

Critiquing the Requirement of Oneness over Multiplicity: An Examination of Dissociative Identity (Disorder) in Five Clinical Texts.

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Abstract

In the health professions there is widespread agreement that dissociative identity is dysfunctional and needs to be cured. This position is based on the assumption that the healthy self is unitary and therefore multiplicity must be disordered. The cure, a requirement of oneness, is integration: the multiple selves must be unified into a single, integrated personality. To uncover themes and assumptions of this dominant approach to dissociative identity, five main texts were examined. From the many discourses identified, two central discourses were selected for further exploration. This paper explores how the identified discourses construct individuals with dissociative identity and how they inform and limit psychological theory and practice. Being exploratory, this paper offers a platform for further in-depth deconstruction and critical evaluation of the underlying assumptions and implications.

Keywords: *Dissociative Identity; Clinical Psychology, Integration.*

*Shall my cure be a far greater burden
Than the one I now bear on my own?
For when the battle is won
You will go home
And it is I who must continue alone.*
(Anon)

A concept which continues to arouse interest and controversy in psychological circles is that of dissociative identity, previously known as multiple personality disorder (MPD). This phenomenon is best understood and examined in the context of one's notion of self. Mainstream psychology tends to view the self as individuated and autonomous, that is, as having core properties that are universal, bounded, atomic and somewhat detached from its cultural, social and historical moorings. Many psychology and psychiatry professionals rely on the traditional idea of a 'true' or 'core' self, a self which is individual, rational, authentic, consistent and the origin of its own actions. From this perspective, it is expected that a well-integrated, healthy person should have a strong and unitary self (O'Connor & Hallam, 2000).

This concept is in contrast to pre-enlightenment and post modern thought that problematises the notion of

the unitary self. [For recent conceptions of the self in psychological literature, see Lester, (1994) and Stam (2004).] Those who embrace an alternate view of self offer the concept of an inherently plural, fluid, flexible, fragmented and decentred self, formed and constrained by social processes. From this perspective a plural self consists of a multiplicity of positions, voices, states of mind and functions (Neimeyer & Raskin, 2000); each self "is a source of differing interpretations of the world, based on differing interpretive schemes" (Lester, 1994, p. 312). This self "has a plural personality, she operates in a pluralistic mode" (Anzaldúa 1987, p.79).

For those who view the self as inherently unitary, two main positions or groups regarding dissociative identity can be identified. The first group either does not believe that dissociative identity exists at all or believes that it can exist but is extremely rare. This group views those who present with multiple selves either as fakes or as holding false beliefs of multiplicity that have been created iatrogenically by misguided therapeutic techniques (Spanos, 1994). The second group acknowledges individuals' use of dissociation as a common response to trauma and/or neglect and reports that there is a significant (perhaps around 1%) group of individuals whose lived experience is one of multiple selves or different identities (Kluft & Fine, 1993; Ross, 1997). As a result of this group's efforts, dissociative identity has become more recognised and was included in the Diagnostic and Statistical Manual (DSM), editions III and IV, published by the American Psychiatric Association. The DSM is regarded as providing the medical and social definition of mental disorder and is a main diagnostic reference used by psychiatrists and psychologists.

However, reflecting this second group's perspective that a healthy person requires an integrated and essentially unitary self, the DSM-IV presents dissociative identity as a disorder (DID) and describes it as "a failure to integrate various aspects of identity, memory and consciousness" (American Psychiatric Association, 1994, p. 484). The criteria for diagnosis according to the DSM are "the presence of two or more distinct identities or personality states (Criterion A) that recurrently take control of behaviour (Criterion B). There is an inability to recall important personal information that is too extensive to be explained by

ordinary forgetfulness (Criterion C). *The disturbance is not due to the direct physiological effects of a substance or a general medical condition* (Criterion D). The distinctive assumption is that identity, memory and consciousness should be integrated into a unitary self.

An alternative position in relation to dissociative identity, partially informed by a post-modern notion of self is that it is not a disorder per se (Rowan & Cooper, 1999), but rather an alternate and potentially functional and adaptive way of being. This position invites a deconstruction of the addition by the DID proponents of the concept “*disorder*” to dissociative identity. In agreement with this, Hacking (1995) is also wary about the term ‘*disorder*’. He purports that it is “*loaded with values and is code for a vision of the world that ought to be orderly.*” (p. 17). Such an addition of the term ‘*disorder*’ contributes to discourses on dissociative identity which are then disseminated by subsequent generations of practitioners as the truth. They inform how practitioners perceive clients with multiplicity and shape a whole treatment approach.

The purpose of this paper is not to detract from the valuable role played by prominent members of the DID field in fostering a greater recognition of multiplicity. Neither is the purpose to imply that such practitioners have negative intent towards people who experience multiplicity. Rather, the intention is to identify the discourses of the DID proponents and to consider their implications for working with people who experience dissociative identity. In this paper, multiple self-states are referred to not as ‘DID’ but rather as dissociative identity or multiplicity, spelt without capitals. This is done to avoid either automatically pigeonholing the experience as inherently disordered or objectifying those who experience it.

Method

The texts chosen are from three of the most well known psychiatrists in the field of dissociative identity, namely Richard Kluft, Frank Putnam, and Colin Ross. Each has published recognised texts and numerous articles on ‘DID’ and all contributed to the recognised treatment guidelines of the International Society for the Study of Dissociation (ISSD) (Barach, 1994). To explore a counter position, a text by a more recent specialist in multiplicity, Margo Rivera, is included. The texts examined were:

Clinical Perspectives on Multiple Personality Disorder (Kluft & Fine, 1993) and articles by Kluft (period of 1983-1996).

Diagnosis and Treatment of Multiple Personality Disorder (Putnam, 1989).

Dissociative Identity Disorder: Diagnosis, Clinical Features, and Treatment (Ross, 1989, 1997).
International Society for the Study of Dissociation (ISSD) Treatment Guidelines (Barach, 1994).
More Alike than Dissociative: Treating Severely Dissociative Trauma Survivors (Rivera, 1996).

To describe and analyse the power structures, ideologies, images and messages within these texts, a variety of qualitative analytical methods were applied as part of a larger study which explores the clinical literature more fully. As a precursor to a more thorough critical discourse analysis or post modern critique, this paper examines the texts from the point of view of content and language, teasing out assumptions and attitudes concerning DID and those who experience it. This paper also offers a brief glimpse into how the identified discourses construct individuals and diagnoses, and how they inform and limit psychological theory and therapeutic practice

Texts are segments of meaning reproduced in any form that can be given an interpretive slant (Parker, 1992). A discourse can be defined as “*sets of statements that construct objects and an array of subject positions*” (Parker, 1994, p. 245). “*Discourse is a practice not just of representing the world, but of signifying the world, constituting and constructing the world in meaning*” (Fairclough 1992, p. 64). Fairclough (1992) argues that it is important that this relationship is understood dialectically. A dialectical perspective emphasises that discourse is a way to study both explicit language and the material anchoring of language.

Discourses can be found ‘*performing*’ in texts. This paper sets in motion the process of exploring the “*connotations, allusions, and implications which the texts evoke*” (Parker, 1992, p.7). The questions that are posited are “*how are descriptions produced so that they will be treated as factual?*” and “*how are these factual descriptions put together in ways that allow them to perform particular actions?*” (Potter, 1996, p. 6).

Language is often a reflection of the attitudes and assumptions of much of society at large. Critical analysis of language used in the dissociative field, heightened awareness of its implications, and considered choice of new and different language to frame the experience of those with DI, can have a major impact on the future directions of therapy in this field.

Analysis and Discussion

From the many discourses discovered in the texts, two central discourses were chosen for exploratory analysis. These were:

1. 'Single' is necessary but not sufficient for health
2. Therapist knows best.

Exploring Discourse No. 1: 'Single' is Necessary... but not Sufficient for Health.

'Single' is Necessary. ...All the texts initially adopt an egalitarian stance towards dissociative identity by acknowledging and praising the functional aspects of dissociation in helping individuals to cope with the experiences of abuse. "*Creating other children inside is an excellent short-term solution to the abused child's problems*" (Ross, 1989, p.128). "*At one time, usually in early childhood, dissociation was a highly adaptive response to overwhelming trauma*" (Putnam, 1989, p. 137).

Descriptions such as "*excellent*" and "*highly adaptive*" express admiration for the processes involved. However the implied praise is qualified: the solution is only "*short-term*" (Ross, 1989, p. 128), the processes only adaptive "*at one time*" (Putnam, 1989, p. 137). The assumption is that a strategy that worked well in childhood is no longer functional in adulthood.

All the texts, excluding Rivera's, make much stronger assertions that multiplicity for adults is dysfunctional, maladaptive, and, in line with the Western medical model, pathological: "*The problem with adult DID is that, like any survival strategy gone wrong, it creates more problems than it solves*" (Ross, 1997, p. viii). "*The person needs to be fixed so that he/she can be effective rather than powerless in the face of the MPD psychopathology and life events*" (Kluft, 1993, p. 291). "*(Adults) require 'symptom stabilisation', 'control' of their behaviour and 'restoration of functioning'*" (Barach, 1994, section II).

The implications of the ISSD Guidelines are twofold. First, individuals with dissociative identity incur a process of medicalisation, through which "*non-medical problems become defined and treated as medical problems*" (Conrad, 1992, p. 209). In this process the concept of disease, for which a biological cause is required is often misaligned with the concept of disorder. Disorders do not have clear aetiologies, yet the practice of psychiatry is still underpinned by the medical and therefore disease model. Second, individuals with multiple selves are further positioned as unstable, out of control and dysfunctional respectively.

These implications are broadened in most texts to a conflation of multiplicity with undesirable behaviour and disease:

The desire for intense dissociated states is built into our DNA ... such states are wonderful, desirable, and healthy in their natural form ... but there is nothing

wonderful about the chemical ecstasy of the heroin-addicted ghetto prostitute. This is why there is psychiatry of dissociation, the goal of which is to substitute healthy, normal altered states for self-destructive, painful ones (Ross, 1989, p. 187).

The emotive language in this extract implies an almost inevitable link between dissociation, drug addiction and prostitution. This is further developed by Ross:

MPD is directly linked to sexuality ... In our 236 cases, 19.1 percent had worked as prostitutes. Many of these people would potentially stop prostituting if they were diagnosed and treated for the MPD. The connection between MPD, childhood sexual abuse, prostitution, sexual promiscuity, and venereal diseases including AIDS, makes MPD a major unrecognised public health problem (Ross, 1989, p. 94).

Statistical data from one sample is used by Ross to factualise a conflation of multiplicity, prostitution and associated diseases such as AIDS and venereal diseases. Although some individuals with multiplicity have these health issues, the language used constructs 'MPD' as the primary problem. However, it is disease that is a major public health problem, not multiplicity. There is no doubt that some people who experience multiple selves are dysfunctional and/or live outside of society's standards, and in some cases a causal relationship could be reasonably argued between multiplicity and dysfunctionality. However, no evidence has been published that dissociative identity inevitably causes dysfunctional and socially unacceptable behaviour or disease.

The assumption of automatic dysfunctionality in dissociative identity is central in the DSM. "*Diagnosis can be made in the absence of significant objective dysfunction*" (Summerfield, 2001, p. 97). Other diagnoses such as Schizophrenia, Major Depression and Post-traumatic Stress Disorder include in their diagnostic criteria that "*the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning*" (APA, 1994, p. 327). However, no such criteria are included for "Dissociative Identity Disorder". Whether or not there is distress or impairment is irrelevant. Unlike other disorders, dissociative identity is deemed a disorder and thereby dysfunctional, purely on the basis that those who experience it have a self that is not singular.

There may be in the general population a large number of people with MPD who are high-functioning, relatively free of overt psychopathology, and no more in need of treatment than most of their peers. They may not have abuse histories and may

have evolved a creative and adaptive multiplicity. If these people exist, virtually nothing is known about them. (Ross, 1989, p. 97)

The phrase “*if these people exist*” expresses some doubt that there can be “*high-functioning*” individuals with multiple selves, continuing the discourse of dysfunction. However the phrase also highlights a gap in the scientific research. Functional individuals who live with multiplicity are most likely not documented because of the very fact that they *are* functional and do not seek therapy. At present, the only documented cases of functional multiplicity are self-documented, for example on internet pages. Although this is not persuasive evidence for the scientific community, such data cannot be summarily dismissed simply to hold to the dominant discourse.

A construction of dissociative identity as inherently disorderly and dysfunctional, in conjunction with many therapists’ world view that a unitary self is normal and best, leads to the assumption that multiplicity needs to be cured: “*The goal of treatment of MPD is not palliation. It is cure*” (Ross, 1997, p. 204). “*Integration as an overall treatment goal*” (Barach, 1994, section IIIA). “*It usually becomes essential to replace dividedness with unity ... for any treatment to succeed*” (Kluft, 1984a, p. 11).

The prescription for cure is integration to oneness as accepted and unquestioned practice. According to this view, multiple selves must be integrated into a unitary identity. “*My model of therapy is no more than this: the patient has developed chronic trauma disorder with MPD in response to childhood abuse. She needs to integrate*” (Ross, 1997, p.294). “*This carries the seeds of a prescriptive rigidity, one which might also serve to confirm an illusion that it is possible to develop a set of principles or codes which can be invariantly applied irrespective of context*” (Gergen, 1992, p.181). In advocating integration, the texts support the traditional understanding of the self as a unitary psychological construct.

The unified, coherent self thereby becomes the regulative norm. One of the ways in which a normative prescription such as unitary oneness operates is through the construction that dissociative identity is deviant. “*Those who lack ‘rightness’ help define what is ‘right’.* Some modes of living become accountable while others remain unexceptional and taken for granted.” (Reynolds & Wetherell, 2003, p. 490).

Alternatively, a position that constructs the self as inherently plural and multiple in nature has the potential to present a very different view of dissociative identity. On first reading, Rivera’s text appears to do this, largely due to the markedly positive language used throughout.

Multiplicity and dissociation are presented as not only potentially functional, but also real strengths:

Multiplicity is not a problem; it is a wonderful thing, individually, socially, and culturally. The problems from which multiples suffer do not derive from the existence of their personality states, their many ways of being in the world. That is their strength (Rivera, 1996, p. 41).

The different voices with different perspectives no longer have to be silenced or devalued. The individual who is now in a position to bear an awareness of the depth, breadth, complexity and contradictory nature of her life experience, can now call all of those voices “I”, accepting none as the whole story, but embracing them all. This is the multiplicity at the heart of all of us. It transcends categories (Rivera, 1996, p. 48).

However, a careful reading of the Rivera text reveals that multiplicity is ultimately not equated with functional living but instead is presented as a problem that needs to be addressed. Rivera falls back on discursive resources that situate dissociative identity within the Western medical model:

You have a serious problem that used to be called multiple personality and is now called dissociative identity disorder. There is good news and bad news about this condition. The good news is that is treatable. Many people who have this problem get completely better. The bad news is that the treatment takes a long time and is very stressful (Rivera, 1996, p. 79).

In some respects Rivera also prescribes integration to oneness:

The more deeply parts of the individual connect with the therapist; the more important it is for the therapist to remember that the client is one person. As the therapist does this, the individual aspects of the system or personalities will gradually transform. They will not be stuck in rigid and repetitive patterns, and the early stages of a fluid responsive self will begin to emerge (Rivera, 1996, p. 122).

“*She can now call all of those voices ‘I’*” (Rivera, 1996, p. 48). Rivera appears to fall back on the traditional concept of encapsulating all parts into a single identity. There has to be an “I”; she does not contemplate an identity as ‘we’. She presents a mixed message: it is not necessary for individuals with multiplicity to be directed towards integration, but if they are left alone the parts will integrate by themselves.

Although in some ways Rivera's text tries to offer a new approach, it really only removes itself to the margins of the medical model. She takes issue with the position of the DID proponents, but does not really establish a clear alternative position of functionality as a "we". If one were to adopt such a position it would not only acknowledge the possibility of a functional multiplicity but also encompass a multi-faceted identity that could use "we" as a description of "self".

The plural self (we) is seen as being consistent with the historical and social condition of pre-enlightenment and post-modernity. The self is formed and performed through interactions in specific and cultural contexts. Hermans (1997) theorised the self as a constellation of dialogically structured positions, each with their own worldview and landscape, in relations of intersubjective exchange and dominance. The "I" moves between positions in an imaginal landscape, depending on time, place and situation, resulting in a multi-voiced self. The self as plural consists of a multiplicity of positions, voices, states of mind, functions etc. (Rowan & Cooper, 1999). This self, therefore is never ultimately bound by a set role but is constantly in the making; it is a self-in-process (Ortega, 1991).

Although psychological discourse does not encourage discussion about separate selves in ordinary speech (Heinimaa, 2000) many people in today's post-modern world would describe themselves as having multiple parts or senses of self, constantly changing and evolving. They would see this as an appropriate response to the multifaceted demands of contemporary society, in which flexibility and horizontal integration are valued as subjective qualities over stability and hierarchical organisation (Rappoport, Baumgardner, & Boone, 1999). Our language also holds an underlying 'multiplicity'. When describing individuals we use words such as balanced and well-roundedness. We often use phrases such as "part of me wanted to and part of me didn't" or "I didn't feel like myself". This "plurality in all of us" Rivera believes, is experienced as a "unity". "*The unmentioned or hidden 'multiplicity' in all of us comprises the many distinct and separate facets of a person's personality, the many ways of being, which make up the 'whole' individual called 'I'.*" (Rivera, 1996, p. 48). Perhaps it is as Erdelyi (1994) describes, "*when the self-system is in disharmony, however, the multiplicity of self-systems tends to be more obvious*" (Rivera, 1996, p.99).

It may also be that "*fragmentation is a way of living with differences without turning them into opposites, nor trying to assimilate them out of insecurity*" (Trinh, 1992, p.156). Rather than focus on the issue of multiple self "disorder", an alternative approach could explore the notion of functionality in conjunction with the

individual's experience. This approach could explore whether the individual experiences their inner and outer world as safe, functional, happy, productive, and as an acceptable way of being in the world. Similarly it could explore whether the external world experiences the person as safe, functional, happy, as productive, and sufficiently consistent in presentation (in all guises) that others can relate to the person. In this way the "diagnosis" of disorder, if one was to be made at all, would be linked with the individual's views on multiple aspects of both internal and external functioning.

Therapeutic goals would vary depending on which of these different aspects of functionality were to be focused on. One issue might be the degree of communication and co-consciousness between parts thought necessary for one's definition of functional. While therapeutic work on developing co-consciousness and communication has frequently been promoted by DID therapists, this has only been portrayed as a step along the way towards integration (Kluft, 1993). Rivera's stance (p. 41 & p. 122) moves towards seeing communication and co-consciousness as a therapeutic end in itself, but still with the goal of developing a functional "I". If the goal is functionality as "we", two approaches are possible. Either therapy works towards a co-ordinated internal system, involving communication and co-consciousness between parts, or the possibility could be explored that functionality can be gained without all parts of the system becoming aware of other parts and able to communicate with them. In Bromberg's (1993) view "*Health is not integration. Health is the ability to stand in the spaces between realities without losing any of them*" (p. 379).

Continuing Discourse No. 1: ... But not Sufficient for Health. Although the texts promote integration as being the cure for dissociative identity, they then state that more is needed to achieve health; that is, integration is necessary but not sufficient for health: "*Treatment does not end with fusion/integration; it only enters a new phase*" (Putnam, 1989, p. 302). There is also the tacit message that on this path to "true health" the "patient" will develop further psychological problems: "*The initial euphoria that accompanies the achievement of unity rapidly gives way to a profound depression*" (Putnam, 1989, p. 318). "*When you complete the multiple personality part of the treatment and the person has achieved integration, you are then dealing with a person with single personality disorder*" (Kluft, 1993, p. 89; 1994)

These problems may even be "*untreatable*":

After the final alter personality has been integrated, there is still a lot of work to do. Others make a transition from MPD to PTSD in a single personality. Such patients may have intense

flashbacks and continue to be suicidal, unstable in their mood and self-destructive in their manner of living for a long period of time post integration. For some the outcome may be resolution of their MPD, with an untreatable personality disorder (Ross, 1989, p. 220).

In no other area of the DSM does the eradication of one disorder inevitably lead to the diagnosis of another disorder. This brings into question the validity of the prescription for integration to oneness, and also reflects the power of social expectations. Individuals must move from socially unaccepted multiplicity to a socially tolerated single disorder.

The texts go on to address the problems of integration: “*Even though the patient may be enormously distressed after integration because they have lost their ability to dissociate, this is still an ideal goal*” (Putnam, 1989, p. 141). Kluft (1995) also notes that many multiples have very unrealistic expectations about how good it feels to be unified. “*The patient may always be tempted to return to the divided state and may even mourn the loss of the alter selves. Vigilance is essential*” (Putnam, 1992, p. 36).

These quotes attribute post-integration problems to the client. The possibility that it is the treatment that is problematic is not questioned and the fact that an individual experiences ongoing distress is viewed as a necessary sacrifice for the achievement of the therapist’s ideal of a singleton self. “*The multitude of voices are thus reduced to a ‘systematically monologized whole’*” (Bakhtin, 1997, p. 9).

Alternatively, if internal and external functionality as “we” is the goal, then iatrogenic distress would be avoided. The therapist’s task would be simply to explore what each part of “we” needs in order to experience health.

Exploring Discourse No. 2: Therapist Knows Best. Representations of the relationship between therapist and ‘patient’ in the texts function to promote a further discourse embedded in the dominant medical model: that the therapist knows best. The texts initially advocate the ideal collaborative nature of the therapeutic relationship when dealing with dissociative identity, but quickly go on to stress the importance of the power of the therapist: “*Treatment will be a collaboration but not democratic. The patient is the patient and I am the doctor. We are not friends, and I am the only one getting paid*” (Ross, 1997, p. 302).

This extract highlights that real collaboration is impossible, stressing the chasm between the doctor as the all-knowing professional and the patient as the unwell one simply paying for the doctor’s expertise. The

therapeutic process therefore becomes one where the dominant goals of the all-knowing professional are imposed despite the client:

There is no need to be apologetic for commitment to the goal of integration and the specific techniques that help the patient get there. The patient will stall and resist the work toward interpersonality integration in countless ways (Ross, 1989, p. 245).

It is most important to decline to engage in arguments over integration with the patient, because this course of action almost inevitably heightens narcissistic investment in the wish to avoid integration and introduces an adversarial tension in to an already difficult treatment. My personal style is to encourage a wait-and-see attitude. Usually by the time integration becomes an issue, it is in the process of occurring and perceived as inevitable. The argument is then irrelevant (Kluft, 1993, p. 109).

The word “*argument*” shapes the client as an adversary and their desire to discuss the issue of integration before committing to it as unreasonable and antagonistic. First, the therapist is constructed as entitled to refuse to discuss the issue of integration because he is right and knows what is best for the client. Second, the text condones a therapeutic approach of subterfuge that disguises, under an apparently easy-going style of “*wait-and-see*”, the use of a process that will lead to an “*inevitable*” predetermined outcome. “*I encourage their (the alters’) communication and teamwork, all of which is in the service of eroding narcissistic investments in uniqueness and separateness and promoting integration.*” (Kluft, 1993, p. 34)

Ironically, while a commitment to maintaining one’s identity would be considered a normal and healthy life force in a singleton, the selves (alters) of an individual with dissociative identity are represented as having a “*narcissistic investment*” when they attempt to preserve their existence, rather than yielding to the therapist’s demands.

“*The medical field holds the power and it sets the agenda*” (Parker, 1995, p.2). The power of authoritative knowledge is not that it is correct but that it counts (Coates & Jordan, 1997). In the face of the expertise of the medical fraternity, which is both sanctioned by and informs society, the “*patient*” with multiplicity is rendered powerless.

As part of this power asymmetry, the “*patient*” with multiple selves is constructed as a child and the therapist as a parent. In the role of “*child*”, the “*patient*” is represented as unable to assess his/her own needs or goals, incapable of equality with a professional person,

and requiring rules and discipline to manage out of control behaviour:

Handling MPD patients is often like handling misbehaving children. Limits, toughness, strict rules and consistent enforcement are the kindest and most effective treatment. Not everyone agrees with that parenting approach, but the patients will eventually teach it to most therapists who are committed to effective efficient therapy (Ross, 1989, p. 224).

With this combination of a belief in the primacy of the therapist's knowledge, a minimising of the client's wants, and the adoption of a parent/child approach, it is only a short step to justifying the use of coercion in therapy with clients who experience multiplicity:

Initially, confrontation should be kind, firm, matter of fact, and incorruptible. Once it is clear that the patient understands what is required but behaves inappropriately nonetheless, more forthright confrontation may have a role. This may be especially forceful if the issue concerns cooperation with therapy (Kluft, 1993, p. 43).

A double standard is sanctioned: the therapist can adopt an authoritarian approach involving force but the client must exhibit "appropriate" behaviour and democratic cooperation. Indeed, a state of siege initiated by the therapist is prescribed:

The strategic integration therapist focuses more specifically on undermining the dissociative defenses that support the multiplicity; this erosion is ongoing and relentless so that the dissociative structure collapses from within (Fine, 1993, p. 137).

The easiest outcome of this war is for the client to submit, to surrender. If not, more invasion is prescribed: "Sodium amytal should be considered when other techniques have failed or when temporary access to an unavailable alter is required... it is a battering ram. It gets you into the system" (Ross, 1997, p. 363).

The medieval war image of the battering ram has echoes of rape and thus could be seen as highly insensitive in light of evidence that a history of prior abuse is common in multiplicity (Kluft, 1990; Ross, 1989). Nowhere within these texts is there an acknowledgement of the possibility that these breaking-down processes may replicate and perpetuate abuse dynamics, further harming the client. It is possibly because of the invasive forcefulness advocated in such therapy that client resistance becomes an issue.

Again and again the patient must be educated and reminded of his or her role and duties in the therapy.

... Unless the therapist takes such steps he or she will find it difficult to confront the MPD patient who is resistant and/or noncompliant. Confrontation will be met with protestations of helplessness and wounded innocence (Kluft, 1993, p. 33).

Resistance to invasion is portrayed as troublesome and constructed as a manipulative overreaction. Critics of this traditional view point out that resistance has been, and in some cases still is, seen as an obstacle that must be circumvented or overcome (Rowe, 1996) and arises from a patronising position that clients "just don't know what is in their own best interests" (Amundson, Stewart, & Valentine, 1993, online version).

An alternative view is that resistance is a positive instinct. "Resistance to violence and oppression is both a symptom of health and health inducing" (Wade, 1997, p. 24). From this perspective, clients could be seen as exhibiting a healthy response to the invasion of the therapist. Such resistance is not unexpected, given that multiplicity is itself a: "Creative and courageous resistance, the refusal by women and children to be destroyed" (Rivera, 1996, p. 18).

Perhaps the therapeutic goal for people who are experiencing dysfunctional multiplicity should be to recognise the creative instinct to resist past abuse, to develop resistance to the legacies of previous and current abuse, including invasions by traditional therapists.

Instead, the majority of the texts examined depict therapy as a site of conflict. The therapist's role is seen as the holder of knowledge, "the expert who diagnoses the client's problem and applies treatment" (Bohart, 2000, p. 143), with an entitlement to use force in order to change the patient. These power relations between therapist and patient "grant powers to some and delimit the powers of others, enable some to judge and some to be judged, some to cure and some to be cured, some to speak truth and others to acknowledge its authority and embrace it, aspire to it, or submit to it" (Rose, 1996, p. 175).

Rivera's text acknowledges the importance of a more collaborative relationship between therapist and client as a more effective basis for growth and change:

Although the therapist has the training and the experience that give her more responsibility for the effectiveness of the treatment, it is crucial that the client not lose control over this part of her life. Therapy is always a partnership, and unless both partners respect the roles and responsibilities of both themselves and the other, the relationship is likely to undermine the client's strengths rather than contribute to her growth (Rivera, 1996, p. 82).

Although Rivera emphasises the notion of “partnership” the growth is still portrayed as occurring on one side only. Perhaps a more equal collaborative client therapist relationship would demonstrate and acknowledge that often the therapeutic relationship is a mutual process of growth and learning.

General Discussion

This analysis does not purport to be a thorough discourse analysis or the only possible interpretation of the texts explored. It is important to note that what we accept as possible interpretations of a text are determined by our “*horizons of understanding*” (Gadamer, 1975, p. 273) and as such these texts are open to other readings, other possible interpretations. Indeed there are as many possible interpretations as there are readers of the texts. However this brief exploration offers a glimpse into the ambiguities, contradictions and complexities involved in the language used to describe dissociative identity. It also demonstrates the need for further qualitative research into the area of dissociative identity.

The present analysis raises many issues, some of which will be discussed here. A prominent issue which has been long recognised in the psychological literature is that of defining self. The literature on ‘the self’ is huge and there is no claim here to cover the numerous ways in which the term has been used in modern and postmodern writings. However when looking at how the authors of the five examined texts viewed the self within the dissociative identity context, the majority proposed the unitary self as the goal of therapy. However when one looks beyond the five texts, there is an acceptance of multiplicity, the multiple self and polypsychism within the psychological literature (see Hermans, Rappoport, Ross, Shotter, & Watkins in Rowan & Cooper, 1999). Mair (1977) proposed the mind to be a ‘community of selves’ while Stone (1998) states that the belief that only one “I” could belong to one body, or even that only one “I” could be present at one time, was: “*a kind of a story we told each other*” (p.85). “*For the post-modern practitioner a multiplicity of self-accounts is invited, but a commitment to none*” (Gergen, 1992, p.180).

Within the views that embrace multiplicity, however, there appear to be varying degrees of acceptance of multiplicity. Ross (1999) takes the position that, while MPD is a psychiatric pathology or psychiatric polypsychism, polypsychism is the “*normal state of the human mind.*” (Rowan & Cooper, 1999, p. 193). Ross defines polypsychism (rarely obtained) as “*a degree of healthy, fluid integration of sub-selves*” (p. 194) and that MPD and polypsychism are distinguished, he explains by “*the difference in the degree of personification of the ego*

states, the delusion of literal separateness of the personality states, the conflict, and the degree of information blockage in the system” (p.193). Although polypsychism may be an ideal, Ross states that what “*we call normal in our culture is actually pathological pseudounity*” (p. 194). He states that “*DID is a psychiatric disorder while pathological pseudounity is a cultural sickness*” (p. 195). “*The integrated DID patient is better off having no DID, even though he or she may now exhibit pathological pseudounity*” (p. 195)

So, is the requirement for oneness necessarily healthy and helping the client? The texts explored indicated that this may not always be so. In general integration was expected to result in further problems (eg. Putnam, 1989). The possibility that the treatment is problematic is not questioned within the texts. Instead the problems resulting from treatment are individualised to the client and at best are seen as a sacrifice that the client has to pay. This highlights issues of power, responsibility, control and agency which will be covered in a further paper.

If treatment is problematic and yet remains unquestioned by the therapist, then does the therapist really know best? This was the second discourse explored within the texts. It was found that the texts placed the client in a subservient role; he or she was required to comply with the therapist or be labelled recalcitrant or possibly not treatable. This type of therapeutic paradigm requires the client to take on board the therapist’s world view and become how the therapist thinks he or she should be, rather than how he or she would choose to be. This also raises an issue of what Hacking (1999) calls “*false consciousness*” (p. 266). The fear concerning false consciousness is the sense that the end product of therapy is a thoroughly crafted person. Not a person with self knowledge, but a person who is worse for having a glib patter that simulates an understanding of herself (Hacking, 1999)

Towards a More Open Stance. I have selected extreme extracts because these may highlight the underlying beliefs that inform the texts. But the texts themselves are not extremes. Indeed these are the most common and widely used texts practitioners read to learn about and inform their practice relating to dissociative identity. These texts both reproduce and produce the discourses that construct dissociative identity at the present time.

Discourses can inform or misinform understanding of multiplicity and therefore enhance or hamper understanding of self/selves. Some beliefs about the self which are most widely shared are the least easy to see; this is because they *are* shared and therefore go unquestioned. By failing to question these beliefs we are

complicit in promoting them: “*there is a tacit and almost heedless allegiance. We influence that which we observe, as much as we are influenced by it*” (Radden, 1996, p. 8).

Wearing (1994) determined that there is a professional dominance of psychiatry and nosographic language of medical discourse used to classify and treat illness and syndromes within the health system. However there are, in contrast to this, many therapists who use and promote alternative “*therapies of resistance*” (Guilfoyle, 2005, p. 101) such as narrative approaches. These approaches not only privilege the client rather than expert accounts, but also bring to the fore the situation of their client and their problems in respect of societal domination or marginalisation. (e.g. Albee, 2000; Ali, 2002; Gilligan, Rogers, & Tolman, 1991; Kaye, 1999). Nevertheless many health professionals are still required to adhere to the rigid and objectified set of categories of illness found within the DSM. The DSM becomes professional knowledge and diagnosis, the language of psychiatry, the “*social representation of psychiatric knowledge, as well as the psychiatric profession’s presentation of self*” (Brown, 1990, p. 389). Moreover, Parker (1995) states “*When the categories from the DSM-IV are used, they become charged with an emotional force which has far-reaching consequences for those who are labelled*” (p.2).

It is important to recognise that “*discursive practices are ways of talking, thinking, feeling and acting that, when enacted, serve to reinforce, reproduce or support a given discourse and at the same time deny, disqualify or silence that which does not fit the discourse*” (Law, 1999, p. 119). The texts explored here indicated both symbolic and real violence towards those who experience dissociative identity. Through the setting down of ideological boundaries and inclusion/exclusion of single/multiple and healthy/not healthy, those with dissociative identity who do not conform to the expected way of being (by completing treatment) are marginalised. The limitations of the mainstream approaches towards dissociative identity become apparent when the assumptions and norms implicit in these approaches are uncovered: that the self is ideally unitary, that the experience of multiple selves is pathological, and the professional has the authority to impose goals and processes on the client, to define any signs of resistance as a problem and to over-power such resistance.

This analysis of traditional psychotherapeutic discourse in relation to dissociative identity raises some important questions. Does the traditional view of dissociative identity empower the client or does it individualise oppression and pathologise their experiences? Does the therapy offer space for clients to develop new forms of subjectivity or does it confirm them within their current restrictive positions and castigate them for their resistance? How are the power relations embodied in

certain specific kinds of techniques, for example the use of a metaphorical battering ram?

If we recognise that personal constructions are shaped and constrained by culture or by the “*shared language and meaning systems that develop, persist, and evolve over time*” (Lyddon, 1995, pp. 69-92), and that knowledges, discourses, and power are interrelated, and that some discourses are legitimated as proper knowledges while others are subjugated (Foucault, 1980, 1983), then how do individuals experiencing a “we” identity negotiate the expectations of the majority? Do they adopt or resist the different discourses? How does the “we” find their voice when faced with powerful traditional professions such as psychiatry and psychology? How is the “we” identity constituted in relation to the dominant discourses of the DID group and the psychological community?

The analysis undertaken indicates that a resistant reading of the texts is possible. It could be that other practitioners and theorists can also be resistant to these texts. The texts themselves do not necessarily indicate what actually goes on in practice. The relation between texts and the practices that might be informed by them needs to be explored.

Although it is not possible at the present time to answer all the questions and issues raised in this paper, further research exploring these issues and the phenomenology, the lived experience, of dissociative identity from the client’s point of view is being undertaken by this writer. This may aid in creating a space for individuals with dissociative identity to speak with their own voices and their own discourses.

It is likely that there will be some resistance to the adoption of more open discourses on dissociative identity into the mainstream. This is because by its very nature dissociative identity challenges and disrupts the dominant views held by the psychological community and society at large. Adopting a more open view of multiplicity depends on and informs a major shift in notions of the self, therapeutic research and practice, and social attitudes in general. Adopting this view may well cause considerable discomfort in the mainstream psychiatry/psychological communities. However it is perhaps this discomfort that has blocked more open views on dissociative identity, rather than anything inherent in multiplicity itself.

Adopting a different therapeutic stance that embraces the possibility of a functional multiplicity in relation to dissociative identity might allow new discourses to develop. Instead of the notion that single is necessary but not sufficient for health, a dissociative identity therapist could also convey the message that

multiplicity is an alternative, valid and potentially highly functional way of being, but internal communication might be necessary for health. Rather than promoting the concept that the therapist knows best, dissociative identity therapy could be underpinned by the idea that therapist and client work best together, with transparency, honesty and mutual learning being paramount, and with “resistance” valued as a healthy survival instinct.

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References

- Albee, G.W. (2000). A critique of psychotherapy in American society. In C.R. Snyder & R.E. Ingram (Eds.), *Handbook of psychological change: Psychotherapy processes and practices for the 21st Century* (pp. 609–706). New York: Wiley.
- Ali, A. (2002). The convergence of Foucault and feminist psychiatry: Exploring emancipatory knowledge-building. *Journal of Gender Studies, 11*, 233–242.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of psychiatric disorders*, fourth edition (DSM-IV). Washington DC: American Psychiatric Association.
- Amundson, J., Stewart, K. & Valentine, L. (1993). Temptations of power and certainty. *Journal of Marital and Family Therapy, 19*, 111-123. Online: <http://www.kennethstewart.com/temptations.htm>
- Anzaldúa, Gloria. (1987). *Borderlands/la frontera: The new mestiza*. San Francisco: Aunt Lute Books.
- Bakhtin, M. (1997). *Problems of Dostoevsky's poetics*. Minneapolis: University of Minnesota Press.
- Barach, P. (1994). ISSD *Guidelines for treating dissociative identity disorder (multiple personality disorder) in adults* (1994). Skokie, IL: The International Society for the Study of Dissociation.
- Bohart, A. C., (2000). The client is the most important common factor: Clients' self-healing capacities and psychotherapy. *Journal of psychotherapy Integration, 10*, 127-149.
- Bromberg, P. M. (1993) Shadow and substance: A relational perspective on clinical process. In P. M. Bromberg, *Standing in the Spaces: Essays on Clinical Process Trauma and Dissociation*, (pp. 379-406). Analytic Press Incorporated.
- Bromberg, P. M. (1993). Shadow and substance: A relational perspective on clinical process. *Psychoanalytic Psychology, 10*, 147–168.
- Coates, J. & Jordan, M., E. (1997). Que(e)rying friendship: Discourses of resistance and the construction of gendered subjectivity. *Queerly phrased: Language, gender, and sexuality*, ed. by Anna Livia and Kira Hall, 214-232. Oxford: Oxford University Press.
- Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology, 18*, 209-232.
- Fairclough, N. (1992). *Discourse and Social Change*. Cambridge: Polity Press.
- Fairclough, N. (1995). *Critical discourse analysis: the critical study of language*. London: Longman.
- Fine, C. G. (1993). A tactical integrationalist perspective on the treatment of multiple personality disorder. In R. P. Kluft & C. G. Fine (Eds.), *Clinical Perspectives on Multiple Personality Disorder*, (pp. 135-54). Washington: American Psychiatric Press.
- Foucault, M. (1980). *Power/knowledge: Selected Interviews and Other Writings, 1972-1977* (C. Gordon, Trans. & Ed.). New York: Pantheon.
- Foucault, M. (1983). The subject and power. In H. Dreyfus & P. Rabinow, *Michael Foucault: Beyond Structuralism and Hermeneutics* (pp. 208-226). Chicago: University of Chicago.
- Gadamer, H. (1975). *Truth and method*. 2nd ed. New York: Crossroads, 1984.
- Gergen, K. J. (1992). Beyond Narrative in the Negotiation of Therapeutic Meaning. In Sheila McNamee and Kenneth J. Gergen (Eds). *Therapy as Social Construction*. (pp.166-185). London: Sage.
- Gilligan, C., Rogers, A.G., & Tolman, D.L. (Eds.). (1991). *Women, girls and psychotherapy: Reframing resistance*. New York: Harrington Park Press.
- Graham, L. (1994). Critical Biography without subjects and objects: An Encounter With Dr. Lillian Moller Gilbreth. *The Sociological Quarterly, 35*,
- Guilfoyle, M. (2005). From Therapeutic Power to Resistance? Therapy and Cultural Hegemony. *Theory & Psychology, 15*, 101–124.
- Hacking, I. (1995). *Rewriting the Soul: multiple personality and the sciences of memory*. Princeton U.P.
- Harre, R., & Gillett, G. (1994). *The discursive mind*. Thousand Oaks, CA: Sage Publications
- Heinimaa, M. (2000). Ambiguities in the Psychiatric Use of the Concepts of the Person: An Analysis. *Philosophy, Psychiatry, & Psychology, 7*, 125-136.
- Kaye, J. (1999). Toward a non-regulative praxis. In I. Parker (Ed.), *Deconstructing psychotherapy*, (pp. 19–38). London: Sage.
- Kluft, R. P. (1984a). Treatment of multiple personality disorder: A case study of 33 cases. *Psychiatric Clinics of North America, 7*, 9-29.
- Kluft, R. P. (1993). Basic principles in conducting the psychotherapy of multiple personality disorder. In R. P. Kluft & C. G. Fine (Eds.), *Clinical Perspectives on Multiple Personality Disorder*, (pp. 19-50). Washington: American Psychiatric Press.
- Kluft, R. P. (1993). Clinical approaches to the integration of personalities. In R. P. Kluft & C. G. Fine (Eds.), *Clinical Perspectives on Multiple Personality Disorder*, (pp. 101-133). Washington: American Psychiatric Press.
- Kluft, R. P. (1995a). Dissociative identity disorder, part I: Definition, description, and diagnosis. *Directions in Psychiatry, 15*, 23, 1-8.

- Kluft, R. P. (1999). An overview of the psychotherapy of dissociative identity disorder. *American Journal of Psychotherapy*, 53, 3, 289-317.
- Law, I. (1999). A discursive approach to therapy with men. In I. Parker (Ed.), *Deconstructing psychotherapy* (pp. 115-131). Thousand Oaks, CA: Sage.
- Lester, D. (1994). On the disunity of the self: a systems theory of personality. *Current Psychology*, 12, 312-325.
- Lyddon, W. (1995). Forms and facets of constructivist psychology. In R. A. Neimeyer & M. J. Mahoney (Eds.), *Constructivism in Psychotherapy* (pp. 69-92). Washington, DC: American Psychological Press.
- Mair, J. M. M. (1977). The community of self. In D. Bannister (Ed.), *New perspectives in personal construct theory* (pp. 125-149). New York: Academic.
- Neimeyer, R. A., & Raskin, J. D. (2000). On practicing postmodern therapy in modern times. In R. A. Neimeyer & J. D. Raskin (Eds.), *Constructions of Disorder: Meaning-making Frameworks for Psychotherapy* (pp. 1-14). Washington, DC: American Psychological Association Press.
- O'Connor, K. P., & Hallam, R. S. (2000). Sorcery of the self: the magic of you. *Theory and Psychology*, 10, 238-264.
- Ortega, M. (2001). "New Mestizas," "'World'-Travelers," and "Dasein": Phenomenology and the Multi-Voiced, Multi-Cultural Self. *Hypatia*, Online <http://muse.jhu.edu/journals/hypatia/toc/hyp16.3.html>
- Parker, I. (1992). *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*. London: Routledge.
- Parker, I. (1994). Reflexive research and the grounding of analysis: Social psychology and the psy-complex. *Journal of Community & Applied Social Psychology*, 4, 239-252.
- Parker, I. (1995). In I. Parker; M. Stowell-Smith; E. Georgaca; D. Harper; & T. McLaughlin, *Deconstructing Psychopathology*, (pp. 1-167). Sage Publications.
- Potter, J. (1996). Representing reality: Discourse, rhetoric and social construction. Thousand Oaks, CA: Sage Publications.
- Putnam, F. W. (1989). *Diagnosis and Treatment of Multiple Personality Disorder*. New York: Guilford Publications Inc.
- Putnam, F. W. (1992). Discussion: Are alter personalities fragments or figments? *Psychoanalytic Inquiry*, 12, 95-111.
- Radden, J. (1996). Relational individualism and feminist therapy. *Hypatia*, 11, 71-96.
- Rappoport, L., Baumgardner, S., & Boone, G. (1999). Postmodern culture and the plural self. In J. Rowan and M. Cooper (Eds), *The Plural Self*. London: Sage, 93-106.
- Reynolds, J. & Wetherell, M. (2003). The discursive climate of singleness: the consequences for women's negotiation of a single identity. *Feminism & Psychology*, 13, 489-510.
- Rivera, M. (1996). *More Alike Than Different: Treating Severely Dissociative Trauma Survivors*. Toronto: University of Toronto Press.
- Rose, N. (1996). *Inventing Our Selves: Psychology, Power and Personhood*. Cambridge, UK: Cambridge University Press.
- Ross, C. A. (1989). *Multiple Personality Disorder: Diagnosis, Clinical Features, and Treatment*. Canada: John Wiley & Sons, Inc.
- Ross, C. A. (1997). *Dissociative Identity Disorder: Diagnosis, Clinical Features, and Treatment*. (2nd Ed.). Canada: John Wiley & Sons, Inc.
- Ross, C. A. (1999). Subpersonalities and multiple personalities: A dissociative continuum. In Rowan, J. & Cooper, M. (Eds.), *The plural self: multiplicity in everyday life*. (pp. 183-197). London: Sage Publications.
- Rowan, J., & Cooper, M. (1999). *The plural self: multiplicity in everyday life*. London: Sage Publications.
- Spanos, N. (1994). Multiple identity enactments and multiple personality disorder: A sociocognitive perspective. *Psychological Bulletin*, 116, 143-165.
- Stam, H.J. (2004). The dialogical self, meaning and theory: Making the subject. In W.E. Smythe & A. Baydala (Eds.), *Studies of how the mind publicly unfolds into being* (pp. 3-28). Lewiston, NY: Edwin Mellen.
- Summerfield, D. (2001). The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *British Medical Journal*, 332, 95-98.
- Trinh, T. (1992). *Framer framed*. New York: Routledge.
- Wade, A. (1997). Small acts of living: Everyday resistance to violence and other forms of oppression. *Contemporary Family Therapy*, 19, 23-29.
- Wearing, M. (1994). The health professions, psychiatric discourse, and the classification of mental illness. *Australian Journal of Communication*, 21, 53-73.
- Yardley L. (Ed.) (1997). *Material Discourses on Health and Illness*. Routledge: London.

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