MULTIPLE PERSONALITY DISORDER IN EUROPE: IMPRESSIONS

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ABSTRACT

Based on his personal knowledge of the field in the Netherlands and on written reports from colleagues in other European countries, the author presents an impressionistic overview of the state of affairs in the field of diagnosis and treatment of MPD in Europe. His main impression is of the relatively advanced state of affairs in the Netherlands, ***although*** *many problems are still encountered. In Britain a few serious developments take place, but mainstream psychiatry is unsupportive. In other European countries developments lag* ***behind*** *even more, but there are also signs that changes for the better will occur. Special attention is given to a systematic study regarding Swiss psychiatrists' familiarity with MPD. Finally, a number of lessons for spreading knowledge about MPD and dissociation and for mutual support among MPD clinicians are presented.*

INTRODUCTION

Previously considered extremely rare, multiple personality disorder (MPD) is increasingly seen in North America as a major psychiatric disorder, where it has definitely entered the mainstream of psychiatry. Indications for this state of affairs are the increasing number of publications on MPD in major psychiatric journals, such as the *American journal of Psychiatry;* the number of special issues of many professional journals dedicated to the subject; the foundation of a professional journal, *DISSOCIATION,* dedicated specifically to MPD; the rapidly increasing membership of the International Society for the Study of Multiple Personality & Dissociation; and a growing number of inpatient treatment units for the dissociative disorders, among other things.

In Europe, the state of diagnosis and treatment of MPD is much less advanced. In most parts of Europe a professional attitude of "ve don't believe MPD exists here," as one Danish colleague recently said (Erik Simonsen, personal cornmunicationjanuary, 1992), is still dominant. In this paper, I present some impressions regarding the state of diagnosis and treatment in different European countries. With regard to the Netherlands, these impressions are based on numerous personal observations and discussions with clinicians. Impressions of the state of affairs in other European countries (and Israel) are based on the scarce existing literature and on information obtained from colleagues who responded to a 1992 request for information on (1) prevalence and (2) treatment of dissociative disorders (in particular MPD), (3) clinicians' attitudes toward MPD, (4) expected future developments, and (5) research being done in their country. These colleagues were approached because of their known interest in the field or because of a personal relationship with the author. They were also asked to mention names and addresses of other colleagues in their own or other European countries who could be approached. Thus a selective sample of respondents was created, with certain countries - such as the United Kingdom - well represented, and others not at all, either because of non-response, or because I was unable to find suitable names and addresses to initiate my inquiries. For these reasons, I am unable to provide information on Albania, Greece, Ireland, Portugal, Roumania, and most countries which belonged to the former Soviet Union. Some colleagues, notably from Belgium, Germany, Israel, Norway, and Sweden, were contacted again in 1993.

This overview starts with a personal impression of the state of affairs in the Netherlands, the European country most advanced in this area. However, despite rapid progress there are some very problematic aspects of the Dutch situation.

The Netherlands

In March, 1992, a Dutch film called "De Ontkenning" [The Denial] made its premiere in a few cinemas in the Netherlands. For many weeks, most shows were completely sold out. This film is a documentary about a young Dutch woman aware of six alter personalities, who all appear in the film in order to tell their story. Many Dutch newspapers carried very positive reviews of this film, and a number of them contained interviews with this woman and with clinicians specializing in treating patients or clients suffering from MPD. The woman also appeared in a few television programs. The

documentary itself was shown on Dutch national television on May 22, 1992, in recognition of the fact that the first International Conference on MPD & Dissociative States outside North America (i.e., the Second Annual 1SSMP&D Spring Conference) was taking place in Amsterdam. Subsequently, the film received awards and won prizes at several international film festivals. In November, 1992, Tom Verheul, the filmmaker, received the ISSMP&D Media Award at the 9th International Conference on Multiple Personality & Dissociation in Chicago.

Meanwhile, biographies on persons who suffered from MPD, such as *Sybil, When Rabbit Howls,* and *The Flock,* sell many copies in the Netherlands. North American textbooks on MPD, such as Braun (1986), Kluft (1985), Putnam (1989), and Ross (1989) , are widely read by a professional audience. The same goes for a Dutch book on trauma, dissociation, and hypnosis (van der Hart, 1991). As a sign of the local developments in this respect, the first Dutch monograph on diagnosis and treatment of MPD and DDNOS is scheduled to appear soon (Nijenhuis, in press). Recently published articles on the treatment of MPD include those by Nijenhuis emphasizing a learning theory perspective (Nijenhuis, 1992a & b) , and those by van der Hart and colleagues on the management and treatment of traumatic memories (van der Hart, Boon, Friedman, & Mierop, 1992; van der Hart & Boon, 1993) . An important dissertation on dissociative symptomatology in women who are adult incest survivors appeared in 1992 (Ensink, 1992). Ensink and van Otterloo (1989) validated a Dutch version of Bernstein and Putnam's Dissociative Experiences Scale (1986). In 1993, Boon and Draijer (1993b) published their studies on the reliability and validity of the Structured Clinical Interview for *DSM-11"1 R* Dissociative Disorders (SCID-D) (Boon & Draijer, 1993b) developed by Steinberg, Rounsaville, and Cicchetti (1990). Several chapters of this study, sponsored by the Department of Science, Health, and Culture of the Dutch Government, had been published previously in the scientific literature, and others are in press (Boon & Draijer, 1991, 1993a), and others are in press. These studies confirm the results of North American studies, adding new data which support the validity of MPD. Also in 1993, the Belgian psychologist Vanderlinden received his Ph.D. at the Free University in Amsterdam on the development and validity of his dissociation scale, the DIS-Q (Vanderlinden, 1993). In a few mental health centers studies on the prevalence of dissociative symptomatology and dissociative disorders have been undertaken. Draijer and Langeland (in press) studied the prevalence of dissociative symptoms and traumatic experiences in childhood in 160 inpatients of the psychiatric hospital Joris in Delft. Based on their findings, the authors estimated that at least 5% of this population had MPD-a percentage remarkably similar to North American findings (Ross, Anderson, Fleisher, & Norton, 1991; Saxe, et al., 1993). Cohen, Wallage, and van der Hart (1992) studied the prevalence of dissociative phenomena and traumatic experiences in childhood in eighty outpatients of a Regional Institute for Ambulatory Mental Health. At the Free University, Amsterdam, currently a study on dissociative symptoms in incarcerated female murderers is being carried out. Studies on diagnosis of dissociative disorders in children, on prevalence of dissociative disorders among psychiatric inpatients, and on the relationship between dissociative disorders and somatic complaints are being prepared.

In 1990, van der Hart and Boon reported that they were aware of sixty MPD patients being treated in the Netherlands (van der Hart & Boon, 1990). Since then Boon and Draijer (1993a&b) were able to get the collaboration of seventy-one Dutch MPD patients, treated by sixty therapists, for their study on the reliability and validity of the SCID-D. As a rough estimate, today about 400 MPD patients are being treated by approximately 250 clinicians all over the Netherlands. Since the appearance of the film "De Ontkenning," many persons who-rightly or wrongly-recognized their own problems in the film's main character, have started looking for appropriate treatment. A small but growing number of psychiatric clinics admit patients under this diagnosis and allow for **MPD**-specific inpatient treatment. One psychiatric hospital-Bloemendaal, The Hague-hosts the country's only Dissociative Disorders Inpatient Unit, with Felix Olthuis, Ph.D., as its clinical director. On a few other locations, attempts are being made in this direction. Two of the fifty-nine Regional Institutes for Ambulatory Mental Health Care (Riagg's)-one in Amsterdam and one in Rotterdam-have their own Dissociative Disorders Teams, and many more have one or more therapists treating MPD patients or clients. Compared to adult patients, diagnosis and treatment of children with MPD are lagging behind in the Netherlands. One positive development, however, is the recent foundation of a specific long-term treatment setting, also providing the necessary pedagogic climate, for severely traumatized children with MPD.

Education in diagnosis and treatment of MPD is rapidly developing. Since a number of North American authorities, notably Drs. Braun, Kluft, and Sachs, have conducted workshops in the mid-1980s (van der Hart & Boon, 1990), Dutch specialists are increasingly training and supervising fellow clinicians. Recently one- or two-day workshops have been given in a number of mental health inpatient or outpatient centers. Hypnosis in the treatment of dissociative disorders has become a standard topic in the training curriculum of the Dutch Society for Hypnotherapy (Nvvh). A training course consisting of twenty sessions (three hours each) has been held in Utrecht, and since then similar courses have been initiated in Groningen and Amsterdam.

The culmination of all this education was, of course, the International Conference on Multiple Personality Disorder and Dissociative States in Amsterdam, May 21-23, 1992 (cf. Loewenstein, 1992). There were 465 participants from the Netherlands and twelve other countries. This conference began with supportive opening remarks by M. Lamping-Goos, M.D., the Chief Inspector of Mental Health, Department of Welfare, Health, and Culture, of the Dutch government, which showed the Department's interest in this rapidly developing area. Dr. Lamping-Goos announced her decision to form a task force which would advise the Department with regard to the adequate diagnosis and treatment of **MPD.** This

MPD task force is currently developing guidelines in these areas. In March, 1993, the Dutch Society of Psychologists (NIP) organized a highly successful one-day congress on the dissociative disorders (in particular, MPD).

There is a general awareness among Dutch clinicians that they should not treat MPD patients solely on their own. If there is no expert support within their work setting, they feel the need to look for it elsewhere. An informal network is being built throughout the country for diagnostic and treatment consultation, supervision, and intervision. Geographical distance is no real problem in most instances, since the Netherlands is a relatively small and densely populated country.

These Dutch developments with regard to diagnosis and treatment of MPD seem to be rather favorable, especially when compared to other European countries. This is also reflected in the fact that the Netherlands is the country with the largest number of ISSMP&D members outside North America (21 as of March 1993), followed by the United Kingdom (5), Norway (5), France (2), Sweden (2), Germany (2), Denmark (1), Italy (1), and Spain (1). Israel has two members. Among countries outside North America, the Netherlands also ranks highest in number of research and clinical presentations at the annual meetings of the International Conference on Multiple Personality/Dissociative States in Chicago, Illinois. In short, a number of developments currently taking place seem to determine that MPD will be increasingly recognized and treated as such: (1) an increase in number of clinicians already treating MPD patients (once they start to treat one MPD patient, chances are high that they will begin to diagnose and treat more); (2) an increase of training opportunities in this area; (3) an increasing number of research studies are being done on prevalence and diagnosis of dissociative symptoms and dissociative disorders; and (4) an increase in awareness among the general public of the nature and origin of this dissociative disorder, highly stimulated by the documentary film "De Ontkenning" and the biographies mentioned before. This is already leading to an increasing number of consumer demands regarding treatment for self-diagnosed MPD.

Given all these positive developments, is there reason to be satisfied with the state of affairs in the Netherlands regarding diagnosis and treatment of MPD? If we take into account the intense suffering of the many people with an extremely traumatized childhood and unrecognized MPD, I believe we are still dealing with a desperate situation. First, a large proportion of patients or clients with dissociative disorders such as MPD are still not being recognized and treated as such. For these patients, this usually means a continuation of their (usually intense) suffering, which is often confounded by clinicians' inadvertent misunderstandings, and sometimes by ensuing maltreatments. Second, in the Netherlands, too, a number of clinicians treating MPD still encounter a less than supportive attitude on the part of their colleagues and superiors. In this context, it is interesting to note, incidentally, that it was a Dutch psychiatrist who, in an English-language publication, made one of the most vicious but unfounded attacks on the validity of the diagnosis of MPD (Van Praag, 1993). Third, most outpatient therapists treating MPD experience great difficulty in having their patients admitted to an inpatient setting with this diagnosis and are often unable to continue their individual therapy within this setting. One psychiatrist had to approach eleven hospitals before she succeeded in this regard. In some cases, this problem has been proven to be disastrous. Fourth, we see a slowly emerging tendency in some general treatment centers to utilize their newly acquired diagnostic skills in the dissociative disorders to reject newly referred patients fulfilling the diagnostic criteria for MPD. The burden of providing adequate treatment is passed on to others. Finally, developments in the area of children and youngsters with MPD are lagging far behind.

Apart from these problematic aspects with regard to diagnosis and treatment of MPD, an increasing number of Dutch clinicians experience severe difficulties in the treatment of MPD patients who report or show signs consistent with reports of Satanic ritual abuse. Boon and Draijer (1993b) reported such indications in 30% of the seventy-one MPD patients they studied in depth. Treatment of these cases is hampered by severe complications, and at present their prognosis is bad. Satanic ritual abuse is also reported with regard to a number of children admitted to a few residential treatment settings.

In conclusion, the situation regarding diagnosis, treatment, and research as it regards MPD and other dissociative disorders is relatively positive in the Netherlands, especially when compared with other European countries. However, there is still much improvement to be desired.

Belgium

Although Coons, Bowman, Kluft, and Milstein (1991) report on the existence of eleven cases of MPD in Belgium, dissociative disorders (in particular, MPD) are rarely diagnosed. Most clinicians deny their existence, although skepticism about the diagnosis has become less entrenched (Johan Vanderlinden, several personal communications, 1992-1993). However, in recent years, a few Dutch and North American specialists, in particular, Drs. Kluft and Fine, have been invited to present on diagnosis and treatment of MPD, sponsored primarily by the Leuven University Center St. Josef, and by the VATHYP, i.e., the Flemish Society of Clinical Hypnosis. The Dutch psychologist Ellert Nijenhuis alone has presented eleven workshop days on MPD in the Flemish part of Belgium. The VATHYP organized in 1992 a well attended symposium entitled "Trauma, Dissociation, and Hypnosis." Also in Leuven, physicians and social workers specialized in cases of child abuse are developing a growing interest in dissociative symptoms in abused children. Thus in Belgium, at least in the Flemish part, the need for further training in diagnosis and treatment of dissociative disorders (in particular, MPD) is rapidly growing. Vanderlinden (personal communication, March, 1993) reports knowing at least twenty colleagues now treating MPD patients. Vandereyckeu and Vandeputte are developing an inpatient treatment program for dissociative disorders including MPD in a psychiatric hospital located in Tienen (An Vandeputte, personal commu-

nication, November, 1992).

With regard to research in this area, Vanderlinden is doing pioneering workwith his newly developing self-reporting dissociation questionnaire (DIS-Q), which has excellent psychometric qualities (Vanderlinden, 1993; Vanderlinden et al., 1991). At two occasions he studied the prevalence of dissociative experiences in the general population in Belgium and the Netherlands. He found, among other things, that respectively 1% and 0.5% of these representative samples showed scores similar to those of a group of MPD patients. Next he studied the prevalence of dissociative experiences in eating disorders (n=150) and several other groups of psychiatric disorders (n=300). Currently Vandereycken and Vanderlinden are supervising a study assessing dissociative experiences in borderline patients and alcoholics. Vanderlinden has reported that the DIS-Q is attracting international attention (e.g., in Hungary and Italy).

United Kingdom

Britain is a unique country in the European community. Curious traditions are highly valued, while at the same time new fashions are in great demand in certain circles. In the area of psychiatry, Britain takes a rather conservative position. Although this country had, in the twenties and thirties, a number of leading authorities in the field of psychological trauma and dissociation (e.g., W. Brown, T.W. Mitchell, C.S. Myers) , nowadays it manages to be most skeptical with regard to MPD. The diagnosis is not mentioned in the *ICD-9,* the diagnostic manual which was commonly used in this as well as many other countries. The *ICD-10* (WHO, 1992) presented a rather outdated description, which clearly reflects the position of British psychiatry:

> This disorder is rare, and controversy exists about to which it is iatrogenic or culture-specific. (...) In the common form with two personalities, one personality is usually dominant but neither has access to the memories of the other and the two are almost always unaware of each other's existence (p. 160).

Given the fact that major research studies in North America and the Netherlands report an average of thirteen to eighteen alter personalities (Boon & Draijer, 1993a&b) ; Putnam, Guroff, Silberman, Barban, & Post, 1986; Ross, Norton, & Wozney, 1989), one wonders what data base is reflected in the statement that two [alter] personalities constitute the "common form" of MPD.

As the United Kingdom shares a common language with North America, one may consider the *British Journal ofPsychiatry* to be the conservative "alter-ego" of the *American journal of Psychiatry*. The latter is the world's leading psychiatric journal with regard to publishing scientific studies on childhood traumatization as an important etiological factor in a number of psychiatric disorders (including MPD) and with regard to prevalence studies of MPD. The former has published a few articles on MPD, most of them written at the London-based Institute of Psychiatry. Not based on much clinical or scientific experience in this area, these articles were rather skeptical regarding diagnosis and treatment of MPD. This disorder was considered to be a "North American culture-bound phenomenon ,"and its treatment should best be done by ignoring the existence of alter personalities (Fahy, 1988; Fahy, Abas, & Brown, 1989). Reporting having seen many cases of MPD in the United Kingdom, Macilwain (1992) strongly questioned this notion of MPD as a culture-specific phenomenon. One is reminded of a similar attitude found in Britain with regard to incest. In her study on incest, Nelson (1982) reported that people in one region or town reported that incest did only occur in another region or town, not in theirs, while those of that other region or town said the same. Based, among other things, on these reports, Nelson was able to conclude that incest happens all over Britain (van der Hart, 1990).

The conservative position of the *British journal ofPsychiatry* is supported by some clinicians in North America. Merskey, a Canadian professor of psychiatry, published in this journal an article in which he admitted to never having seen a patientwith MPD in his 36-year clinical career (Merskey, 1992a) . He stated that "the diagnosis of MPD represents a misdirection of effort which hinders the resolution of serious psychological problems in the lives of patients" (p. 327) - a completely unfounded position for which he was severely berated by three Canadian colleagues (Chande, 1992; M. Fahy, 1992; Fraser, 1992) , and by Putnam (1992) and Spiegel (1993) , among others. In a subsequent paper, Merskey (1992b) expressed his belief that Breuer's famous patient, Anna O., had a severe depressive illness instead of MPD, as Ellenberger (1970), Loewenstein (1993), and Ross (1989) concluded. It is worthwhile to note that Weissberg (1993), another MPD skeptic, recently acknowledged elsewhere Anna O.'s MPD, but attributed its development to Breuer's mistreatment of the case. Bruce Jones and Coid (1992) proposed to use the presence of borderline personality organization as an exclusion criterion for MPD, while several other studies show that MPD can be distinguished from borderline personality disorder (BPD) and that many MPD patients also met BPD criteria (Boon & Draijer, 1993b; Horevitz & Braun, 1984; Ross et al., 1990) . In the *British journal ofPsychiatry,* positive remarks regarding MPD as a valid diagnosis are reserved for "Letters to the Editor," written by clinicians and researchers in response to publications by Fahy and Merskey. One significant but easily overlooked statement can be found in an article by three Dutch psychiatrists on another subject, deja vu (Sno, Linszen, & DeJonghe,1992) : "Particularly as regards patients with multiple personality disorders, the diagnosis ofschizophrenia is sometimes erroneously made."

A most skeptical book on the subject has also been written by an English psychologist (Aldridge-Morris, 1989). In a recent personal communication, he wrote:

> I am certainly skeptical about this phenomenon (a prevalence of 50,000 in the U.S., with some individuals claiming up to 100 alter egos!), and would say that such a suspension of belief typifies the British position. I do hear, now and again, of an occasional, putative, multiple personality patient who is being

> seen by some unknown therapist. This information normally appears on a radio programme or in some popular magazine. There is nothing, to my knowledge, in any respectable professional publication here, which leads me to change my view that this is largely a culture-bound phenomenon with a strong iatrogenic component. What one is also going to see shortly, is a burgeoning of interest in ritual, Satanic abuse. This is creeping into the headlines with increasing frequency, and itwon t be long before someone follows the lead of certain U.S. investigators in linking the two phenomena. These are exciting times for skeptics. (Aldridge-Morris, personal communication, February, 1992).

Given this generally prevalent professional attitude, it is no wonder that there are very few possibilities for MPD patients in Britain to receive treatment for their conditions. This is exemplified by a self-diagnosed woman with MPD from London, who wrote in desperation for help to a Dutch clinician who specialized in the treatment of MPD patients:

> I am writing to you as a last-gasp attempt to get some help. For the last year and a half I have been trying in vain to get adequate help. (...) I have tried to get help in the U.K., but to no avail. I have now become so distressed that I am unable to work and my doctor has listed me as ill, and I am now reliant on State benefit. There seem to be few adequately trained therapists anywhere in the South of England, let alone London, who can deal with multiple personality issues. What few therapists that do exist, are already fully committed with existing MPD clients. (...) In my experience there is a lot of denial amongst the psychiatric and psychotherapy professionals as a whole in the U.K. (Anonymous, 1992)

The view of another clinician familiar with the condition, Dr. Hellmut Karle, is very much in line with this. Karle is a clinical psychologist and former head of child psychology, Guy's Hospital, London, and recently published a book on his successful treatment of an MPD patient (Karle, 1992). In a personal communication (February, 1992), he wrote:

> As far as I can establish, the diagnosis of MPD itself is rarely if ever used in the U.K. On the whole, most British psychiatrists and clinical psychologists do not believe the condition exists and consider that the phenomena which, according to *DSM-III-R,* define it do not constitute a syndrome or a disorder. (...) Diagnoses of dissociative disorders more generally are also rarely used, I believe, although amongst the psychoanalytically-oriented practitioners (psychiatrists, clinical psychologists, and psychotherapists), the concept of dissociation as an ego-defense mechanism is commonly used. (...) I very much doubt if there will be any major change in U.K. attitudes in the foreseeable future. (...) I have some hope that the more psychoanalytically-minded practitioners will take an interest in the possibility that MPD does exist and is highly relevant to a substantial proportion of their clients, but I am pretty sure that the psychiatric fraternity will reject the concept. The client concerned [about whom Karle wrote his book] was "diagnosed" repeatedly over many years as "depressed, inadequate, unhappy, and lonely" by psychiatrists, including a Professor of Psychiatry who saw her during the period I was treating her. He utterly rejected my diagnosis, and with scorn!

Dr. Liz Hall (personal communication, April, 1992), a clinical psychologist from Scotland, also laments the lack of interest in psychiatrists in the U.K.:

> The knowledge about MPD in Britain is constrained by the inherent belief within the British Psychiatric Field that MPD does not exist. It is not represented in *ICD-9,* the British classification of psychiatric disorders. As a result, a diagnosis of MPD is often suggested by other professionals (psychotherapists, clinical psychologists, and others) and is met with a sometimes unhelpful response from the psychiatric team.

For Karle, the principal clinical problem related to inadequate treatment of MPD is:

> the sad state of psychological therapies in the U.K., something shared with all aspects of psychiatric and psychological services in the National Health Service. Apart from the fact that only people with substantial financial resources of their own can receive training in therapy which is more than brief and very cursory (and does not include personal therapy), the fashion here has moved strongly away from individual and analytically-based therapies to systemic family therapy, a superficial and marginal way of controlling and managing rather than healing. (Karle, personal communication, March, 1992).

Macilwain (1992) presented a similar message. There is, however, in Britain, also a still rather small group of clinicians diagnosing and treating MPD patients as such. In London, there is an Institute for Self-Analysis where some therapists are specialized in this area. There is a group in Coventry, headed by Dr. John S. Davis, a clinical psychologist. And there is a center of expertise in the clinical psychology department of Grampian Health Board, Aberdeen, Scotland, which is headed by Dr. Liz Hall, a clinical psychologist. There is also the National Society for the Prevention of Cruelty to Children (NSPCC), which is detecting an increasing number of cases of child victims of alleged Satanic ritual abuse, some of them having been diagnosed as having MPD (Tate, 1991) . The link between MPD and Satanic ritual abuse, which Aldridge-Morris was expecting to be made in Britain, has

already been observed in that country. For instance, Hall (personal communication, April, 1992) referred to this issue when she wrote:

> The extremes of abuse that are disclosed by MPD survivors of abuse are horrifying and often defy belief, especially when the abuse is penetrated as part of an abuse network. However, we are consistently hearing the same kinds of disclosure from survivors who originate from all parts of the country and recognize that the organized networks of sexual abusers use similar methods to maintain the secrecy of the abuse. One of those methods appears to be the deliberate creation of abuse situations that will lead to the child dissociating and ultimately to the fragmentation of the very young child's personality.

Dr. John D. Davis, from the Psychology Department of the University of Warwick, is one of the leading British clinicians specialized in treating MPD patients. He gave the following impressions about his country (Davis, personal communication, January, 1992):

1) I think that the diagnoses of dissociative disorders, particularly MPD, are very rare in Britain. Most practitioners have no experience of identifying or treating these disorders, and many are either little informed about them or skeptical. Through my membership in ISSMP&D, I get a number of enquiries from individuals who are almost certainly multiples desperately seeking therapists in other parts of the country, but I know of only a handful of practitioners to whom I could refer. Within the "establishment" of psychiatry, psychology, and psychotherapy, little interest has yet been shown. (...)

2) Generally speaking, practitioners have little knowledge of how to treat these disorders. Once they encounter them, practitioners become avid consumers of the published literature and tend to search for support/guidance if they can find it. My wife and I, who are self-taught in this regard, provide telephone consultation to some practitioners who feel very isolated in their work.

3) Attitudes toward MPD vary from the curious/intrigued to the skeptical/hostile. I think there is already beginning to be a positive shift in awareness/receptivity. I have given talks on MPD to a British meeting of the Society for Psychotherapy Research and to some psychotherapy organizations at which the audience has generally been very receptive.

4) I am quite sure that the dissociative disorders will become much more widely recognized and accepted in the next few years. We are currently, I think, at the tail end of the time-lag for information to percolate across the Atlantic. We are also seeing a growing awareness of ritual abuse, which will inevitably facilitate an awareness of MPD. There is an informal network of practitioners working with cult-abused individuals, who are becoming sensitized to MPD, including its manifestations in children.

5) The u-eatment of MPD poses serious problems for our health services in several ways. There is pressure towards brief work in all public sector services, making provision for these patients extremely difficult. It is also rare for outpatient services to countenance treatment more frequently than once weekly. Conversely, most inpatient settings are quite unsuited to treat this clientele. Here in Coventry we avoid hospitalization at all costs! Within the private sector, there is of course no intrinsic difficulty in providing requisite treatment time, but many patients lack the resources to finance such treatment. Only a minority of the population have health insurance, and the attitudes of insurance companies to treatment of MPD have not to my knowledge been put to the test in Britain. [However, Karle wrote to this author: "Some eight or so years ago, a client of mine appeared to be a classic case of MPD and I so advised her General Practitioner. He put that diagnosis on the certificate he provided for the Department of Social Security (to obtain social security benefits for her while she was unemployed) and that diagnosis was accepted."]

6) We have been carrying out a small screening project in Coventry to try to establish the prevalence of dissociative disorders amongst referrals to our psychology service, using the DES and DDIS. Although we do not have detailed results as yet, it is clear that dissociative disorders are not at all rare in our service. I believe that the Institute of Psychiatry is also engaged in a similar venture, but I have no details to hand. I do not know of any other research on this front in Britain, though we have a voluntary organization attempting to collect data on ritual abuse, as well as a Government-sponsored enquiry and a Scotland Yard team attempting to establish whether it "exists."

In conclusion, in the United Kingdom there is a slowly growing awareness of MPD, especially outside psychiatry. The subject is controversial, and persons with MPD have a hard time in finding apt treatment. In case the diagnosis is made and met by a favorable attitude of the clinician, there are usually severe restraints, one of them being the restrictions in mental health care provided by the National Health Service.

The situation in the U.K is perhaps best summarized by Dr. Liz Hall (personal communication, April, 1992):

> Throughout the U.K. there are professionals in many different agencies working with sexual abuse survivors who are coming across individuals who have been subjected to very severe abuse at a very young age and who have developed MPD as a result. With the lack of psychiatric support both about sexual abuse and MPD, this has left many workers struggling with the complex issues without suitable resources or support and supervision. Until the U.K. psychiatric services acknowledge both issues, this situation is likely to continue.

France

For French psychiatry, the 19th Century was its Golden Age. One of its treasures is the vast literature on hysteria, with its special interest in **MPD,** of which Azam (1893) and Bourru and Burot (1895) gave famous case examples. Another one is Janet's dissociation theory, which forms the basis for modern thinking on dissociative phenomena and dissociative disorders (Janet, 1889, 1907, 1911). A few statements made at the time on the prevalence of MPD are as timely as they were a century ago. Thus Camuset said, in 1882, in his early report on Louis Vivet, about whom a famous study was written: "We believe that these cases are much more numerous than one postulates on the basis of the few known cases" (p. 75) . **In** discussing the same Louis Vivet and a few other cases, Bourru and Burot (1895) stated likewise: "These facts of the variations of the personality are less rare than is usually believed" (p. 148).

In recent times a few articles written by French psychiatrists are beginning to appear. Although Bourgeois and Geraud (1990) believe that "numerous American authors have been credulous victims of mythomanical patients," others are less negative (DeBonis, Charlot, Hardy, & Feline, 1988; Malarewicz, 1990). Milbert (1991) used the notion of dual personality to explain a case of dysthymic psychosis. On March 23, 1992, the Laboratoires Delagrange in Chilly-Mazaran organized an evening on MPD, with Sherrill Mulhern, Ph.D., as the main presenter. She met with some skepticism on the part of French clinicians, in particular with regard to North American publications (Henri Faure, personal communication, March, 1992). Interestingly, the response rate to my inquiry from French colleagues knowledgeable on MPD and other dissociative disorders was very low.

Spain

In Spain, the *DSM-III-R* dissociative disorders are rarely diagnosed as such, according to Dr. Francisco Orengo Garcia, a psychiatrist who spent a year at Putnam's Unit on Dissociative Disorders at NEMH (Orengo Garcia, personal communication, May 1992) . Under the remaining influence of old German diagnostic fashions, important symptoms related to the dissociative disorders were regarded as psychotic and, therefore, as schizophrenic. This also pertains to the diagnosis of MPD, which is almost completely unknown in Spanish psychiatry. However, hysteria and hysterical syndromes are still commonly used nosological categories.

An almost hidden but not infrequent "therapeutic" practice in rural and in some urban areas is related to so-called *curanderos* lay healers belonging to a pseudo-religious faith, who can enter into a special state of "grace" through which they supposedly are able to heal. Sometimes these curanderos treat cases of alleged devil possession. Recently, ayoung woman died during one of such rituals.

Dr. Orengo Garcia has no knowledge of research on the *DSM-III-R* dissociative disorders. However, from the point of view of the *ICD-10* (WHO, 1992), his own psychophysiological research on conversion disorders would, indeed, belong to the field of dissociative disorders.

Germany

Germany has the honor of having produced the first report, in 1791, of a patient who [presumably] suffered from MPD (Gmelin, 1791). Since then, not much has been heard on MPD in Germany. Thus, in two data banks, Medline and Psyclit., 318 publications on MPD were mentioned between January 1983 and December 1991, but none was related to Germany (Bongartz, personal communication (1992). Translated editions of *Sybil, When Rabbit Howls,* and *The Flock* and one sensationalist article in the weekly *Der Spiegel* did appear before early 1992 (Anne Jurgens, personal communication, February, 1992).

In German mainstream psychiatry and psychotherapy, MPD is not diagnosed as such (Anonymous, 1990; Eberlin, personal communication, March, 1992). Psychoanalysis is not interested: Dr. Gabriele Meimeth sent some of Kluft's articles on MPD to the editors of the influential psychoanalytic journal *Psyche.* They returned them with the comments that MPD is a psychiatric illness and as such not suitable for a psychoanalytic publication (Meimeth, personal communication (March, 1993). One is reminded of the attitude which the late Cornelia Wilbur met in the sixties when she tried to publish her papers on MPD in North American psychoanalytic journals. Most psychotherapists with whom Dr. Meimeth discussed MPD were not much interested either.

In German psychiatry, patients showing features of MPD are regarded as borderlines, "unusual psychopaths," or, when in worse shape, psychotics or schizophrenics. Jurgens, a psychologist and psychotherapist in Bielefeld, mentioned that dissociative disorders in incest survivors, but not MPD (Anne Jurgens, personal communication (February, 1992). Since she attended a workshop on MPD in Bremen, presented by Onno van der Hart, from the Netherlands, in March 1991, Steenstra, a therapist specializing in the treatment of survivors of childhood sexual abuse, had spoken with many colleagues on this subject (Zwannet Steenstra, personal cotnmunication,January, 1992). For all of them, this particular conversation was the first occasion on which they had heard anything about it. The ignorance among clinicians is illustrated by the account of one German MPD patient who, during a crisis could not reach her therapist and contacted a psychiatrist on duty instead. After she had tried to explain something about her condition, he believed she had a con-

tagious disease and therefore refused to come near her.

Anne Jurgens has diagnosed two MPD patients and is currently treating one of them on an outpatient basis. Two colleagues in the same city are each treating one MPD patient. Apart from that, Jurgens had no concrete evidence about other German clinicians treating MPD patients. However, at the International Conference on Multiple Personality Disorder& Dissociative States, Amsterdam, May 21-23, 1992, she met with several other German colleagues and subsequently formed an informal network of therapists treating MPD patients.

Jurgens made her two diagnoses of MPD in an inpatient setting; at a hospital for psychosomatic disease in Bielefeld. **Her** report of what happened subsequently, as well as the reports of the two patients themselves, show the difficulties experienced by the patients themselves as well as by the pioneering clinicians even in a setting which was able to accept the diagnosis. I believe that these reports are not typical of Germany specifically, but could-often with worse contents-be given from most European countries. Jurgens (personal communication, February, 1992) stated briefly:

> In our clinic we experienced initially many problems, splitting phenomena and resistances. In the meantime the diagnosis is accepted, and for my patient in outpatient therapy I receive regular supervision from my Clinic Chief, who is very interested and supportive. Our clinic setting is not very suited for MPD treatment, since we work a lot with groups, which proved itself to be difficult. Also the treatment duration has proved to be difficult. There was much jealousy among other patients.

Ms. X, Jurgen's MPD patient, wrote that when she was diagnosed as having MPD (Anonymous personal communication, February 1992):

> A long and difficult fight took place, unfortunately. Within the clinic there was much irritation among therapists, who did not want to believe in this diagnostic category or could not imagine its existence. In particular, there were many difficulties regarding the unorthodox form of therapy, which soon proved to be effective and helping, however. Some therapists and nurses were even afraid of us and did not want to deal with us. (...) This went so far that Ms. Y [the other recognized MPD patient] and I requested to participate in a team meeting, in order to talk with all the therapists and to stand up for ourselves. The result was that they tried to accept us but also decided not to approach other patients in terms of their MPD and not to treat other patients with MPD. Also, after discharge, every "normal" patient can be re-admitted when being in a crisis, but we on no account. Since then, this attitude changed a bit, but the same fear for us still exists. Furthermore, we were not allowed to talk with other patients about ourselves, because of which much irritation and misunderstanding occurred, as we got a special regime. For instance, we were not permitted to participate in group meetings and received only individual therapy. All this isolated us even more from the other patients. Soon the question arose how we could continue after the time in the clinic. We talked with a few therapists we knew and carefully asked if they had heard something about MPD. Almost all of them had heard about it, but most of them did not want to deal with it and referred us to (non-existing) specialists. Others declared that it did not matter how the illness was called, whether depression or psychosis, or even MPD, because treatment would be the same anyway. (...) Then we began to know a female therapist who very much wanted to deal with MPD and who was eager to meet us now and then in order to learn more about it. Very soon and without explanation, however, she withdrew her offer and did not want to talk with us anymore. To whom [ever] we turned, we always got negative reactions. Fortunately, Ms. Jurgens, the therapist who diagnosed our condition in the clinic, finally decided to continue treatment also upon discharge from the clinic.

Ms. Y, the other MPD patient diagnosed as such, was less successful. She searched unsuccessfully for a therapist all over Germany and even in the Netherlands. In the end, Ms. Jurgens was able to persuade a colleague to take her in treatment for her MPD. Meanwhile, interest in inpatient treatment of MPD has been growing in the Bielefelt Clinic for Psychosomatic Disease. In November, 1992, Felix Olthuis, Ph.D., presented a two-day workshop on this subject for interested staff members and other interested clinicians at the Clinic.

Jurgens and Ms. X have taken the task of informing the public about the subject of MPD. The feminist journal, *Emma,* published Ms. Vs story in the September, 1992, issue. Michaela Huber (1992), a German psychologist and psychotherapist treating several MPD patients, added important comments on this subject. Huber received about one hundred reactions from readers, half of them from therapists treating one or more MPD patients and from MPD patients themselves (Huber, personal communication, March, 1993). The therapists reported on negative attitudes by their superiors and peers, and about problems with insurance companies. They requested professional exchanges on the subject, possibilities for professional education and supervision, and relevant literature on MPD. The patients reported stories about their traumatic experiences with the health system; those from the former German Democratic Republic reported ECT as the treatment of choice.

Huber (in press) wrote an extended scientific book chapter on MPD. Apart from the usual information on diagnosis and treatment of MPD, she also dealt with the subject of allegations of Satanic ritual abuse which she and a few colleagues in Germany have encountered in some of their patients.

Huber has currently written the first professional book in German on diagnosis and treatment of MPD, for which she has already made a contract with a major publisher. In short, apart from all the skepticism and ignorance encountered in Germany, encouraging developments have also begun to take place.

Denmark

From Denmark, Erik Simonsen, M.D., Director of the International Society for the Study of Personality Disorders, told that nobody in Denmark is, so far, interested in MPD. "We don't believe it exists here" (Erik Simonsen, personal communication, February, 1992) . Another Danish clinician, Suzette van Hauen-Drucker, explained that this is, indeed, the situation within the State-subsidized mental health care system. However, among an alternative group of therapists, the knowledge of MPD is as follows: Many have heard of it and see it in their practice but call it something else and treat it with whatever method they use for all their patients. They claim to have good results. The question is, however, how many of these patients are really suffering from MPD (Suzette van Hauen-Drucker, personal communication, February, 1992). Van Hauen-Drucker herself is treating sew eral **MPD** patients. Jens Jorgen Gravesen, M.D., President of the Danish Society for Medical Hypnotherapy, told he knew of one MPD patient diagnosed (and treated using hypnosis) as such in Denmark. Among members of this Society, there is some knowledge about MPD and dissociative states (Jens-Jorgen Gravesen, personal communication, March, 1992).

Smidt, a psychologist, is treating several patients with dissociative disorders other than MPD (Berate Smidt, personal communication, April, 1992). She finds that the concept of dissociation is extremely valuable in her work with these and other traumatized patients. Smidt conducted an informal survey among Danish clinicians, mainly psychologists and psychiatrists. Her conclusion supports the impression given by Simonsen's position and Van Hauen-Drucker's observations: MPD and the concept of dissociation are little known and rarely used in clinical practice in Denmark. The prevalent attitude in psychiatry was illustrated well enough by the remarks made by a superintendent of a child psychiatry ward: "MPD is the outcome of hypnosis, and something that naive American psychologists find in criminals who are cheating them." (Cited by Smidt, personal communication, April, 1992) . Smidt was impressed with the reluctance among the psychiatrists to answer questions related to MPD. Within the field of psychiatry, she met only one authority-a psychologist, in fact who knows and has been using the diagnosis of MPD or other dissociative disorders. However, this chief psychologist and professor at the leading psychiatric hospital, "Rigshospitalet," has recognized only the most outspoken cases of MPD: five or six cases during thirty-five years. Smidt is familiar with a group of about fifteen to twenty Danish psychologists, whom she describes as progressive, influential, active, and eager to learn, who know and work with the concept of dissociative states. They relate this, however, more to the area of PTSD-a field rapidly developing in Denmark, especially among clinical psychologists-than to MPD.

Sweden

Sweden is a country where one would expect much professional interest in MPD and other dissociative disorders. Sweden has a large society for clinical and experimental hypnosis, which under the stimulus of Dr. P.O. Wikstrom, is very much internationally oriented. Its journal, *HYPNOS,* has become the journal of the European Society of Hypnosis in Psychotherapy and Psychosomatic Medicine. Many North American authors publish in it. The popular biographical books *When Rabbit Howls* and *The Flock* have been translated into Swedish.

Little seems to be known in Sweden on the subject of MPD, however. Some work in this area is done in Gotenborg, where Carolusson (Susanna Carolusson, personal communication, April, 1992) and others are treating a number of MPD patients. Through her hypnosis courses, Carolusson teaches other clinicians about the subject. However, her impression is that outside this group the diagnosis of MPD is not in the vocabulary of Swedish psychiatrists and psychologists. She believes that MPD patients with more ego-strength would be diagnosed as schizoid while those with more severe symptomatoiogywould be called psychopaths or schizophrenics.

From Lund, psychologist Argus-Zivaljic reports that she met complete ignorance from colleagues on MPD when she inquired on this matter some three years ago (Viola Argus-Zivaljik, personal communication, June, 1992). When she subsequently presented an MPD case to the staff of her hospital, psychologists and psychiatrists responded with skepticism, in contrast to the openmindedness of the nurses. The chief psychiatrist believed the patient to be a schizophrenic in need of high doses or neuroleptics. Argus-Zivaljec intends to share her observations with colleagues via publications in Swedish professional journals and the organization of a national meeting on MPD.

Psychologist Karilampi (Ulla Karilampi, personal communication, April, 1993) received a grant from the Swedish Hypnosis Society to write her Master's thesis, "Introduction to Dissociation," and was asked to hold a minor symposium on the subject during the Society's Annual Meeting. This thesis contains an authorized translation of the DES. According to Karilampi, even among the members of this Society there are still many who consider MPD to be a North American syndrome. Karilampi finally mentions that Swedish newspapers started to report on Satanic ritual abuse cases in that country: These allegations are not taken too seriously by the Swedish police.

Several factors suggest that once there is more knowledge on MPD available in Sweden, developments in this clinical field will move rapidly: (1) there are many openminded therapists; (2) hypnosis is widely used in treatment; (3) there exists great interest in child abuse and incest (although as yet hardly, if ever, linked to dissociation); (4) the Swedes are open to international developments, especially in the field of hypnosis; and (5) students who become acquainted with the subject of dissociation show considerable interest.

Norway

In Norway, a number of psychiatrists and psychologists affiliated with the Rogaland Psychiatric Hospital in Stavanger recently have become very active in the field of the dissociative disorders, in particular MPD (Jan Haslerud, personal communication, April, 1992) . Having diagnosed their first MPD patient in 1991, they formed a "Dissociation Group," which not only developed clinical skills with regard to diagnosis and treatment of MPD, but also engaged in research involving the DES and a translated version of the SCID-D. This group has no information on other centers in Norway diagnosing and treating MPD (Helge Knudsen, personal information, April, 1993). "Most of our Norwegian colleagues have been more skeptical and have adopted a wait-and-see attitude," according to Dr. Jan Haslerud.

In February, 1993, the Norwegian Psychiatric Association held a meeting in Oslo on dissociation. The research studies by Dr. Colin Ross and his associates were cited. Dr. Jan Haslerud presented an outline of the Stavanger dissociation study mentioned above. In April, 1993, the Stavanger group organized a two-day workshop on the diagnosis and treatment of MPD, presented by Onno van der Hart, from the Netherlands. It was attended by one hundred professionals affiliated with their hospital and another twenty invited guests. Dr. Helge Knudsen again presented the preliminary results of the Stavanger dissociation study. From November 15th to the 19th, 1993, the Stavanger Psychiatric Hospital will host its third conference on Schizophrenia. On November 19, Dr. Richard J. Loewenstein will lecture on diagnosis and treatment of MPD, and the Stavanger dissociation group will present its final results of its dissociation study.

The Stavanger group's tendency to look for international support and collaboration should serve as an example for similar groups of interested clinicians and researchers. The hospital s clinical tradition of continuity of (mental) health care is also exemplary. It is always expected that outpatient therapists will take part in the treatment of their patients during their stay in the hospital. Patients admitted more than once always return to the same ward and get the same attending clinician and nurse. This group's acceptance of the validity of the diagnosis of MPD is probably related to its openmindedness in other regards as well.

Finland

In Finland, very little interest in dissociation and MPD exists. Of the very few clinicians dealing with the subject, Reima Kampman is best known. His position on MPD is not in harmony with the North American majority of MPD clinicians. He believes that alter personalities could be artificially created in normal, highly hypnotizable subjects (Kampman, 1974, 1975, 1976) , and he wrote a positive report regarding Aldridge-Morris' highly skeptical book on MPD (Kampman, 1992), which was severely criticized by North American authorities in the field (e.g., Ross, 1991b). Kampman agreed with the Aldridge-Morris opinion that MPD is over-diagnosed in the United States, but maintained that it nevertheless exists as a disorder. Eeva S3rkko (1983) wrote a novel, *Seitsemdn Sisarta* (The Seven Sisters), based on Kampman's treatment of a female MPD patient (Tejo de Brujn, personal communication, March, 1992).

Austria

From Austria, Dr. Eric Bolcs, current President of the European Society of Hypnosis, reports that the dissociative disorders, in particular MPD, are very rarely diagnosed. If such a diagnosis would be made, in his opinion, hypnosis and relaxation therapy would probably used in treatment (Boles, personal communication, May, 1992).

Russia

Allison (1991) reported about a trip organized in 1990 for a group of American psychiatrists to meet Russian psychiatrists who were interested in MPD and dissociation. However, in Moscow the group did not meet any interested psychiatrist, and in Leningrad they encountered only one such psychologist, who was already in contact with North American mental health professionals.

On the other hand, the Association of Practical Psychologists in Russia expressed its interest in the present International Conference on Multiple Personality Disorder & Dissociative States (Yulia Aloyshina, personal communication, December, 1991). Aloyshina mentioned that some of its psychologists are treating MPD patients, and she enquired about the possibility of some Russian psychologists attending. The Dutch psychologist Nijenhuis (personal communication, March, 1993) reported that he was invited by Dr. Leonid Krol to give a two-and-a-half day workshop on diagnosis and treatment of MPD, in Moscow, during October of 1993.

Czechoslovakia

Vancura, a Prague-based clinical psychologist who is very interested in hypnotic approaches to traumatized people, is currently aware of the presence of dissociative disorders in many of his patients which he formerly regarded as borderlines (Michael Vancura, personal communication, April, 1992) . Also from Prague, psychiatrist Dr. Janotova reports that MPD is not used as a diagnostic category (DanaJanotova, personal communication, April, 1992). Dr. Kovanicova, a psychiatrist from Kosice, agrees, but can report two cases which a colleague could recall from his thirty-year practice (MilanaKovanicova, personal communication, May, 1992). From her own practice, she mentions a patient with recurrent fugue states. This is the type of case which clinicians familiar with MPD would certainly screen for other dissociative symptoms.

Vancura checked with seven psychiatrists and four clinical psychologists, who together represent the whole spectrum of clinical approaches to psychopathology. Most of them stated they do not use the diagnostic category of MPD. Two reported that they had seen signs of it, but had classified them under a higher order diagnosis which subsequently became the focus of treatment. Others confessed they would not know how to treat such a condition. The consensus is that the **MPD** will become a legitimate diagnostic category, especially when psychotherapy is more emphasized in their

country. There is no research in this area going on in Czechoslovakia.

Hungary

Johan Vanderlinden (personal communication, March, 1993) , from Belgium, reported that Drs. Eva Banyai and Varga Vatolin, from Budapest University, have started an epidemiological study using a translated version of his DIS-Q on the prevalence of dissociative experiences in the general Hungarian population. Dr. Ferenc Tury is doing a prevalence study on dissociative disorders among the patients of the psychiatric hospital in Miskok.

Poland

From Krakow, Jerzy Aleksandrowicz, Professor of Psychiatry, wrote that in his department of psychotherapy, not even one case of MPD has been seen during the past fifteen years. No studies on the subject have probably been published in the Polish scientific literature (Jerzy Aleksandrowicz, personal communication, April, 1992).

Bulgaria

Coons et al. (1991) mentioned two cases of MPD reported to them in 1990. Based on an informal poll amongst some prominent Bulgarian psychiatrists and psychologists, Nicola Atanasov, a clinical psychologist, found that MPD is rarely diagnosed as such in Bulgaria (Nicola Atanasov, personal communication, May, 1992). One hypothesis she offered is that psychiatry in this country is predominantly biologically-oriented, with limited possibilities for patient contacts. Psychotherapy, especially long-term, is restricted to a very limited number of patients. Atanasoz was unable to find even one colleague treating MPD, and she was unaware of Bulgarian publications on this subject. She personally had not seen a single case of MPD or any other dissociative disorder during ten years of clinical work in a psychiatric clinic. However, she expressed the hope that Bulgarian psychiatrists and psychologists would join international efforts to research, diagnose, and treat MPD. Dr. Maria Ivanova (personal communication, April, 1992), a psychiatrist and psychoanalyst, reported that, following her personal interest, she was treating a number of MPD patients. The informal view among colleagues is that the prevalence of this disorder is increasing. In her opinion, MPD patients can be found in particular in groups which occupy themselves with bioenergetics, astrology, white and black magic, and mass hypnosis.

Switzerland

In Switzerland, the only systematic study in the field has been done with regard to the question how frequently patients with MPD are diagnosed (Modestin, 1992). Modestin, professor of psychiatry and medical director at the Psychiatric University Clinic Burghozli, Zurich, sent all qualified Swiss psychiatrists a questionnaire on MPD along with the *DSM-IH* description of MPD and three classical 19th Century case examples. A total of 836 (66%) answered after two mailings, and 770 questionnaires qualified for evaluation. Thirty-nine percent of the psychiatrists reported that they had not known the concept of MPD before the present study. Three percent of the psychiatrists indicated that, at the time of the inquiry, they were treating or examining one or more patients who met *DSM-III* criteria for MPD, and 63 (10%) indicated that they had seen MPD at least once during their professional career. The patients were not equally distributed among the psychiatrists; three of them reported that they had seen much higher numbers of patients with MPD - reports which Modestin seriously questioned. He found that the point prevalence of MPD among patients seen by psychiatrists in Switzerland amounts to .05% to 0.1% (based on the entire caseload of the sample) , and he concluded that MPD appears to be a disorder that genuinely exists, even though it occurs relatively rarely.

In a personal communication, Professor Modestin (Jiri Modestin, personal communication, January, 1992) added that there is much diversity in attitude among Swiss psychiatrists towards MPD. Also in Switzerland, there are many who regard this diagnosis with great skepticism. Others, also affected by American videotapes on MPD, have the impression that iatrogenic components play a role in the development of this disorder. Finally, there are also psychiatrists who regard the disorder as possession: i.e., as a phenomenon which does not belong to the domain of psychiatry but rather to that of parapsychology.

Modestin is to be commended for his attempt to throw light on the question how frequently patients with MPD are diagnosed in Switzerland. His pioneering study should inspire researchers in other countries to do comparable studies. Modestin, who admitted to not having seen a patient with MPD himself, stated that his study was meant to show how frequently MPD patients were *encountered and diagnosed* in Switzerland. I believe that the term "encountered " is unfortunate, since this ignores the possibility that many cases of MPD have been overlooked by his respondents. That this has happened in fact is very likely. His study brought to light only forty-four cases currently reported by a group of 770 Swiss psychiatrists (or seventeen, if four "doubtful cases" and twenty-three others reported by only three psychiatrists were excluded). By comparison, in the Netherlands, Boon and Draijer (1993 a and b), were able, by just asking around among colleagues, to get sufficient referrals to diagnose seventy-one patients with MPD using the SCID-D. There is still very little knowledge about MPD among Swiss psychiatrists, like most of their European colleagues. Specific diagnostic skills for the dissociative disorders are not developed, and diagnostic instruments such as the DDIS (Ross, 1989) and the SCID-D are not used. It is important to note that Modestin did not instruct those he surveyed on how to elicit information on the relevant symptoms. Instead, he presented them with three crude 19th Century case examples, which provided little or no education about the more subtle signs of MPD shown by the majority of cases. Had Modestin given his respondents a copy of an article such as one on an office mental status examination for MPD by Loewenstein (1991), and if they had taken the trouble to study its contents seriously, one may assume that he might have come up with a much higher prevalence of MPD patients seen by Swiss psy-

chiatrists than shown in the present study.

Israel

Although geographically not located in Europe, in issues of culture and sport, Israel is often affiliated with it. As such, it may be apt to include the state of the art in this country in this review. Although the Israeli psychologist Berman published a number of international papers on MPD (e.g., Berman, 1981) , it was only in 1987 that interest became more widespread. van der Hart gave a two-day workshop on diagnosis and treatment of MPD for members of the Israel Hypnosis Society, and at the Third National Conference of the same Society, Somer presented the first Israeli scholarly paper on diagnosis and treatment principles of MPD (Somer, 1987). Two years later he published a paper on diagnosis and treatment of MPD in *SIHOT,* the Hebrew language *Israel Journal of Psychotherapy* (Somer, 1989). Since then, a number of in-service workshops and presentations on the topic have been held at the Haifa office of the Israel Institute of Treatment and Prevention of Stress (IITPS).

Nine Israeli clinicians have recently been identified as having at least one MPD patient in his or her caseload. In 1992, twelve MPD cases were currently known in Israel, three ofwhich were being treated at the IITPS. Six of these patients were either immigrants or foreign residents from the United States. In addition, in March, 1992, clinicians at the IITPS were treating eleven MPD and DDNOS patients, nine ofwhom being immigrants or foreign residents (Eli Somer, personal communication, March, 1993).

Dr. Eliezer Witztum, of the Ezrath Nashim Mental Health Center in Jerusalem, and his colleagues, and Dr. Eli Somer, of the IITPS have treated demon and dibbuk possession cases presented by Hassidic and Sephardic Jewish patients (cf. Somer, in press; Witzum &van der Hart, 1993). **Most** of such dissociative disorder cases, however, are treat**ed** by rabbis and folk healers, and rarely get to the attention of Israeli mental health professionals.

The 12th International Congress of Hypnosis, held in Jerusalem in July of 1992, gave interested Israeli clinicians an opportunity to attend an MPD workshop given by Dr. Richard P. Kluft. Following this workshop, several clinicians expressed their interest in forming a national MPD/DD Study Group in Israel. On March 22, 1993, Dr. Somer presented the first Hebrew language workshop in Israel on diagnosis and treatment of MPD. He conducted a second workshop during the Israel Psychological Society's Annual Workshops in Naharyia, June 15-17, 1993.

A growing media interest is shown in two articles on child abuse and MPD, published in two Israeli newspapers in January and February, 1993.

DISCUSSION

From this impressionistic overview, a number of tentative conclusions, lessons, and points of discussion can be drawn.

1) *The advanced position of the Netherlands in Europe.* This review shows that MPD is much more accepted and recognized in the Netherlands than in any other European country. This is also reflected in the fact that it is the country outside North America with the largest contingent of members in the ISSMP&D and in the International Society for Traumatic Stress Studies. Such facts point to a relatively strong awareness among Dutch clinicians of psychological trauma and its sequelae. This is not the place for an in-depth exploration of Dutch sensitization to trauma issues. However, several factors are of note. First, this awareness and interest traditionally has concerned traumatization during World War II, and since the early 1980s has also encompassed childhood traumatization-in particular, incest. Second, a strong Women's Movement exists in the Netherlands, and it has put sexual violence on the political agenda. Influenced by the Women's Movement and by the alarming results of Draijer's survey among a representative sample of Dutch women and girls in particular (Draijer, 1988, 1990) , there now exists a general awareness of the prevalence and negative impact of child sexual abuse. Mental health professionals, psychiatrists included, are developing a growing insight into the relationship between adult psychopathology and childhood traumatization. Third, there exists in the Netherlands a well-organized system of mental health care, with much more possibilities for rendering adequate mental health care than is likely in some neighboring countries, notably Britain. Within this system, the fifty-nine Regional Institutes for Ambulatory Mental Health Care (Riaggs) form the cornerstone of ambulatory mental health care. These Riaggs offer much more possibilities for adequate treatment in general than do some other European countries. Fourth, within the Dutch mental health care system there exists much more cooperation between the various disciplines, in particular, between psychiatry and other disciplines, than exists in some other European countries. In the Netherlands, also, psychiatrists are interested in dissociation and in diagnosis and treatment of MPD, whereas comments from Britain, Denmark, and Germany point to the negative attitude psychiatrists generally exhibit vis-a-vis **MPD.** This attitude may, however, be closely related to the state of affairs in the official mental health system in those countries. There the role psychiatrists can play within this system is narrowly defined, and may constrict their outlook. They have almost no time to devote to psychotherapy. In the Netherlands, in contrast, many psychiatrists, also in the Riaggs, are partially or completely involved in psychotherapeutic practice. Fifth, the Netherlands (for better or worse) are relatively open to North American influences, as is shown in high sales of American Iiterary and professional publications. Therefore, North American publications on MPD are probably more widely read

there than in other European countries. Sixth, there exists already a number of Dutch publications and empirical studies on the etiology, diagnosis, and treatment of MPD. The importance of this factor can not be underestimated. In contrast, in other European countries there is a tremendous lack of solid professional texts, whether in the form of articles or books. As mentioned above, once practitioners encounter MPD and other dissociative disorders they become avid consumers of the published literature. A lesson to be drawn is that systematic efforts must be made to publish informative articles and books for a professional audience in the respective national psychotherapy and psychiatry journals. This is also important for Britain, where the barrier against North American publications is based upon a cultural and professional bias rather than a language difference.

2) *The influence of biographical works on MPD.* Because of the proliferation of popular autobiographical books on MPD-such as *Sybil, When Rabbit Howls, The Flock,* and *Voices,* most of which are translated into other languages-many individuals are diagnosing themselves, correctly or not, in terms of MPD, and begin to look for therapists willing and able to treat them in these terms. Although in most countries they are extremely frustrated in their search, they nevertheless exert a growing pressure on mental health professionals to provide appropriate diagnostic and therapeutic services. For many clinicians also, these popular books provide their sole source of written information on the subject. This popular literature should be supplemented, not only by scientific publications in national professional journals but also by informative articles and programs in the mass media. An educated general public is able to exert pressure on the mental health system to provide proper treatment for MPD patients (Bente Smidt, personal communication, April, 1993).

3) *Influence of teaching seminars and workshops on MPD.* Many teachers on diagnostic and treatment issues of MPD in both North America and the Netherlands have experienced that once participants become acquainted with the phenomenology of MPD, through clinical lectures and video presentations, many of them start to recognize the signs and symptoms in patients they have previously treated or are currently treating. In my opinion, this recognition is especially strong among clinicians working in inpatient settings and those who are already specialized in treating survivors of childhood sexual abuse hut were, until then, uninformed about MPD.

Especially from the recognition of MPD in patients currently in treatment, a tremendous need to learn more about diagnostic and treatment issues often develops; i.e., Now I know this patient has MPD, what do I do next?" There is not only the need to read more, but to get guidance and support. There are at least three lessons to be drawn in this regard. One is the need to systematically provide teaching seminars and workshops in different geographical areas or even specific places, such as outpatient clinics and psychiatric hospitals. Training opportunities in such treatment centers are especially relevant. As all disciplines within these centers can participate in the learning experience, a cultural transformation may take place. Experienced clinicians should perhaps systematically offer their teaching services to various hospitals and professionals societies on a national and international level. As experience has taught us, a complication arises when MPD as a teaching subject is so little known in a specific local area or country that announcing a presentation or workshop on this subject may not attract many interested clinicians. An example is a workshop on diagnosis and treatment of MPD presented by Ellert Nijenhuis, Ph.D., from the Netherlands, during the 1991 Annual Meeting of the German Society for Clinical and Experimental Hypnosis, where only six participants showed up. However, a two-day workshop in Bremen, Germany during the same year on the same subject attracted an overwhelming response because it was announced as a workshop on treatment of survivors of childhood sexual abuse. Obviously, the second lesson is that the old principle of strategic therapy or culture-sensitive therapy should be applied here as well: State the problem and solution at least in terms of the client's own current cultural idiom. The third lesson is that isolated practitioners who are in need of finding other regional colleagues involved in the same, should try and organize a local teaching seminar or workshop given by an outside expert. This will not only enhance these clinicians' own knowledge and skills but will probably also enhance the interest and knowledge of other participating colleagues. Specialists conducting such workshops do well to take heed of Kluft's (1990) discussion of andragogical principles of adult learning.

4) *The need for networking.* Many clinicians beginning to treat MPD patients feel the need for expert guidance and support. This is fortunate, because doing this type of treatment on one's own is very risky indeed. Not only does it take time to discover the right treatment approaches, but it also involves, as a rule, making many treatment errors as one learned by trial and error, some ofwhich are very dangerous indeed. It cannot be stressed enough, that, whatever their general therapeutic experience or expertise is, practitioners beginning to treat MPD patients should find some form of guidance and support. When working in isolation, telephone consultations with a more experienced colleague may be the only alternative. Furthermore, one should do one's utmost to find

more colleagues in the region involved in such treatment or merely interested in the subject matter in order to form a study group and discuss various treatment issues, amongst them issues of transference and countertransference (Kluft, 1990). In North America, the ISSMP&D has been very supportive of such local study groups. Ideally, these study groups should receive consultation or guidance from an expert colleague. If such a person is not available in the region, one should be brought from outside on a less frequent basis, or the group should on occasion travel to him or her. Studying the relevant clinical literature together is, of course, an important adjunctive activity of such groups.

5) *The need for research.* However sound and important North American research on dissociation and MPD has been and is, there will always be voices in the European mental health community who dismiss the results precisely because the studies have been carried out in North America. There is, therefore, a tremendous need to carry out systematic studies in each European country separately (as well as in international collaboration). Auseful first focus might be to study the prevalence and phenomenology of dissociative disorders. The results should not only be published in international professional journals, but also in the national ones. This would enable the national fields of psychiatry and psychology to assimilate the newly acquired knowledge in a gradual and culturally-sensitive manner. (As an ironic aside, it should be added that in the Netherlands, psychiatrists have a tendency to accept new observations and findings from Dutch colleagues only when these are published in American professional journals.) Good examples of such research already carried out in Europe are Boon and Draijer's Dutch study on the reliability and validity of the SCID-D (Boon & Draijer, 1991, 1993a&b), Ensink's study on child sexual abuse and psychiatric symptoms in adult females (Ensink, 1992), and Vanderlinden's studies in Belgium and the Netherlands with the DIS-Q (Vanderlinden, 1993; Vanderlinden, Van Dyck, Vandereycken, &Vertommen, 1993) . Furthermore, the most widely used scale in dissociation research, the DES (Bernstein & Putnam, 1993), is readily available as is the DDIS, another structured diagnostic instrument for the dissociative disorders (Ross, 1989). Important areas for research are diagnosis and treatment of dissociative disorders in children, and systematic outcome studies-still non-existing-with regard to treatment of MPD. In both areas, however, North America, with its longer and more extensive MPD treatment experiences, should take the lead.

CONCLUSION

Although developments in diagnosis and treatment (and even research) of dissociative disorders, in particular MPD, are definitely occurring in Europe, there is a long way to go-in some countries even all the way-before catching up with the state of the art in North America. One impression based on this report is that many European pioneers in diagnosis and treatment of MPD work in isolation, in unsupportive environments, and have little contact with like-minded colleagues. They should be comforted by the fact that many North American experts in the field have been in the same position that they occupy now, and the same applies for a number of Dutch clinicians in more recent times. These pioneers have suffered the same hardships, have met with the same kinds of scorn, skepticism, and resistance from their peers and the mental health establishment, and have had the same limited resources as have their European counterparts in most parts of the region. Many North American experts not only have developed well-established outpatient treatment facilities for MPD, but have also established inpatient units for dissociative disorders, in particular, MPD patients. They have published tremendously on the subject in highly valued professional journals and books (cf. Goettman, Greaves, & Coons, 1991), and quite a number of them are involved in highly significant research. They have succeeded in having MPD accepted by mainstream North American psychiatry, as is shown by its inclusion as a separate diagnostic category in the *D3M-III* in 1980. Furthermore, they have established the International Society for the Study of Multiple Personality and Dissociation (ISSMP&D) , which grew from a handful of originators in 1984 to more than 2600 members in March, 1993. In other words, these colleagues also know from experience that, despite tremendous odds, radical changes for the better are possible. What is needed is not only the accumulation of clinical wisdom and dedication to one's own MPD patients, or local or even national cooperation. There is a strong need for international and intercontinental cooperation.

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