HISTORICAL VERSUS NARRATIVE TRUTH: CLARIFYING THE ROLE OF EXOGENOUS TRAUMA IN THE ETIOLOGY OF MPD AND ITS VARIANTS

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ABSTRACT

The author notes- a current trend toward viewing multiple personality disorder (MPD) and its variants as a form. of chronic post-traumatic stress disorder based solely on exogenous childhood trauma, and cautions against prematurely reductionistic hypotheses. He focuses on Kluft'c Third Etiological Factor, which includes the various developmental, biological, interpersonal, .c iocultural, and Sychod'tflarflic3/laplflginflLeJlces and substrates that determine the form taken by the dissociative defense_ He hypothesizes a credibility continuum of childhood and contemporary memories arising primarily from exogenous trauma at one end, and endogenous trauma (stemming from intrapsychic adaptational needs) at the other. The author offers alternative multidetermined explanations for certain unverified trauma memories that currently are being accepted and validated as factual experiences by many therapists. Ile describes some potentially deleterious effects of validating unverified trauma memories during psychotherapy, and recommends that the MID patients' need for unconditional credibility be responded to in the same manner as other transference-generated productions.

INTRODUCTION

Despite the renaissance and growing acceptance by the mental health profession of multiple personality disorder (MPD) as a distinct clinical syndrome during the present decade, a healthy degree of controversy remains over certain aspects of diagnosis and treatment. For example, some MPD authorities prefer that amnesia be included as a diagnostic criterion for this disorder, while others are concerned this might result in a number of false negative diagnoses in individuals who otherwise fit the descriptive criteria by history and mental status examination (Kluft, Steinberg, & Spitzer, 1988; Ross,1989). From a treatment standpoint, therapeutic pluralism best describes the variety of psychotherapeutic approaches currentlyoffered by clinicians (Kluft, 1988b) .

To date there has been general agreement among authorities, however, regarding the etiology of MPD. Since its introduction in 1984, Kluft's Four-Factor "Theory has provided a useful conceptual framework for understanding the complex origins of this syndrome. Kluft hypothesized that MPD represents the final common pathway of a wide variety of contributing influences interacting in various combinations. Factor 1, a possibly inherited dissociation potential, phenomenologically is seen as a high capacity for autohapnotic trance experiences. Factor 2 comprises life experiences that traumatically overwhelm non-dissociative adaptive ego defense mechanisms. Factor 3 consists of certain shaping influences and substrates that arc thought to determine the form taken by the dissociative defense. Factor 4 is the absence or inadequate provision of soothing, restorative experiences for the traumatized child by significant others (Kluft, 1984).

Factors 1, 2 and 4 have received considerable attention by investigators in the field, who convincingly have demonstrated a link between unrepaired traumatic early life experiences and the development of multiplicity or its variants in the dissociation-prone child. In the process of establishing MPD as a chronic dissociative post-traumatic stress disorder, however, Kluft's third factor appears to have gotten short shrift.

Osier said, "It is much more important to know what sort of patient has a disease than what sort of disease a patient has" (Conners, 1982). Yet in contrast to the rising flood of works being published on the cause-and-effect role of childhood trauma in the creation and perpetuation of disaggregate self states (Kluft, 1988c), there has been a conspicuous drought in the area of studies focusing on dissociation-prone personality development from a biological, genetic, and psychodynamic perspective. With a few exceptions (e.g., Bliss, 1984, 1986, 1988; Ulman & Brothers, 1988; Young,1988a, 1988b; Carlson & Putnam, 1989), the MPD literature remains remarkably barren of papers addressing the influential etiological effects of such inherent mechanisms and potentials as hypnotic trance logic, absorption, imaginative involvement, fantasy-proneness, and other personality traits and characteristics of the highly hypnotizable; or links to object relational concepts such as self- and object-representations, introjection, internalization, identification, projection, projective identification and splitting. Similarly, few have written about such childhood extrinsic influences as experiences of contradictory parental demands (Spiegel, 1986) and reinforced role-playing, or contemporary extrinsic influences such as the audiovisual media and literature,

tactical errors in interview technique, and effects of previous therapy (Kluft, 1984).

The purpose of this paper is to utilize Kluft's third factor as a springboard for exploring the issue of the veracity of adult MPD patient memories of childhood and contetnporarv trauma experiences. In addressing the sensitive issue of patient credibility it is the author's intent to impugn neither the data collected by investigators in the field who believe' most or all MPD patient memories to be factual historical accounts nor the honesty and integrity of N1PD patients and their therapists. Rather it is hoped that by scrutinizing the shaping influences that determine the form that is taken by the dissociative defense and the wax that experience is remembered, this paper will generate lively discussion over current trends in investigative and therapeutic endeavors.

In order to approach the subject thoughtfully, the author first will examine why the credibility issue has heretofore conspicuously been neglected in the MPD literature, and offer a rationale for its current exploration.

THE STRUGGLE FOR SCIENTIFIC CREDIBILITY

The past decade has witnessed an almost exponential increase in the number of published articles on childhood trauma (especially physical and sexual abuse) and its potential causative link to the development of chronic disturbances of object relations and adaptive ego functioning. Many of these works have focused on the dissociative defenses and dissociative states as they are manifested in multiple personality disorder and its variants, producing chronic functional disturbances of memory and identity (Putnam, 1985; Kluft, 1985a, .1985b, 1986, 1987). Some investigators also have begun to study the relationship between child abuse, especially incest, and the development of non-dissociative post-traumatic stress symptoms or severe character pathology, such as borderline and narcissistic personality disorders (Donaldson & Gardner, 1985; Beck & van der Kolk, 1987; Goodwin, 1985b, 1988; Herman, Russell, & Trocki, 1986; Herman & van der Kolk, 1987; Ulnuan & Brothers,1988).

With more accurate reporting of the prevalence of intrafamilial physical and sexual child abuse in the 1970s and 1980s, Freud's repudiation of the seduction theory has been under legitimate fire (Masson, 1984; Bliss, 1988). As Wilbur's case of Sybil (Schreiber, 1973) became widely known publicly in the early 1970s and Allison began reporting on his work with MPD (Allison, 1974; Allison & Schwarz, 1980), the link between child abuse and multiple personality came under the scrutiny of additional investigators and theI-apists studying and treating cases similar to theirs (Putnam, Guroff, Silberman, Barban, & Post_, 1986; Kluft, 1985a) .

From the outset, however, one of the central methodological problems in the scientific investigation of such a link has been difficulty obtaining independent corroboration of the abuse histories. Most studies to date have been retrospective and based on uncorroborated self-reported historical data from diagnosed adult MPD patients (Putnam, 1985; *Tuft,* 1985b; Putnam, 1986; Putnam et al., 1986). Further complicating the picture is the fact that frequently these data have been based on memory material obtained during thcr apist-induced hypnosis or spontaneous autohypnotic trance states. The assumed veracity of memories recovered (luring hypnosis has come under as much legitimate fire as has Freud's repudiation of his seduction hypothesis (e.g., Orne, 1979; Lawrence & Perry, 1988).

More recently investigators have begun to focus on prospective studies in which children who have experienced documented abuse are being screened at regular intervals liar evidence of developing psychopathology, including dissociative syndromes. Preliminary findings are reinforcing; the hypothesis that. dissociation as a defense and/or a state phenomenon is likely to prove much more prevalent in the abused child than in matched controls (Putnam, 1985, 1986, 1989). Additionally, childhood cases ol MPD have been discovered and treated by therapists who more easily are able i etrospectively to confirm fact ual t.t aurna experiences (Fagan & McMahon, 1984; Kluft, 1985b, 1986; Riley & Mead, 1988; Putnam, 1989).

Some investigators have attempted to verify self-reported abuse histories in adult dissociative patients (Schreiber, 1973; Bliss, 1984; Bliss & Bliss, 1985; Ilerman & Schatzow, 1987). Kluft, who made no effort to seek such docunrenta-Lions, nonetheless obtained external corroboration in 15 percent of a cohort of 105 MPD patients he personally treated (Putnam, 1985), and Coons and Milstein (1984, 1986) were able to obtain some type of independent verification of abuse histories in 85%, of a group of 20 MPD patients.

Sufficient evidence has accumulated during the past two decades to savwith some confidence that there is a suspected causal link between traumatic childhood experiences and multiple personality disorder. As vet, however, it has not been *pmven* that childhood trauma causes MPD (Putnam, 1989). Investigators begin to tread on shaky ground when they try to extrapolate on the basis *of* relatively small samples of corroborated abuse data, since there may remain undiscovered additional links in the causal chain *of* influences leading to the common phenomenological presentation of multiplicity. Various biological predispositions, psychodynamic mechanisms, and sociocultural factors may play vet unformulated key roles in the development of a dissociative diathesis.

Herein lies much of the sensitivity surrounding the issue of credibility. From Freud's repudiation of the seduction theory until quite recently, the road to credibility for abused children and adult survivors has been entirely uphill throughout the twentieth century (Goodwin, J985a; Haugaard & Reppucci, 1988; Summit, 1989; Ross, 1989).. Now that society is more willing to air its family secrets and the movement to "believe the children" has gained momentum, there is perhaps a reluctance on the part of those in the vanguard to pause and take a (:loser look at the direction in which the scientific study and treatment of dissociative disorders may be heading.

PATIENT AND THERAPIST SENSITIVITY TO SKEPTICISM

Kluft. (1988c) arbitrarily has defined extremeh complex multiples as (hose having 26 or more alters. As therapists' caseloads of MPD patients rapidly expand due to their improved diagnostic acumen, increasing numbers of these extremely complex multiples are being identified and treated. Many of these recently diagnosed patients are recovering memories during therapy sessions of abuse experiences of such a progressively bizarre and exotic quality and incredible quantity as to test the credulity of even the most empathic and open-minded therapist. The most widely addressed and publicized example of this has been a virtual epidemic of MPD patients reporting childhood and sonrc e satanic cults (Braun & Sachs, 1988; Young, 1988c; I.yons. 1988; Braun, I989a,1989b;Ganaway, 1989a; Johnston, 1989). Some of these patients have appeared on television talk shows (at tunes supported by their therapists) recounting participation in multiple human sacrifices. Members of the Cult Crime Impact Network estimate that if these reports are accur ate, as rnanvas 50,000 human sacrifices a year are being carried out by a nationwide covert network of satanic cults (Price, 1989; Johnston, 1989). Snowden estimates that 25(1 therapists nationwide are working with satanic ritual abuse cases, with one psychologist alone, for example, treating as many as thirty victims on a regular basis (Price, 1989).

Prior to the rise in reported satanic ritual abuse memories, MPD investigators and therapists could more comfortable address patient reports of childhood trauma as being largely fact-based in the light of at least some level of independently corroborated histories in the literature. This is becoming more difficult from a scientific perspective, now, as therapists are enjoined by patients to validate increasingly bizarre memory material.

Now that a theory of traumatic origin has gained a solid foothold in the MPD field, the author has observed a trend toward facile acceptance and expressed validation of uncorroborated trauma memories by therapists who have become sensitized to years of accusations that MPD patients' memories are purely fantasy (Kluft, 1988a; Ganaway, 1989a). In the wake of the current wave of extensive, incredible, often unverifiable abuse accounts, however, therapists who continue to feel compelled to suspend their critical judgment in active support of the veridicality of all of their patients' reconstructed traumatic memories may be placing the MPD field in particular and research on child abuse in general at risk. There is danger of sacrificing what hard-won scientific credibility they have earned in the service of providing what mistakenly may be considered an unequivocal healing experience for the patient. Such assumptions are -mistaken, because it will be shown later in this paper that there may be antitherapeutic consequences of the validation of uncorroborated memory material in MPD patients.

Unless scientifically documented proof is forthcoming, patients and therapists who validate and publicly defend the unsubstantiated veracity of these reports may find themselves developing into a cult of their own, validating each others' belief systems while ignoring (and being ignored by) the scientific and p.syc hotlrerapeutic co mmunity at large.

THE NEED FOR AN ALL-INCLUSIVE THEORY

Circa 1510 Leonardo da Vinci said, "Experience does not err, it is only your judgement that errs in promising itself results which are not caused by your experiments" (Boorstint 1983). More recently, in a plenary presentation at the Third International Conference on Multiple Personality' Dissociative States, Nerniah (1986), acknowledging the important contribution of MPD investigators and therapists in validating a fact-based childhood trauma link in the development of multiplicity, cautioned against letting the theoretical pendulum swing so far away from previous hypotheses as to dismiss established psychoanalytic theory altogether. That, indeed, could result in throwing the baby out with the bath water. lie suggested instead that **MP1)** be considered a product of a mutually potentiating combination of both factual trauma and childhood phase-specific sexual fantasy and conflict. In so doing, Nerniah was one of the first implicitly to urge that Kluft's Factor 3 not be ignored in etiological formulations.

Av-iable new theory not only must successfully incorporate existing theories, hut also must provide a logical and reasonably parsimonious explanation for previously unexplained phenomena. An etiological theory for MPD that relies entirely on fact-based exogenous truuna to account for the development of multiplicity fails to explain related dissociative syndromes for which no exogenous trautna can be identified. For example, such a theory would not. explain the existence of seemingly autonomous alter-like entities in spiritualists and channeler.s without abuse histories, or the MPD-like syndrome seen in alleged victims of UFO alien abduction schemes (Evans, 1987; Klass. 1989; Garraway , 1989a).

In the remainder of this paper the author will examine the aspects ofMuff s Third Etiological Factor that impact on the veracity of MPD patient trauma memories, using his own case material to demonstrate the need for integrating psychodynamic principles with experimental hypnosis findings and sociocultural factors in the ongoing study and treaunent of multiple personality disorder and its variants. Drawing from Muffs outline of the shaping influences and substrates that are hypothesized to determine the form taken by the dissociative defense (Kluft, 1984), the personality features and peculiar characteristics of cognition and memory in the highly hypnotizable individual will be examined. Relevant childhood and contemporary interpersonal and sociocultural influences will be touched upon. Psychodynamic and neurophysiological issues will he explored. Also, using a synthesis of these shaping influences, alternative explanations will be considered to account for the manifest content of certain trauma memories in MPD patients and individuals with related dissociative phenomena. Finally, the potential impact on progress and outcome of different therapeutic approaches to traumatic memory material will be discussed.

THE GRADE FIVE SYNDROME: HYPNOTIZABILITY AND MPD

Bliss (1984, 1986, 1988) *has* postulated that the crux of the syndrome of multiple personality disorder represents an unrecognized abuse of' self-hypnosis. While this may he a gross oversimplification of the syndrome, there remains little doubt. that hypnotizability plats a vital role in the etiology and proliferation of multiplicity (Kluft, 1984; Frischholz, 1985; Bliss, 194, 1986; Putnam. 1985).

Each year in doing consultation clinics for the preconference workshops at he International Conferences on Multiple Personality/Dissociative States, the author continues to be surprised at the number of experienced therapists who have yet to grasp that they are treating patients who in effect are continually moving in and out of hypnotic t[r]ance states, no matter what the therapists' intent may be regarding the use of hypnotic techniques. On one occasion when the author was cautioning that memories recovered in a hypnoid state should he understood as an admixture of fact and confabulatory material, one consultee argued that this could not possibly be the case with her MPD client, as she never used hypnosis in therapy sessions; child alters simply would emerge spontaneously in vivid reenactments of their trauma.

Those familiarwith the characteristics of the most highly hypnotizable individuals recognize that a propensity for spontaneous trance experiences, spontaneous age regressions under hypnosis, and the revivification of memories in the present tense are hallmarks of this somewhat unique group. Spiegel (1974) distinguished this population of high hypnotizahles by labeling them *The (;radeFi Syndrome,* after his schema for measuring what he believes to be a biologically derived continuum of hypnotizability that remains fixed and measurable in adulthood on an arbitrarily-devised scale of 0 to 5. Fives, the most hypnotizable, are relatively uncommon, constituting less than 5 percent of the general population.

Fives, or "highs," *also* share a particular configuration of personality traits or characteristics that may become exaggerated and contribute to their psychopathology when psychological decompensation occurs (Spiegel & Spiegel, 1 978) . There is *a posture of trust in* interpersonal situations desc[r]ibed by Spiegel as "an intense beguilingly innocent expectation of support from others in a somewhat atavistic, prelinguistic mode...that goes beyond reasonable limits to become postured and demanding." This can become a pathological compliance with people in the environment, including the therapist. *Suspension of critical judgement* refers to the readiness to replace current premises and beliefs with new ones without the careful cognitive screening that usually takes place in less hypnotizable persons. This is consistent with another characteristic of this group, *trance logic,* which was originally described by Orne (1959) as the capacity to be unaware of even extreme logical incongruity. Highs have little difficulty with an hypnotically induced hallucination, for example, of the therapist sitting in two different places in the interview room at the same time.

Highs are known *as* well for *an* intense *capacity fin-concentration* or focused attention, and for dissociating as they are doing so. This trait has been obser[r]ed and measured experimentally by others *as absorption.* (Hilgard, 1977). *They* also possess an *excellent memory,* often being able to store and recall especially visual detail in the manner that a sponge absorbs water. Spiegel notes that this learning is usually uncritical and all-inclusive, which is in part explained by the above-noted suspension of critical judgement, as well as by another characteristic of this group: a marked propensity for *ref filiation will new events* with an almost magnetic attraction. Finally, *a fixed personably core is* present underneath what appears on the surface to he this marvelously malleable overlay- so fixed as to be massively resistant to negotiation or change. Spiegel desc[r]ibed examples of clearly demonstrated conversion symptoms in these patients which, although removable under hypnosis, always returned in the waking state. There was so much secondary gain (hidden p.sychodynamicsignificance) in certain symptoms as to make them virtually nonnegotiable in terms ofpermanently breaching the dissociative defense and deprogramming them from the trance logic (Spiegel Sc Spiegel, 1978).

In the first 2 1 /2 years as director of a hospital-based dissociative disorders program, the author personally treated or interviewed in consultation a total of 82 individuals who met DSM-111-R diagnostic criteria for dissociative disorders. Ofthese, 51 (66%) met the criteria for adult MPD. Virtually all of the patients in the MPD group also met Spiegel's criteria for the Grade Five Syndrome. Considerable space has been devoted here to this syndrome of personality char acteristics because of the obvious similarities in the two groups and the implications regarding learning, remembering and relating to others in every day lift as well as in the therapy setting. Before discussing these, however, additional pertinent findings in the experimental hypnosis field will be reviewed.

HYPNOTIZABILITY AND MEMORY

While the excellent rote and eidetic memory demonstrated by Grade Five Syndrome individuals might lead to the hypothesis that memories recovered in trance states by this group would be especially rich, vivid and accurate in detail, formal experiments have demonstrated that this hypothesis is only half right; they are indeed vivid and rich in detail, hut not necessarily accurate. The experimental hypnosis literature is replete with studies clearly demonstrating that it is not possible to distinguish accurate from inaccurate details of hypnotically retrieved memories without independent verification; hypnosis tends to increase "recall" of both (Orne, 1979; Orne, Whitehouse, Dinges, & Orne, 1988; Perry, D'Eon, & Tallant, 1988; Sheehan, 1988a; Laurence & Perry, 1988). Furthermore, virtually even• study that has examined the subjects' confidence in the veracity of their memories has demonstrated that hypnosis increases confidence in the veracity of both correct and incorrect recalled material (Laurence & Perry, 1988; Sheehan, I988b).

Further compounding the risk of inaccuracy of memories in the MPD patient is evidence that high hypnotizables feel more compelled than low hypnotizables to Ellin memory gaps with confabulated fantasies when pressed for details

(Spiegel & Spiegel, 1978; Orne, 1979; Laurence & Perry, 1988). This finding is consistent with the previously described personality traits and characteristics of Grade Fives. H. Spiegel (1978) has described a *cor/wi..dve* triad consisting of compulsive compliance, source anutesia and rationalization that is particularly common in highs and predisposes (liern to respond even in the waking stale to leading questions as if they were suggestions or commands without conscious awareness that t hey are so doing (Ganaway, 1988) . Ile, Ornc (1979) and others have demonstrated experimentally how the formation of an entire beliefs stern with its own set of supporting pseudomemories can he cued by a simple suggestion from the interviewer, and, if not extinguished. could potentially become part of the subject's permanent sense of narrative truth.

These data suggest that MPD patients should be considered at high risk for contamination by pseudomemories in the hands of therapists who unwittingly or not. verbally or otherwise, cue them to respond to the therapists' expectations or needs. Therapists need not be the source of the contamination, however. There is evidence as well that other exogenous sources such as books, movies, or special childhood and adult relationships may provide material that can be assimilated in a dissociated state and later be recalled under hypnosis as original material believed by the subject to be personal experience. The most publicized examples of this have been reincarnation stories elicited during hypnotic age regressions (Laurence & Perry, 1988; Planer, 1988; Young, 1988b).

In such cases as these it reasonably could be hypothesized that the assimilation of the exogenous material in a dissociated state served particular psychodvnamic defensive needs during a window of vulnerability in the subject 's life. Since MPD patients typically have begun to establish a matrix of dissociated self states by early childhood, there would be ample opportunities for the introjection of externally derived "raw materials" into the fabric of the evol'ing internal landscape or "inscape " to flesh out physical characteristics of alters and to fill in gaps irr their experiential histories. The resultant system of alters and the internal world in which they live would then represent the evolution of an admixture of genuine and "borrowed" experiences, further refined and elaborated by the patients' defensive and restitutional fantasies (Young, 1988b).

HYPNOTIZABILITY AND FANTASY-PRONENESS

The association of a robust level of imaginative involvement (the fantasy-prone personality) with high hypnotizability has been known for years (Hilgard,.J., 1965, 1 970;Hilgard, E., 1977; Wilson & Barber, 1983; Zlotogorski, Hahneman, & Wiggs, 1987; LeBaron, Zeltzer, & Fanurik, 1988; Rhue & Lynn, 1989). In the multiple personality disorder patient, however, the role of fantasy in establishing and maintaining the defensive network of alters and the mental matrix in which they reside is just now beginning to be understood and appreciated (Bliss, 1986, 1988; Ulman & Brothers, 1988; Young, 1988a, 1988b).

Considering the pre-operational level of cognitive functioning that exists during the early childhood period when multiplicity is thought to take shape (Piaget, 1962; Phillips, 1975) and the Grade Five personality characteristics of the population at risk for multiplicity, it should be no surprise that rich imaginative involvement plays a key role irr determining the form taken by the dissociative defense. Within the world of trance logic the uniqueness and vastness of the internal system is limited only by the c'eativity and psychocivnamic needs of the const'uctor. Created alters may take the form of children, adolescents or adults of either sex, or not he human at all (Bliss, 1986; Smith, 1989). The author has encountered demons, angels, sages, lobsters, chickens, tigers, a gorilla, a unicorn, and "God" among the alters of MPD patients he has interviewed, to name only a few. The inscalres in which they exist have ranger! from labyrinthine tunnels and mazes to castles in enchanted forests, high-rise office buildings, and even a separate galaxy. One male alter in an adult female multiple described a parallel internal existence with the host personality part since his creation at age 5 during prolonged and well documented father-daurghter incest. The girl had imagined that if she were a boy she would be left alone. In the elaborate world she created inside the mind, the male alter grew up, married, bought a house, drove a pickup, had children, played with them in the snow on the front lawn of their imaginary home, and led an apparently fulfilled life, while the female host through the years continued to lead a constricted and schizoid lifestyle in the real world. Memories of the male alter's experiences were reported as being every bit as eertain and real as the host's.

The above example reinforces Young's (1988b) observation that. the structuralization of fantasy in the formation of alter personalities often ser'es a defensive purpose of mastery and restitution in the wake of genuine trauma.

NARRATIVE TRUTH VERSUS HISTORICAL TRUTH

It is a small but cautious step from Young's (1988h) observations on fantasy to the more controversial position that memories of the actual trauma thought to activate the dissociative defense sometimes may represent illusion, hallucination, or pure fantasy. The intention of the author in taking this step is not to discount the validity of exogenous childhood trauma, but to implore investigators and therapists to maintain good critical judgement when encountering clearly controversial memory material.

The degree to which fantasy is incorporated into the development of dissociative defenses may vary from patient to patient, but can he expected to be present to some degree in every multiple, since it represents one of the basic ingredients necessary to construct the often elaborate inscape, or internal world of alters living by the laws of trance logic. In this regard it is no coincidence to discover that multiplicity appears to have its developmental origins in the preoperational, somewhat primary' process cognitions of early childhood (Kiuft, 1985b, 1986; Riley & Mead, 1988). Fantasy and magical thinking not only are normal and acceptable at this time (Piaget, 1962), but often a preferable alternative to an external environment that by comparison may be perceived

as dull, unstitmdating, and unproviding of narcissistic need gratification (situations of marked deprivation of good enough mothering), or conversely perceived as so pervasively traumatic as to be massively overwhelming to the psyche in a life-threatening sense (situations of severe recurrent physical, sexual and/or emotional abuse with recurrent boundary violations). Many pathological families no doubt mix both of these with capricious overt intrusive nurturing in a confusing and unpredictable manner that creates continuous double bind cognithe distortions (Spiegel,198(i). This clinical picture sets an ideal stage for the use of self-hypnosis, absorption, and imaginative involvement as coping mechanisms of choice.

In guiding the MPD patient through the uncovering of early life experiences and exploring the matrix of the dissociative defense, then, the therapist should he prepared to encounter a mixture *of* fact *and* fantasy. As in psychodynamic psychotherapy with other disorders, the reconstruction of memory is subject to so *much* defensive distortion as to require the label of narrative truth, or psychical reality, as opposed to historical truth, or fact-based reality (Spence, 1982). This particularly holds true for the highly hypnotizable MPD patients, who additionally are vulnerable to distortion effects from intrusive inquiry or iatrogenic dissociation. Kluft (1984) cautions, An a given patient, one may find episodes of photographic recall, confabulation, screen phenomena, confusion between dreams or fantasies and reality, irregular recollection, and willful misrepresentation. One awaits a goodness offit among several limits of data, and often must be satisfied to remain uncertain " (p. 14).

FANTASY, **HALLUCINATION** AND ILLUSION AS **ADAPTATIONAL** AIDS

The manner in which confabulations and distortions of fact-based experiences of perceived trauma develop in MPD and its variants is no less complex and convoluted than the overall incorporation of" fantasy itself in a defensive and restitutive role. It would be a prodigious task well beyond the scope of this paper to tease out the various interwoven extrinsic influences and intrapsychic needs that lead to the resultant perceived experiences that are reported to the therapist. Religious beliefs and sociocultural mores, values and expectations interface with pre-existing perhaps genetically encoded archetypal images to shape the form that the fantasies will take (Stevens, 1982; Hufford, 1982; Kenny. 1986; Evans, 1987; Campbell, 1988; Planer, 1988) . Meanwhile the script for the internal acting out of a given fantasy is being written according to intrapsychic and interpersonal psychological needs.

While this process may be so complex and idiosyncratic as to defy generalizations, in the author's sample of treated dissociative patients, alters associated with fantasied traumatic memories have been observed to be serving two main psychodynamic needs in particular for mastering perceived victimization in the real world. These are: 1) a defensive need to screen intolerable, conflict-ridden, fact-based traumatic experiences from consciousness (e.g., the perpetrator *is a* villainous knight in *a* past-life rape memory rather than a close relative in the present life); and 2) a defensive/ rest.itutive need in the face of overwhelming feelings of badness, guilt, shame and low self esteem following prolonged narcissistic injury. This is done by imparting a grandiose sense of specialness to the created alter or to the otherwise mundane and app rentlv senseless real-life situation (in the above example the alter experiencing the past-life trauma might be a famous historical figure, perhaps a queen, or the special situation might be that the alter undergoes martyr-like victimization in the name of a God-sent mission). The following examples from the author's own case material help to illustrate the variety of ways that fantasy, hallucination, and illusion are used in this manner by the multiple in the course of protecting and preserving the integrity of the dissociative defense matrix to act as a buffer with reality.

Reported traumatic memories considered to be fantasy and/or illusion (which may or may not include int.rojection of extrinsically encountered characters, themes, ideas or entire stories) include: abuse experiences reported by alters claiming to represent pre-incarnations ("past lives"); malevolent. demon possessions by alters claiming to be invading spirits from outside the bode; pre-birth traumata creating intrauterine dissociative splits (there is no anatomical or physiological basis for sentience prior to 20 weeks gestation, and no meaningful EEG pattern *of* electrical activity until roughly 30 weeks [Hall, 19891); and childhood ritual abuse memories of having the heart removed and replaced with an aninral heart while fully conscious.

The author- has encountered contemporary scenarios, as well, that demonstrate the power of the internal system's creative imagination to manufacture simulated trauma through self-hypnosis as a form of psychodynamic resistance to disruption of the dissociative defense during therapy. Consider the following case vignette:

> Ms. A, ail year-old female, urgently telephoned her psychiatrist to report that an internal persecutory alter had just emerged and deeply slashed her vagina with a razor blade, leaving her with profuse hemorrhaging. She was instructed immediately to arrange for assessment and treatment at a nearby hospital emergency room, after which she was admitted to the hospital's psychiatric unit.. On his arrival the psychiatrist was surprised to learn that a careful gynecological examination by the emergency room physician had revealed virtually no evidence of physical injury. During a subsequent interview it was determined that the alter in question had induced a vivid autohypnotic hallucinatory experience in the host in an effort to frighten her into cancelling farther therapy sessions. At a later date the same alter caused the patient to hallucinate a scene of her body covered in blood hanging in the shower stall of her bathroom.

The use of fantasy, hallucination and illusion by the multiple in the psychodynamic formation of screen memories has obvious appeal for its adaptational value, serving to conceal from patient *and* therapist perhaps more prosaic but still less acceptable factual traumatic memory material,

as shown in the next case illustration;

> Sarah, the host alter in a 50 year-old multiple, was shocked when Carrie, a heretofore unknown 5 year-old part spontaneously emerged during a therapy session to relive in vivid detail her participation in a bizarre ritual abuse mass murder on a mountainside not far from her childhood home. After witnessing 12 little girls from her Sunclav school class bound, raped and brutally murdered, this alter, who had been given the number "13," was spared by the cult leader (identified as a member of her church) and was taken to his home and later released.
>
> Following abreaction of this memory the patient looked to her psychiatrist for validation or invalidation of the memories as factual, adding that other alters were telling her that Carrie had many more heinous crimes of this type to reveal. The therapist remained neutral, allowing the patient to explore further her associations to this new material. Two sessions later Sherry, a previously known child alter, spontaneously emerged to confess that, as painful as it was to admit to herself, she had created Carrie to absorb the terror she had felt when her grandmother would read to her murder stories out of detective magazines when babvsitting. While perceiving her smother, father, and sister all as chronically abusive, the patient had revered her grand mother as the only nurturing and protective figure in her childhood. It had been preferable to screen out the unthinkable reality that even her grandmother had been emotionally abusive by ingeniously creating an alter who would remember the crime stories as actual experiences witnessed by or participated in by the patient.

In the above illustration, had the author become focused on and overfascinated by the manifest content of Carrie's abreaction, very possibly both patient and therapist could have been led down a prolonged diversionary path of fictional detective story reenactments, while her grandmother's pristine image was safely preserved. This type of creative resistance may prove more prevalent than MPD therapists would prefer to think, especially in the extremely complex multiple with layered systems of apparently deeper and darker secrets of elaborate criminal abuse activities. It underscores the need for circumspection by the therapist when encountering controversial memory material.

SATANIC RITUAL ABUSE: FACT OR URBAN LEGEND?

At no time is the need for prudence in dealing with traumatic memories more apparent than when treating MPD patients with ritual abuse histories. During the past four years, the author and others working with extremely complex multiples in psychotherapy have been encountering memories of increasingly bizarre and heinous criminal ritual abuse in the context of an alleged vast covert network of highly organized transgenerational satanic cults. (Braun & Sachs, 1988: Young, 1988(; Braun, 1989a, 1989h; Ganaway, 1989a; Johnston, 1989). As many' as 5(1 percent of admissions to a 14-bed specialized dissociative disorders inpatient unit under the direction of the author are arriving with or are uncovering during their hospital stays memories of participation in ritual abuse scenarios in the context of organized cults with satanic overtones. Patients there and elsewhere in North America are reporting vividly detailed memories of cannibalistic revels, and experiences such as being used by cults during adolescence as serial baby breeders to provide untraceable infants for ritual sacrifices (Lyons, 1988; Stratford, 1988; Johnston, 1989; Ganawav, 1989a).

No less than 12 papers were presented at the Sixth International Conference on Multiple Personality/Dissociative States regarding diagnostic and treatment approaches for the MPD patient/ ritually abused cult survivor, as well as an additional full day post-conference workshop devoted exclusively to critical issues in the treatment of satanic ritual abuse. Clearly this has become a very high profile topic and a source of considerable controversy both inside and outside of the field of dissociative disorders.

The crux of the controversy lies not in the question of whether or not these individuals actually are experiencing what. they report to therapists--- the, author consistently has been impressed with the honesty and intensity of their terror, rage, guilt, depression, suicidality, and overall behavioral dysfunction accornpanying the awareness of cult involvement. The question is, rather, to what degree do these vividly recnactec.l experiences represent purely factual accounts of multigenerational cult activities with actual human sacrifices as described, versus fantasy and/or illusion borrowing its core material from literature, movies, 'IA', other patients' accounts or unintentional therapist suggestion?

Many investigators, therapists, and clergymen in the MPD field and elsewhere consider the existence of such criminal cult activity to be proven fact, focusing on the most efficient way to "deprogram" satanic cult survivors (Smith & Pazder, 1980; Stratford, 1988; Kahaner, 1988; Johnston, 1989; Braun, 1989b; Greaves, 1989; Young, 1989). Such a focus, while well-intentioned, may be premature considering the lack of any hard scientific evidence corroborating patient accounts of this type of widespread organized criminal cult activity (Lyons, 1988; Mulhern, 1988; harming, 1989) . In years of coordinated efforts, local, state and federal law enforcement agencies including the FBI Behavioral Sciences Unit have been unable to validate the existence of such cults, let alone document evidence of human sacrifices (Sparry, 1988).

This is not to say that dangerous cults do not exist. Galanter (1989a, 1989h) and others have scientifically documented the existence of and potential for psychological harm and violence within movements such as Moon's Unification Church, the People's Temple, the Children of God, and a host of other highly organized religious, quasi-religious and mystical cults (Evans, 1973; Mulhern, 1988; West, 1988). Relatively small scale criminal activity with self-styled cult overtones has been documented periodically as well, such as the Manson case (Lyons, 1988); the Sellers case

(Dawkins & Higgins, 1989), involving quasi-satanistic influences; and the April, 1989, ritual murders in Matamoros, Mexico, involving a highly distorted adaptation of Santeria and Palo Mayombe.

The documentation of MPI patients' satanic cult involvement is a much thornier issue, however. The very dramatic, widespread, highly consistent vet elusively r.mveriliable nature of these organized .satanic ritual abuse accounts has led some sociologists and social psychologists to categorize them under the rubric, "urban legends" (Lyons, 1988).

There are several possibilities that alone or in combination could explain the phenomenology of MPD satanic ritual abuse accounts, ranging from factual to imagined experiences. These possibilities include:

1. Factually detailed childhood and/or contemporaneous memories of actual transgerrerational organized satanic cult involvement, with real or illusory human sacrificial rituals.

2. Factually detailed childhood and %or contemporaneous memories of actual ritual abuse either by self-styled cultists dabbling in satanism or non-cult abusers wishing to create the *illusion* of an organized satanic cult, with real or illusory sacrifices to ensure compliance, secrecy, and poor credibility on the part of the forced participants.

3. Fantasy, illusion, and hallucination-mediated screen memories in the form of childhood or contemporaneous organized satanic cult involvement, *internally* derived as a part of the defensive and restitutive role of the dissociative network of elaborated alters. Likely to combine an admixture of "borrowed" ideas. characters, symbols, myths, and fictionalized accounts of satanism from exogenous sources with idiosyncratic internal system beliefs. Once activated internally, an entire parallel world of cult characters could then manufacture memories of ritual abuse trauma that would he indistinguishable from factual memories.

4. Same as number 3 above, but *externally* derived contemporaneously as the result of unintentional implantation of suggestion or expectation by a therapist or other perceived authority figure with whom the patient desires a special relationship, interest and/or approval. Once seeded, the internal system of alters would begin to manufacture an elaborate pseudohistorv of ritual abuse memories that may conveniently replace previously unsatisfactory internal explanations for intolerable but more prosaic childhood trauma.

There is as yet no unimpeachable evidence to validate possibilities 1 and 2 (Lyons, 1988; Spray, 1988; Lanning, 1989); neither have they categorically been proven false. Arguments that nearly identical detailed accounts of rituals from many different patients enhance their validity (Hill & Goodwin, 1989; Braun, 1989) are countered by authorities who cite die number of hooks (e.g., *Michelle Remembers and Satan's Underground)* and TV shows currently disseminating these accounts, as well as massive networking among patients and therapists across the country who are sharing detailed information and cross-validating each other's histories (Mulhern, 1988). This media blitz already has reached the point where complex multiples not contaminated with the expectation of finding hidden satanic ritual abuse memories may soon become the exception rather than the rule.

One hears anecdotal reports of patients and some therapists being contacted and even threatened by cult members, as well as claims of the discovery of exogenous cult cues or triggers for suicidal or homicidal pre-prograntrned behaviors planted in greeting cards, letters, tapes, and telephone calls (Braun & Sachs, 1988; Braun. 1989; Young, 1989; Beere, 1989). In such cases an equally plausible explanation must be considered that satanically-oriented alters within the patient or an MPD peer are creating such disturbances as a resistance to progress in therapy, or to validate each other's experiential memories. Over-interpretationsofavailable data on the part of the treaters also must be considered.

Therapists who readily accept exogenous cult programming as a given fact that requires no scientific validation interestingly may he engaging in an evolutionary U-turn in the scientific study of dissociative disorders. By focusing predominantly on external agents (cult cues and triggers) to account for the patient's behavior in a given situation, the therapist is returning to the concept of "psychological causahty." This concept is the common denominator in culturally determined possession states such as *amok* and *latch,* and is defined as "the belief that events occur because someone or something that has become personified has willed its occurrence" (Putnam, 1989).

With respect to this cultural expectation factor, it is interesting to note that little contemporaneous exogenous cult cueing or triggering is observed on the inpatient unit directed by the author, where the nursing staff is instructed to approach cult ritual abuse memories with no greater degree of fascination or precaution than is demonstrated for more prosaic abuse accounts of other patients. Mail and phone calls are not screened; the patient's internal system is expected to monitor its own behavioral responses, and usually does. Yet these patients qualitatively are the same as those who apparently are plagued by alleged external cues in other programs where cult awareness is a priority.

Until further scientific evidence is available to support possibilities 1 or 2 versus 3 or 4, the prudent choice for a given therapist, following the principle of Occam's Razor (Sheaffer, 1986), would he the one that contains the *fewest speculative elements.* For the cognitive-behaviorist, 1 or 2 might seem less speculative, relying on an extrapolation of the demonstrated cause-and-effect relationship between factual trauma and MPD (Ross, 1989). For the psychodynamicist, however, 3 and 4 may be more appealing, as they offer a more parsimonious explanation for those who place a premium on the psychodynamic underpinnings of the phenomenology.

In looking for clues for or against the factual origin of satanic cult memories, it might prove valuable to compare these individuals to another group of alleged serial trauma survivors currently receiving considerable national attention: victims of UFO extraterrestrial abductions.

CLOSE ENCOUNTERS OF THE DISSOCIATIVE KIND

Reports of UFO sightings have been under the scrutiny of goverment and lay investigators for over forty years, but the scientific community still awaits the first shred of hard evidence that we have, in fact, been under the surveillance of extraterrestrial intelligence (Sheaffer, 1986; Klass, 1989).

An interesting epiphenomenon of UFO fascination during the past two decades has been a growing number of published biographical accounts of individuals purporting to have been serially abducted and experimented upon by extraterrestrials (Hopkins, 1981, 1987; Sheaffer, 1986: Strieber, 1987, 1988; Evans, 1987; Klass, 1989; Bird, 1989).

Close examination of these abduction accounts by anyone familiar with the satanic cult ritual abuse memories of complex MPD patients reveals an interesting parallel between the clinical phenomenologies of the two groups. UFO abductees are easily hypnotizable, highly imaginative, and typically uncover their first memories of an abduction experience during hypnotic interrogation by self-proclaimed UFO abduction experts who have been consulted because the subjects have experienced unexplained episodes of missing time coupled with post-traumatic stress symptoms of increased startle response, anxiety attacks, insomnia, depression, guilt, feelings of unsafeness, or of being stalked or monitored (Sheaffer, 1986; Klass, 1989). Typically these individuals have read about. or seen movie or TV accounts of UFC) abductions and, drawn in by an identification with the core dissociative symptoms, seize upon the UFO abduction hypothesis as the only "logical " explanation for their own dissociative experiences (Strieber, 1987, 1988).

During hypnotic interviews these individuals typically provide vivid, detailed accounts of being forcibly taken to a chamber in a spacecraft where they are undressed, fastened to a table, and subjected to a ritual of tissue cutting and/or violations of various orifices of the body by a central alien figure while other figures surround them to observe. Eventually they are returned to earth, but not before being programmed to keep the abduction a secret. Some are able to show previously unexplained scars on the body as alleged proof of their abductions (Sheaffer, 1986; Stricher, 1987; Klass, 1989; Bird, 1989).

During subsequent hypnotic sessions often they will spontaneor)sly age-regress, experiencing revivified memories of serial abductions dating back into early childhood or infancy (Strieber, 1987, 1988). A number of female abductees have uncovered memories of being serially abducted for experimental breeding purposes. They would be impregnated by the extraterrestrials, who later return to kidnap the fetus to use in their experiments. One ofHopkins' (1987) hypnosis interviewees recounted having had as many as nine ova or embryos taken serially between 1977 and 1985. Despite the heinous nature of these crimes, few victims have reported them to legal authorities (Klass, 1989).

Once abductees become aware of these memories. often they begin to experience additional bizarre phenomena resembling florid dissociative pathology, including voices inside the head of alleged extraterrestrials "telepathically" communicating messages, advice or warnings; automatic handwritings and other influences on the body; hallucinated images of aliens (visions); or other strange happenings such as possessions disappearing or magically moving about (Hopkins, 1979, 1987; Strieber, 1987, 1988). Another commonly reported phenomenon is being followed ur harassed by "men in black," mysterious individuals who are thought to be sent by the aliens to warn or threaten abductees that they are not to talk to others about their experiences (Sheaffer, 1986).

Skeptics of these accounts of serial abductions and harassments by "men in black" cite the unscientific methodology used by the self-styled UFO experts who are identifying the hundreds of such cases now sweeping the nation (Sheaf= fen, 1986; Klass, 1989; Bird, 1989). Klass (1989) details the manner- in which Hopkins "advertises" for new cases through his books, particularly- looking for individuals who have experienced repeated episodes of unexplained time losses or distortions, unexplained lesions or scars on the body, mysterious somatic complaints, and other signs and symptoms that would make an excellent checklist for detecting undiagnosed MPD cases. He then screens the hundreds of respondents and selects certain interesting cases to interview under hypnosis, more often than not turning up strikingly similar, heavily detailed "abduction" experiences in individuals who never have met one another. Klass, citing Orne (1979) and others On the validity problem with memories recovered under hypnosis and the high risk of iatrogenic factors in Hopkins' lay hypnosis interview techniques, labels Hopkins the 'Typhoid Mary" of covert 1_)1FO abductions (Klass, 1989).

Evans has studied these and other types of "entity" encounters in depth, and along with Bird (1989) and Sheaffer (1986), suggests that these individuals are having psychological experiences that are accomplishing something that they, for internal reasons, need to have happen (Klass, 1989; Evans, 1987) . The following case example demonstrates how a pre-existing relatively unstructured system of alters may be dynamically influenced by a charismatic authority figure when an individual with a pre-existing dissociative syndrome is in a window of psychological need-vulnerability.

> Salley, a college educated woman in her late 30s, presented in a suicidal state with classical symptoms of MPD. Her score on the Dissociative Experiences Scale was well above 40. She also met DSM-11I-R diagnostic criteria for borderline personality disorder. She reported internal voices belonging to perceived autonomous internal self-states who repeatedly were fighting with her for executive control of the body. When successful, they often were self-defeating or self-harming. She had grown up with harsh, disapproving Christian timdamentalist parents, and had renounced traditional religious dogma at an early age after observing hypocrisy in her church. While attending a private Christian school she became aware of the creation of a number of "false-self' parts of her mind who alternately would role play to meet the demands of her parents and others. Internally, she continued to flounder in the absence of a cohesive sense of identity or an acceptable ontological

belief system.

In her 20s, Salley was attracted by the charismatic leader of a new age UR) cult whose dogma suddenly made sense out of her dissociative experiences. It was explained to her that the various internal parts represented simply cosmic detritus that through cult cotnrnitment would be shed prior to the final harvesting of the chosen Few who would join the leader in another dimension of the universe. Following this epiphany, Sallev s internal system of alters reconfigured to organize around her newfound heliefs. Later while proselytizing lot the cult, she experienced UFO close encounters of the third kind, witnessing spacecraft land and aliens emerge.

This case, and no doubt many others of the hundreds of identified UFO sighting and abduction cases, illustrate the influential impact that trusted authority figures may have on the stntcturalization of fantasy for defensive and restitutive reasons in vulnerable individuals with latent or clinical dissociative disorders.

The similarities are remarkable between accounts of these individuals and accounts of MPD patients who uncover satanic cult ritual abuse memories often under hypnotic interview conditions. Considering the current lack of scientific evidence corroborating either UFO abduction or cult abuse memories, it is not unreasonable to consider that possibility 4, the exogenously seeded manufacture of elaborate screen memories in a need-vulnerable individual, may account for some satanic cult ritual abuse memories.

Once the existing alters are reconfigured to incorporate the cult material (or new systems of alters are created to serve the purpose), the stage is then set for the internal, or sometimes external, acting out of the cult fantasies. This brings fresh meaning to possibly more prosaic childhood trauma experiences that previously were so unsatisfactorily understood (e.g., indiscriminate beatings, rapes, deprivation, or incarcerations) that they begged for better definition. A secondary gain would be the eliciting of the interest, fascination and approval of the therapist/cult abuse expert, who like Hopkins, may eagerly be seeking validation for his or her own idiosyncratic beliefs. In such cases therapy might. be derailed for months (or years) onto a satanic siding, while the original childhood trauma goes unclarified, uncortfronted, and uninterpreted.

Satanic cult deprogramming efforts in the context of confabulated as opposed to factual cult abuse memories conceivably could take on the quality of a Space Invaders video game played by the therapist against the imaginatively manufactured cult system of alters: as one layer of cult cues, triggers or suicidally-programmed alters is neutralized, another layer descends into the field of battle, until either the therapist tires of the game, or the host personality runs out of quarters.

A final comment on the screen memory possibility is in order before leaving the subject. Eventually someone will postulate that because of the uncanny similarities, alien abduction experiences in fact must be screen memories for factual covert satanic ritual abuse. Perhaps so. But in view of the lack of scientific evidence supporting either type of report, using that logic it would have to be considered just as likely that some satanic ritual abuse experiences mat: he screen memories for factual alien abductions.

FURTHER PSYCHODYNAMIC AND NEUROPHYSIOLOGICAL CONSIDERATIONS

Among the various shaping influences and substrates determining the form taken by the dissociative defense. Blurt postulates certain inherent potentials for psvchoclynrnnic dividedness that are tapped by the highly hvpnotizable individual who is experiencingwhat is perceived as overwhelming stress on the developing ego s adaptive capacities (Kluft, 1984). In this category he includes imaginary cornpanionship, the process of introjection, internalization and identification, and along developmental lines, libidinal, narcissistic and object relational considerations.

As noted earlier, Nemiah (1986) has cautioned against altogether discounting the importance of libidinal fantasies in shaping the dissociative diathesis that. results in MPD). Ulman and Brothers (1988), viewing multiplicity from a perspective of self psychology, hypothesize that severe childhood trauma results in the shattering and faulty restoration of archaic narcissistic fantasies. Fink (1988) points out the need for a psychodvnamic theor-y that integrates both narcissistic and libidinal levels of experience in the traumatized patient.

Regardless of theoretical differences among various psvchodynamic schools, accumulating empirical evidence suggests that dissociation sent es both defensive and restorative roles in the traumatically overwhelmed child, with fantasv acting as a vehicle for mastering otherwise untenable life experiences (Young, 1988b; Ulrnan & Brothers, 1988).

No doubt there are many reasons why specific. themes are chosen for development by a patient in shaping fantasybased trauma memories as a means of coping with fact-based trauma. Impinging on the psychodynamic formulation would be aforementioned extrinsic religious, sociocultural and interpersonal (object relational) influences, as well as perhaps neuroanatomical and neurophysiological factors.

Galin (1974)Jaynes (1976), and Sidtis (1986) are among those who have theorized on the implications of left and right cerebral hemisphere specialization with respect to cognitive style; the left for an analytical logical mode, and the right for a holistic Gestalt mode (favoring visual and spatial over verbal cognitive functions, and emotion over logic). Spiegel and Spiegel (1978) note an obvious parallel between the right hemisphere cognitive style and the personality characteristics of highly hypnotizable individuals. Scientists studying cornmissurotomy patients have experimentally demonstrated this striking duality. Gazzaniga suggests that the brain is organized into modules capable of actions, moods, and responses (Revak, 1988). He labels one such left hemisphere module or system the "interpreter," which explains and organizes various independent experiences and behaviors of other modules to provide a subjective illusion of unity. In effect, the left brain absolutely insists on interpreting actions. It demands an explanation for all perceptions, mood changes and behaviors, and if it is not

provided a logical one (as occurs in the commissttrotont5 patient) it literally will make one up to diminish cognitive dissonance (Gazzaniga, 1988).

The psychodynamic implications of such a neurophysiological model may be demonstrated in a hypothetical example of how a pseudohistory of ritual abuse memories might develop in a dissociative patient. Consider the fantasy= prone highly hypnotizable child who lives in the setting of a dvsfitnctional family and is constantly being subjected to double binding cognitive distortions and boundary violations (Spiegel, 1986) , leading to mobilization of the dissociative defense. With increased fragmentation and compartmentalization of strongly affect-laden experiences and increasingly bizarre and paralogical right-brain mediated dissociative phenomena occurring in the context of trance logic, the left brain interpreter finds itself having to confabulate a logical explanation fur illogical, senseless experiences that the right brain is willing to accept without critical judgement. Various primitive internal right brain images and externally• derived religious and sociocultural influences are then drawn upon in the left brain's confabulatory process that eventually results in a new set of memories that become part of the patients narrative truth (Jaynes, 197(i). Psychodynanrically. the need is present in the pre-operationally thinking child to ascribe some higher, or at least more logical, meaning to a confusing dichotomy of events and personae he or she witnesses. for example, in the hands of a caretaker. abuser relative. The father who appears to be the pillar of Christian morality and ethics by day may inflict upon the child senseless pain, suffering anti{ humiliation typified by no less than Satan himself when abusing her in the darkness of night (Gan away, 1989a). The structuraliz.ation of the fan tasy into a satanic ritual abuse scenario with a clear-cut good versus evil distinction would provide the needed logical explanation for confusing experiences, as well as serving a restorative function by allowing the child to experience the grandiose belief that she is, in fact, enduring the suffering not because she simply is bad or defective, but because she is special - perhaps being groomed to become a high priestess some day.

Regardless of how heinous the confabulated ritual abuse experiences may be, they are more tolerable to the patient than having his or het fact-based experiences go frustratingly unexplained.

Another psychodvnamic factor in this scenario Wright be the patient's counter-phobic need repeatedly to endure and survive in fantasy progressively more life-threatening traumatic experiences in an attempt to convince herself that she can master and survive the equally frightening, albeit mundane, traumas of the real world. Secondary gain also may come from stimulated release of endogenous opioids through repeated internal or external reenactment of progressively more severe trauma fantasies (so-called "trauma addiction "), with the patient having become desensitized to the level of endogenous opioids stimulated by more prosaic factual trauma (van der Kolk, 1989).

The adaptive role of fantasy-based screen memories is worth mentioning here again, as well. The MPD patient is able to build so convincing a set of diversionary pseudomemories as to keep both unsuspecting patient and overfascinated therapist busy for weeks or months sorting them out and working them through, while the more conflictual fact-based trauma may remain safely screened.

Finally. object relational concepts may play an important role not only in the choice and timing of' fantasies. but in the insatiable need to be believed that. is seen itu this patient population.

Working in therapy on an outpatient and inpatient basis with a number of high and lower functioning MPD patients, the author consistently has observed certain recurrent t-artsfererue/countertransference paradigms that appear to correspond to expected internal object relations units in victims of childhood trauma (Ganaway, 1989h). The two that concern us here are represented by; 1) the rescued, safe, nurtured, protected, and believed child .sell-representation affectively connected by love and devotion to the in trojected "good parent" object-representation who unconditionally meets all of these needs; and 2) the victimized, disbelieved, ignored, abandoned, discounted, betrayed child self-representation affectively connected by a mixture of depression, rage, disappointment. mistrust, fear, guilt, shame and self-blame to an abuse-enabler internal object-representation (often the neglectful "non-abusive" parent) who failed to intervene in the trauma scenario. The latter object relations unit usually reflects the patient's perceived childhood reality, while the former represents the fantasied wish for what ideally could have been.

Through the defense mechanism of projective identification (Ogden, 1982, 1989) both the idealized parent and the unwanted abuse-enabler object-representations at varying times are projected into the therapist with the intention that these roles will he acted out by the therapist under the unconscious control and direction of the patient..

Experienced MPI) therapists are aware of these patients' excessive neediness and proneness to push limits and violate boundaries in the therapy setting (Greaves, 1988; Chu, 1988). Often this is in the service of acting out in a repetition compulsion the pathological but comfortably familiar disturbed early childhood relationships. The expectation of abuse and the fantasy of unconditional, unlimited acceptance and caretaking invariably are reflected in the transference.

In this context, the need to be believed can be seen as more than just the realistic expectation that the therapist will work with the patient to uncover and process the patient's experiential truth; it becomes a core aspect of the repetition compulsion to re-enact the traumatic relationship between the victim and the abuse-enabler. Starting out with the unrealistic wish for unconditional credibility, the patient may find him- or herself in an ever-increasing spiral of therapist-testing to see what it will take finally to provoke the expected rejection and disbelief that will replicate the original relationship and justify the unacceptable feelings of rage and betrayal that properly should be directed to the original abuse-enabler. Should the therapist agree to become the container for the projections, the trap has been set. What follows may be a series of, IT you believed that, then will you believe this?" questions to the point of therapist incredulity

and morbid patient. satisfaction that the expected betrayal and disappointment finally has occurred.

As noted earlier, the MPD patient is especially skilled in the adaptive use of Iantasyunconsciously to meet defensive needs. If the above scenario of projective identification is not recognized by the therapist as another manifestation of the patient's pathological acting out in the transference of early object relations disturbances, there may be a risk of catalyzing increased production of confabnlatoiy historical material to fuel the repetition compulsion.

Other object relations disturbances as well may he acted out in the transference. The self blaming patient who as a child tried earnestly to please and win approval of the feared abuser in a vain effort to master her own victimization (Spiegel, 198(i) may act out this relationship in the transference by dutifully and agonizingly reenacting one lengthy abuse scene after another in therapy sessions, believing this is what the therapist wants and needs. The manifest content of die reenacted factual trauma experiences might he reconfigured and redressed by the use of unconscious fantasy to fit whatever theme appears to fascinate the therapist most.

TREATMENT IMPLICATIONS IN THE CONTEXT OF UNCORROBORATED TRAUMA MEMORIES

Despite the growing trend toward treating multiple personality and its variants purely as a subtype of post-traumatic stress disorder, the evidence presented irl this paper supports a broader treatment approach incorporating traditional psychodvnamic psychotherapy that focuses on the developmentally dependent overall adaptive ego functioning of the individual rather than solely on the syndrome itself. The jury is still out on the question of what components of multiplicity belong on DSM-111-R Axis I and what components are more compatible with an Axis II diagnosis. Very possibly there someday may be recognized a "Dissociative Character Disorder" in addition to a disaggregate self state (Kluft, 1988c) Axis I diagnosis that would integrate the developmental dynamics and phenomenology of borderline and narcissistic personality disorders with traits of high hypnotizability, fantasy-proneness, and other characteristics of Spiegel's Grade Five Syndrome (it is interesting to note the considerable overlap of the two on comparison). In one recent study, no significant differences were found between mean scale MMPI scores of 10 MPD patients and 10 BPD patients (Kemp, Gilvertson, & Torern, 1988).

Therapy of particularly the more complex MPD patients often addresses concomitant serious character pathology, in particular borderline defense mechanisms such as primitive denial, projective identification, borderline-type splitting, primitive idealization, devaluation, and omnipotence. Boundary issues must be consistently addressed. Langs' (1982) concept of secure-frame therapy is useful in stressing the importance of maintaining firm limits and good boundaries during the psychotherapy of MPD patients. The need for constant monitoring of limit and boundary issues is well documented in the literature (Greaves, 1988; Chu, 1988; Kluft, 1988c) and is born out of an awareness of the marked disturbances in the normal development of early object relations, a consequence of the severely dysfunctional, traumatizing family system that fails to provide stimulus barriers and restorative experiences (Kluft's Etiological Factors 2 and 4).

Maintaining a neutral therapeutic stance on the veracity of uncorroborated trauma memories is one of the many ground rules necessary for maintaining a secure therapy frame with this patient population, no less important than other limit and boundary issues. The patient ultimately must reinternalize the insatiable need for external validation (in the same manner as other transference wishes for restate, protection and nurturing) in order to work through the mistrust of her own perceptions and memories until finally reaching a level of self-validation that will give her a sense of rnastcty over what once was a lragmeirted internal world o1 interwoven fact, fantasy, and illusion. At some point during the process it will he crucial to focus on the original object of the fantasied wish to be unconditionally believed and work through the feelings of rage, betrayal, disappointment, self-doubt. and invalidation that fin- so long have been displaced onto safer objects.

The therapist who agrees to take from the patient the responsibility for believing or disbelieving the historical truth other memories runs the same risk as the therapist who agrees to take on the total responsibility for keeping an ambivalently suicidal patient alive. Once the therapist_ has made that verbal commitment, it frees up the patient internally to be wholly for death, and a resultant power struggle ensues. Similar power struggles may occur when the therapist agrees to validate unverified meurorics as anything more than the patient's own narrative truth. This frees the patient to *disbelieve all* of her own trauma experiences, which then unconsciously may be acted out as described earlier by testing the limits of the therapist's credulity with fantasy-based accounts of increasingly incredible trauma memories until the therapist either interprets the defensive maneuver or finally is provoked into verbally discrediting the patient. The reverse process likewise may occur if the therapist presents an actively skeptical stance. Neutrality proves to be the most therapeutic approach, then, in the absence of independent corroboration of facts.

Fenichel (1954) described a somewhat similar psychodynamic mechanism in explaining pscudologia f;nt.ast.ica as a means of facilitating repression or denial. If a patient's prevarications are believed by another person, then what is known to he untrue seems real and believable. If what is untrue seems true, then that which seems true might be untrue. In this way, more prosaic factual exogenous trauma memories may be dismissed as imaginary.

No matter how compelling seems the need to validate every traumatic memory in the service of promoting a healing experience, it must he kept in mind that the patient has on the deepest level, deeper than the transference wish to be believed, protected, and nurtured, entered into a therapeutic alliance with the good faith and expectation that the therapist always will remain firmly grounded in reality, and will help the patient carefully sift through the mixture of fact, fantasy and illusion, eventually to settle on what the patient must decide is his or her final truth.

Klt.di (1988c) endorses this viewpoint. in his observations on the treatment of extremely complex MPD. In terventions he considers contraindicated on the basis of adverse expected responses include, "the expression of fascination, surprise, excitcrnerrt, dismay, belief, disbelief, or the voicing of any opinion that could cause the alters to feel a need to demonstrate their authenticity" (p. 53).

It remains to he determined if there are different subgroups of child and adult multiples that beg definition and possibly warrant different treatment approaches. Such a typology might include perhaps a population of multiples whose dissociative symptoms and experiential memories arise exclusively as a response to factual (exogenous) trauma (Type I) ; another whose symptoms stem entirely from fantasied (endogenous) trauma (Type II) ; and a third consisting of an admixture of the two ('Type 111). The author predicts that a "credibility continuum" for MPI) eyerrtua.tlIv will be defined that will range from purely factual memories to purely° fictional, with the majority of multiples demonstrating some combination of fact-based childhood/adult trauma experiences and fantasy-derived defensive and/or restitutive screen memories incorporating symbolism, condensation, displacement, and other mental mechanisms similar to those operational in the formation of dreams. At least one investigator has noted the marked similarity between the inner world of alter personalities and dream content (Mariner, 1980).

SUMMARY

Kluft's Four-Factor Theory of Etiology- has yet to be improved upon as an all-inclusive explanation for the development of multiple personality and its variants. In outlining his four factors, he respects the complexity of the dissociative defense and expresses his understanding that multiple personality is the final pathway of a wide variety of combinations of influences (Kluft, 1984) .

The author has focused on Factor 3, Kluft's list of various shaping influences and substrates that determine the form that will be taken by the dissociative defense in the development of MPD, as a useful conceptual framework within which the sensitive and somewhat controversial topic of the veracity of trauma memories has been explored. Clearly there is much investigation yet to be done in this area, and predictably it will require a multidisciplinary approach in view of the complex interplay among psychobiological, developmental, psychodynamic, interpersonal, situational, religious, and sociocultural influences that ultimately determine the phenomenological presentation and natural history of the disorder in a given individual.

Some potentially deleterious effects of validating unverified trauma memories during the psychotherapy of MPD and its variants have been described, and recommendations made for treating the patient's credibility concerns in the same manner as other transference-generated productions. It has been the purpose of this paper to provoke lively discussion and to stimulate further research into the intrinsic and extrinsic shaping influences and substrates that remain largely unexplored yet vitally important keys to unraveling the dissociative conundrum. ■

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