protective mechanism against the onset of pathological dissociation was argued. Active support is important in early childhood attachment, identity development, socialisation, and practical support and intervention in times of strife. The path toward dissociation clearly represents a dearth of support for victims of DID. The need for support continues, however, and this need is met, like the order, artificially, through the improvised social solution.
The role of social support

As much as the cast of alters for DID sufferers personify the conflict, the characters help to not only contend with the conflict but build a solid base of social support. In the case of Sybil, the presence of an external support structure was, with the exception of her paternal grandmother while she was alive, completely absent. DID presented her with the capacity to generate the social support she needed. A key figure in her improvised support structure was Mary. While Mary was not a dominant figure in terms of frequency or duration at the helm, she essentially became the critically important maternal figure, replacing her grandmother and providing the kind of support not available from her mother. Vicky, the memory trace, is the supportive friend, looking out for Sybil's psychological and physical health. She will intervene to develop friendships that Sybil lacks the confidence to endure, feed her malnourished body when she has the chance, and support her through her facilitation of psychotherapy.

Fatherly roles, represented by Sid and Mike, support Sybil by practical means, surprising her with handiwork. Because they embody qualities of both father and grandfather, they provided an opportunity for Sybil to live out unresolvable conflict associated with these two men, but also enjoy support from the improvised roles. In addition to other dynamics, many of the cast of alters have the common goal of looking
after Sybil. Even those alters critical of her weaknesses (potentially even those alters who are persecutors) play a significant role in building the supportive social infrastructure lacking in the outside world. Despite the fact that these supportive characters are fabrications, the role that they play in this maladaptive response is real. Kluft (1985a) recounts the case of eight-year-old ‘Tom’ whose alter personalities have been co-opted from television’s epic heroes. His supporting cast of characters include an alter resembling Captain Kirk from Star Trek, and the Incredible Hulk, both of whom support Tom when he is afraid or angry. Representing nurturing maternal figures are ‘Betty and Wilma’, two alters whose identities were taken from The Flintstones cartoon television programme.

It is interesting to note the significant role of television characters in Tom’s creation of supportive alter personalities. The place of the media in the context of the psychological health of society is discussed at some length in Chapter 4. Notwithstanding the cultural implications of his choices for alter personalities, the television characters provide Tom with the support necessary to contend with his reality.

In a less elaborate case of the disorder, Brenner (1999) describes his treatment of ‘Andrea’. When he witnessed his host patient being mutilated with a razor by a
persecuting alter, the host was unavailable to intervene. His appeal for help yielded another alter personality who came forward to support the host in collaborating with the therapist to seek treatment. The arrival of the supportive ‘Other Andrea’ is a clear and dramatic indication of the value of the role of support in the cast of alters.

**The improvised social solution model of DID**

The three elements of DID, creating order, contending with conflict and providing support are all factors in the improvised social solution of DID. The solution to these issues in the external world is a social one, usually involving a support network of family and friends. As we have seen in previous chapters, access to such a support structure is often limited for the DID sufferer. Born, indirectly from this lack of support, DID improvises the required social elements to work out conflict and protect and support the victim.

An explanation of the social solution model of DID requires revisiting the place of social support, identity development and attachment in the aetiology of DID. In the presence of sadistic abuse, what may differentiate continued healthy functioning or other psychiatric illnesses from DID is a factor not of the length and severity of abuse but of
the nature and lack of the victim's social support. As discussed in Chapter 5, examples of cases of traumatic sexual abuse have vastly varying degrees of outcome. While some victims proceed to develop pathological symptomatology, others seem virtually unaffected. The objective of this paper is to investigate the reasons for these discrepancies. Quality of attachment, identity development and the acquisition of protective mechanisms appear to be predictive of susceptibility to DID. The model of DID as an improvised social solution postulates that the social failures that led to vulnerability are rectified, albeit maladaptively, through an improvised social structure.

**The determinants of DID**

The literature indicates that some factors are clearly predictive of psychological outcome in the presence of severe trauma (Browne & Finkelhor, 1986; Russell, 1985). The identification of these factors in the context of the improvised social solution model helps to bring significance to the role of DID. The earlier chapters of this thesis identified some of the most important issues in determining susceptibility to DID. In fact, what was identified were complex systems of progressive development, both of risk factors and of protective mechanisms. Quality of attachment sets the stage for identity development and the acquisition of social skills necessary to generate a supportive
environment. Given similar traumatic experiences, this thesis argues that social factors play a large role in predicting the psychological outcome.

A securely attached child will develop a strong sense of identity, enabling him or her to venture afield to develop a supportive network. This child is unlikely to pathologically dissociate in the presence of abuse or trauma. By contrast, however, a child who is insecurely attached often will not develop a strong sense of identity, and consequently, will be unlikely to generate a functional protective social network. Rutter supports this notion of a strongly interdependent structure of protective mechanisms that operate on different levels. According to Rutter (1985), protective factors operate through their direct and indirect effects on interpersonal interactions over time. The same compounding influences occur with risk factors.

**The role of protective mechanisms**

While the specific mechanisms behind pathological dissociation may be elusive, the conditions paving the way to DID are increasingly clear. As articulated in Chapter 5, protective mechanisms represent the flip side of risk factors, promoting the maintenance of good psychological health despite the presence of abuse or trauma. DID sufferers clearly do not benefit from protective mechanisms. The improvised social solution
reintroduces a forum for the integration of protective mechanisms. In this arena, the social solution is clearly not protective against DID, but rather against the perpetuation of the damaging environment that caused the disorder.

In Chapter 5 we cited a host of protective factors. A brief summary may be useful in placing protective factors in the context of the improvised social solution. Garmezy (1991) said a supportive family milieu and access to an external support system are important, as are a stable and cohesive family climate, non-conflictual relations between the parents and good parent-child relationships. Joseph (1994) stated children need nurturing, structure and a good role model. Rutter's (1985) protective factors in fostering resilience include: altering exposure to and interpretation of risks, reducing negative chain reactions that exacerbate the effects of the risk, establishing and maintaining self esteem and self efficacy, and creating new opportunities, particularly in educational and occupational settings.

Protection provided by the improvised social solution

The improvised social solution provides the breadth of protection of the mechanisms described above, but instead of maintaining optimal psychological health
and resilience, the improvised solution merely allows the individual to continue functioning despite what otherwise would be paralysing trauma. The way DID achieves this is through the dynamics of the alter personalities. Earlier, this chapter examined the role of the alters in managing internal conflict. Repackaging memories, emotions and behaviours into distinct integral elements allows for the expression of conflict within the DID sufferer by separating conflicting behaviours and messages from their abusive caretakers. This allows the DID sufferer to control the expression of conflict, and also provides some safety in the presence of supportive alters. Furthermore, the structure of the alters in DID serves the function of protecting the host against horrific episodes or memories with which they are not likely to be able to contend. The amnesic barriers between the host and the alters may keep the host safely ignorant of physically inescapable issues and problems or irreconcilable past traumas.

The supportive structure, so important as a protective mechanism is recreated in the world of the DID sufferer despite its notable absence in his or her external reality. In general, the supportive infrastructure necessary for resilience is developed through the participation of protector personalities, a common presence among DID sufferers. Protector personalities may manifest themselves as maternal or paternal characters or supportive friends.
Another protective factor represented in the system of alters is the non-conflictual relations between parents and between the child and parent. It is important to state at this juncture that each system of alters is distinct and meets the specific requirements of the individual. Consequently, if certain roles are met externally, they may not be present among the alters. Sybil’s case represented conflict between child and parents. In response, her alters represent the loving and benign characters of Mary and Sid, the nearly archetypal mother and father. Mary, particularly, may be important in her role as the supportive, nurturing and accepting figure of mother. Beyond the supportive structure in general, the role of mother figures very prominently in the development of protection through strong early attachment and the consequent identity formation and social networking. Many DID sufferers appear to be particularly vulnerable in both the absence of the nurturing and loving mother, and the fact that mother is so often the abuser or accomplice (e.g., Putnam, 1989; Ross, 1989). Mary’s character provides for the psychological presence of a maternal support without negating the impact of the trauma delivered by her mother. She provides an important context of warmth and acceptance.

**The role of the alter in protection**

The alter personality system is more than a blunt tool to provide improvised support or separate conflicting elements. The operations of the alters, while remaining
quite inexplicable, perform sophisticated tasks to promote post-traumatic resilience. As noted above, Rutter's (1985) protective mechanisms foster resilience by altering exposure to risk, reducing opportunities to exacerbate the risk, and establishing and maintaining self esteem and self efficacy. These mechanisms suggest some ability to control one's external environment. While this ability is clearly limited in the case of the DID sufferer, the alters provide the control necessary to create these mechanisms to promote a kind of resilience in the form of coping skills.

The emergence of an alter in the course of a traumatic episode serves the function of limiting the host's exposure to further abuse or trauma. Particular circumstances may be better dealt with by different alters, which emerge when necessary to keep traumatic exposure to the minimum. Putnam (1989) has observed a kind of "adaptive logic" to the switching process that sees an appropriate alter emerging in most circumstances. "The ability to switch and bring forth the personality appropriate to a given situation endows MPD patients with a chameleon-like capacity that they use, in turn, to mask the multiplicity" (p.118). Despite whatever heightened abilities in camouflaging the disorder, the switching from host to alter and among the alters ensures the optimal reduction of trauma and the presence of the persona most capable of dealing adaptively with any given circumstance. This propensity of DID patients to switch alters according to a particular
circumstance is not limited in use to the presence of abuse. An introverted and insecure host may not cope well with friendly social overtures. A secure and extraverted alter may step in to limit the trauma of the occasion and foster positive and rewarding social relationships.

**Adaptive component in a maladaptive strategy?**

This thesis regards DID as a principally maladaptive disorder. A large component of its facility seems to be in developing coping mechanisms through the improvised social solution: creating order, contending with conflict and providing a custom-created support structure to fill in the gaps present in the DID sufferer’s external support network. However, DID may not be completely maladaptive.

The emergence of socially facile alters makes possible the development of a social infrastructure. Adept at social situations, alters unencumbered by social paralysis or maladroitness, contribute to the development of supportive relationships crucial to the maintenance of long term psychological health. In this way, the internal social solution may cross over to help create an external solution in the form of a new support network. This is not to say that this potentially adaptive component is universally achieved or
without problem. It is not, nor does it make the disorder principally adaptive. For alters to generate a supportive external structure for sustained use by the host requires the support structure to positively engage the host in the absence of the alter with whom the relationship was formed. The stronger (and more often present) the support structure, the more likely it is for this crossover to occur. Regardless of the likelihood of the host benefitting from what is, in effect, the alter’s social support structure, the active and positive social relations of the alters may minimise the development of other psychological problems for the host, particularly depression.

**The role of order in the improvised social solution**

The two main functional features of the improvised social solution are the provision of a support system to buffer the effects of the experience or legacy of trauma and contend with the tension resulting from irreconcilable conflict present in key social relationships. The imposition of order is a fundamental precept in achieving the functions of DID. The notion of order is critical to an understanding of the improvised social solution. It is similarly a cornerstone in the argument of DID as an autodefault mechanism that is activated in the presence of overwhelming trauma without the protective benefit of social support. Schumaker (1995) argues that the tendency of humans is to achieve a state of mental order. When that order isn’t easily achieved from
the external environment, we achieve it artificially. A state of mental disorder results in heightened tension as the mind attempts to corroborate conflicting information. This process does not, however, require pathological dissociation. Religion, through faith, allows a willing suspension of the constraints of logic. According to this perspective, the lack of mental order suffered by victims of sadistic abuse from caregivers inhibits functioning. The internal conflict discussed earlier in the chapter, is a factor of the lack of mental order, a state rectified through the elaborate improvisation of alter “solutions”. The artificial order to which Schumaker refers is achieved by filtering information by way of dissociation. The inference of this understanding of DID is that this disorder represents a purposeful (though not conscious) mechanism to reduce the state of mental tension resulting from the prevailing abuse.

DID is not characteristically a disorder that results from consistent, ordered situations. As indicated in Chapter 3, children most likely to exhibit dissociative symptomatology are those displaying disorganised/disoriented attachment styles. Children who develop this type of attachment are typically subjected to fear-inducing and, importantly, unpredictable parental behaviour. The lack of predictability often coincides with spontaneous sadistic abuse among DID sufferers. The lack of predictability precludes the maintenance of psychic order for the victims.
Functions of the internal social solution

The presence of an abusive and unpredictable parent is clearly not sufficient cause for the development of DID. Assuming such a person is merely a component of an otherwise large social structure with which a child might anchor identity development and garner support, the abusive character remains an anomaly. In the child's perception, such a character may be fearful and strange, but not psychologically threatening. However, in the absence of a functional support structure, the child's attachment and identity development are very much linked to the parents. These parents, who in the case of DID victims frequently display complicity, ought to be an essential source of support, but instead provide insecurity and abuse, and a greater need for the support for which the children are being deprived. It is in this arena where order may not be rationally achieved.

The opposing messages of love and loathing directed at the child by a person on whom he or she is completely reliant, defy understanding. It is in this situation that order may be created artificially through DID. A premise of this thesis is that order is a fundamental criterion for mental functioning. Where order may not be achieved rationally, DID achieves it artificially by filtering unresolvably conflicting elements from
consciousness into alter personalities. As stated earlier, alters operate within a very limited range of behaviour and emotion. Their discrete scope facilitates control of order by channeling conflicting elements from the external world into distinct alters. This system allows DID victims to internally contend with opposing behaviours presented to them in the external world. The system also allows them to cope with the feelings that these behaviours generate for them. As with the rest of the internal social solution, this ordering process is not conscious.

Order is the state within which the mind functions. The concept of DID as an autodefault indicates that in the event of systemic psychological collapse, the mind overrides the paralytic trauma and conflict to impose the illusion of order. The function of DID as autodefault may be likened to a central processor reboot. Potential for disorder is unlimited, and means for achieving order vary greatly. Opposite DID on the superficial end of the spectrum, order may be maintained by ignoring incongruous elements or rationalising experience according to limitless possibilities. The process neatly excludes or handily explains incongruity, permitting unhindered mental functioning. In the situations that lead to DID, however, more drastic measures are required. The disorder represents a basic reordering and recategorising of experience to create order where none would be otherwise present.
The notion of DID as an autodefault reflects a psychological system that can no longer create order itself by any means. The external support structure that, when present, provides confidence, encouragement and context, is not present where DID steps in. The strong sense of identity that provides a protection against psychological and physical onslaught is not present when DID is required. In most cases, the lack of support structure is the final stage of vulnerability after a series of developmental weaknesses that predispose the victim to DID.

**Why is DID the autodefault?**

Despite the complex and elaborate stage play created by the alters in the reestablishment of psychological order, DID is essentially a primitive capacity with a main goal of survival. The mechanism is maladaptive, as explained above, with the primary function of separating emotional needs and conflicts and providing a safe haven for their expression. Because of the amnesic barrier that plays a vital role as a protective feature of the disorder, DID does not resolve the conflict. While other psychological disorders or conditions may help to contend with psychological issues, DID is custom made to accommodate the accumulation of social failures that lead to systemic collapse. For example, anxiety may allow subjects to contend with issues through repression, and
phobias, through projection (e.g., Nevid, Rathus & Greene, 1994). Eating disorders have been theorised to allow subjects to exercise control and autonomy (e.g., Davison & Neale, 1994). DID, by contrast, is the whole scale psychological response to the subject’s inability to enlist any other defensive strategies in the presence of psychological collapse. Other disorders may provide a diversion or escape from issues. DID is the autodefault mechanism because it contends not only with conflict resolution, but also creates the necessary supportive infrastructure and maintains a semblance of order in the presence of chaos. Other disorders may provide diversion or refuge from psychological problems. They do not supply an improvised social solution, nor the sophisticated capacity to generate illusion of order. DID manifests differently in each individual, providing the necessary level of support and conflict resolution, and the capacity to develop the disorder, given the presence of the determinants, is universal.

**DID as an evolutionary development**

The idea that DID is universally available as a social solution to a social problem contradicts many theorists whose arguments point strongly toward innate predisposition and genetic predetermination (e.g., Braun and Sachs, 1985; Kluft, 1985b). The fact that DID is universally available as a psychological response is important in two regards. The
first is that this position reasserts this thesis’s findings that the development of this disorder is a factor of environmental conditions. The second is in support of the assertion that DID is an evolutionary development and not a vestige of the pre-conscious mind.

Chapter 2 introduced the contradictory theories of Schumaker (1995) and Jaynes (1976). Jaynes’ arguments indicate DID might be a vestige of the pre-conscious bicameral mind, while Schumaker’s theory claims dissociation is an evolutionary development to accommodate the species’ increased intelligence and requirement for order. One might argue that the autodefault nature of DID might have its genesis in either of these two possibilities. What points to evolutionary development as a more robust theory is the universality of dissociative capacity. It would seem unlikely for a vestige of pre-conscious mental structure to be universally accessible. A further argument in favour of dissociative capacity as an evolutionary development is the existence of dissociation as a normal part of our mental repertoire. The fact that we may dissociate in several ways to accommodate environmental demands points to the intuitive likelihood that other forms of dissociation also find their roots in environmental factors. Schumaker’s perspective on DID as a developmental response of the psyche to disorder supports this thesis’ position that DID is an adaptive social solution to an environmental weakness.
Summary

The internal social solution model of DID contends that in the absence of social factors such as early secure attachment, strong identity development and the acquisition of a social support structure, DID is triggered in the event of enduring unpredictable sadistic abuse to artificially create psychological order. The development of artificial order is a key element in achieving DID's primary functions of compartmentalising conflict to facilitate the playing out of dynamics, and generating an internal support structure to replace critical supportive elements absent in the external world.

DID operates as an autodefault mechanism that is activated when the victim is unable to maintain psychological order using other means. The lack of protective mechanisms operate as risk factors, and in the event of trauma, the psychological system is faced with mental collapse as a result of the ensuing paralytic chaos. Under normal circumstances, secure attachment, strong identity development and a solid support network preclude the need for the improvised social solution provided by DID. Without them, however, DID provides an ordered framework within which to find protection and allow for the expression of emotion. The autodefault mechanism is likely an evolutionary product developed to facilitate the maintenance at all cost of psychic order.
DISCUSSION

Most perspectives on DID acknowledge to some degree the social components of the disorder. This consideration may range from recognising it as a factor in trauma, or as an important feature in the onset of DID. What appears to be the case, however, is that predominant theories on DID stop short of acknowledging the full role of social factors in the aetiology of the disorder.

*Strengths of the improvised social solution model of DID*

The role of trauma, usually in the form of sadistic abuse, is almost universally recognised as a factor in the aetiology of DID. Genetic predisposition, capacity to dissociate, fantasy proneness, and creativity have all been put forth as contributing predisposing factors, as indicated throughout this thesis. Other elements, like age of onset of abuse and hypnotisability, appear in the research in what seems to be an attempt to corner the nature of this elusive disorder. These perspectives on DID presented throughout this thesis fall short of seeing the disorder as psychopathology stemming from purely social circumstances.
The improvised social solution model proposed in this thesis builds on the widely accepted understanding of DID as a coping strategy or defense mechanism activated in the face of overwhelming trauma. The improvised social solution model results from an attempt to reconcile the diverse components of the disorder. The result is the development of an intuitively sound model that is rigorous in its explanatory power. The model finds that, despite the catalytic presence of trauma, all of the aetiological factors for this disorder involve social failure. Furthermore, the manifestation of DID is entirely responsive to that failure. Because the explanation for this disorder is so inherently social, there is no need to provide genetic or physiological explanations for the disorder.

The improvised social solution is particularly challenging to the school of thought that proposes that an innate capacity to dissociate is a prerequisite to developing DID. This position, which encompasses not only “dissociative capacity” but also hypnotisability, argues that only those who are prone to do so will develop DID. There is no evidence to support this perspective. The improvised social solution model draws strength from the argument that dissociation is a universal capacity. But it was also developed in light of the measured response of the disorder to the specific social situation. As explained in the thesis, DID provides the mechanism and personae to contend with traumatic events occurring in a real world lacking the necessary supportive structure. This includes an arena for the expression of conflict and emotion, and the
fabrication of key characters conspicuously absent from the real world for the victim. This is a highly effective and sophisticated system. Where the difference between this model and others lies is in the conception of the disorder as a social solution to a social problem. And in this difference is to be found the implications for the model.

**Therapeutic implications for the model**

The implications for the improvised social solution model of DID are great. Understanding the aetiology and functioning of the disorder are of most immediate value in the prevention of the disorder and in developing a novel therapeutic approach.

DID is an evolved capacity to protect the host in times of severe stress caused by trauma and abuse. This protection occurs as a default mechanism in the absence of protective support structures. Knowledge of this dynamic is of particular value in the face of incipient DID. At this stage, the budding improvised social solution has not reached the stage where alterpersonalities have been fully elaborated and the mechanism is fully functional. As discussed in the body of the thesis, the improvised social solution operates through the establishment of order. This elaborate, energy consuming process is not the preference. It is, rather, the default in the absence of all else. During the incipient stage, the provision of adequate support to help the victim contend with his or her unpleasant
realities may be all that is required to fend off the psychopathology. Bearing in mind that DID is not a result of trauma, but rather of poorly developed support and relationships in the face of trauma, the establishment of necessary support structures is clearly protective. This model is based on the assumption that the failure of social support is a huge aetiological factor. The provision of support precludes the development of an improvised solution.

Although this thesis has not been concerned with therapeutic approaches, it is necessary to say that there are important therapeutic implications to the improvised social solution model. Much like the protective role social support may play in avoiding DID, perhaps the implementation of critical support may help to wean DID victims off dependence on supportive alterpersonalities. This strategy, in conjunction with therapy to contend with conflict resolution, may be the key to psychological health for DID sufferers.

Traditional integrative techniques may be supplanted with a support-based approach designed to satisfy the voids that acted as risk factors for the victims. Alternatively, a therapeutic approach for incipient cases may be to bolster the arsenal of protective factors. Much like the social solution intervention at the incipient stage, treatment for victims of DID may be based on the fulfillment of key support roles. These
may be identified through abuse history and the tell-tale presentation of alters. Recall that
the presentation of alters is indicative of specific requirements both in terms of support
structure and emotional outlets. A common technique among therapists using the
integration model is to identify and engage alter personalities, requesting that they
occupy, at least temporarily, the same space (e.g., Braun, 1986; Spira, 1995; Kluft, 1999).
Fine (1999) states the groups of alters become progressively adept at working together
until the group may spontaneously integrate. Fine’s model of strategic integration of like
groups of alters is typical of the general model which features careful therapeutic
intervention to facilitate the management and fusion of alters. What the improvised social
solution model may help to develop is a therapeutic strategy that facilitates integration (if
necessary) by developing the requisite elements of support to make redundant the
maladaptive dissociative response. With a sound supportive infrastructure in place, the
focus of psychotherapy may then be to contend with ongoing conflict. The limitation of
the integration model appears to be its emphasis on correcting the maladaptive
dissociative response through sophisticated alter management without cultivating the
supportive infrastructure necessary to sustain the integration.
Certainly one of the most significant limitations of this model is the lack of definition for the variables. For example, the thesis contends that early childhood attachment, identity formation and the adoption of supportive infrastructure are protective against the onset of DID in the event of trauma. The alternative is that the absence of early attachment, hindered identity formation and limited social support are risk factors for the onset of DID. Given the extremely broad scope of this thesis as it explores the full social mechanism surrounding DID, many of the qualitative variables have defied definition. Evidence cited in the thesis points to the relationship between the risk factors, protective mechanisms and DID. The details relating the balance among the range of protective and risk factors are not yet available. For example, it is not clear whether an intimate relationship with one's grandmother is as much or more protective as a relationship with a close group of friends. Similarly, is a transient relationship with a mentor as valuable as a long-term enduring peer or family relationship?

This thesis postulates a critical connection between early childhood attachment, identity formation and vulnerability to dissociate. Although the argument works with strong, well defined attachment models, the element of identity formation currently lacks definition. Similarly, while the link between attachment and identity formation is strong,
the threshold between poor attachment and weak identity formation is, perhaps necessarily, ill defined. Furthermore, the threshold between hindered identity formation and hampered social development is also subjective. Even if one used a psychometric tool to measure strength of identity, and this score was correlated with number and quality of social connections, identity measures may not be relevant. For the purposes of this thesis, identity is a multi-faceted construct. The cultural, social and familial roles may provide differing degrees of protection, or perhaps may be particularly protective in combination. It has yet to be determined whether one element of identity, such as culture, is of greater value in moulding one's sense of self, and one's resilience against psychopathology.

Similar limitations occur in the realm of protective mechanisms. At this early stage in the development of this model, quantity and quality (effectiveness) of protective mechanisms have not yet been ascertained. At this point, the level of protective factors necessary to ward off DID is not yet known. We know that solid attachment increases the likelihood of strong identity development and, in turn, further protective factors. What we do not know, and may never know, is whether a single protective factor (including attachment or identity formation) is enough to preclude the development of DID. If it is not, what combination of factors will be sufficient. In all likelihood, there is no firm
answer to these questions because of the variability of response and resilience among victims of abuse.

**Future directions**

All of the limitations identified above provide opportunity for future research into the improvised social solution and into the factors contributing to risk and resilience. Of particular value will be the determination of thresholds, as identified above. Another important area of research is the determination of which protective factors are of greater value in fostering resilience. For example, while membership in extracurricular activities and positive relationships with grandparents are both considered valuable protective factors against psychopathology, it is important to know if one protective factor is particularly effective. The identification of the strength of protective factors will help develop therapeutic and preventive strategies. By identifying and promoting the principal protective mechanisms, there may be achieved greater efficiency and effectiveness in therapeutic intervention. There may exist a huge range in the psychological value provided by the protective mechanisms identified in this thesis. While this thesis identifies the clear interdependent and complementary nature of attachment, identity formation and the development of subsequent protective mechanisms, one of the most exciting prospects for the development of the improvised
social solution model is that of its practical application. Clearly, prevention (as opposed to treatment) is the preferred application for this model. Preventative intervention in the case of incipient DID should be a future area of research. Furthermore, the use of the model in a practical environment may help to establish thresholds and determine the primacy of protective factors.

As much as DID is a personal disorder resulting from a social and cultural phenomenon, the implications of research stemming from this model will potentially have both social and cultural consequences. The context of this research is a cultural setting that appears to be fostering vastly increased incidence of psychopathology. Specifically, numbers of DID diagnoses have grown nearly exponentially during the past few decades. While this situation clearly has its roots in individualism, the inevitable consequence of postmodernism, the recognition of the relative value of protective factors may help to stem the tide of psychopathology. New research into this area may indicate significant protective value in community relationships, for example. In light of the serious large-scale psychological consequences of the age, this model may provide the basis of an innovative public health strategy. This strategy may potentially promote the role and value of family and community in the protection against mental illness and DID. Such a strategy may seek to model the community ties and structures found in traditional or non-Western communities unaffected by the legacy of modernity.
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