Contents

Notes on contributors x

PART I
Mapping the territory: childhood aetiology, attachment research, attachment patterns, abuse, dissociation, Dissociative Identity Disorder and culture 1

Introduction 3
VALERIE SINASON

From a DID mother for her daughter 19
MIKI

From a mother for her DID daughter 19
BEVERLEY’S MOTHER

DID and marriage: a personal perspective 20
DAISY

1 Multiple voices versus meta-cognition: an attachment theory perspective 21
PETER FONAGY

2 Multiplicity revealed in the Adult Attachment Interview: when integration and coherence means death 37
HOWARD STEELE

3 Undoing the effects of complex trauma – creating a lifespan trauma narrative with children and young people 47
ARNON BENTOVIM

http://www.routledgementalhealth.com/attachment-trauma-and-multiplicity-9780415491815
PART II
Attachment focus: mainly theory

My name is Driven
MARY BACH-LOREAUX

As thick as thieves, or the ritual abuse family – an attachment perspective on a forensic relationship
ADAH SACHS

A theoretical framework for understanding multiplicity and dissociation
JOHN SOUTHGATE

Post-traumatic stress disorder and dissociation: the Traumatic Stress Service in the Maudsley Hospital
FELICITY DE ZULUETA

PART III
Attachment focus: mainly practice

Halloween
TOISIN

Growing out of it
CUCKOO

The shoemaker and the elves
VALERIE SINASON

Snow White and the seven diagnoses
JEAN GOODWIN

Will you sit by her side? An attachment-based approach to work with dissociative conditions
SUE RICHARDSON

http://www.routledgementalhealth.com/attachment-trauma-and-multiplicity-9780415491815
12 Profound desolation: the working alliance with dissociative patients in an NHS setting
PETER WHEWELL

Addendum
ALISON COOKSON AND THE CLINICAL TEAM AT CLAREMONTE HOUSE

PART IV
Other frames of reference: linguistic, diagnostic, forensic and historic issues

Labels
BEVERLEY

Poem
TOISIN

Trying to Leave
DAVID

13 Dissociation sounds more scientific
GRAEME GALTON

14 Dissociative disorders: recognition within psychiatry and RAINS
JOAN COLEMAN

15 Interview with Detective Chief Inspector Clive Driscoll
VALERIE SINASON

16 Multiple personality disorder and schizophrenia: an interview with Professor Flora Rheta Schreiber
BRETT KAHR

Information for people with DID and professionals working with them

Index
Introduction

Valerie Sinason

A second edition allows a second thinking and hearing. In the 6 years or so since the first edition came out, there are more graduates in psychology, psychotherapy, medicine, psychiatry, social work, nursing and counselling wondering why their trainings have failed to equip them for this work. There are more volunteers working with rape crisis centres, Samaritans and other such crucial places, adding to their knowledge on this subject. There are more people with DID educating those they meet and feeling some parts of their society are beginning to consider the reality of their existence. There are also more babies and small children born into traumatagenic families who are at risk of developing DID or are already developing it.

While a reprint alone would answer the needs of some, a second edition with brand new chapters (Chapters 5, 13 and 15) and updated references and chapters hopefully offers something to both old and new readers.

Let us begin at the end. The telephone rings at 10pm. A terrified child’s voice can be heard at the other end of the phone. There is the noise of a train in the background and the sound of people talking. ‘Please, please stop her from going back. He’s going to hurt us. He puts stingy stuff in me and I go all sore. Don’t let her go back. I am frightened.’

The voice rises in terror until I remind her that she is not going to be taken back, that her abuser is dead, that she is safe. The voice softens and relaxes. The panic subsides. The 6-year-old voice on the telephone belongs to a professional woman of 40 with Dissociative Identity Disorder.

The woman could not avoid a train journey in order to attend a crucial meeting concerning her new work. At one point on the journey the train was going to stop at the town she had lived in as a child. Rationally she knew her abusers were long since dead and impossible to prosecute (see interview with Detective Chief Inspector Clive Driscoll, Chapter 15). However, the severity of her early abuse had led to fragmentation. Merely stopping at that station was enough to bring back a state of panic.

Instantly, to aid the woman, out of cold storage came the brave 6-year-old friend. Frozen in a terrible state of now-ness that had not changed for
over 30 years she emerged. The woman had only just come to therapy. Many of her inside people, alters, self-states, whatever language the clients wish to use, had autonomous existence. Created to protect her, they hid the discrepancy between the sadism of her attachment figures and her need for love. They came out when she could not manage, to hold the memories of trauma (both actual and corroborated as well as fantasy and flashback – see Goodwin, Chapter 10) and help her survive. Some states/people were truly frozen – not just in time but in their emotional states, pointing to disorientated disorganised attachments (see Fonagy, Chapter 1; Steele, Chapter 2; Sachs, Chapter 5; Richardson, Chapter 11) and even earlier infantile trauma.

After 2 years of treatment they began to thaw, grow and discard their old strictures. Some of the frozen friends could, in this particular case, then slowly melt into their host, bringing their strength, fragments of memory and courage back to the core personality. Others could state their wish to stay separate. ‘Multigration’ (see Southgate, Chapter 6) or cooperation is a matter of choice, not compulsion. Otherwise therapy, in my opinion, becomes a tool of oppression.

How this all starts is a human universal. What happens when a child has to breathe in mocking words each day? Sometimes, that mocking voice gets taken inside and finds a home. It then stays hurting and corroding on the inside when the original source of that cruelty might long ago have disappeared or died.

‘You stupid idiot, thick disgusting dunce!’ Ella shouted when she accidentally spilled her tea on the floor. Ella was 60 and had a severe learning disability. Whenever she made any mistake she mocked herself with the words of her sadistic father, even though he had died more than 20 years ago. By keeping his angry words she was keeping him alive and sparing herself from the helplessness of being a victim on the receiving end. By shouting at herself she was identifying with him, being him and therefore not having to remember being the frightened unwanted helpless little child.

A loved child of 2 toddled around the kitchen. He put his hand up and almost touched the gas heater. ‘Hot!’ he shouted. He shouted in the voice of his mother who had been frightened for his safety when she had left the heater unguarded the day before. Like young children all over the world, he was taking in the language and intonation of his attachment figures. When his mother shouts ‘Hot!’ in a frightened angry voice her face does not look the same as when she is beaming lovingly at him. Cross Mummy and Loving Mummy are very different people, even though they are Mummy.

When all goes well, we take for granted the internal representations of the outside network in each of us. Ironically, it is when things go wrong that we notice the amazing process of what we are made of linguistically. Like Ella, Edward would attack himself verbally.
‘Stupid piece of shit. Edward! Stupid piece of shit. Get under’. This was the verbal calling-card of a severely intellectually disabled man I worked with (Sinason 2010). He was able to show me he was repeating the cruel words said to him by a real external person. I now see them as a verbal flashback. The childhood refrain ‘sticks and stones may break my bones but names will never hurt me’ is not true. Names enter us like weapons.

**Dissociation and fragmentation as a childhood defence**

However, what happens when the toxic nature of what is poured into the undeveloped vulnerable brain of a small child is so poisonous that it is too much to manage? Little children, who have had poured into them all the human pain and hate adults could not manage, somehow grow up. Legions of warriors are lost to society through suicide, psychiatric hospitals, addiction and prison. What happens to them, especially when those who hurt them are attachment figures (see Fonagy, Chapter 1; Steele, Chapter 2; Sachs, Chapter 5)?

This book is about one way of surviving that preserves attachment at all costs. It is about a brilliant piece of creative resilience, but it comes with a terrible price. It is a way of surviving so difficult to think about and speak about that, like the topic of learning disability, its name changes regularly. Dissociative Identity Disorder (DID) is the newest term. Where and in whom the dissociation or the disorder lies, however, is a crucial issue in its own right. My own clinical experience is that everyone with DID is profoundly alert, with a memory like a barrister’s. What is fragmented is continuous narrative. People without DID, on the other hand, keep a continuous memory (albeit faulty) but often dissociate by the painful reality of trauma.

As this goes to press, DSM V is being worked out. However, the current DSM IV criteria is that DID is:

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).

At least two of these identities or personality states recurrently take control of the person’s behaviour.

Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness and not due to the direct effects of a substance (e.g. blackouts or chaotic behaviour during alcohol intoxication) or a general medical condition (e.g. complex partial seizures).

(American Psychiatric Association 2000)

This is not helpful for where there is DID and alcohol.
Despite the classification, British professionals and their clients remain culturally vulnerable, as DID remains disturbingly under-studied by all professions and both undiagnosed and misdiagnosed. Cultural responses are highly relevant (see Swartz, Chapter 4) as The Netherlands provides a remarkable alternative vision. Indeed, Ellert Nijenguis, the distinguished clinician and researcher on this topic, was awarded a knighthood by Queen Juliana of the Netherlands for his services to the country on dissociation (Van der Hart et al. 2009).

However, what is the emotional experience of children and adults living in our country at a time when the condition that is troubling them (and its traumatic aetiology) is both so misunderstood and little understood? Indeed, where ritual abuse is the cause of DID (Steele, Chapter 2; Sachs, Chapter 5, survivor poems), survivors and those working with them can face dissociation, denial or discrediting in the network. There are no NICE guidelines for DID, although we have requested such an intervention, but we predict instead a rise of manualisation as a means of distancing feelings in the future.

However, as De Zulueta (1995) comments:

> a refusal on the part of psychiatrists and therapists to validate the horrors of their patients' tortured past implies a refusal to take seriously the unconscious psychological mechanisms that individuals need to use to protect themselves from the unspeakable. Such a denial is, however, no longer ethical, for it is this human capacity to dissociate that is part of the secret of both childhood abuse and the horrors of Nazi genocide, both forms of human violence, so often carried out by ‘respectable’ men and women.

### Dissociative identity disorder

What is it like to be suffering from something that is not yet adequately recognised? And not only is the DID not recognised, but the nature of the sadistic abuse that has caused it in the majority of cases is even less recognised (Sachs and Galton 2008). I am repeating this question, as to my mind it is a major source of further societal iatrogenic damage to people with DID.

> ‘I’m an attention seeker, don’t you know?’ said one patient bitterly (her choice of term). ‘And I’m hysterical and dysfunctional. Amazing isn’t it? My abusers can rape and torture me for years and they are wandering the streets perfectly happy and I am the one with a life sentence.’

In the last two decades, colleagues and I have assessed and treated children, adolescents and adults, mostly female, who have Dissociative Identity Disorder (DID). There is a very significant gender bias in this
condition. Indeed, abused boys are far more likely to externalise their trauma in violence (see Bentovim, Chapter 3), although both sexes use internalising and externalising responses. Cultural issues as well as gender issues need exploring (see Swartz, Chapter 4).

The majority of children and adults we assessed had been diagnosed or misdiagnosed as schizophrenic (Leevers 2009), borderline, anti-social disorder or psychotic. Sometimes the diagnoses were correct but only applied to the alter-personality who visited them. Hence one psychiatrist assessing ‘Mary’ correctly diagnosed psychosis, and another who assessed the patient a week later correctly disputed that diagnosis and declared ‘Susan’ had borderline personality disorder. Without early specialist training on the consequences of abuse, some professionals attack each other’s contradictory diagnoses without realising the aptness of Walt Whitman’s words ‘I am large. I contain multitudes.’

I am including myself here. In 1988 I published a paper on the significance of different play material for sexually abused children. One of the clinical vignettes was about a girl of 11 who I called Anne. She had a psychotic mother who was frequently hospitalised and an alcoholic father. They separated while she was still a baby. Anne was often left with the maternal grandmother when her mother was hospitalised or an aunt and uncle. Her father reappeared when she was 2, stating that an uncle had oral intercourse with her. This was acknowledged and she was placed into care where the same situation occurred. She was then moved into a residential home, where she lived from the age of 5 to 11 until finally an adoptive family was found.

In my published vignette (Sinason 1988), I wrote that Anne ‘spoke in three distinct voices; a harsh moving voice, a prissy voice and a shy childish voice’. In the classroom she kept to one voice, but whenever she was distressed or stressed the voices would alternate. I spoke about her fragmentation and what exacerbated or ameliorated it, but I had no idea whatsoever about dissociation or dissociative disorders. It was a tribute to Anne and Co. that they took the best of what I could give them to grow from, rather than focus on my incapacities.

It is worth mentioning here that there are other ‘invisible’ DID patients in treatment without their therapists knowing that is what they have and, again, many have found a way of taking nourishment however incomplete it might be.

Anne had a mild dissociative disorder rather than a full-blown DID. She had been removed from florid abuse from the age of 5. Nevertheless, in witnessing the way she made use of large toys to reveal her abuse and her multiplicity, I was able to comment ‘it seemed that the actual concrete physical presence of the dolls that stood for her fragmented experiences kept the different voices and meanings inside their own physical entities, freeing her to return to the outside with one voice’ (p. 353).
It was to take 22 years for me to consciously note the same process with a young woman with a severe learning disability who on projecting her alters into soft toys was more able to maintain a consistent voice! Dissociative disorders, as we show, cover a wide spectrum and the ‘mild’ end requires proper attention too.

**Hiding selves**

In the face of professional confusion and societal denial, some patients have managed to hide their multiplicity when told they were making it up. Nicholas Midgeley, in the first edition, asked the key question concerning why such small numbers of children present with severe dissociative states. Our patients have almost all spoken of the negative responses to their childhood disclosures, which led to hiding their symptoms (see Sinason, Chapter 9). Children were told they would ‘grow out of it’ or it was ‘just like an imaginary friend’. The pain such misdiagnoses cause can be seen in the poems by survivors in this book. It says a lot for Anne’s capacity that she coped with my incapacity to truly recognise her others.

Unfortunately, when some practitioners penalise the host when ‘alters’ appear and will only refer to the biological name, the host personality learns not to speak of fragmentation, and, at the same time, some alters learn to be silent or respond to the host’s name. This is often misperceived as a treatment success. It is not understood that for the patient it is experienced as a psychically annihilating secondary trauma. Indeed, Kluft, a pioneering American clinician, predicted such attitudes led to long-term therapeutic failure.

‘Outside of hospital I am still being abused’, says Ellen, ‘but I can at least choose my own personal therapist. All my alters like that. But if they came out inside the hospital I would just be seen as mad and for me the psychological abuse that comes from that is worse than the cult.’

**What is dissociative identity disorder and how does it happen?**

‘Sybil’ and ‘The Three Faces of Eve’, however dated, remain the main public image (see Kahr, Chapter 16) of dissociation. Somehow it has remained easier to consider the subject safely contained in a Hollywood film or a book rather than on the street and in the homes, schools, universities, workplaces and psychiatric hospitals of the country. DID people become successful professionals, writers, dancers, artists, scientists, shop-workers, singers and parents. They also become prostitutes, drug addicts, criminals and pornstars. Sometimes they cover the range of possibilities within their one frame.
Jane, for example, was a successful part-time university lecturer, but Enya, one of her alters, ran a sado-masochistic brothel, while Mel was involved in small-time theft. Each had their own friendships, clothes and homes. Some are intellectually brilliant and some are severely intellectually disabled (Sinason 2010).

How do we make sense of this?

We cannot reach the place to make sense of that without following through the continuum of responses to trauma. To begin with, can we ever really manage to consider the meaning of trauma? Think of the ordinary way an able-bodied person changes their language when they have an accident and break their leg. Suddenly, we hear of ‘the leg’. It is not ‘my’ leg anymore. Dissociation.

Now think of a child being bullied in a school playground. Everything goes slow-motion, even though the heart beats fast, ears are alert, smell is sharp: an almost universal experience. Take it further. Eight-year-old Mary is being beaten up by her father, her crucial attachment figure. She feels she is looking down watching another child being hurt. It cannot be her. Her imagination creates 5-year-old Jane so that as the beating turns into rape, the dissociation provides survival means. Professor Peter Fonagy has evaluated the aetiology of DID from trauma at 90% (Fonagy and Target 1995).

However, that survival means is maladaptive when the abuse ends (if it does) and Mary and Jane end up living in different homes, not understanding why they each lose time. Yet all over the UK these heroic and troubled survivors have to deal with lack of specialist resources.

The BACP (British Association for Counselling and Psychotherapy) deserves congratulations as the first major umbrella organisation in the UK taking seriously the ethical difficulties in working in this area where professionals have not been adequately trained.

**John Bowlby and DID**

In 1988, in a clinical supervision, John Southgate showed John Bowlby drawings of little children being abused (see Southgate, Chapter 6). Dr Bowlby could see that the patient who drew the pictures had Dissociative Identity Personality. Bowlby was the world-famous psychoanalyst who created attachment theory (see Fonagy, Chapter 1; Steele, Chapter 2; de Zulueta, Chapter 7; Richardson, Chapter 11; Sachs, Chapter 5; Southgate, Chapter 6) and proved to the Western world that separation of young children from their attachment figures had substantial long-term impact.

Bowlby’s work on separation and attachment did not find an immediate positive response. Indeed, upper-class English Christian psychiatrists, doctors and psychoanalysts who had been sent away to boarding school...
found his ideas as disturbing as their Jewish counterparts who had lost their safe family links through the Holocaust.

**DID as a paradigm shift**

As Bowlby himself tells us, we cannot know what we cannot bear to know. The impact on professionals of hearing about childhood torture that leads to dissociative states is far more powerful and disturbing than the impact of hearing about the consequences of separation experiences. So the response to this subject has been even less positive than to Bowlby’s evidence of childhood separation trauma almost half a century ago.

However, it is important to remember that only 30 years ago most major psychotherapy and psychiatric training schools in the UK did not accept the existence of child abuse and condemned what they saw as the unhealthy excitement that was considered to emanate from the earliest exponents.

As well as trauma, DID raises problematic philosophical and psychological concerns about the nature of the mind itself. Ideas of a unitary ego would incline professionals to see multiplicity as a behavioural disturbance. However, if the mind is seen as a seamless collaboration between multiple selves, a kind of ‘trade union agreement’ for co-existence, it is less threatening to face this subject. This is an issue that continues to be debated internationally and is crucial in considering many psychological problems. For this edition I have not included the philosophical enquiry of Professor Hinshelwood as I feel that is now better understood. However, I will include his succinct summing up comment that ‘truly to understand the nature of DID will include dissolving a whole cultural set of baggage that is deeply invested in the notion of the undivided individual’.

**Fragmentation in the team**

The primary split of DID creates a curious secondary splitting between staff. In having one professional pronounce that a condition does not exist versus another who states that it does, we are witnessing the trauma-organised systems (see Bentovim, Chapter 3) that systemically mirror the DID experience. The conflict between personalities is accurately and ironically mirrored in the conflicts between professionals, which is why teamwork is so important (see de Zulueta, Chapter 7; Whewell, Chapter 12).

One problem, as pointed out in Chapter 8, is that ‘The concept of DID is not part of the psychoanalytic tradition. Relatively few psychoanalysts make use of the concept of dissociation’. This reduces the support that can be offered to teams in difficulty. Jungian analysts, however, have found this area more linked to their theoretical background than others (Kalsched 1996; Wilkinson 2006).
However, psychotherapists of any theoretical background, outside of the Bowlby Centre, also have negligible training in brainwashing, military mind control or abuse through religious belief systems (Sachs and Galton 2008). These are not areas of mainstream professional training, despite the profound influence such practices have on vulnerable minds (Sinason 2008). Mental health professionals also do not have any basic grounding in this subject.

This book aims to provide basic clinical and theoretical information for the mental health professional and the interested layperson. It is of concern to all because, while we hope that this brilliant but tragic adaptation to trauma is as rare as the torture it stands witness to, extreme states show us writ large the stresses and responses of ordinary life.

**Theoretical formulations**

Many of the authors provide particular reviews of literature that influence their understanding, and they are very varied. Whatever the background training professionals have had, many of us find that with DID no single theoretical approach provides an adequate toolkit. Authors refer to a range of energy and cognitive therapies (Bentovim, Chapter 3; de Zulueta, Chapter 7; Mollon, Chapter 8) as well as psychodynamic and arts therapies even when sharing an attachment focus. I shall only provide a brief historical summary here.

There are many shades of dissociation that lead all the way to full-blown DID. It was Charcot, the great 19th-century neurologist, who first brought the concepts of hysteria and its symptoms of neurological damage and amnesia to public attention. While he demonstrated the psychological aetiology of hysteria as opposed to an organic aetiology, he was not particularly interested in the meaning, and it was Janet and Freud who became interested in taking the work further. By the mid 1880s (Herman 1992) both recognised that altered states came from trauma and that somatic symptoms represented disguised representations of events repressed from memory. Janet produced the term ‘idée fixe’, while Freud underpinned the concept of traumatic repetition as a way of working through. Breuer and Freud coined the term ‘double-consciousness’. Breuer and Freud (1893–5) wrote that hystericss suffered from reminiscences (Studies on Hysteria) and Janet (1891) also described how one patient improved when, after removing the superficial layer of delusions, he realised the fixed ideas at the bottom of her mind.

However, it was Freud (1896) who, in *The Aetiology of Hysteria*, firmly based the origins of hysteria in traumatic sexuality. He saw this as the key issue, the ‘caput Nili’. Freud’s shock at his own findings and his inability to conceive that abuse in his own social class was so widespread is not surprising. It is far easier, even 100 years later, to pick up the signs of abuse.
in working class or ‘underclass’ children. In fact, Freud never gave up entirely on the significance of the abuse of early seduction.

Freud’s modification and transforming of his clinical views came at a significant moment in European history. Charcot, before his death in 1893, was coming under attack concerning the scientific validity of his public demonstrations. There were rumours that the women were actresses pretending to go into trances; and Janet, who stayed faithful to the traumatic origins of hysteria, was not successful in having his ideas passed on. Breuer collaborated with Freud in publishing the case of ‘Anna O’, but did not like Freud’s finding concerning early sexual trauma. After The Aetiology of Hysteria was published, Freud wrote to Fliess: ‘I am as isolated as you could wish me to be; the word has been given out to abandon me, and a void is forming around me’ (4 May 1896).

The void that always forms around messengers with unwanted news was spreading and sadly returned the study of hysteria, hypnosis and altered states in Europe ‘into the realms of the occult’ (Herman 1992).

**DID and ritual abuse**

Internationally, the largest amount of DID is diagnosed in connection with disclosures of ritual abuse (Becker, Karriker and Overkamp 2008; Sachs and Galton 2008; Sarson and McDonald 2009), hence the discrediting of or inability to perceive the possibility of the one existing automatically precludes rational thinking about the other.

**Towards a Definition of Ritual Abuse**

*Sinason and Asha-kin Aduale, Safeguarding London Children (2006)*

‘A significant amount of all abuse involves ritualistic behaviour, such as a specific date, time, position and repeated sequence of actions. Ritual Abuse, however, is the involvement of children, who cannot give consent, in physical, psychological, emotional, sexual and spiritual abuse which claim to relate the abuse to beliefs and settings of a religious, magical or supernatural kind. Total unquestioning obedience in thought, word or action is demanded of such a child, adolescent or adult under threat of punishment in this life and in an afterlife for themselves, their families, helpers or others.’

**Towards a Definition of Spiritual Abuse**

*Sinason and Asha-Kin Aduale, Safeguarding London Children, June 2006*

‘Spiritual abuse is the enforcement of a position of power, leadership or attachment in which total unquestioning obedience in thought, word or
action is demanded of a child, adolescent or adult under threat of punishment in this life and in an afterlife for themselves, their families, helpers or others. In this abuse, there is no room for the individual to be allowed their own relationship with the divine as the abusers claim they are the only link.’

It is worth noting that both at the Portman Clinic and in the Clinic for Dissociative Studies we have not found evidence of fundamentalist religious beliefs, recovered memory or Munchhausen’s as issues in those alleging this kind of abuse (Hale and Sinason 1994). Indeed, the pilot clinical study on patients alleging ritual abuse that Dr Robert Hale, then Director of the Portman Clinic, and I submitted in July 2000 included the finding that the only 2 out of 51 subjects who had any link with evangelist religious groups made contact with them after disclosing ritual abuse, and only because no-one else would listen to them.

Those who had memories of ritual abuse as a trigger for fragmentation had never lost such memories and had expressed them to other professionals long before attending the Clinic.

While rigorously trained professionals are well aware of the suggestibility of traumatised clients, especially those who have been hypnotised (Mollon, Chapter 8), and work in a non-directive manner, it is worth noting that virtually all the clients or patients who came to the Clinic for Dissociative Studies (and before that to the Portman Clinic project on ritual abuse) had long been aware at some level of their own dissociation.

I have stated elsewhere (Sinason 1994) that the number of children and adults tortured in the name of mainstream religious and racial orthodoxy outweighs any others.

Wiccans, witches, warlocks, pagans and Satanists who are not abusive and practice a legally accepted belief system are increasingly concerned at the way criminal groups closely related to the drug and pornographic industries abuse their rituals.

In trying to deal with worrying patients who have to be treated regardless of the doubts around their disclosures, mental health professionals often have to face these contentious issues. This makes it much harder for a proper considered response because professionals, like everyone else, are affected by the consensus. In my past work at the Portman Clinic and in my clinic, we have noted the secondary traumatisation of professionals caused both by the impact of the patients’ narrative and then by the disbelieving stance of colleagues. Indeed both professionals and, more importantly, patients, suffer from societal discrediting processes (including the media at times) in addition to their primary trauma. This applies to lawyers and police officers as well as mental health professionals. It was only in 2009 that UK citizens have had to accept that our government was involved indirectly in the torture of British Moslem prisoners in Guantanamo Bay.
Like other professional groups, sections of the media have been courageous in spearheading awareness of injustice while other sections provide such distorted reporting that colleagues are inhibited from taking on this work. This also impacts on the police (see interview with DCI Clive Driscoll, Chapter 15).

Some sections of the public sometimes fail to understand the difference between clinical concerns at what is heard in a session and the amount of proof necessary to prove beyond reasonable doubt in a criminal court. The influential *Today* programme interviewer was shocked to hear that photographic evidence of sites with mutilated animals, injuries that could not be self-inflicted, and remains of ceremonies do not necessarily lead to successful prosecutions (see Chapter 15). Proving beyond reasonable doubt who has committed a crime is a different task to proving something criminal has happened to someone.

However, the increase in referrals from worried clinicians, families and survivors themselves from all over the UK is moving towards the critical mass that is required to implement proper provision and treatment strategy.

The clinical needs of this patient group are very specific. To provide adequate conditions of safety, careful thought is required. Often there is a need for sessions that last double time (100 minutes) with face-to-face patients who are too terrified to lie down on a couch, which is a very different experience for the average psychodynamic practitioner. Considering the clinical and technical issues of using emails, video and telephone calls to provide extra support at different times also takes a great deal of thought (on the theoretical reasons why this might be necessary, see Sachs, Chapter 5). Many psychodynamic practitioners find they are using cognitive elements or creative elements too. While the Clinic for Dissociative Studies has also benefited from the sensori-motor therapies and a range of other body–mind treatments, they are not the subject of this book. However, readers are recommended to look at the work of Dr Janina Fisher who works in Bessel Van der Kolk’s Trauma Centre or fellow American Pat Ogden (Ogden et al. 2006).

If a lucky-enough professional needs a multiplicity of supports to manage this subject, we need to think very hard about the level of trauma the actual patient/client feels and their family and close friends (see survivor poems and comments). Whatever we feel is only a shadow of that. If we cannot manage to hear the pain of the clients, what does that say about the level of pain that was forced into them at an early age?

One courageous ritual abuse survivor, on being told by the team psychiatrist that her behaviour and disclosures were upsetting the nurses, commented:

What do you expect me to say? I am the patient. That is why I am here in this case conference. I am sorry the nurses are upset. But I tell you. I
would rather be the nurses who are upset than be me and have to deal with in my head what I have gone through.

It has to be faced that not all health service clinicians or private therapists and volunteers can manage this work. People need to honestly look at their own emotional capacities. This is like working in a war zone. Even the most experienced can succumb to secondary traumatisation or a need for ‘home leave’ even after years of work. In the absence of adequate training, emotional capacities become more significant and the most untrained volunteer might have a greater emotional capacity than the most highly trained specialist in the local team. This can raise problems of hierarchy and obedience, something that cult survivors know only too well from their own experiences. It also has to be said that while most of those who have chosen to stay in this work feel they have encountered truly fine human beings, some have been hurt by the dysregulated feelings and relentless attacks and complaints that can come the clinician’s way from those who cannot express anger to their familial abusers (Mollon, Chapter 8; Southgate, Chapter 6). This second edition is therefore also an optimistic statement in that the clinicians who wrote in it are still active even in retirement: Dr Joan Coleman (Chapter 14) still runs the Ritual Abuse Information and Network Support despite being a decade past retirement age!

There are many fearful societal templates about this subject. But I would like consider it through a fairytale: *The Shoemaker and the Elves*. The link (Chapter 9) came to me in an unusual first meeting with a patient and helped to transform the session. As you may recall, there was a poor shoemaker facing eviction and poverty and yet, because he was hardworking, he worked to the very end, leaving out the last two shapes of leather to make into shoes for the morning. In the morning, to his shock, there were two perfectly made pairs of shoes. They caught the eyes of a rich customer and the money paid allowed the shoemaker to buy leather for four pairs of shoes. These too appeared perfectly made in the morning, were sold and brought in money for eight pairs of shoes. It carries on until the shoemaker and his wife finally decide to stay up to meet their benefactors. When he spies little elves, who are in rags and poorly fed, he and his wife make lovely sets of clothes and shoes for them all and leave out food. As they can see he is now rich and successful, the elves happily go away. He carries on making his excellent shoes.

The point of the story is that the shoemaker did know how to make good shoes. His success was not fake. He was able to acknowledge the secret night-time help he got from his tiny alters! When people with DID acknowledge their night-time help, they can then at some point be happy with the dissociated gifts they have and that helps them to deal with the pain of their situation. And their gifts and hard-won knowledge furnish the rest of society.
Acknowledgements

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The views expressed by the contributors, including myself as editor and chapter-writer, are individual opinions. Inclusion in this collection does not imply theoretical or clinical agreement between authors or between editor and authors or authors and editor. Despite our shared concern for
attachment processes, may our differences be held as richly within the boundaries of this book as the separate and valued people/alters that make up a DID system.

References


FROM A DID MOTHER FOR HER DAUGHTER

Amy’s Mama has DID

Amy has a mama that loves her lots and lots and lots. Amy’s mama at times behaves in a different way than Amy’s friends’ mamas. This is because she has DID.

Amy’s mama was hurt when she was a little girl. It made her very sad so she pretended that it was happening to another little girl. This made the hurt and pain go away. Every time Amy’s mama got hurt she pretended she was someone else. When she grew to be a big lady she had lots of pretend people. Amy’s mama called these pretend people ‘inside’ people.

Sometimes Amy’s mama behaves like a little girl and plays with Amy in a childish way. Amy has fun. When Amy’s mama is tired or sad, one of her inside friends will come out and look after and play with Amy. Amy knows that her mama has not gone away and that she is there if ever Amy needs her.

Amy’s mama talks to a good lady called a therapist about her problems. She listens to her sadness and wants Amy and her mama to be happy.

It is sometimes hard for Amy having a mama with DID. She gets angry with her mama and sometimes gets frightened that her mama has gone away. Amy always talks about how she feels. She talks about her mama being different people. This is good for Amy that she does not have to have secrets.

Amy’s mama wants to know how Amy feels and Amy can always talk to her mama about her feelings even if she is angry with her. Amy knows that her mama loves her lots and lots and lots.

Amy’s mama is trying to be the best mama to Amy that she can.

Miki

FROM A MOTHER FOR HER DID DAUGHTER

How I coped as a mum caring for my daughter who had DID would fill a book so I have just chosen the following. Don’t be upset by the label. The mind is a wonderful thing and can be your best friend or worst enemy. I am thankful my daughter developed DID. It saved her life. I was ‘tested’ in every which way and only showed love in return and learnt very quickly when to intervene and when to stay silent. I also learnt very quickly about triggers and could anticipate and prevent a crisis. When my daughter couldn’t talk I suggested she write things down and she did by way of

http://www.routledgementalhealth.com/attachment-trauma-and-multiplicity-9780415491815
poems and drawings. Always be available when your child wants to talk. Don’t ask questions. Focus your child on their own inner strength – it has got them this far. Use what you can for help.

Beverley’s Mother

DID AND MARRIAGE: A PERSONAL PERSPECTIVE

I am writing this as a survivor of Ritual Abuse, have DID and have been married for 30 years. Due to the brevity of this piece I am going to explain a few of the difficulties/issues (not by any means all!) that my husband and I have experienced.

My system contains a series of adult and child parts with a lot of amnesia between parts which help me exist and function. I have had a few of these adult parts function as the main personality for a few years at a time. This has meant that the part that my husband married has not always been around, e.g. I don’t remember marrying him and have a lot of past memory loss but feel married. I don’t remember the actual birth of my daughter but know she is mine (my husband reports that he doesn’t think I am the same personality he married!!). Another part turned up and led my life for 3 years and although my body was around 40 years old, she felt in her 20s and was shocked to find she was married and had a grown daughter, none of which she knew about, and didn’t wish to live with anyone! As you can imagine all this takes some adaptation and therapy! Also my husband is married to a whole set of internal children; luckily he enjoys being a father to these.

DID brings added problems and stress when maintaining a household, marriage, responsible job and general life while ‘losing time’ (amnesic periods while other parts take over) living with triggers, having flashbacks, nightmares and horrific memories surfacing. Also, living with physical illness due to injury. This is a huge challenge which at times is overwhelming.

Things which help? Well, an adaptive, loving, caring, committed husband not frightened to learn about DID. A specialist therapist, fully human and not standing behind a psychoanalytical cold stance and an understanding therapeutic team which provides therapy and support for my husband and me. When stress and emotional exhaustion are high we try to take a bit of relaxation and time, together or separately, away from difficult situations; sometimes easier said than done. To always try to work towards a better relationship and understanding with each other; this involves a lot of talking things through. Above all keep a sense of humour!

Daisy