

SIX COMPLETED  
SUICIDES IN  
DISSOCIATIVE  
IDENTITY DISORDER  
PATIENTS: CLINICAL  
OBSERVATIONS

Richard P. Kluft, M.D.

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Richard P. Kluft, M.D., is Senior Attending Psychiatrist and Director of the Dissociative Disorders Program at The Institute of Pennsylvania Hospital, and Clinical Professor of Psychiatry at Temple University School of Medicine

For reprints write Richard P. Kluft, M.D., The Institute of Pennsylvania Hospital, 111 North 49th Street, Philadelphia, PA 19139.

#### ABSTRACT

*Recent studies demonstrate that the majority of dissociative disorder (DID) patients inflict self injury, and that 1-2.1 % of DID patients have succeeded in killing themselves. Six female DID patients ranging from 26 to 38 years in age suicided. All had received prior diagnoses of borderline personality disorder and affective disorder. In four cases the suicide attempts were planned to evade detection; in one case there was implicit planning by default; in the last matters defied ready classification. The major motivations for suicide appeared diverse, and included vindictiveness, the overwhelming impact of flashbacks that could not be distinguished from reality, inner warfare among the alters, anticipated object loss, guilt in connection with a parent's death, and pain and hopelessness associated with abandonment. However, these patients' traumata and burdens did not seem more overwhelming than those of comparable DID patients. Five of the completed suicides had in common the use of lying to attain their goals, ready rationalizations for dishonest and inappropriate behavior, disrupted or failed therapeutic alliances, a delusional intensity of the alters' convictions that they enjoyed complete separateness, and the alters' entertaining mutually incompatible subjective understandings of their personal realities. In these five an unresolvable clash between objective and subjective realities had occurred before the fatal events, and the patients, profoundly invested in their views, were unable or unwilling to accommodate to the demands and constraints of conventional reality. Suicide may have provided the illusion of the omnipotent reestablishment of their desired construction of reality, and precluded further painful confrontations, humiliations, and narcissistic deflations. The sixth suicide appears to have been due to inadequate treatment.*

Dissociative identity disorder (DID) patients have a high frequency of self-directed aggressive behaviors. Their treatments are frequently punctuated with episodes of suicidality and self-mutilation (Kluft, 1983, 1984a). Of the one hundred recent cases studied by Putnam, Guroff, Silberman, Barban, and Post (1986), 61% had made serious suicide attempts and 71% had made suicide gestures. One patient had suicided. Furthermore, 53% reported attempts at internal suicides or homicides; i.e., the attempt of one personality to kill another. In 34% of their cases one or more personalities would mutilate the body to punish another alter.

Of the 236 DID patients studied by Ross, Norton, and Wozney (1989), 2% had attempted suicide, and 2.1% had killed themselves. In a later multicenter study, Ross, Miller, Reagor, Bjornson, Fraser, and Anderson (1990) found that 92% of their subjects had recurrent thoughts of death and suicide, wanted to be dead, or had attempted suicide. Since this study required all subjects to receive a structured interview, completed suicides could not enter their cohort of subjects. Coons and Milstein (1990) found that 48% of their patients had self-mutilated. Loewenstein and Putnam (1990) observed that 100% of their male DID patients and 88% of their female DID subjects had experienced suicidality, and that 23% of the males and 36% of the females were self-mutilators. Clinicians in practice find many of the percentages cited above for self-mutilation much lower than those they encounter among their patients.

Putnam et al. (1986) and Kluft (1994) underscore the danger of assuming that an apparently low rate of successful suicides in surveys indicates that DID is a condition with low lethality. Surveys generally ask the respondent to describe the patient he or she has known the best or the longest. Relatively successful, or at least surviving cases are more likely to remain in treatment and to be best known. Also, it is not unreasonable to assume that many clinicians with experience with more than one DID patient will be inclined to offer data on a patient who is doing well in treatment and has been studied in depth, rather than one who has done poorly, proven a puzzle, and/or has destroyed herself or himself. Kluft (1982) has offered evidence suggesting that many suicide attempts and completed suicides may be achieved by as yet unrecognized DID patients. Therefore, it is reasonable to conclude that the survey statistics currently

available underrepresent the frequency of completed suicides among DID patients. In any case, it is clear that DID patients have a risk of completed suicide that is several thousandfold in excess of the American national average of 12/100,000 (World Health Organization, 1982). This is all the more remarkable because demographically suicide is highest among older males, and DID populations characteristically are dominated by an excess of younger women.

It remains uncertain why DID patients should have such high rates of self-destructive behaviors and completed suicides. There is a certain appealing logic to reason that the extreme misery that they have suffered, their disillusionment with a world in which they have been abused and betrayed, the painful nature of the effective treatments available to them, their inability to achieve successful self-control, their vulnerability to revictimization, and their characteristic difficulties in relationships might predispose them to see self-destruction as a welcome surcease for their sorrows, a desperate but effective way to evade the pain that haunts their every moment. This indeed would be a conclusion consistent with the subjective accounts offered by many DID patients in psychotherapy. However, such a conclusion has not been documented; the fact is that most DID patients who offer such rationales for suicide remain alive. Therefore, as understandable as such arguments may be, they may, paradoxically, be more characteristic of DID survivors than DID patients who actually destroy themselves. With these considerations in mind, the author determined to collect a series of successful suicides among DID patients known to him, and to study them in order to determine what factors might have played a role in their demise.

## METHODS

### *Subjects*

The author reviewed his files for DID patients he had observed in treatment who had committed suicide. This yielded two cases. He also reviewed follow-up data on patients he had treated who had gone into treatment with others or who had been treated by him while in hospital and returned to other therapists. Four additional cases were found.

All six patients were female. Their ages ranged from 26 to 38. All had additional diagnoses of borderline personality disorder and affective disorder (major depression in three, depression not otherwise specified in two, and manic depressive disorder in one). In only one case did the depression respond reliably to medications. Five had histories of substance abuse; two were abusing substances at the time of their suicides. Four had abused street drugs, and five had abused prescription drugs. Four had abused alcohol extensively for a period of at least six months.

Four suffered asthma and all had had diagnoses of irritable bowel syndrome. One suffered poorly controlled grand mat seizures. Five had long histories of hospitalization, with

both numerous and long admissions over five years or more. One had had several brief hospitalizations over the year prior to her suicide.

Five were single and childless. One was married and had two children. Five alleged prolonged and complex abuse with multiple perpetrators; one alleged abuse over several years by one family member. Four alleged involvement with satanic ritual abuse. One alleged sexual exploitation by a prior therapist, and two by physicians. Four stated that they had supported themselves with prostitution for some period.

All had been in treatment intermittently since adolescence. Three had been in treatment with the author for over three years, and three had been in treatment with him for three to six months. All had had three or more therapists prior to being treated by the author.

### *Procedures*

Available charts and ancillary materials were reviewed. Dimensions relevant for the characterization of suicidal patients were drawn from Roy (1989) and Mann and Stanley (1988).

## FINDINGS

### *Patient Vignettes*

*Case I.* Minnie was a 38-year-old DID patient in treatment with the author for five years before she discontinued treatment. She had a pattern of flamboyantly denying the reality of her life circumstances in several alters, and frequently left her children abruptly unattended to pursue her crushes on celebrities or her affairs with a series of men. She had made several serious suicide efforts by ingestion, and twice had barely been prevented from throwing herself beneath a train. She was a brilliant woman, contemptuous of her husband, whom she considered beneath her. In one alter, Juliet, she idealized and was addicted to the process of falling in love. She ingeniously contrived to accost celebrities, to obtain their personal telephone numbers, and to harass them with professions of her affections. She maintained that she was too perfect in her dedication to love to be part of this world. The patient appeared to enjoy creating additional alters, and generated a series of past life alters. After a difficult and demanding period of treatment, she achieved apparent integration. Her adaptation as an apparently integrated individual was histrionic and narcissistic.

Hospitalized after a suicide attempt which was occasioned by her finding her reality circumstances intolerable, she was followed by the author and a young male resident, toward whom the patient developed an intense erotic transference. She dropped out of treatment with the author when this resident entered private practice, and entered treatment with him. After months of unsuccessful efforts to seduce this man, she decided against further treatment.

A few weeks later the author was contacted by the patient's

husband, who had just learned that his wife had killed herself under circumstances that were particularly hurtful to him and to her children. He met the husband at the emergency ward and went with him to identify the body. Both were stunned to see that in death the patient retained the beatific smile characteristic of Juliet. A suicide note, typed, stated: "I die for love." Minnie's current psychiatrist declined to discuss the case further.

*Case 2.* Jessie, then 32, was transferred to the author's care from a state hospital, where the diagnosis of DID had been made after months of chaotic behavior, with numerous attempts at suicide by hanging, ingestion of caustics, overdoses of sequestered medications, and an attempted self-immolation. In addition, she had attacked, intimidated, and psychologically terrorized particular staff members. She had been admitted there after months of care on an orthopedics unit, necessitated by the sequelae of a deliberate single car accident. She had required two tracheotomies in connection with her ingestions of caustics. She was a severe alcoholic and drug abuser, with cirrhosis, pancreatitis, and parotiditis as consequences of the alcohol abuse. A severe epileptic, she avoided taking her medicines in many alters. It was learned that this was a personal form of "Russian Roulette," the object of which was to see which alter would suffer the consequences of the seizures and their complications. She had a large system of alters, and denied the author access to it on most days. The alters that were accessible characteristically offered to barter sex for drugs, behaved contemptuously to the author, and frequently threatened to attack him. She was a pathological liar. She provoked fights with other patients, and, despite efforts to keep her from maintaining contact with her incestuous father and a prior doctor with whom she had had an affair, she remained in contact with both, as well as alleging that she was active with a satanic cult. Several of her major alters gloried in humiliating one another and exposing one another to danger.

She was transferred back to the state hospital as untreatable. She was discharged within days by a doctor who disputed the DID diagnosis. Thereafter she returned briefly to the author, who was alarmed by her discharge and apprehensive that she would kill herself. She refused treatment and informed him that she was working near her mother's home in massage parlors that were fronts for prostitution. She said she was specializing in sadomasochistic customers, and that several alters were competing to see which would lose by being out when she died. Within weeks she had a seizure while eating and asphyxiated.

*Case 3.* Sally was a 26-year-old woman referred to the author for DID, borderline personality disorder, and major depression from an out-of-state private hospital. She was hostile, and quite willing to bend or break the truth to appear "good" and in the right. She justified her own falsehoods by making reference to the false front of respectability her family had justified maintaining. Feeling she had been abused

while her sibs had not, she was vindictive to them. She wanted above all for her mother to rescue her from her abuser, whom she alleged was her deceased maternal grandfather, and to show her that after all, she was loved even more than her sibs. In a number of ways she provoked men to hurt her, and tried to involve her mother in these situations, trying to coerce her to come to her aid.

In one typical vignette, she attacked hospital staff members and the author in an attempt to provoke retaliation to which she could point as reason for mother to rescue her from the hospital and take her home to give her exclusive dedication and care. Shortly after discharge, she attacked the author from behind with such ferocity and clear intent to destroy him that counteraggression was necessary. This led to a mutual decision to discontinue treatment as soon as she could find another therapist. She persuaded her mother to come with her to interview other therapists. On her way back from one of these visits mother was killed in a traffic accident. Despite the author's warning that she was very much in danger and should enter the hospital, she dropped out of treatment and went to a colleague whom she convinced she had never had DID. She accumulated a massive amount of medication from this colleague, left home after taking elaborate efforts to evade detection, and died of a massive ingestion of alcohol and prescription drugs.

*Case 4.* Josie was 38 years old when she hanged herself while on a locked psychiatric unit. The author had treated her for eight years, during which she had made numerous serious suicide attempts, some rendering her comatose for up to a week. She also had inflicted severe and disfiguring self-mutilations. She had a pattern of lying about her degree of safety and integration, which has been discussed elsewhere (Kluft, 1984b; 1986). She also misrepresented her ongoing use of street drugs. Unbeknownst to the author until three years after her death, she had entered a suicide pact with another DID patient, and used hanging, the other patient's fantasied way of self-destruction, in what proved to be her fatal episode. Her suicide had been confusing to the author, because he thought that she was on the verge of stable final integration. However, he learned from the patient involved in the pact that Josie had developed the conviction that the author and his associate, also involved in her care, would terminate her treatment within six weeks in order to have more time for a particular project. She felt that she could not endure the loss of these two people who had offered her care and support, and chose to destroy herself to avoid it. She committed suicide in a manner that was exceedingly hostile to all of those who had been dedicated to her care for years, and, before doing so, liquidated certain assets that were to have been used to pay for her extensive therapy bills. She placed these funds in the hands of those whom she alleged had abused her.

*Case S.* Kelly, a 26-year-old woman with DID, had been in treatment with the author for four years, and had appar-

ently achieved final integration. However, she found facing the world without alters terrifying, and began a series of ill-advised affairs with abusive men, and resumed the use of illicit substances. She was hospitalized medically and then psychiatrically after a nearly fatal single car accident which was clearly intentional. She proved to have a previously unsuspected alter that stated its purpose was to protect the patient from all pain. It insisted that the author was an abuser. Inquiry indicated that this alter had been formed in the context of sexual exploitation by a prior therapist. This alter appeared to make a solid therapeutic contract with the author, but this was a deception to encourage her discharge. Once released from the hospital, she refused to cooperate with therapy. This alter refused to accept that the current date and situation was accurate, and remained oriented toward the past. The alter consisting of all of the other integrated personalities spent much time in fantasy, trying to block out her current circumstances. The more recently discovered alter insisted that it, and it alone, could protect the patient, and that protection might consist of suicide if matters became too difficult. The patient was ingesting chloral hydrate pills and cutting her wrists when another patient serendipitously called her and, assessing the situation as difficult, called the author. He arranged for her immediate hospitalization. After several hours Kelly was deemed medically stable, and transferred to a psychiatric setting, where she agreed to treatment. However, as she was being taken from an admission suite to a unit she broke away and ran from staff. She collapsed and was without vital signs. Attempts to resuscitate her were unsuccessful; a ventricular arrhythmia proved intractable. The Medical Examiner's report suggested that a breakdown product of chloral hydrate had caused myocardial irritability, and that the rapid sympathetic discharge that accompanied her attempt to escape led to a fatal arrhythmia.

Case 6. Perri was a 26-year-old woman with DID and pronounced borderline features. She was preoccupied with being liked by others, and every one of her many suicide attempts and violent behaviors had occurred in the context of real or perceived rejection. Referred to the author at a dissociative disorders program, after a rocky start Perri worked exceptionally well and integrated all thirty-six alters rapidly. However, as her return home neared, the agency that had referred her for hospital care and signed an agreement to resume her treatment on discharge declined to allow her to continue in treatment at an optimal level, and indicated that it would not follow the recommendations of the dissociative disorders program. Another agency in her home town indicated it would treat her, but could not give her service at once. Hence she was returned to the original agency for follow-up until the second agency could provide her with psychotherapy. Days turned into weeks, and weeks turned into months. Feeling uncared for at the agency covering her, Perri withdrew and began to reach out frantically to staff at the dissociative disorders program. She felt betrayed when they

could not meet her level of neediness. The author called the agency that had promised to treat her, and was told that Perri would be called in soon. Approximately one month later, Perri lost her integration. Again this agency was called, and informed of her difficult situation. One month later, the agency still had not called Perri for treatment. In the context of a minor personal rebuff, she took a fatal overdose. Her body was not found for days.

#### **Group Characteristics**

Table I demonstrates the prevalence of suicide-related features in the six patients described above. In essence, these DID patients share much in common with patients from other diagnostic categories who complete suicides. They were depressed, likely to have abused psychoactive substances, had physical illnesses, and had personality disorders (here predominantly borderline, but note that Minnie was histrionic and narcissistic, Jessie narcissistic, Josie and Perri masochistic or self-defeating). Therefore all suffered co-morbidity. They all had sociopathic aspects, but none qualified for the diagnosis of sociopathic personality disorder or Briquet's syndrome. All had been discharged from the hospital within months of their suicide, all had made prior attempts, and at least five had planned to die. Most were unmarried, hostile, and had difficulties in interpersonal adjustment. Rejection, loss, or anticipated loss affected five of the six.

Table 2 demonstrates several features of these patients that might be considered relevant to their treatment and prognoses. Including Jessie, who never would give an enumeration of her alters, five of the six would qualify as extremely complex (Kluft, 1988), but none were the highly polyfragmented type of case described by Braun (1986). Two patients, and intermittently a third, were quite overt, and two-thirds were quite invested in the separateness of their alters. Four, all of whom alleged ritualistic abuse, indicated numerous abusers, but two indicated very few abusers. Four had achieved some degree of integration, and had transiently appeared to have achieved full final integration. One (Josie) twice successfully dissimulated her still-active DID for periods of many months. Four had demonstrated good to excellent therapeutic alliances at some time in the treatment, while two had not. Four had been abused as adults, and two patients, and intermittently a third, remained enmeshed with her abusers.

Conspicuously, all six patients defended their dishonest behavior, were at least occasionally quite manipulative, disavowed undesired aspects of reality with vigor, and demonstrated an avoidant shame script (Nathanson, 1992). That is, "the strategies through which we humans attempt to avoid, disguise, prevent, elude, or circumvent embarrassment and guilt....Included here are all the ways one can say no to shame" (Nathanson, 1992, p. 339). This series of findings seems to describe both conscious efforts and coping strategies that attempt not to acknowledge unpleasant reality, and

TABLE 1  
Suicide-Related Features in Six DID Suicides

Feature	Minnie	Jessie	Sally	Josie	Kelly	Perri
Depression	+	+	+	+	+	+
Alcoholism		+	+	+	+	
Drug Abuse			+	+	+	+
Schizophrenia						
Physical Illness	+	+	+	+	+	+
Past Attempts	+	+	+	+	+	+
Personality Disorder	+	+	+	+	+	+
Recent Discharge	+	+	+	+	+	+
"Sociopathy"	+	+	+	+	+	+
Alone		+	+	+	+	+
Unemployed		+		+	+	
Married	+					
Planfulness	+	+	+	+	+	+
Rejection	+					+
Loss	+		+			+
Anticipated Loss				+		
Hopelessness			+	+	+	+
Pessimism			+	+	+	+
Hostility	+	+	+	+	+	+
Interpersonal Maladjustment	+	+	+	+		+
Comorbidity	+	+	+	+	+	+

to buffer the patient from pain.

**DISCUSSION**

That DID patients who complete suicide in many respects resemble the overall population of psychiatric patients who kill themselves is not a surprising finding. What proved counterexpectational was that the DID patients who succeeded in destroying themselves differed in many respects from the majority of DID patients who represent themselves as suicidal in the course of their treatments.

In over twenty years of treating dissociative disorder patients, the author has become accustomed to approaching suicidality in terms of these patients' responses to: 1)

interpersonal conflict, rejection, and separation; 2) the impact of painful memories and traumata, and the shame and guilt associated with one's real or imagined part in them; and 3) the personalities' conflicts, interactions, and impacts upon one another. However, this study, which, it must be emphasized, is too small, preliminary, and tentative to serve as the basis for generalizations, suggests that many of those DID patients who destroy themselves are distinguished not so much by the uniqueness or agony of their concerns as by the intensity and grandiosity of their narcissistic investments in endorsing alternative versions of reality in which they can live with greater comfort, and their intolerance of confrontations that demonstrate the fallibility of such constructs. When they feel vulnerable and deflated, they erect compensatory grandiose

TABLE 2  
Selected Characteristics of Six DID Suicides

Feature	Minnie	Jessie	Sally	Josie	Kelly	Perri
Number alters	>50	?	5	>50	>30	>30
Sessions/wk.	2	5 -* 0	2-3	3-5	2	0
Number alleged abusers	Many	Many	1	Many	Many	2
Overtness	+	+		+/-		
Investment in separateness	+	+	-	+	+	
Integration	+			+	+	
RA alleged	+	+		+	+	
Flashbacks		+			+	
Enmeshment with abusers				+	+/-	+
Abuse as adult		+			+	+
Therapeutic alliance (max.) *	4	0	2	4	5	5
Euthanasia motive				?	+	
Defended dishonesty	+	+	+	+	+	+
Manipulative	+	+	+	+	+	+
Disavowal	+	+	+	+	+	+
Avoidant shame scripts**	+	+	+	+	+	+

\* Maximum therapeutic alliance score as per Kluff (1994).

\*\*From Nathanson's (1992) "compass of shame," not exclusive of other scripts.

defenses and alternative views of reality. When these, too, cannot be sustained, they are unwilling or unable to live in a world that cannot support the constructs they find essential to maintain their defensively motivated and compensatory self-esteem. They make a desperate effort to deny intolerable realities and overwhelming shame in a self-destructive act that offers a comforting and ego-syntonic escape, allows them the final illusion of the omnipotent reestablishment of their desired constructions of reality, and precludes further painful confrontations, humiliations, and narcissistic deflations. It is both the loss of a series of illusory buffers and

the attempt to erect a permanent buffer in death that unites most of these suicides. Those DID patients who were preoccupied with suicide but did not destroy themselves had not erected such intensely-held illusory buffers. When their less grandiose buffers were eroded, or crashed, their falls were not from as high a height, and had less disastrous impacts. Elsewhere (Kluft, 1993) the author has advanced the idea that a most pressing and central problem in the treatment of DID is that the DID patient, by dint of possessing alternative systems of self (the personalities) operating on different data bases (due to the dissociative amnesic barriers across

the several alters) with different but generally flawed cognitive processes (see Fine, 1988, 1990, 1991) suffers, in effect, from multiple reality disorder. He further argues that it is the clashes between the alternate constructions of reality more than the alternate constructions of personality that provide the greatest barriers to treatment, and the greatest risk to the patient. In five of these six patients, the operation of incompatible multiple reality constructs appears to have played a major role in their self-destruction.

Minnie's alter Juliet committed suicide. Juliet had provided Minnie with self-esteem across her system of alters by engaging in fantasies and behaviors that allowed her to see herself as a beautiful embodiment of love, and to believe that she was the real or potential recipient of love from idealized men. Juliet appears to have been remobilized when the mundane reality of her life as an integrated person deflated her lifelong coping style of compensatory grandiosity. In her suicide she appears to have stated that she was superior to mere mortal existence, and to have contemptuously denied her ties to her ill-used husband and children.

Jessie refused to engage in therapy and encounter a therapist who might challenge the complete conviction of her alters in their own separateness, and in the grandiose compensatory fantasy scenarios in which they convinced themselves that they lived. She instead lived simultaneously involved in what she experienced as romantic relationships with her incestuous father, her sexually exploitive doctor, and the alleged head of a satanic cult. Her alters subjected themselves to an endless series of "johns" which they then fantasized as the more desirable lovers noted above. Several powerful alters each imagined themselves in the more desirable situations, and convinced themselves that the others were cheap prostitutes working out of massage parlors, and were beneath contempt. No single alter believed it could be killed by the risk-taking behaviors that surrounded her refusal to take her anticonvulsants; nor could any powerful alter accept the physical realities of her circumstances. As a total human being she accepted the inevitability of her death as preferable to a confrontation with the squalor of her circumstances and the deterioration of her physical health.

Sally always felt free to change her perception of reality to suit her preferences, and often succeeded in persuading others to accept her version of events. Her dealings with the author convinced her he was a danger to her defenses; she stated this openly and perceived him as a threat. When she began to feel the true nature of her circumstances she disrupted treatment by attacking him, and made heroic efforts to force her mother to center her life around her. Her mother's death proved too difficult for her to handle in her customary way. Her efforts to deny the death failed. Crushed by guilt, and devastated by shame, she became an obligatory suicide whose only hope was to undo the separation from her mother by joining her in death.

Josie repeatedly lied to the author and his associate, and

believed that she had manipulated them to take care of her, although this was not the case. She disavowed unpleasant realities until they could not be denied, and avoided shameful situations by distraction and substance abuse whenever possible. She apparently convinced herself that the author and his associate were determined to abandon her care, a belief that was without foundation. She made firm contracts for safety with the author, gave her assets to those from whom he had tried to protect her, and killed herself in a manner that was quite defiant and hurtful to those who had cared for her. She did so in an alter believed fused by the author, but whose persistence was later admitted by the DID patient with whom she had made a suicide pact. Its name was The Supreme One."

Kelly had always distorted reality as best she could to sustain alternate views of herself and the world that disavowed her vulnerability and her repeated revictimizations. When she was apparently integrated, she was devastated by the realities of her circumstances. The last alter to be found denied its vulnerability, and represented itself as a virtual "superhero," fighting against those forces that would expose the patient to harm. The patient died as a result of that alter's attempts to impose a euthanasia when unpleasant realities became undeniable, and of its unwillingness to be at the mercy of those upon whom it projected negative expectations.

Perri had indeed gone to extraordinary lengths to try to distort reality in order to defend her self-esteem, but ceased to do so while in therapy with the author. With the total failure of her anticipated aftercare program to materialize, Perri regressed, lost her integration, despaired of help and/or recovery, and destroyed herself. Telephone conversations with her shortly before her death suggested that she did not mount a grandiose defense. She was miserable and desperate for the help which had been promised, but was withheld. She died a preventable death which the author attributes to callous bureaucracy, inefficiency, and laziness in a health care delivery system. She does not appear to fit the pattern found in most of the other patients.

Since the first presentation of this material the author has become aware of many additional DID suicides. Unfortunately, he has not been able to study relevant case materials in depth in order to expand the data base of this report. Several of the patients described to him appear to have features consistent with the need to reestablish alternate realities at any costs. A number of others appear to have killed themselves in connection with other dilemmas, such as having "burned their bridges," the failure of health care delivery systems to provide adequate care, object loss, and exhaustion after prolonged misery. More than one has committed suicide when managed care enterprises denied their continuing with a particular therapist or maintaining a desirable intensity of treatment.

It remains to be seen whether the study of other corn-

pleted DID suicides will sustain the tentative impression that the breakdown of one or more illusory alternative constructions of reality and the erection of a suicide scenario that involves a compensatory grandiose repair is characteristic of a large group of those DID patients who succeed in destroying themselves. Interim, it appears worthwhile to treat DID patients who show intense investments in alternative incompatible constructions of reality with special caution, and to avoid pressing their therapies into traumatic and highly conflictual materials before addressing the cognitive underpinnings of these alternate constructions and softening their incompatibilities. In a recent article, Fine (1991) has outlined strategies for achieving such objectives. ■

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