The Relationship Between Dissociation and Object-Relations Impairment in Adult Female Incest Survivor Clients with and without Personality Splitting

Linda Jean Stuppy
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Andrews University

Department of Educational and Counseling Psychology

THE RELATIONSHIP BETWEEN DISSOCIATION AND OBJECT-RELATIONS IMPAIRMENT IN ADULT FEMALE INCEST SURVIVOR CLIENTS WITH AND WITHOUT PERSONALITY SPLITTING

A Dissertation

Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Linda Jean Stuppy

March 1996
THE RELATIONSHIP BETWEEN DISSOCIATION AND OBJECT-RELATIONS IMPAIRMENT IN ADULT FEMALE INCEST SURVIVOR CLIENTS WITH AND WITHOUT PERSONALITY SPLITTING

A dissertation presented in partial fulfillment of the requirements for the degree Doctor of Philosophy

by

Linda J Stuppy

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ABSTRACT

THE RELATIONSHIP BETWEEN DISSOCIATION AND OBJECT-RELATIONS IMPAIRMENT IN ADULT FEMALE INCEST SURVIVOR CLIENTS WITH AND WITHOUT PERSONALITY SPLITTING

by

Linda Jean Stuppy

Chair: Jimmy Kijai
ABSTRACT OF GRADUATE STUDENT RESEARCH

Dissertation

Andrews University

School of Education

Title: THE RELATIONSHIP BETWEEN DISSOCIATION AND OBJECT-RELATIONS IMPAIRMENT IN ADULT FEMALE INCEST SURVIVOR CLIENTS WITH AND WITHOUT PERSONALITY SPLITTING

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Date completed: December 1995

Problem

Childhood incest appears to play a role in the formation of Dissociative Identity Disorder (DID) (formerly Multiple Personality Disorder). This study investigated whether a relationship exists between dissociation and object-relations impairment in incest survivors and whether DID incest survivors have higher levels of these characteristics than non-DID incest survivors.
Method

The Dissociative Experience Scale, Bell Object Relations Reality Testing Inventory and Childhood Maltreatment Interview Schedule-Short Form were completed by a sample of 60 adult female incest survivor clients, 29 who met the diagnosis for DID and 31 who did not.

The Results

All three hypotheses were supported at a .05 level. A significant relationship between dissociation and object-relations impairment was found. The DID group reported significantly higher levels of dissociation and object-relations impairment than the non-DID group and higher incidences of childhood maltreatment and adult traumas. A discriminant analysis found that DID clients can be differentiated from non-DID clients based on dissociative experiences and object-relations scores. The DID group consistently reported higher incidences of childhood maltreatment, psychological abuse, and adult traumatization than the non-DID group.

Conclusions

The findings support an object-relations model for incest and suggest that personality splitting found in DID clients may be related to a developmental arrest in early-life intrapsychic splitting mechanisms described by Kernberg (1966, 1975, 1976) and others. It is possible that therapists may serve as "transitional objects" for incest survivors with object-relations deficits. Past research has viewed incest as leading to a variety of PTSD symptoms, however some effects, especially personality splitting, may originate even before the incest occurs when very young children are exposed to harsh or psychologically overwhelming situations.
To

The incest survivors who participated in this study,
their therapists, and to Dr. Cornelia Wilbur,
who inspired me in my early work with
DID clients

My doctoral committee for their mentoring and guidance,
and my family and friends who provided emotional
support along the way.
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CHAPTER I

INTRODUCTION

One of the first documented case studies of multiple personality disorder was in 1646 (as cited in Bliss, 1980). It involved a woman who was unaware of an alter personality who stole her money. In 1789, at the beginning of the French Revolution, a 20-year-old German woman was reported as suddenly being able to "exchange" her personality for the manners and ways of a French woman. As a German, she knew nothing of her French personality (cited in Ellenberger, 1970). Since then, a number of other cases of multiple personality disorder have been reported in the literature (Ellenberger, 1970; Schreiber, 1973; Smith, 1989; Taylor & Martin, 1944; Thigpen and Cleckley, 1950).

During the past several years multiple personality disorder (MPD) has been diagnosed and treated with increasing frequency in North America. MPD was not recognized as a separate diagnostic entity by the American Psychiatric Association until 1980 (DSM-III). That same year George Greaves published a review article entitled "Multiple Personality: 165 Years After Mary Reynolds" and within 18 months received requests for more than 5,000 copies from more than 55 countries (Greaves, 1993, chap. 3). In 1984, the "International Society for the Study of Multiple Personality Disorder and Dissociation" held its first conference in Chicago.

Despite the resurgence of interest in MPD, there remains a great deal of controversy over its legitimacy as a diagnosis. Ross (1989) noted that "multiple personality disorder is not a transient aberration, peculiar to 20th-century North America.... The fragmentation of self and the transformation of identity have been recognized by all races" (p. 9). MPD is a complex chronic dissociative disorder. What distinguishes it
from other psychiatric conditions is the ongoing coexistence of relatively consistent but alternating separate identities, plus recurrent episodes of memory distortion, and/or frank amnesia (Kluft, 1987).

In 1994, the name for "multiple personality disorder" was changed to "dissociative identity disorder" (DID) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychological Association [APA], 1994, pp. 484-491). The criteria for this disorder include:

1. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self)

2. At least two of these identities or personality states recurrently taking control of the person's behavior

3. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness

4. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behavior during alcohol intoxication) or a general medical condition (e.g., complex partial seizures). (In children, the symptoms are not attributable to imaginary playmates or other fantasy play.)

Although the term "multiple personality disorder" has been used for over 100 years to describe this disorder, for the sake of continuity, the term "dissociative identity disorder" (DID) was used in this study. The term DID refers to MPD in the historical literature and was used to operationalize the disorder according to DSM-IV (APA, 1994) criteria.

A number of theories have been advanced regarding the etiology of this disorder. Most contemporary writers agree that DID appears to be the result of severe and
repetitive childhood trauma, particularly sexual and physical abuse (Braun, 1986; Kluft & Fine, 1993; Putnam, 1989; Ross, 1989; Spiegel, 1993). Judith Herman (1992) in her book *Trauma and Recovery* stated that “the ordinary response to atrocities is to banish them from consciousness” (p. 1). This may explain, in part, not only why survivors of such abuse try to relegate memories of abuse to their unconscious but why there has been a great deal of skepticism regarding DID in North America. This is in spite of a significant increase in the diagnosis and treatment of this disorder in recent years (Ross, 1989).

Although sexual abuse, especially incest, is the most frequently reported type of childhood trauma in the histories of DID patients (Putnam, Guroff, Silberman, Barban, & Post, 1986; Saltman & Solomon, 1982), there has been little overlap in the literature on DID and the literature on adult survivors of incest without personality splitting. The literature on DID over the past 15 years has mainly focused on case studies, theoretical articles on etiology, diagnosis, treatment, neurophysiology, professional skepticism, forensic issues, and other characteristics of the disorder. The literature on incest survivors without personality splitting has focused primarily on long-term effects and treatment.

There have been important similarities in some of the long-term effects found in adults with DID and incest survivors without personality splitting. Survivors in both groups have been seen as frequently experiencing posttraumatic stress disorder symptoms (PTSD) (Browne & Finkelhor, 1986; Finkelhor, 1990; Putnam, 1989). Spiegel (1993, p. 125) described DID as a “posttraumatic multiple personality disorder,” noting the high prevalence of repeated childhood trauma, particularly physical and sexual abuse (as high as 90%) in patients with DID.

PTSD symptoms found in sexual abuse survivors both with and without personality splitting include: flashbacks, nightmares, numbing, a sense of estrangement.
dissociative detachment and out-of-body experiences, daydreaming or fantasizing during the abuse, somatic complaints, nervousness, depression, anxiety, and poor sleep (Courtois, 1988; Eth & Pynoos, 1985; Figley, 1985; Fink, 1992; Goodwin, 1988; Kluft, 1987; Lindberg & Distad, 1985).

Dissociation, a prominent PTSD symptom and psychophysiological defense mechanism found in individuals with DID and incest survivors in general, involves a "disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment" (DSM-IV, APA, 1994, p. 477). Dissociation has been reported for over 100 years in the DID literature and in the past 12 years in the general incest literature (Chu & Dill, 1990; Ellenberger, 1970; Gelinas, 1983; Janet, 1889).

Another long-term traumatic effect of early-life incest, which has not received much attention in the research literature, is object-relations impairment. Melanie Klein (1933) first began writing about object-relations theory in the 1930s. Object-relations theory is particularly useful in understanding psychiatric disturbances like dissociation and personality disorders. Within object-relations theory, the psychic structures of the mind are thought to evolve out of human interactions rather than out of biologically derived tensions (Cashdan, 1988). Object-relations impairment deals with the structural and dynamic relationship between the self-representations of the mind and object representations (based on other people) and how this process can become developmentally arrested (Mandel, 1986). Putnam (1989) appears to have indirectly referred to object-relations impairment in regard to DID when he noted that the dissociative process is receiving attention as a model for understanding the impact of trauma on such crucial developmental tasks as the consolidation of a sense of self.

Object-relations and self-psychologist theorists have always been concerned with the development of the self (Fairbairn, 1941; Kernberg, 1966, 1975, 1976; Klein, 1933; Kohut, 1971; Mahler, Pine, & Bergman, 1975; Winnicott, 1971). Object-relations
theorists differ somewhat on how the process of splitting occurs, and how intrapsychic mental structures come to be built up within the personality. It is conceptually possible that dissociation could lead to an arrest (an overuse of the splitting process) and an interruption of the general identification and internalization process required to form a singular, stable, and cohesive sense of self.

In the literature on DID, dissociation has been theoretically linked to object-relations impairment in DID adults by Confer and Ables (1983). In their review of various etiological explanations for DID, they referred to Kohut (1971), a self psychologist, and other theorists like Kernberg (1976) and Gruenewald (1978) in providing an object-relations conceptual frame of reference for explaining the development of alter personalities in DID clients. Confer and Ables (1983) suggest that having an internalized object world of part identities is what distinguishes DID clients from schizophrenic clients.

Rationale

The impact of incest has been widely documented in both clinical and non-clinical populations. Many believe there is a relationship between incest and the pathological use of dissociation in adult incest survivors. The increased interest in dissociation is reflected by the dramatic increase in publications on this topic in recent years. While there were only 36 publications on dissociation between 1971 and 1980, there were 407 between 1981 and 1992 (Goettman, Greaves, & Coons, 1994).

There are others who also see a relationship between incest and object-relations impairment in adult incest survivors. Although dissociation has been linked to child sexual abuse, physical abuse, and other traumatic events for over 100 years (Janet, 1889), the relationship between incest and object-relations has been less clear.
There are a number of case studies, theoretical articles, and anecdotal references in the literature that seem to support the idea that incest leads to increased dissociation in adults. This appears to be especially true for individuals with DID. Goddard (1926), for example, who treated a woman with DID, appears to be one of the first to document a DID patient's report of incest in a case study. Although Goddard considered the patient's report of sexual abuse a hallucination, numerous case studies, articles, and books have documented the presence of incest in histories of individuals diagnosed with DID (Braun & Sachs, 1985; Kluft, 1985; McElroy, 1992; Ross & Norton, 1995; Schreiber, 1973).

In five major studies, including more than 1,000 DID patients, it was found that at least 80% of these patients had experienced sexual abuse in addition to physical abuse (Braun, 1984b; Braun & Gray, 1986; Putnam et al., 1986; Schultz, Kluft, & Braun, 1986; Schultz, Braun, & Kluft, 1989). Other studies have also emerged that examine the relationship between childhood sexual abuse and dissociation in general (Anderson, Yasenik, & Ross, 1993; Chu & Dill, 1990; Coons, Cole, Pellow, & Milstein, 1990; Kirby, Chu, & Dill, 1993; Strick & Wilcoxon, 1991). Since the mid-1980s there also appears to be an emerging body of empirical research that addresses the relationship between incest and object-relations impairment (Frank, 1992; Katz, 1989; Mandel, 1986; Nifakis, 1990; Panucci, 1992/1993; Riederle, 1994; Sexton, 1994; Silbert, 1992/1993; Taylor, 1990; Wieder, 1985).

In contrast to the number of articles and books in the literature that have reported on a history of incest in adults who dissociate, the literature has been quite limited in regard to case studies that report on object-relations impairment in adult incest survivors. Although there are some anecdotal references to object-relations impairment in some case studies, an article by Kaufman, Peck, and Tagiuri (1954) appears to be one of the first to...
speculate on a possible relationship between incest and object-relations impairment. Empirical research on both dissociation and object-relations impairment has been hampered by the absence of standardized and reliable instruments to measure these constructs until the mid-1980s. The concepts of dissociation and object-relations impairment, as well as constructs like "splitting," have also been difficult to operationally define.

In examining the literature on incest, dissociation, and object-relations impairment, there appear to be no empirical studies that examine the relationship between dissociation and object-relations impairment in adult incest survivors except for three small scale studies by Alpher (1991, 1992a, 1992b). Some object-relations theorists starting with Klein (1933), and various DID writers, have theorized about the role that splitting might play in early childhood development and may shed some light on our understanding of the long-term effects of incest. It appears, based on the literature, that adequate object-relations development, including an integrated ego and sense of self, is at the center of a healthy psychological life. If such object-relations development is compromised through various early-life adverse or traumatic events, of which incest may be one, then it is possible that this study may shed some light not only on the relationship between dissociation and object-relations impairment in adult incest survivors, but also on why some adult incest survivors develop personality splitting while others do not.

Statement of the Problem

The problem this study addresses is the possible influence that childhood sexual abuse, especially incest, has on levels of dissociation and object-relations impairment in adult survivors with and without personality splitting. Although not a primary focus of this study, an effort was also made to examine how DID incest survivors and non-DID incest survivors differ on various childhood maltreatment variables and adult traumatic
Purpose of Study

The purpose of this study was threefold and was designed to investigate: (1) if there is a relationship between dissociation and object-relations impairment in adult female incest survivor clients diagnosed with DID (personality splitting) and those not diagnosed with DID (no overt personality splitting); (2) if there is a significant difference between adult female incest survivor clients diagnosed with DID and those not diagnosed with DID on a measure of dissociation; and (3) if there is a significant difference between adult female incest survivor clients diagnosed with DID and not diagnosed with DID on a measure of object-relations impairment.

In addition, seven childhood maltreatment factors developed by Briere (1992), in the Child Maltreatment Interview Schedule--Short Form (CMIS-SF), were analyzed to determine if variables other than the incest experience were present more in incest survivors with DID than incest survivors without personality splitting. The seven childhood maltreatment factors included: (1) parental substance abuse, (2) parental domestic violence, (3) parental physical abuse, (4) sexual abuse (kissing and fondling), (5) sexual abuse (intercourse), (6) parental psychological unavailability, and (7) parental psychological abuse. Although not considered clinically as important in the development of later life psychiatric problems and difficulties in interpersonal functioning, six adult traumatic factors identified by Briere were also analyzed. These included: (1) rape or sexual assault, (2) being beaten or battered in a sexual or romantic relationship, (3) being physically attacked by a non-sexual partner, (4) combat exposure, (5) being exposed to a life-threatening event or being in fear of having a physical injury, and (6) observing someone being assaulted, injured, or killed. In addition to the childhood maltreatment and adult traumatic factors, the age at which abuses occurred, the
characteristics of the abusers, and the characteristics of the abuses were also examined.

Theoretical Framework

A theoretical framework for this study was proposed on the basis of object-relations theory and the role that dissociation appears to play in an abuse/trauma model. Object-relations theory is built on the premise that young children will identify with external "objects" in their life (usually important people) and will then internalize these objects to form internal representations that serve as a template for forming a stable, cohesive sense of self and identity (Kernberg, 1966, 1975, 1976).

While the sense of self that is formed from this process appears to have unity, including a single stream of consciousness, more recent object-relations theorists, like Cashdan (1988), have suggested that the self consists of a group of complex intrapsychic representations made up of multiple objects. As a result, while an individual may have a subjective sense of being one person, the person may display different characteristics, personality traits, moods, and behaviors in different situations.

Confer and Abels (1983) described this phenomenon as it relates to DID as a dissociated "sub-system" in which alter personalities are created at a very early age in life. Gruenewald (1978) has suggested that such personality fragments may become overt and function somewhat autonomously. Benner and Evans (1984) have suggested that disunified states of co-consciousness may characterize all persons. According to Watkins and Watkins (1990) everyone has "ego states"; however, in DID, the barriers between these ego states are less permeable. Although alter personalities in DID individuals usually seem to be patterned after real or fantasized people, the literature has suggested they can also be patterned after non-human personality components (Smith, 1989) or even animals (Hendrickson, McCarty, & Goodwin, 1990). Price (1987) has also
described situations in which hidden ego states emerged in therapy, displayed some behavioral control in the course of hypnotherapy, or were responsible for some of the presenting symptomatology.

The question arises, why do adults with DID have such a fragmented sense of self in which alter personality states seem to have histories of their own, display characteristic personality traits, and alternately take some control over the conscious experience of the person's main or "host" personality? This host personality, in classic cases of DID, is usually amnesic for experiences that occur when the alter personalities are "out" and "switching" takes place. Individuals with less classic cases of DID (Kluft, 1991), or "pseudomultiplicity" (Alarcon, 1990), may have some degree of "co-consciousness" during the switching process. Co-consciousness can also occur from personality integration as a result of treatment (Kluft, 1988b).

The reason why some incest survivors develop DID and why some do not may relate to the early-life environment of the child when a subjective sense of self is developing. An infant who is chronically bombarded by overstimulating life experiences, including physical abuse and sexual abuse, and/or a harsh or frightening environment, may find that the intrapsychic defense mechanism of "splitting" becomes overused and arrested (St. Clair, 1986). Individuals with DID do not develop a subjective sense of a singular "self" and will even at times refer to themselves as "we" if they are aware of their identity fragmentation. Instead of becoming integrated, the personality remains undifferentiated and pluralistic.

Individuals with DID often identify with reality-based "objects" (people) in their external environment. Ganaway (1989) and Terr (1991) suggest that the personality states found in DID are often the result of exogenous factors, like traumatic events and endogenous factors like self-hypnosis and creatively escaping the traumatic events.
Young (1988) and others have commented on the use of fantasy in the
development of DID. Even normal children under stress, who do not develop DID,
appear to have a greater tendency to dichotomize feelings (Harter, 1977) and may
compartmentalize experiences both intellectually and emotionally. In DID clients this
normal maturational process of trying to psychically organize experiences appears to be
fixed.

While dissociation appears to peak during childhood (Morgan & Hilgard, 1973),
trauma appears to enhance and preserve into adulthood a child's normal capacity to
dissociate (Frischholz, 1985; Putnam, 1989; Spiegel, 1984). If a child experiences
repeated traumatic, overwhelming, or over-stimulating events at a very young age, the
child may begin to retreat from his or her contact with others by dissociating more. This
dissociative response, which seems to fall on a continuum (Bernstein & Putnam, 1986),
can be induced spontaneously in traumatic or other stressful situations, and if used
extensively, appears to be no longer under the control of the person (Spiegel, 1993).
Events that would ordinarily be connected in consciousness are divided from one another
(Hilgard, 1986). Individuals who dissociate regularly because of trauma, appear to have
alterations in behavior, affect, senses, and knowledge (BASK Model), which in extreme
cases can lead to DID (Braun, 1988a, 1988b).

The development of DID may also relate to the issue of pain. Dissociation may be
used not only to ward off unpleasant memories but may be used to reduce the perception
of pain during acute trauma. Many victims, according to Spiegel (1993), report a strange
kind of unreality about the traumatic experience. This alteration may be transient, or may
lead to an ongoing rupture in self-integration, ranging from episodes of depersonalization,
psychogenic fugue states, amnesia, and, in extreme cases, to DID. Nash, Lynn, and
Givens (1984) found that subjects who have been physically abused in childhood have
higher hypnotizability scores (a feature associated with dissociation) compared to
nonabused subjects. This conditioned response has been compared in DID patients to self-induced hypnosis (Bliss, 1984).

Some have suggested that DID individuals may have more of an innate capacity to dissociate. Chu and Dill (1990), however, found in adult psychiatric patients that those with early-life sexual abuse histories dissociate more as adults than those with physical abuse histories. Although studies like this one need to be replicated, there appears to be some emerging evidence in the literature that childhood abuse, including both physical and sexual abuse, may lead to a pathological over-use of dissociation.

The formation of alter personalities appears to have its onset during a circumscribed window of experiences occurring in childhood (Putnam, 1989; Stern, 1984). Although dissociation appears to occur in adults who have been traumatized, for example, in combat situations (Branscomb, 1991; Bremner, Southwick, Brett, Rosenheck, & Charney, 1992). DID does not usually appear in adulthood unless a person has already demonstrated a history of forming alter personalities in early childhood. McDougle and Southwick (1990) reported on the emergence of an alter personality in adulthood in a person with combat-related PTSD; however, early-life trauma and splitting had not been ruled out with this person.

It has been hypothesized in this study that DID develops when very early-life trauma, in the form of abuse, neglect, or a harsh, overstimulating and/or frightening environment, leads to a chronic overwhelming state of affairs in infancy. As a result, the intrapsychic mechanism of splitting is overused. Splitting appears to serve as a way to order early-life events by keeping apart conflicting or contradictory feelings to protect the ego or to defend against overwhelming psychological and physically painful events.

Although disunified states of consciousness may be typical of all children during infancy, this process appears to become arrested and accentuated in those who develop
DID. Continued abuse, traumatic events, or a harsh environment can be expected to result in continued dissociation and a splitting off of and encapsulation of experiences so they can be managed and tolerated. A secondary process of repression then comes into play in which unpleasant memories are forgotten. Over time this can lead to a maturational inability to synthesize later life experiences (St. Clair, 1986). The person will continue to feel overwhelmed, dissociate, and relegate painful or unpleasant experiences to alter personality states. Over time this pattern can become quite entrenched and result in personality fragmentation. In some individuals the formation of new alter personality states may continue into adulthood.

It is also possible that continued sexual abuse, physical abuse, and other childhood maltreatment factors like neglect or psychological abuse will lead to so much dissociation that the object-relations process that depends on the introjection and identification with important people (objects) will become further impaired. As a result, adults who have learned to habitually dissociate or split off painful or unpleasant emotional events can be expected to dissociate more as adults and have more problems with object-based interpersonal relationships, reality testing, general coping, and identity.

Although object-relations impairment may manifest itself in various ways in adulthood, Bell (1970, 1991, 1994) has suggested that problems in interpersonal relationships and reality testing may be specific outcomes of such impairment. Because individuals with DID appear, based on the literature, to have been more traumatized sexually and in other ways than incest survivors without personality splitting, it is likely that they would spend more time in dissociated states as adults than non-DID incest survivors.

Because dissociative states appear to be characterized by withdrawal and flight into fantasy, it is also expected that DID individuals as adults would have a poorer grasp on
reality. Interpersonal relationships, in general, could be expected to be more impaired in DID adults since the development of healthy object-relations in adulthood seems to depend on the formation of stable self-representations acquired during the first year or two of life. Such stable self-representations appear to serve as a template for guiding adult interpersonal relationships and a more stable sense of reality and self.

DID adults, who can be expected to dissociate more than adult incest survivors without personality splitting, will continue to have deficits in their relationships with others. Such impaired object-relations in DID adults would appear to represent a maturational inability to assimilate new life experiences within a unified personality. Although incest survivors without DID may manifest higher levels of dissociative experiences and object-relations impairment, due to their incest, than individuals with no incest history, it was expected in this study that they would demonstrate significantly lower levels of dissociation and object-relations impairment than DID incest survivors because of less maltreatment during childhood.

**Hypotheses**

Hypothesis 1: There will be a positive relationship between scores of dissociation and object-relations impairment in adult female incest survivors with and without personality splitting. It is hypothesized that there will be a positive correlation between scores on the Dissociative Experience Scale (DES) and the Bell Object Relations and Reality Testing Inventory (BORRTI) in both groups in this study.

Hypothesis 2: There will be a difference between adult female incest survivors diagnosed with DID (splitting) and those not diagnosed with DID (no overt splitting) on the Dissociative Experiences Scale (DES).

Hypothesis 3: There will be a difference between adult female incest survivors diagnosed with DID (splitting) and those not diagnosed with DID (no overt splitting) on
the Bell Object Relations Reality Testing Inventory (BORRTI).

Significance of the Study

Theoretically, this study appears to be important because it addresses the relationship between dissociation and object-relations impairment in adult female incest survivors, especially those with DID. Although it is unclear at the present time whether personality splitting occurs on a "continuum" in incest survivors, it is hoped this study will begin to enhance our understanding of this phenomenon. From an etiological perspective, it may also add to our understanding of the role that sexual abuse, physical abuse, and other maltreatment factors play in the formation of DID and some of the other long-term negative effects experienced by adult incest survivors who do not have personality splitting.

Since theory frequently guides practice, this study may be important in determining what types of treatment strategies might be most effective with DID incest survivors and incest survivors who may demonstrate more subtle forms of dissociative symptomatology and object-relations impairment. Individuals with DID who present for treatment are frequently misdiagnosed and often spend a number of years in treatment settings before being correctly diagnosed. In the past, even when the disorder is diagnosed, several years of treatment are frequently needed before symptoms can be reduced or eliminated.

Although the focus of treatment for DID and other incest survivors in the past has often been on resolving past traumas through abreaction and catharsis, this study may be important in expanding our understanding of the role of the therapist as a "transitional object" for the client. It may be necessary for DID clients to identify with various individuals, including the therapist, to enhance ego strength and a more stable sense of self before abractions can be tolerated by the client or integration can occur. Even
though clinicians experienced in working with DID clients have long realized the important role that the therapeutic relationship plays in treatment, the concepts of introjection, identification, and ego identity described by Kernberg (1966) and other object-relations theorists have rarely been addressed in the DID literature.

This study is also important since more research is needed to ferret out the relationship between incest and other predisposing factors as these factors relate to adult psychopathology. Although incest has been commonly regarded as "traumatic" in nature, there may be other types of childhood abuse or environmental factors prior to, during, or after the incest that have led to the chronic and often deleterious effects found in adult survivors.

**Definition of Terms**

**Alter personality:** "Any personality, or personality fragment other than the host personality" (Braun, 1986, p. xiii).

**Co-consciousness:** "The state of being aware of the thoughts or consciousness of another personality. It can be unidirectional or bidirectional, with, or without co-presence, and with or without an influence of one upon another" (Braun, 1986, p. xiv).

**Dissociation:** A "disruption" in the usually integrated functions of consciousness, memory, identity, or perception of the environment (DSM-IV, APA, 1994, p. 477).

**Host personality:** "The personality that has executive control of the body for the greatest percentage of time during a given period" (Braun, 1986, p. xiii).

**Incest:** Any self-reported sexual contact (ranging from fondling to intercourse) between a child before the age of 17 with a person who would be considered an ineligible partner because of his/her blood relationship and/or social ties (i.e., father, stepfather, grandfathers, uncles, siblings, cousins, in-laws, and what we call "quasi-family" [i.e.,
mother's sexual partner living in the home]).

**Integration**: "The process of bringing together the separate thought processes (personalities and fragments) and maintaining them as one" (Braun, 1986, p. xiv-xv).

**Objects**: The "objects" in object-relations are human beings. To quote Kernberg, "The term 'object' in object-relations theory should more properly be 'human object' since it reflects the traditional use of the term for . . . relations with others" (St. Clair, 1986, p. 58). "These relations may be internal or external, fantasized or real, but they essentially center around interactions with other human beings" (Cashdan, 1988, p. 3).

**Object-relations**: "The structural and dynamic relationship between the self-representations and the object representations. Object-relations develop in a hierarchical manner, with earlier, more primitive levels serving as the foundation for later, more advanced levels" (Mandel, 1986, p. 17).

**Representation**: Refers to "how the person has or possesses an object; that is, how the person psychically represents an object" (St. Clair, 1986, p. 5).

**Self**: Occupies a different level of conceptualization than does the term 'ego'. An observer cannot see the ego directly, since it is an abstract concept that exists only in psychology books. The ego is conceptualized as an organizer of psychic functions and can be observed in the manifestation of such functions as thinking, judging, integrating, and the like. Self is used in several senses - - most broadly, as the whole subject in contrast to the surrounding world of objects. The self is our basic experience of who we are (St. Clair, 1986, p. 9).

**Self representation**: Refers to "the mental expression of the self as it is experienced in relationship with the objects or significant persons in the child's environment" (St. Clair, 1986, p. 6).
Splitting: One of several psychic mechanisms to which both object-relations theory and self psychology call attention. This mechanism includes both normal developmental processes as well as defensive life experiences. Infants make use of splitting to help order chaotic early life experiences. . . Thus early splitting refers to the maturational inability to synthesize incompatible experiences into a whole (St. Clair. 1986, p. 10).

In this study, when used in reference to DID, it means "the creation of a new entity by the splitting off or coalescing of energy which forms the nucleus of a separate personality or fragment" (Braun, 1986, p. xiv).

Switching: "Going back and forth between already existing personalities or 'fragments'. Switching may be precipitated by external or internal stimuli" (Braun, 1986, p. xiv).

Delimitations

A delimitation of this study was that only female clients who were at least 18 years old were considered for inclusion as research subjects. All subjects had a prior history of incest occurring before age 17, and met the diagnostic criteria for incest defined earlier in this chapter. Male incest survivors were not included due to anticipated difficulties in obtaining adult male incest survivors from an outpatient population. Greaves (1980) has found, for example, that adult male DID incest survivors are more likely to be found in prison settings rather than in outpatient treatment settings. Ross and Norton (1989), however, have reported few differences in the clinical characteristics of men and women with DID.

Another delimitation of this study was that all incest survivors were outpatient clients and lived primarily in southern Michigan and in northern Indiana. Clients were recruited by networking with therapists working with DID and non-DID clients at a variety of private practices, agencies, and university-based counseling centers. Another delimitation was that all research participants were volunteers.
Limitations

This study has been limited by the voluntary nature of the sample. The characteristics of individuals who agreed to volunteer may differ significantly from the characteristics of individuals who might not choose to participate.

A second limitation involves the absence of a matched control group. As a result, inferences from this research may be more difficult to make than if a matched control group had been utilized. It is possible that factors in the treatment settings themselves have had an effect on the outcome of the results rather than the variable of splitting.

A third limitation of this study has to do with the size of the sample. Although DID is more common than formerly believed in treatment settings, it is not as common as a number of other psychiatric disorders. As a result, it was not possible to gather data on a large sample of clients. In order to obtain the number of DID clients who did participate, an effort was made to network with therapists outside of the Kalamazoo area who treat DID clients and non-DID clients. As a result, this was a regional study conducted in the Midwest, with the results less generalizable to incest survivors living in other parts of the country.

A fourth limitation is that for practical reasons only female incest survivor clients participated in this study. Although some preliminary studies on DID suggest there are very few differences between males and females in this diagnostic group (Ross, 1989), caution should be taken in generalizing the results to male incest survivors.

A fifth limitation affecting the generalizability of this study involves the racial composition of the sample, which included primarily Caucasians. Only 10% of the sample consisted of minorities, making it inadvisable to generalize the results of this study to non-Caucasians or other ethnic groups.
CHAPTER II

REVIEW OF THE LITERATURE

Long-Term Effects of Sexual Abuse

Childhood sexual abuse has been viewed from a posttraumatic stress disorder framework since Breuer and Freud (1893-1895/1955) published Studies on Hysteria in 1895. Janet, a contemporary of Freud working with patients in France, came up with a conclusion that was strikingly similar to Freud's in 1889—that hysteria was caused by psychological trauma.

Janet (1889) felt that unbearable emotional reactions to traumatic events produced altered states of consciousness, which he called "dissociation" and which Breuer and Freud (1893-1895/1955) called "double consciousness." Both Freud and Janet felt that the somatic symptoms found in patients with hysteria represented disguised representations of traumatic events that were no longer remembered. Both recognized the important role of abreaction in the treatment of hysteria and that hysterical symptoms could be lifted when retrieved memories were brought into consciousness.

Although Freud originally felt that childhood sexual abuse played a prominent role in the development of hysteria, he eventually abandoned his "seduction theory." Freud stated in a report titled The Aetiology of Hysteria (1896/1962):

I therefore put forward the thesis that at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience, occurrences which belong to the earliest years of childhood, but which can be reproduced through the work of psychoanalysis in spite of the intervening decades. (p. 203)

Because of Freud's later retraction of his seduction theory in which he attributed memories of adult survivors of sexual abuse to fantasy and not factual occurrences, only a
limited number of psychoanalytic articles have addressed the issue of incest (Wolf & Alpert, 1991).

Rosenfeld (1977) reported that the attitudes about incest began to change around the late 1960s for two reasons: (1) the alarming number of reports of childhood sexual abuse being reported to child-protection agencies when this action became mandated; and (2) a number of psychiatrists in widely separate geographic areas who began to notice that incest was not a rarity among their patient populations.

The women's movement in the 1970s began to focus attention on the reality of incest especially among adult female survivors (Courtois, 1979; Meiselman, 1978). The attitudes that had prevailed in the research literature, that incest was not particularly damaging psychologically, began to be dispelled. The following literature review describes a number of studies that address many of the long-term effects of incest found in adult female survivors.

Benward and Densen-Gerber (1975) interviewed a sample of 118 females with a history of drug abuse. They found the occurrence of incestuous experiences to be of sufficient frequency to suggest that incest could be a factor leading to the development of antisocial behavior.

Courtois (1979) looked at a sample of adult female incest survivors who were volunteers and not part of a clinical group. She found that the impact of incest in this group was highly subjective and not too predictable. Younger victims seemed to have more severe reactions involving personal identity and relationship problems with men. Women who sought therapy had more severe reactions than women who did not.

Tsai, Feldman-Summers, and Edgar (1979) studied three groups with 30 women in each group: a clinical group seeking therapy for childhood sexual molestation, a nonclinical group of women who were molested but never sought treatment, and a control
group. Findings indicated that the clinical group was significantly less well adjusted than either of the other two groups on measures of psychosocial functioning and the MMPI.

A study by Simari and Baskin (1982), which looked at the issue of sexual orientation, found that only a small percentage of the 29 female lesbian incest survivors had been homosexual before the incestuous experience, whereas almost all the 54 male homosexual incest victims had identified themselves as actively homosexual prior to the incestuous experience. They concluded that turning to homosexuality as an escape is more likely to be the exception than the rule, but that it may be more likely to be used as a coping defense mechanism in an individual whose own sexual orientation is not firmly established.

Prostitution has also been found to be a long-term effect of incest. Silbert and Pines (1981), in studying 200 juvenile and adult street prostitutes, found two-thirds were sexually abused by father figures. Self-harm is another characteristic described in the literature as a long-term effect of incest. In a clinical sample of 45 female paternal incest victims, ranging from 7-38 years old, 58% said they had engaged in self-injurious behavior (DeYoung, 1982).

Ruch and Chandler (1982) found in a sample of 408 female adult rape victims, child rape victims, and child incest victims, that the incest victims were the most severely traumatized of these three groups.

Other studies on incest in the 1980s further refuted the previously held notion that incest does not lead to long-term negative consequences in adult female survivors. In a questionnaire administered to 952 female and male college students, Fritz, Stoll, and Wagner (1981) found more negative consequences of molestation in females than males. Herman and Hirschman (1981) found that in 40 women who had experienced father-daughter incest 35% had been involved in alcohol or drug abuse, and that the group as a
whole had a higher rate of suicide attempts and adolescent pregnancy than a group of 20 women whose fathers had been seductive but not overtly incestuous.

Moving from the general denial of the damaging long-term effects of incest found in the literature prior to the 1970s, the research on incest seemed to move full circle in the 1980s. While studies in the 1970s and early 1980s seemed to document a number of different negative long-term consequences of incest, the majority of studies in the 1980s began to see incest as a very traumatic experience. Based on the PTSD model, a variety of negative and serious symptoms were reported in the literature and were assumed to be caused by the incest experience.

Emslie and Rosenfeld (1983) studied a group of 65 children and adolescents hospitalized for psychiatric problems. Although their study did not look at adult survivors, it may have implications for understanding the later effects of incest on adults. They found that 38% of the nonpsychotic female subjects, 10% of the psychotic girls, and about 8% of all boys had incest histories. They concluded that psychological pathology serious enough to warrant hospitalization may not be a simple effect of incest itself but is a consequence of severe family disorganization.

Gelinas (1983) in a summary of 10 major studies on incest found the following to be the most frequent long-term effects: sexual dysfunction, difficulties with sexual contact, periods of promiscuity or prostitution, running away, and increased risk of adolescent pregnancy. She was also one of the first in a review article to report dissociation as a characteristic in adult survivors of sexual abuse and to see a relationship between sexual abuse, dissociation, and DID.

Henderson (1983), in trying to make some conclusions about whether incest is harmful, reported that due to the absence of well-controlled studies, it was difficult to separate out the effects of incest from other highly correlated variables such as low level
of parental education, low family income, poor child-rearing practices, and a high degree of family disorganization. Van Buskirk and Cole (1983) also found in their study of eight females seeking treatment for incest that these women were non-assertive, had difficulty with relationships, and described fathers who were cold, domineering, self-centered, and exploitive.

Sedney and Brooks (1984), in surveying a nonclinical population of college women, found that 16% of the 301 in the sample reported childhood sexual experiences. Although the adults who had been victims of abuse were indistinguishable from their peers demographically, they reported greater symptoms of depression, anxiety, and self-abusive behavior. Women whose experiences occurred within the family were at greater risk for disturbance than women whose experiences occurred outside the family.

A prevalence study of 2,019 men and women ages 15 and over in Great Britain by Baker and Duncan (1985) reported that 51% felt harmed by their sexual abuse and only 4% reported that it had improved the quality of their life. Jehu, Gazan, and Klassen (1985) listed problems with dissociation, depersonalization, and derealization in 12 out of 22 adult female survivors of sexual abuse. These women also experienced problems with nightmares, anxiety/phobic disorders, obsessions, compulsions, interpersonal problems, various sexual problems, low self-esteem, guilt, and depression.

Lindberg and Distad (1985), in studying a clinical population of 17 women who had experienced incest, also found evidence of multiple symptoms suggesting an incest trauma model. These included intrusive imagery, feelings of detachment, constricted affect, sleep disturbance, guilt, and intensification of symptoms when exposed to events resembling the incest trauma. Similar PTSD symptomatology and/or a high level of psychiatric symptomatology were found by a number of other researchers in the late 1980s and early 1990s (Alexander & Lupfer, 1987; Blume, 1990; Briere, 1988; Briere &
Brunngraber (1986) in studying the short-term and long-term effects of sexual abuse found through interviews with 21 adult, female, paternal incest survivors that on a short-term basis they experienced emotional, social, physical, familial, and interpersonal difficulties. On a long-term basis, Brunngraber concluded that they also experienced more difficulties in their relationships with men and sexuality. Herman, Russell, and Trocki (1986) studied two groups of adult women with histories of incest: a non-clinical sample and an outpatient sample. Women who had suffered forceful, prolonged, or highly intrusive sexual abuse, or who had been abused by their father or stepfather, reported the most long-lasting negative effects.

Browne and Finkelhor (1986) found that the most common long-term effects of childhood sexual abuse were depression and self-destructiveness. Other long-term effects included symptoms of anxiety, isolation, stigmatization, negative self-concept, negative self-esteem, substance abuse, and various effects on social functioning. Finkelhor (1990) noted that while the PTSD model seems to adequately explain some of the long-term effects found in adult incest survivors, it does not account for all symptoms. Schetky (1990, chap. 3) has noted that in determining the source of trauma in incest studies, it is very important to distinguish between the sexual abuse and traumatic events that may have occurred prior to, during, or after the sexual abuse. Briere (1992) has found that there is some preliminary research that suggests that sexual abuse effects usually
remain when one controls for other forms of maltreatment (Briere & Runtz, 1990; Swett, Surrey, & Cohen, 1990).

Sexual adjustment after incest was examined by Westerlund (1987). A variety of maladjustment areas were identified in a sample of 43 volunteer participants. Some of the problems identified were: distorted body image, body hatred and devaluation, and estrangement from the body including detachment and dissociation. Other problems cited were: celibacy in some participants, sexual aversion and inhibition, compulsions, the absence of fantasy, sexual desire difficulties, and problems with orgasm.

A study on the long-term effects of sibling incest on four adult female clients between the ages of 20 and 29 by Daie, Wilztum, and Eleff (1989) suggested that these clients had lasting difficulties in establishing and maintaining close relationships, especially sexual ones. Feinauer (1989) found that the most devastating effects, based on the clinical records of 350 women who had experienced incest by a variety of relatives, friends, and strangers, were related to being abused by a trusted person.

Rew (1989) found that female survivors experience more low self-esteem problems, PTSD symptoms, depression, suicidal attempts, and drug and alcohol abuse than nonincest survivors. Tamura (1989) found that survivors had more problems with fear, depression, low self-esteem, guilt, self-blame, locus of control, impulse control, and other problems such as non-assertiveness, psychosocial disturbances, and dissociative experiences. She concluded, however, that the link between childhood sexual abuse and later maladaptive behavior is not as conclusive as researchers would like it to be.

Lewin (1991) collected data on 90 incest survivors. She found that subjects reported an average of 14 symptoms. Lewin has suggested based on her study that a "Post Incest Syndrome" be developed as a separate diagnostic category. Sheldrick (1991) found that the long-term effects of incest can be classified as: emotional/psychological, sexual, interpersonal, or social. Sheldrick noted, however, like Finkelhor (1990), that specific
etiological factors will need to be ferreted out in future research on incest. Walker (1994) noted that not all adult incest survivors will experience the same impact from the same type of abuse.

Calam and Slade (1989) saw an association with unwanted sexual experiences in a group of 130 female undergraduates. This study, which investigated the relationship between physical and sexual abuse, found that unwanted sexual experience forced on women as children might be related to the development of eating disorders in some women. Esposito (1990) also investigated the relationship between incest and eating-disordered behavior. An outpatient sample was drawn consisting of 22 incest survivors and 27 non-incest survivors. Results indicated that there was a significantly higher degree of eating disordered behavior in the incest survivor group compared to the non-incest survivor group.

Since around 1983, clinicians have been reporting another type of child abuse, which is referred to as ritual abuse. Ritual abuse includes not only sexual and physical abuse, but systematized methods of thought control, brainwashing, and intimidation. Victims are sometimes forced to perpetuate violence and sexual abuse on other victims.

Bensinger (1990) found in comparing 53 adult women reporting ritual abuse and 49 reporting only sexual abuse that ritual abuse survivors reported more severe symptomatology and report much more severe types of abusive experiences than those who were only sexually abused. The ritual abuse survivors as a group scored significantly higher on measures of PTSD, dissociative phenomena, and self-attribution of blame.

Although various articles on incest have referred for some time to dissociation as a long-term effect of childhood sexual abuse, it has been only since the late 1980s that some empirical studies have emerged that examined this effect.
Briere and Runtz (1987) found that 44% of women seeking services at a crisis center reported a history of childhood sexual abuse. Out of 152 teenage and adult women studied, dissociation was found among a number of long-term effects. They noted at that time the lack of empirical studies examining this issue. Briere (1988), in examining the long-term clinical correlates of childhood sexual victimization, found in a sample of 195 female clients also seeking services at a crisis center that at least 68% of these women had a history of sexual abuse compared to 32% who had not been abused. Briere found that sexual intercourse and possibly concomitant physical abuse specifically was associated with later dissociation and suicidality.

Chu and Dill (1990) studied 98 female psychiatric patients in which 63% of the subjects reported physical and/or sexual abuse. In general, subjects with a history of childhood abuse reported higher levels of dissociative symptoms than those who did not. The results, however, might be somewhat skewed in that patients who were psychotic or highly agitated were excluded from the study because of issues relating to informed consent. Strick and Wilcoxon (1991), in comparing dissociative symptoms in women in outpatient therapy with and without histories of incest, found using the DES that the incest survivor group had significantly higher scores. Even when subjects in the study were matched by diagnostic category and age, the DES scores remained significantly higher for the incest survivor group. Kirby et al. (1993) found that adults with 10 or more physical and sexual abuse experiences as children scored significantly higher in dissociation than those survivors experiencing less than 10 experiences.

Vanderlaan (1992) administered the DES to 75 female adults receiving outpatient treatment for incest. In a post hoc analysis, Vanderlaan found a relationship between the following factors and higher DES scores: an older age when the incest stopped, a greater number of different types of incest experiences, an earlier age when physical abuse
began, and a greater number of different types of physical abuse.

Sablatura (1991/1993) also found dissociation as a long-term effect of childhood sexual abuse in a sample of 346 undergraduates who were given a questionnaire. Subjects who were sexually abused reported significantly higher levels of depression, dissociation, sleep disturbance, psychophysiological symptoms associated with anxiety, and PTSD symptoms than women with no childhood sexual abuse histories.

In the late 1980s and 1990s some research on the long-term effects of incest began to focus more on the relationship between incest and various psychiatric symptoms, disorders, and the need, in some cases, for hospitalization. Stone, Unwin, Beacham, and Swenson (1988) studied four patient samples with respect to a past history of incest, and found 216 with a diagnosis of borderline personality disorder according to DSM-III (APA, 1980) criteria. The results of this study seem to suggest that the experience of incest may be especially common among hospitalized patients with borderline personality disorder.

Craine, Henson, Colliver, and MacLean (1988) in another study on hospitalized patients found that 51% of a sample of 105 female state-hospital patients had been sexually abused as children or adolescents. The long-term effects of childhood sexual abuse seemed to be so persistent and pervasive that Scott (1992) noted that a history of childhood sexual assault significantly increases an individual's odds of developing eight psychiatric disorders in adulthood. This epidemiological study of 3,131 individuals over the age of 18 years estimated that 3.9% of all psychiatric cases within the population can be attributed to a history of childhood sexual abuse.

Murphy et al. (1988) randomly surveyed 391 adult incest survivors who were sexually abused in childhood before the age of 18, nonvictims, and adults victimized by sexual assault. They found that the incest group had significantly higher levels of psychological distress than nonvictims and adult sexual assault victims.
Steiger and Zanko (1990) compared women with eating disorders with normal women and women with heterogeneous psychiatric problems. They found that the incidence of past sexual abuse was quite similar for binge eaters and other psychiatrically disturbed females. Steiger and Zanko concluded that childhood sexual abuse does not appear associated with women who develop anorexia nervosa, but admitted that the latter group might be more concealing in their reports of childhood sexual abuse.

In looking at the issue of intrafamilial sexual abuse, Jackson, Calhoun, Amick, Maddever, and Habif (1990) found that in comparing 22 young women, ages 18-33, who had experienced intrafamilial sexual abuse, with 18 women who had reported no abuse, that those in the incest group had lower levels of sexual satisfaction and self-esteem, distorted body images, as well as greater depression. The researchers cautioned, however, that the effects may be related not only to the incest experience itself, but to the general family environment in which the incest occurred.

The issue of increased vulnerability to further sexual victimization was studied by Wisniewski (1989). In doing a path analysis of a variety of long-term effects, Wisniewski found among a sample of 3,187 women enrolled in 32 institutions that a model including incest and/or multiple victimization had the greatest explanatory value. A history of family violence also seemed related to harmful aftereffects. A 1990 study by Briere and Runtz found that while psychological abuse seemed related to low self-esteem and physical abuse to aggression, sexual abuse seemed related to maladaptive sexual behavior in adult survivors.

Greenwald and Leitenberg (1990) sent questionnaires to 1,500 female nurses to estimate the prevalence of PTSD in a non-clinical and non-student sample who had been sexually abused as children. They found in the 54 incest survivors who responded that there appeared to be a lower percentage in this group of those who met DSM-III-R (1987) criteria for PTSD than what has been found in clinical samples of incest survivors. The
severity of PTSD symptomatology in this group was greatest in the case of father-daughter incest and if sexual intercourse had taken place or been attempted. Tharinger (1990) noted that incest survivors have long-term problems that are not typically seen as reflecting PTSD, like sexualized behaviors, hypersexuality, sexual maladjustment, and heightened sexuality.

Ego development was investigated along with PTSD by Titus (1991) in adult female and male incest survivors. Titus examined these effects in female and male incest and physical abuse survivors being treated at three mental health centers. Titus found that no one sexual abuse variable or family of origin variable studied was able to predict the level of ego development in adult survivors. Titus did find, however, that subjects who had experienced both sexual and physical abuse were more likely to have lower ego development than subjects who had just experienced sexual abuse.

Whetsell (1990/1991) found in her sample of 99 adult females in treatment for childhood sexual abuse that they reported more severe sexual abuse than had been reported in many previous studies. The sexual abuse lasted longer, occurred more frequently, began at an earlier age, and was more likely to be done by a primary caretaker. Whetsell also found that the presence of force during the sexual abuse experience significantly predicted anxiety, dissociation, and somatization. Cahill et al. (1991) found that women who have been sexually abused in childhood have emotional problems, negative self-perceptions in relationships, and sexual adjustment difficulties.

Although most of the literature on incest and sexual abuse has focused on father-daughter, adult-child sexual abuse, Giora (1991) investigated the relationship between sibling incest and the long-term effects in 80 incest survivors. Women sexually abused by a brother were more likely to feel emotionally neglected by one or both parents growing up. They also reported more physiological problems, anxiety, depression, guilt.
hostility, verbal, physical, and sexual abuse by an adult partner, concerns over sexual functioning, and self-abusive behaviors.

Laviola (1992) looked at family-of-origin issues in 17 women who had experienced brother/younger sister incest. Laviola found in interviewing these women that all described their family of origin as dysfunctional. They were also given four objective self-report measures and, among other long-term effects, experienced negative self-esteem, sexual response difficulties, and intrusive thoughts of the incest.

Bushnell, Wells, and Oakley-Browne (1992) found in interviews with 301 women with psychiatric disorders, living in New Zealand, that there was a wide array of disorders associated with intrafamilial childhood sexual abuse. They found childhood sexual abuse was especially prominent in the women who were experiencing problems with depression, substance abuse, and eating disorders.

Pribor and Dinwiddie (1992) found in comparing a group of 52 women with sexual abuse histories with 23 women with no sexual abuse histories, who had been matched on the characteristics of age and race, that the prevalence of psychiatric disorders was higher in the incest group. Rates of anxiety disorders, major depression, and alcohol abuse/dependency were significantly higher in the incest group than the comparison group.

Another study by Murrey et al. (1993), which looked at the prevalence of childhood sexual abuse in a client sample, found that 44% of those diagnosed with depressive disorder and 49% of those diagnosed with anxiety disorder had a history of childhood sexual abuse. They also discovered unexpectedly high rates of reported sexual abuse in clients diagnosed with panic disorder, obsessive-compulsive disorder, major depression, and dissociative disorder not otherwise specified.

A variety of long-term effects was found by Alexander (1993) in a sample of 112 female incest survivors who completed a number of clinical assessment measures.
Hierarchical regression analysis indicated that sexual abuse characteristics (especially early age of onset) predicted depression, intrusive thoughts, and, to a lesser degree, an attempt to avoid memories of the abuse.

Moeller, Bachmann, and Moeller (1993) found that 53% of a sample of 668 middle-class women in a gynecological practice reported physical, sexual, emotional abuse, or some combination of abuse. This group, compared to non-abused women, reported experiencing a significantly greater number of hospitalizations for illnesses, a greater number of physical and psychological problems, and lower ratings of their overall health.

Another study that attempted to look at some of the differential effects of childhood sexual abuse was done by Koopman (1994), who sent a questionnaire to 62 women in outpatient therapy. Forty-five percent experienced a variety of psychological complaints. The results indicated that the earlier the abuse is terminated, the less detrimental the aftermath.

Hofman-Patsalides (1994/1995), in examining the long-term effects of incest in 42 women with incest histories, found that when compared to a control group of 19, the incest group demonstrated a higher incidence of chronic somatic complaints and alexithymia. They also found higher rates of reproductive, gastrointestinal, musculoskeletal, and neurological, immune system problems. Weems (1993/1994) found that, in a sample of 32 female incest survivors over the age of 22, those who suppress their anger exhibited more physiological/psychological symptoms than those who did not.

Wendt (1993/1994), in comparing adult women molested during childhood and non-molested sisters found that as adults the non-molested sisters did not differ significantly from those women who had been molested in the quality of their intimate relationships. Both the women molested and their non-molested sisters were significantly less healthy.
in their personal adjustment and in the quality of their adult interpersonal relationships than women raised in non-incestuous families. Wendt drew the conclusion that the dynamics of living in an incestuous family environment may be responsible for the long-term psychological and interpersonal problems found in adult survivors and not the incest experience itself.

Summary of Research

Prior to the 1970s the literature on incest was quite limited. Most studies that were done regarded incest as a fairly benign event. Within psychoanalytic circles children's reports of incest were regarded as "fantasies." In the late 1960s, as child protection laws were passed and psychiatrists were beginning to see a connection between incest and some of the symptoms they found in their adult patients, there appeared to be an increasing social concern over the long-term effects of incest.

In the 1970s the women's movement in the United States seemed to bring an increased awareness and social concern over the damaging long-term effects of incest. Books (Courtois, 1979; Meiselman, 1978) and some studies were published that reported on the long-term deleterious effects of incest. Starting in the 1980s the literature on incest began to document the existence of PTSD symptoms in many adult female incest survivors, especially those in clinical populations. Around the mid-1980s, dissociation, which was first described as a long-term effect of incest by Gelinas in 1983, also began to be studied empirically. By the late 1980s and early 1990s research on the long-term effects of incest found that many incest survivors were experiencing a number of psychiatric symptoms and disorders, and in some instances even required hospitalization.

Some researchers over the past few years have begun to question the adequacy of the PTSD model (Browne & Finkelhor, 1986; Finkelhor, 1990). There appear to be some
incest survivors who never seem to require treatment, or others who experience sexual
dysfunction, interpersonal problems, or other difficulties in functioning who do not
clearly fall within the PTSD model. Recent research on incest has begun to look at the
differential effects of various kinds of abuse on functioning and how various
characteristics of the abuse experience may relate to later adjustment. There seems to be
a need to develop a broader-based model for explaining the long-term effects of incest
that looks at developmental issues as well as other forms of childhood maltreatment. It is
possible that some of the PTSD symptoms, general psychiatric symptoms, and more
serious disorders and characterological problems in adults may be multiply-determined. It
is also possible that the development of a person's sense of self within the first year or
two of life may ultimately effect how the incest experience is handled by an individual
and may explain why incest survivors seem to display such a diversity of symptoms, with
varying degrees of overall severity.

Sexual Abuse and DID

Between 1914 and 1924 fifteen cases of DID were reported in the United States
compared to 10 cases of schizophrenia (Flor-Henry, Tomer, Kumpula, Koles, & Yeudall,
1990). Between 1927 and 1939 over 1,000 cases of schizophrenia were reported, but
only 2 patients with DID. Greaves (1980) was able to identify 50 cases in the 1970s.
Ross (1991) noted at the beginning of 1980 only about 200 cases had been reported in the
entire world literature. By 1990 at least five large series of cases totaling 843 individuals
were reported in the literature in North America (Coons, Bowman, & Milstein, 1988;
Putnam et al., 1986; Ross, Norton, & Wozney, 1989; Schultz et al., 1989). In 1991, Ross
estimated that as many as 10,000 professionals have had direct contact with diagnosed
cases of DID in North America during the past 10 years. It is very likely that a number of
cases have not been identified due to misdiagnosis. skepticism regarding the disorder, as

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well as the covert way in which the disorder often manifests itself in clinical settings (Franklin, 1990; Kluft, 1991).

The relationship between sexual abuse and the development of DID has been anecdotally reported in the DID literature by many writers. The following review focuses on case studies, empirical research, and specific references to the role of sexual abuse as an etiological factor in the development of DID.

The earliest case reports on DID were limited mainly to descriptions of the patient and did not speculate on etiology. Although a number of traumatic events were implicated in early studies, Goddard (1926) seems to have been one of the first to mention sexual abuse in connection with a case study. Around the time of Goddard's treatment of a DID patient with an incest history, another DID patient who had been admitted to a psychiatric clinic in Milan, Italy, recovered memories of incest during a violent abreaction in therapy (cited in Ellenberger, 1970). The incest memories in this latter case study were later confirmed.

Taylor and Martin (1944) in their review article on DID noted the role of severe conflicts in the etiology of DID, but did not elaborate on what these conflicts were, or mention incest as a precipitating factor. It was not until the 1970s that the first case histories clearly linking DID to childhood sexual abuse began to emerge (Schreiber, 1973). Horton and Miller (1972) noted the occurrence of incest in their case study of a DID client but did not specifically address how incest might lead to the formation of DID.

Coons (1980) appeared to be one of the first to make a clear statement on the role that sexual trauma might play in the formation of DID. Although early-life sexual abuse has been recognized as a possible factor in the creation of DID, the relative importance of sexual abuse compared to other potentially traumatic factors has not been assessed.
Saltman and Solomon (1982) noted that although the majority of published cases of DID seem to have incestuous backgrounds, discussion has been scarce regarding the causal relationship between incest and DID. Fagan and McMahon (1984) stated that a relatively common outcome of childhood sexual abuse might be DID. They described four cases in which children who were sexually abused demonstrated periods of dissociation and alter personalities. Spiegel and Rosenfeld (1984) also reported on an adolescent girl who had been physically beaten and raped on more than one occasion. When she dissociated, it was not to an alter personality with a different name but to her core personality at age 4.

Wilbur (1984) described how different alter personalities in DID clients she treated had learned to deal with sexual affects and conflicts resulting from early childhood sexual abuse. She reported on a female patient who had been raped by her father at age 4.5. This client continued to be used as a sex object by her father and his friends. She would switch to an alter personality who would passively participate in the abuse to prevent further physical and sexual abuse. Stern (1984), in examining the etiology of DID, reported on eight DID clients. He found that all eight had been physically abused, six emotionally abused, five sexually abused by a family member, five neglected, and three tortured. Bliss (1984) found in a sample of 48 female inpatients diagnosed with DID that 60% reported a history of childhood sexual abuse and 50% reported a history of physical abuse.

Bliss (1984) has suggested that DID may be formed from self-induced hypnosis. Self-hypnosis appears to be related to dissociation and severe childhood punishment. Nash et al. (1984) in a study of 1,200 males and females ages 18 to 20 found a relationship between severe childhood punishment and later adult hypnotizability. Sexual abuse as a separate type of abuse was not specifically addressed in this study. It is possible, however, that sexual abuse survivors may also engage in self-hypnosis and excessive fantasizing during the sexual abuse experience.
Braun and Gray (1986) found that 41% of the DID patients who were sexually abused were abused by a father, 23% by a mother, 17% by a male sibling, and 2% by a female sibling. Many were abused by more than one family member. Fifteen percent had been sexually abused by both parents.

Sexual abuse is the most frequently reported type of childhood trauma in DID patients (Putnam et al., 1986). Also, in terms of the various types of childhood sexual abuse cases reported in DID clients, incest appears to be the most common type of sexual abuse (Putnam et al., 1986; Saltman & Solomon, 1982). Sexual abuse usually has been considered to be only one of several childhood traumatic events found in the histories of adults with this disorder. Other traumatic events reported by Putnam et al. (1986) include: physical abuse, physical and sexual abuse combined, extreme neglect, witnessing a violent death, other types of abuses, and extreme poverty (Putnam et al., 1986). Kluft (1988a) in describing cases of "extremely complex" DID reported that 92% of his sample had experienced incest among other traumatic events in their childhood.

Putnam (1989) noted that the active incestuous involvement of both parents and/or siblings in DID clients is more common than in incest survivors who do not have DID. He reported, however, that data are scanty and may be misleading in this regard. Single episodes of sexual molestation or rape during childhood were reported in only 15% of DID patients (Putnam et al., 1986). Multiple episodes of sexual molestation and rape during childhood in DID patients appear to be the norm.

One characteristic of childhood sexual abuse in clients with DID, which may differentiate them from incest survivors without splitting, is the extreme sadism that is reported by some DID clients. Putnam (1989) based on his own treatment of DID patients stated that

- bondage situations: the insertion of a variety of instruments into vagina, mouth, and anus; and various forms of physical and sexual torture are common reports. Many
multiples have told me of being sexually abused by groups of people, of being forced into prostitution by family members, or of being offered as a sexual enticement to their mother's boyfriends. (p. 49)

Due to the repression of childhood sexual abuse memories commonly seen in adults with DID, the incidence of sexual abuse may actually be underreported. Ross and Norton (1989) found in their study evidence of childhood sexual abuse in 64% of male patients and 81% of female patients. The researchers reported the possibility that an additional 11% of males and 8% of female respondents may have been sexually abused but had uncertain memories. Herman and Schatzow (1987) reported that memory retrieval is a problem for incest survivors in general. Briere and Conte (1993) also found in a sample of 420 females and 30 males that 59% identified some period in their lives before age 18 when they had no memory of their sexual abuse.

Six large series of studies between 1986 and 1990 document the high prevalence of childhood sexual abuse in the histories of DID patients. Coons (1986), in a clinical investigation of 20 cases of DID, found a history of physical and sexual abuse in 85% of his sample. Putnam et al. (1986) found among 100 patients with DID that 83% had been sexually abused and 75% physically abused. Coons et al. (1988) reported on 50 cases in which 68% had been sexually abused, 60% physically abused, and 96% both sexually and physically abused. Schultz et al. (1989) found in their sample of 355 patients that 86% had been sexually abused and 82% physically abused. Ross, Norton and Wozney (1989) found in their total sample of 236 DID patients that 79% had been sexually abused, 75% physically abused, and 89% both sexually and physically abused.

Ross, Miller, et al. (1990) also found in a sample of 102 DID clients that 90% had been sexually abused, 82% physically abused, and 95% both sexually and physically abused. This study found that the average duration of both types of abuse was 10 years, numerous perpetrators were identified, and, in over 50% of the cases, the abuse started before age 5. Sexual abusers were more often male than female but a substantial amount of the sexual abuse was perpetrated by both mothers and fathers.

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Coons, Bowman, Pellow, and Schneider (1989), in examining the prevalence of childhood and adult trauma in various clinical populations, found that 100% of patients diagnosed with atypical dissociative disorder and 82% of patients diagnosed with psychogenic amnesia reported a history of sexual, physical, and verbal abuse, or neglect in childhood. About half also reported some type of adult trauma. Baldwin (1990) reported that both repeated sexual and physical abuse seem to be antecedents of DID and appear responsible for the increasingly large number of cases being reported in the literature.

Kluft (1990), who has extensively treated DID patients, has done research on DID, and has been frequently consulted on the treatment of DID patients, reported that the majority of patients referred to him have been incest survivors. He indicated, however, that the client's incest history has been frequently overlooked in cases that others have referred to him.

Ross, Anderson, Heber, and Norton (1990) have noted a relationship between childhood sexual abuse and DID in a study involving DID patients, prostitutes, and exotic dancers. In this study the researchers found that 80% of the DID patients had experienced childhood sexual abuse. Sixty-five percent of the exotic dancers had been sexually abused in childhood. Thirty-five percent of the exotic dancers also met the diagnostic criteria for DID. Ross has suggested that dissociative disorders, especially DID, may be prevalent in groups such as these.

Whitman and Munkel (1991) concluded, based on their review of the literature on DID, that over 90% of all cases were directly traceable to severe abuse in childhood. They reported that the abuse tended to begin in early childhood and extend into adolescence. They also reported that the sexual and physical abuse tended to be unprovoked by the behavior of the child, was purposeful, bizarre, sadistic, and usually...
inflicted by a parent or other caretaker.

Although reported cases of DID are increasing, McElroy (1992) pointed out that the diagnosis of this and related dissociative disorders in children has been quite rare. He noted that a history of sexual abuse is extremely common in childhood cases of DID. He reported that it is important in diagnosing DID in children that a distinction needs to be made between normal imaginary companions and DID alter personality states. Riley and Mead (1988) reported on a case history of a 3-year-old female who had already suffered multiple ongoing traumas in infancy, including sexual and physical abuse. This child was followed in treatment from age 14 months onward. Her treatment was videotaped from the time right before an alter personality was fully developed until integration occurred. LaPorta (1992) also provided a case history of a 9-year-old girl who had been sexually abused, and after treatment was no longer demonstrating dissociative behaviors or personality switching.

Cult involvement appears to represent one sub-population of DID clients. Fraser (1990) noted that out of 36 DID clients he had worked with in therapy, 28% had been physically and sexually abused in Satanic cults. He reported at the time of this article that the average client with DID with no cult history had 8 to 15 personalities. He provided, however, case studies of two of his clients who were cult abuse survivors: one who had over 300 separate personality states, and the other, 57.

Gould and Cozolino (1992) noted that ritual abuse often includes the sexual abuse of children and frequently leads to the development of DID. They reported on some cases where cult members deliberately tried to create alter personalities to serve the cult's purposes. This, however, is often done outside the awareness of the child's host personality. Goodwin (1993) noted that there is a reluctance and ambivalence on the part of professionals to accept sadistic abuse, which parallels the reluctance in the 1950s and
1960s to accept the physical abuse of children, and in the 1970s, to accept the sexual abuse of children. This would seem to indicate that sadistic cult-related abuse is probably underreported in the research literature.

Young, Sachs, Braun, and Watkins (1991) reported on a group of 37 dissociative disorder clients who reported ritual abuse in childhood by Satanic cults. These clients, who ranged in age from 18 to 47 years, were evaluated over a period of 2 years. All 37 reported sexual abuse. Other types of abuse reported by at least half or more of the clients included: witnessing or being physically abused or tortured, witnessing animal mutilations or killings, experiencing death threats, and being forced to use drugs. Many of the DID clients as children were also forced into cannibalism, buried alive in coffins or graves, or in some cases forced to later sacrifice their own children.

Ross and Norton (1995) in a survey of 236 DID patients found that the combined effects of both sexual and physical abuse were associated with more self-destructive and parasuicidal behavior, voices arguing in the head, psychotropic medications, psychiatric diagnoses, an increased frequency of Schneiderian first-rate symptoms of schizophrenia, and a higher rate of DID in first-degree relatives. They concluded that physical abuse appeared to be associated more with general psychopathology, while sexual abuse appeared to be linked more to specific features of DID.

Flora (1989), Taliercio (1991), Dunn (1992), and Putnam (1993), after extensively reviewing the literature on DID, concluded that sexual, physical, and emotion abuse all appear to play a role in the formation of DID. Flora (1989) saw DID originating during a very early-life narcissistic period of development. Putnam (1993) noted that the sexual and physical abuse of DID occurs earlier than for non-DID patients. Although the question of whether early-life sexual abuse, physical abuse, or other factors lead singly, or in combination to the formation of DID, is still unanswered in the research literature on DID, Putnam has concluded that the early age of the abuses, and their repetitive and
severe form, may be important factors in why some individuals who have been abused in childhood develop DID and some do not.

**Summary of Research**

Most contemporary writers who have theorized on the origins of DID have accepted the PTSD model as a way of explaining the many long-term negative effects found in this population (Braun, 1984b; Coons et al., 1988; Fink, 1992; Kluft, 1984; Putnam, 1985; Spiegel, 1984, 1988, 1993). Sexual abuse appears to be present in an extremely large percentage of adults with DID who have been studied. As an etiological factor, however, it has possibly been underreported in retrospective studies because it is sometimes not remembered due to repression and dissociation. It has possibly also been underreported because of the sensitivity of the subject. Also some individuals have perhaps been afraid to report sexual abuse if they were threatened as children and told not to disclose the abuse.

Numerous explanations have been offered on how DID develops. Most theorists have agreed that severe and repetitive sexual, physical, and emotional abuse are frequently found in the histories of DID and may lead to the development of the disorder. Some theorists have commented on the early age at which various types of abuse occur in this clinical population. Although sexual abuse has been reported retrospectively in a number of studies involving large numbers of DID patients, Noll (1989) has noted that our theoretical understanding of the phenomenology of DID is still largely inadequate.

The exact role that sexual abuse may play in the formation of DID, especially personality splitting, is still unclear. Since some research in the general incest literature (Briere & Runtz, 1990; Swett et al., 1990) has suggested that sexual abuse effects usually remain when one controls for other types of abuse, it is possible that sexual abuse may...
play a more prominent role in the development of DID. Although Ross and Norton (1995) found that sexual abuse seemed to be more closely linked to the development of specific features of DID, more research is needed in this area.

**Dissociation and Splitting in DID**

**Early Theorists**

Although dissociation has been defined as a disruption in the functions of consciousness, memory, and perception of the environment (DSM-IV, APA, 1994), the DSM-IV does not define the term "splitting." The broad definition of splitting used in this study is one used by St. Clair (1986, p. 10). St. Clair viewed splitting as a general term used in object-relations theory and self-psychology that calls attention to both "normal developmental processes" as well as "defensive life experiences." which relate to a "maturational inability to synthesize incompatible experiences into a whole." In regard to DID, Braun (1986, p. xiv) viewed splitting as "the creation of a new entity by the splitting off or coalescing of energy which forms the nucleus of a separate personality or fragment."

In the theoretical and empirical literature the terms dissociation and splitting are used somewhat interchangeably. As more research is conducted in the area of dissociation, the literature may eventually provide a more detailed analyses of how these two phenomena are related.

In the following literature review, both the concept of dissociation and splitting are often viewed as an adaptive response to traumatic, overwhelming, overstimulating, and sometimes physically painful events. These events are frequently severe, repetitive, chronic, or offer no psychological or physical escape for the person. Splitting based on object-relations theory is viewed primarily as an intrapsychic mechanism growing out of
early-life experiences (often pre-Oedipal). In some cases, this process can become arrested and may be what leads to a fragmented personality structure in some individuals.

In DID, such splitting appears to represent fairly impermeable cognitive structures that seem to lead to amnesia in the "host" personality and various degrees of co-consciousness within the personality structure. There appears to be a great deal of difference between various individuals with DID and how much information is transmitted across these alter personality states and the host personality. It should be noted here that the term "splitting" may be somewhat of a misnomer since it is questionable that an individual's personality actually "splits." The splitting observed in DID clients might more accurately be represented by such terms as a "shifting" of consciousness or "discontinuousness" of conscious experience. Since, however, the term "splitting" has been rather universally adopted to explain the alterations in personality states found in DID clients, the term is retained in this study.

The term "dissociation" is commonly attributed to Pierre Janet, who first used the term in 1889 (Ellenberger, 1970). Janet viewed dissociation as a discontinuous phenomena that was experienced only by people with certain psychiatric problems, especially those diagnosed with hysteria, and was absent in normal individuals. According to Carlson (1986), Benjamin Rush, signer of the Declaration of Independence, was probably the first to use the concept of dissociation in the United States. Putnam (1989) stated that Rush, who collected case histories on dissociative clients for his lectures and writings on physiological psychology, theorized that the mechanism responsible for the doubling of consciousness found in DID individuals lay in a disconnection between the two hemispheres of the brain. This was the first of many speculations on the role of hemispheric laterality and the development of DID.

Originally, Freud's early thinking on the underpinnings of DID was similar to Janet's. In his work with Breuer (1893-1895/1955), Freud wrote:
We have become convinced that the splitting of consciousness which is so striking in the well-known classical cases under the form of double consciousness is present to a rudimentary degree in every hysteria, and that a tendency to such dissociation, and with it the emergence of abnormal states of consciousness (which we shall bring together under the term "hypnoid") is the basic phenomenon of this neurosis. (p.12)

Freud, however, had some difficulty in adequately explaining the phenomenon of DID since he viewed repression as a "horizontal split" between the conscious and unconscious, and not as a the "vertical split" between separate entities of consciousness which, was the view of Janet (1889). In "A Note on the Unconscious" Freud (1912/1958) stated:

We have no right to extend the meaning of this word so far as to make it include a consciousness of which its owner himself is not aware. If philosophers find difficulty in accepting the existence of unconscious ideas, the existence of an unconscious consciousness seems to me even more objectionable. The cases described as splitting of consciousness, like Dr. Azam's might better be noted as shifting of consciousness -- that function -- whatever -- oscillating between two different psychical complexes which become conscious and unconscious in alternation. (p. 263)

Braun (1986) reported that Freud's interest in dissociation later diminished as he came into increasing ideological conflict with Janet and moved away from Breuer on a number of issues. Prince (1919), who believed that dissociation fell on a continuum, wrote extensively on DID. Prince noted that dissociation was a normal process and that there would be chaos in the mind if there were not some repression of conflicting processes. He regarded pathological dissociation as an exaggeration of this normal mechanism. He suggested that some mental processes are normally inhibited, but that this is more extreme in individuals with DID.

A review article by Sutcliffe and Jones (1962) showed a sudden increase in the number of cases of DID reported between 1880 and 1910 and then a decline after this period. The decline in publications on DID between 1910 and 1980 was accompanied by a disappearance of publications on dissociation in general. Ross (1989) speculated that Freud's repudiation of the seduction theory was probably a major force in the discrediting
of DID in the research literature. Rosenbaum (1980) suggested that the role of schizophrenia, which became a popularly accepted diagnosis during this period of time, may have also led to the misdiagnosis of DID and underreporting of individuals with DID. Since 1980 there has been a proliferation of research on DID and dissociation.

Ellenberger (1970) and Berman (1974) provided reviews on the history of dissociative identity disorder and "splitting" in 19th- and 20th-century psychoanalysis. Various theorists have speculated on the mechanism of splitting, with some focusing on its relationship to dissociation and DID. In 1981, Berman in a review of the literature on DID emphasized the psychogenic nature of DID, the role of childhood trauma, and the emphasis on unconscious processes of splitting in the formation of DID. He noted: "The psychoanalytic emphasis on Oedipal dynamics is recently extended to pre-Oedipal identifications and to the role of internalized object-relations" (p. 99). Although, historically, psychoanalytic writers have not generally addressed the role of dissociation in the research literature, preferring to look at personality disturbance from the role of conflict and ego defense mechanisms like repression, a number of object-relations theorists have examined the role of personality splitting.

Object-relations Theorists

Object-relations theory has its origins in traditional psychoanalytic thought but focuses more on the concept of mental representations rather than conflict in the development of personality. Object-relations theorists have traditionally been more concerned with the role of ego "deficits" and the concept of impaired ego strength in relation to psychopathology. Most of the references to object-relations theory in the DID literature have been anecdotal in nature and reported in case studies. Crisp (1983), however, provided a review of the role of splitting and has suggested that the splitting
described by various object-relations theorists may be a useful frame of reference for understanding how DID develops.

Klein (1933) who originally coined the term "splitting" saw the process as a normative stage in infant development. She felt, however, that under certain circumstances splitting could lead to serious psychopathology. Fairbairn (1941) noted that the ego actively seeks a secure relationship with a growth-promoting object. He felt, however, that the ego could be split into several macrostructures as a result of some inevitable painfulness in early life. According to Fairbairn, the unity of the ego is threatened when a very young child views the same object simultaneously as both good and bad. As a result, the external object is also split into a good and a bad object. Both the split ego components and split external object undergo complex restructuring and repression.

Glover (1943) theorized that "ego-nuclei," islands of personality structure, form as a result of perceptual-cognitive maturation. Each one develops in conjunction with an early infantile need and is given its affective tone through interactions with the mother. The ego-nuclei give representation to the objects of any important instinct, secure the discharge of tension resulting from frustration from the object, promote reality testing, reduce anxiety, and eventually develop into an ego. Glover hypothesized that given conditions of emotional stress, the ego tends to split and permits a pathological amount of expression of these ego-nuclei.

Klein (1946) in her later writings on object-relations theory conceptualized splitting as representing the earliest level of ego development. Klein used the term "projective identification," which was meant to indicate a process in which parts of the self are split off and projected on to an external object or part object. Kernberg (1966) criticized Klein's theory of splitting based on what he perceived was a lack of precision in her use of the term.
Bion (1958) stated that dissociation should be distinguished from splitting because it does not occur between one part of the psyche or another. Bion described dissociation as a splitting between the natural lines of whole objects and indicated that it manifests itself in the nonpsychotic part of the personality.

Although Jacobson (1964) does not use the word "splitting," she reported that during the infantile period of development, self and object images, as well as images of different objects, undergo temporary fusion and separate and join again. Jacobson's formulation conveyed an extremely archaic nature of perceptual, cognitive, and affective organizations of the infant but saw the process as fluid and constantly changing.

Kemberg (1966), like Glover (1943), recognized the importance of "ego-nuclei," which form the basis for later ego states. Kemberg (1966) saw these ego states as compartmentalized psychic manifestations and saw "introjection" as one of the earliest, most primitive basic levels in the organization of the internalization process. Kemberg viewed introjection as the reproduction and fixation of an interaction with the environment by means of an organized cluster of memory traces. He viewed the process as both a mechanism for psychic growth and as a defense for the ego. He also viewed the affective coloring of the introjection as an essential aspect of the process of developing bad and good self objects. Introjections with similar valences were conceptualized as developing into self-images and eventually leading to the differentiation of the self and ego boundaries.

Kemberg (1966) saw identification as a higher-level form of introjection, an internalization process, in which memory traces include the image of the object adopting a role in an interaction with the self. The image of the self more clearly differentiates from the object, and affective coloring of the interaction takes on a less intense and less diffuse quality than in the case of introjection. Ego identity, according to Kemberg, represents the highest level in the organization of internalization processes. Ego identity
represents a consolidation of ego structures, connected with a sense of continuity of the self. The concepts of "representations" (how a person has or possesses an object) and "self representations" (the mental expression of the self as it is experienced in relationship with the objects of significant persons in the child's environment) (St. Clair, 1986) appear to be built upon the processes described by Kernberg.

Kernberg (1966) saw "splitting" as an active defensive process, which can come into existence only after introjections have fully developed. He conceptualized this as probably occurring around the third or fourth month of life, reaching a maximum over the next few months, and gradually disappearing in the latter part of the first year. He saw splitting as a normal process in which introjections are actively kept apart or split for ego defensive purposes. He recognized, however, that excessive, pathological early splitting can threaten the integrity of the ego and the future developmental capacity of the ego as a whole. Ultimately, Kernberg saw pathological splitting as interfering with the integration of affects, with the development of a representational world, and the overall integration of the self. Kernberg (1975) in his continuum of the classification of borderline personality disorders clarified the relationship of the Oedipal and pre-Oedipal processes and the importance of both vertical and horizontal splitting in the development of personality disorders.

Kohut (1971), a self psychologist, felt there were two different types of splits in the ego. According to Kohut, horizontal splits distanced that part of the ego in touch with reality from that part in touch with narcissistic impulses, while vertical splits separated contradictory aspects of the personality based on disavowal. The deep horizontal split of the Oedipal stage was seen as a specialized instance of splitting called repression. Kohut also felt that when innumerable small intolerable disappointments in the self and objects occurred, the representations involved would retain their personified drive-connected quality in the inner world.
Winnicott (1971) stated that dissociation should be distinguished from repression and can result in a "false self." Stoller (1973) described a case of DID in which a number of such splits were evidenced (splitting off of feelings into another personality, splitting of masculinity, and splitting between a true and false self).

Lichtenberg and Slap (1973) noted in their review of the literature on splitting that although the term is frequently described in the literature, it is an elusive concept. They suggest that the term be restricted to two discrete interrelated phenomena: "to describe a mode of organizing experiences in infancy, and to delineate a mechanism of representations -- which develops from it" (p. 772). They saw splitting in infancy as involving memory traces of pleasurable good or pleasurable bad experiences.

Mahler et al. (1975) suggested that the infant does not experience himself or herself as a separate entity initially but only gradually establishes separate psychic representations of self and other. They saw this as occurring through an individuation process occurring in a series of stages going from an autistic and symbiotic stage to eventually a stage of individuation. Mahler et al. (1975), like Kernberg (1966), conceptualized that the earliest experiences of the infant give rise to an organization of memory traces. Pruysier (1975), in his extensive review of the concept of splitting, concluded that the concept of splitting is an attempt to reconstruct the child's mind but that it runs the risk of being an adultmorphic imposition.

A fixation at a narcissistic pre-Oedipal stage was viewed by Gruenewald (1977) as the underlying basis for the development of the splitting as seen in DID individuals. Gruenewald saw the disorder as a regressive defense, falling on a continuum like other personality disorders, which can demonstrate full-blown or attenuated manifestations. Gruenewald (1978) suggested that the personality fragments found in DID may become overt and function autonomously as part-identities. She concluded that the formation of DID can occur only in very early development. Pathological splitting was seen as an

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inability to assimilate introjects, presumably because trauma precluded this from occurring. Each unassimilated introject becomes a seed from which an ideational and affective subsystem develops. Gruenewald (1986) in a special issue on "dissociation" refined her definition of dissociation. She noted that dissociation is a descriptive term for processes not directly accessible to observation but known by their consequences.

Marmor (1980) noted that the term "splitting" is frequently equated with the term "fragmentation." In describing the psychoanalysis of a DID patient, he reported that splitting was used as a way to separate the conscious from the unconscious, to remove and re-distribute affect, and as a means of organizing external and internal objects. Marmor also saw it as a process whereby part-objects are substituted for whole objects. He concluded that splitting appears to be a process that does not really split the ego, but results in the formation of two separate simultaneous attitudes with no dialectical relationship. He viewed the transference found in DID patients as a function of splitting in which a person's observing and experiencing aspects of personality are both present.

Nemiah (1981) has identified two principles that can be used to differentiate pathological from nonpathological dissociation. In pathological dissociation, the person experiences a significant alteration in his sense of identity, and second, manifests disturbances in memory in which the amnesia may be partial or complete.

Robbins (1981) criticized object-relations theorists who conceptualized splitting as occurring only in early infancy. Robbins concluded that the early forms of splitting described by some object-relations theorists seem to imply capacities well beyond the reach of a 6-8-month-old. He also criticizes object-relations theorists for failing to clarify the similarities and differences between normal and pathological processes of splitting. Robbins reported that in the case of pathological splitting, because of excessive quantities of unpleasureable experiences, there may be a paralysis and disintegration of the infantile mental apparatus. Lampl-DeGroot (1981) suggested that the splitting seen in DID is not
along the psychic structures of the id, ego, and superego but is the same kind of splitting
escribed in depersonalization.

Crisp (1983, 1987), in an exploration of the literature on splitting and DID, noted
that DID has generally been seen in terms of Oedipal conceptualizations and that few
articles have considered DID from a pre-Oedipal object-relations concept. In keeping
with the contributions of Kernberg (1975), Crisp saw DID as occupying a stage between
these two developmental positions. Part-egos are still in existence, but the higher
developmental defense of repression is present as well. In DID, both types of splitting
may be involved since vertical splitting results in the separation of contradictory
personality states, and horizontal splitting results in repression and amnesia on the part of
the host personality for certain traumatic life events and activities of alter personalities.

Confer and Ables (1983) described dissociation as playing a role in the development
of DID from an object-relations perspective in their review of various etiological
explanations of DID. They did not, however, clearly elaborate on the relationship
between dissociation and splitting. In referring to Kohut's theory of the self (1971), they
conceptualized individuals with DID as having a more cohesive and stable personality
organization than psychotic individuals. They suggested that adults with DID may utilize
fantasy and incorporate experiences from life to mold alter personalities after fantasized
or real persons, which then leads to a sub-system of dissociated selves.

Kumin (1986) discussed the formation of self- and object-representations and
reported that there is a certain degree of fluidity of these processes that is not necessarily
pathological. While object-relations theorists generally believe that the early stages of
representations are undifferentiated and later become more differentiated around the third
year of life, Kumin theorized that the achievement of self and object representational
constancy is relative and continues to be refined and differentiated throughout life. Based
on his view of self-development, the splitting described in the object-relations literature, and in the DID literature, may refer more to a "shifting" than "splitting" process. Kumin noted that even in the most mature individual, the capacity for fluid personality shifts and transformations is still retained.

Crisp (1987), in addition to recognizing the combined roles of vertical and horizontal splitting elaborated on in her early writings on DID, later described other types of splitting found in DID. These included: splits between true and false self, male-female splits, splits between internal and external worlds, splits between observer and nonobserver parts of the ego, splits in time, and projections involving splitting in the analyst.

Although most object-relations theories have not been empirically validated, Beebe and Lachman (1988) have videotaped infant-mother interactions that seem to suggest that the development of object-relations representations result from an interaction between infant and mother. They concluded that early interaction structures are represented in a presymbolic form the first year of life and provide the basis for emerging symbolic forms of self- and object-representations.

Garfinkle (1989) hypothesized that the separate personalities found in DID are not simply the products of ego splits, but are at the instant they are formed, a 'doubling' of the personality that is being copied by means of projective and introjective mechanisms. Separateness is maintained in DID clients due to fears on the part of the host personality of being intruded on by the alter personalities.

Object-relations theory may be viewed not just as products or defenses but as a dynamic process that views the development of the self as an interchange between an individual and the environment. Benjamin (1990) reported that when there is a loss of balance between intrapsychic and intersubjective experience, between fantasy and reality, a problem will develop. For example, feelings of aggression that cannot be resolved with
the outside "other" by an infant can be transferred into a drama of internal objects that are elaborated on intrapsychically.

Sandler (1990) proposed that the "internal object" in object-relations theory be regarded as a structure and that these internal objects influence perception and thought and later, fantasy, and transference. He concluded that fantasy figures could also be threatening and persecutory, but persist because they fulfilled the function of containing unwanted aspects of the self-representations and provided a sense of security.

Hamilton (1990) commented that splitting may not just arise due to parental failures but stated that it can occur in individuals when affects are overwhelming, needs are unmet, or there is a general failure in ego function. This view of splitting may have particular applicability in regard to sexual abuse in children who may not have developed the psychological or physical maturity to respond to the over-stimulating aspects of sexual abuse. Roth (1992) stated that the alter personalities in individuals with DID give flesh to intellectual models of developmental arrest, fixation, good and bad introjects, and regression. Roth suggested, that over time, this disorder may provide some insight into the central role that intrapsychic objects play in the development of both normal and arrested psychological maturation.

**Contemporary Theorists**

DID remains a somewhat controversial diagnosis even though it has been reported in the clinical literature for over 100 years through case studies. DID appears to represent an "anomaly" of human experience that tends to elicit either a sense of disbelief or fascination in those who encounter the disorder for the first time. Dell (1988) noted in a survey of professionals treating DID that 40% of these professionals, at the time of his study, had been subject to malicious harassment, ridicule, or deliberate interference in the medical care of their patients. Some have theorized that DID is an artifact of the therapy...
process itself (Spanos, Weckes, Menary, & Bertrand, 1986) or do not see DID as a valid psychiatric disorder.

Kluft (1989) noted, however, that although the formation of new alter personalities can occur as a result of the stressful aspects of the treatment itself, or as a response to other current life stressors, the disorder itself is not an iatrogenic outcome of treatment. Flora (1989) in a historical review of DID in North America in the 19th and 20th centuries noted that DID is still a highly controversial diagnosis. Flora summarized some of the skepticism found in the literature but seemed to acknowledge the role that physical and sexual abuse play in the development of the disorder. Ross (1989) stated in his review on the etiology of DID that although some features of DID can be created in experimental subjects (Spanos et al., 1986), there have been no studies that have been able to create DID as a full-fledged disorder. Although there appears to be some skepticism toward DID, especially in regard to accepting the presence of alter personality states in individuals diagnosed with this disorder, the majority of research articles and numerous case studies document the legitimacy of DID as a psychiatric disorder.

Although most contemporary theorists have not described the dissociation and splitting found in DID from an object-relations perspective, Kluft (1986b, chap. 4) included some object-relations concepts in his "four-factor theory" relating to the etiology of DID. His four factors include: (1) dissociation potential as measured by hypnotizability; (2) life experience of severe trauma, which overwhelms the child's ego functioning; (3) ongoing dissociative phenomena such as imaginary companions, introjections, internalization, and identification (including in some cases identification with a parent who may also have DID); and (4) insufficient restorative experiences. In this theory Kluft regarded pre-Oedipal failures of integration of self and object representations as one of many potential contributions to DID organization. He concluded, however, that because of the ease with which some patients integrate, that
such object-relations formulations might not accurately reflect the mental structures of all DID patients.

Ross (1989) has studied the relationship between DID and a number of disorders, including schizophrenia. He found, as did other researchers, a high comorbidity between DID and a number of psychiatric disorders such as: somatization disorder, substance abuse, bulimia and anorexia nervosa, panic disorder, depressive and anxiety disorders, mood disorders, obsessive compulsive traits, and personality disorders. Based on his research and a review of the research in the area, he reported that it is not unusual for a DID patient to meet the diagnostic criteria for at least 10 different psychiatric disorders. As a result, he has recommended that DID be re-classified as a “chronic trauma disorder” with other less severe disorders being subsumed under this broad diagnostic category.

In Ross's view (1989) the terms splitting and dissociation in DID are synonymous. He cited Jom's article (1982) on repression to support this position. Ross noted that there is an overlap between a number of related concepts in dissociation, including fantasy proneness, hypnotizability, absorption, and dissociation. Overall, however, there appear to be some differences in opinion on the relationship between the concepts of splitting and dissociation based on some writers (Clary, Burstin, & Carpenter, 1984; Gruenewald, 1977; Horevitz & Braun, 1984; Young, 1988).

Ross (1989) saw dissociation to be the opposite of association and agreed with 19th-century academic psychologists that the psyche can be reduced to a collection of elements including thoughts, memories, feelings, motor commands, impulses, and sensations. As a result, any two psychic elements may be in a dynamic relationship with each other (associated) or can be relatively isolated and separated (dissociated). In DID clients there appear to be a number of psychic elements that are dissociated.

Braun (1990, chapter 11) noted that although DID is listed as one of a number of
incest-related syndromes, a causative relationship may lie with a constellation of child abuse factors rather than the incest experience alone. Braun has reported that although a number of theories have been advanced regarding the etiology of DID, the exact role that incest and other types of sexual abuse play (like extrafamilial and ritual abuse) is unclear.

Some of the first explanations for DID were supernatural in nature and included concepts like spirit possession or reincarnation (Berman, 1974; Ellenberger, 1970; Stern, 1984). Braude (1988) noted that despite some initial interest on the part of some parapsychologists who were interested in studying dissociative phenomena, there has been less interest in recent years in looking at the relationship between splitting, dissociation, and altered states of consciousness.

A psychoanalytic model has been advanced by some to explain the splitting and dissociative symptomatology found in DID (Clary, Burstin, and Carpenter, 1984; Gruenewald, 1977, 1978, 1986; Lasky, 1978; Marmer, 1980; and Wilbur, 1984). Noll (1989), in an interpretive article on Jung's theory of dissociation, noted that Jung regarded splitting as fundamentally a normal process, but believed that its characteristics were most noticeable in pathological states. The tendency to split need not be a question of the development of DID or schizophrenic alterations in personality, but merely "complexes" involving parts of the psyche that detach themselves from consciousness to such an extent that they not only appear foreign but can lead an autonomous life of their own.

Although psychoanalytic formulations of DID have been popular, Ross (1989) noted that DID occurs in a systemic context and cannot be adequately explained by an exclusively intrapsychic explanation. He also discussed the difficulties in empirically studying traditional psychoanalytical concepts, which are often obscure and difficult to integrate with other schools of thought.

Since at least the 1920s in this country, there has been an interest in physiological
studies relating to dissociation and splitting in regard to DID. Studies have revolved around examining the relationship between temporal lobe epilepsy, hemispheric disconnection theories, and state-dependent learning/consciousness models. In examining whether there might be a relationship between DID and temporal lobe epilepsy, however, Ross (1989), in his review of the literature on the subject, reported that he believed temporal lobe epilepsy is a separate disorder and has little overlap with DID.

Sperry (1968) triggered an interest in hemispheric studies after surgically removing the corpus collosum in one of his patients. After the surgery, the patient after observing herself make a left-hand response stated: "Now, I know it wasn't I that did that!" (p. 733). Brende (1984) regarded dissociation, or switching, as a physiologically based mechanism resulting from a functional disruption of neurotransmitter communication between each of the hemispheres. Ross (1989) reported that the main difficulty with hemispheric disconnection theories is that they were initially formulated to explain dual personalities. They have less explanatory power when used to explain more complex DID disorders. Putnam (1989) like Ross (1989) in reviewing the research on DID reported that there appear to be few data to support either the temporal lobe epilepsy model or cerebral disconnection theory.

Hilgard's (1986) neodissociation theory of divided consciousness and his concept of the "hidden observer" phenomenon (1984) may also explain in part how DID develops. The hidden observer phenomenon is a process observed in hypnosis that demonstrates the self-observing characteristics of the ego. Hilgard reported that the "unity of consciousness" is illusory (p. 1) and that individuals have many subsystems of habits, attitudes, prejudices, interests, and specialized abilities, which may be available but latent. He described a central regulatory mechanism as facilitating or inhibiting these
Ludwig (1983) defined dissociation as the fundamental "psychobiological mechanism" underlying a wide variety of altered forms of consciousness including conversion hysteria, fugue states, spirit and possession trance states, and self-hypnosis. In DID clients, he noted there are dramatic differences in electroencephalographic activity, as well as other stimulus-processing changes in hysterical conversions. McFadden and Woitalla (1993) also found differing reports of pain perceptions by four different alter personalities in a 49-year-old female patient. Physiological studies on DID, which have always been popular, may eventually shed new light in explaining DID from a biopsychological model.

Most theorists, except for perhaps Spanos et al. (1986), have endorsed the concept that early-life trauma, particularly chronic and severe childhood sexual and physical abuse, can potentially lead to the development of DID. Spanos, Weckes, Menary, and Bertrand have suggested that DID is an artifact of the doctor/patient relationship based on cues by the doctor or mutual reinforcement of role performance by the doctor and patient. Braun and Sachs (1985), Braun (1986), and Kluft (1985) have developed clinical etiological models for DID, which generally incorporate the ideas that: individuals with DID appear to be very good at dissociating, use dissociation to cope with severe childhood trauma, have a form and structure of DID that depends on the person's temperament, and that DID results from the child not receiving enough love or care to incorporate and deal with the childhood traumas (Ross, 1989).

Braun (1988a, 1988b) has developed his BASK model referred to in chapter 1 which is based on the concept of behavioral reinforcement. He described how behavior, affect, sensation, and knowledge are all affected by dissociation and fall on a continuum from full awareness to suppression, denial, repression, and dissociation. He theorized that as
alter personality states are developed they are reinforced by various interactions. Eventually certain "cues" in the environment can trigger particular alter personalities to come out. Fine (1988), like Spiegel and others who view dissociation and splitting from a PTSD model, hypothesized that individuals develop personality splitting because either there is not enough time to equilibrate between episodes of trauma or because the meaning of the assault is so unbearable.

Another explanation for DID, which seems to be conceptually related to a physiological process, is the state-dependent learning or state of consciousness model (Reus, Weingartner, & Post, 1979). This model has been drawn from research popular in the 19th century on state-dependent learning. It is based on the theory that neurotransmitter levels associated with intense mood states may dictate how information is retrieved. If information is decoded under one mood state it cannot be encoded or later retrieved unless the person is in the same mood state. The level of affective arousal is an important component in remembering certain information. This theory may at least partially explain why abreactive experiences in treatment are necessary to retrieve memories of childhood physical and sexual abuse that were stored during a different mood state. This model may also explain why individuals who have been traumatized by an experience may psychologically relive the event through cues that trigger flashbacks.

Putnam (1984), like a number of other clinicians and researchers, sees dissociation as a psychophysiological process linked to traumatic experiences. Putnam (1991) espoused an eclectic, dissociative model of autohypnosis that involves discrete states of consciousness, separated by amnesia, and based on neurobiological processes. Putnam (1992) saw the personality switching in DID clients as one of a number of state change disorders (1988). He reported that some of the shifting state changes seen in DID patients may be set up in infancy and may be similar to some of the state changes observed in other affective, mood-based disorders (Putnam, 1992).
A strong case has also been made for a relationship between DID and hypnosis in the research literature (Ross, 1989). Although Freud eventually rejected the idea of the hypnoid state as being a necessary feature of hysteria as cited in Ellenberger (1970), Morton Prince (1919) and others continued to investigate the altered states of consciousness found in DID patients. Clinical case studies and research have supported the belief that DID individuals are highly hypnotizable and can easily enter trance states.

Bliss (1980) has written extensively on the self-hypnotic theory and outlined the main characteristics of autohypnosis in 14 DID patients. Overall, there has been a historical link between the study of hypnosis, dissociative disorders in general, and DID since the turn of the century. Initially, it was hypothesized in some of the literature on DID that DID individuals have a genetic predisposition toward being more highly hypnotizable than other individuals. Spiegel (1986, 1988, 1989a, 1989b, 1990, 1991), however, has suggested that individuals with DID are both highly hypnotizable and have a history of severe developmental abuse or neglect. Through autohypnotic trance states the individual is able to forget physically painful and psychologically painful events. Although it is possible that some individuals may be more prone to dissociation because of a genetic predisposition, some research suggests that adults who have been physically abused in childhood have higher hypnotizability scores than individuals who have not been abused (Nash et al., 1984).

Bliss (1984) in his autohypnotic model showed how individuals with DID scored higher on hypnotizability. One problem with this model is deciding whether the personality is in a hypnotic state or whether the alter personalities are in hypnotic states (Ross, 1989). It appears that the host personality dissociates and goes into an altered state of consciousness when other alter personalities take executive control. The alter personalities possess reality-based information, which the host personality is normally
oblivious to until some co-consciousness develops. Hypnoid or trance-like states, however, have been identified as predictors of DID in children (Fagan & McMahon, 1984; Kluft, 1986b). Viewing DID as an altered state of consciousness has been popular and is often described in conjunction with other models (Braun, 1984a).

Closely related to the self-hypnotic model, or altered states of consciousness models, is what could be loosely described as the "fantasy" model. Putnam (1992, p. 95), for example, has posed the question of whether alter personalities are "fragments" or "figments" of the imagination. Kluft (1984) found a surprising absence of imaginary companions in reviewing the early-life histories in 20 successfully treated patients. Kluft speculates that what has been externalized during the earlier years as imaginary companions or friends later becomes re-internalized. This, then, becomes a center of subjective experience and is no longer perceived solely as an external object. These personality states are then perceived as "objects" of the self. Gillett (1986) and a number of others have speculated on the connection between the imaginary friend phenomenon and the development of DID in young children.

Young (1988) and Terr (1991) have also reported on how children seem to produce elaborate fantasies when exposed to continuing trauma. This, in combination with self-hypnosis, may lead to the development of DID in children and later in adult manifestations of the disorder. Recent research has begun to demonstrate a relationship between fantasy proneness, autohypnosis, and dissociation (Lynn, Rhue, & Green, 1988). Spiegel (1986) described the splitting found in dissociative disorders as, among other things, a cognitive process, or encapsulation, of an event. Children in their minds distance the traumatic event as if the trauma did not happen to them but to someone else. Spiegel (1986, pp. 63-64) noted that "what early in life is a literal helplessness over their physical world, becomes in later life a metaphorical helplessness over their psychological world and the dissociative process."
Ganaway (1989) has provided an integrated model for understanding the development of DID in children based on both an endogenous model (fantasy) and an exogenous model (traumatic events). Based on this model children will fantasize while trying to escape from unbearable physically and/or psychologically traumatizing events. Over time, a character is created in the mind of the child who can then serve to experience the event for the child.

Fink (1992) also described the over-identification process in a DID client who used fantasy to escape from traumatic events. He provided a case study of a woman who formed an alter personality she named "puffball" while being sexually abused in a field of dandelions. This case typifies how both the elements of autohypnosis and fantasy can be used in children to form alter personalities. Coons (1984) noted that although some researchers have reported creating phenomena similar to some aspects of DID under hypnosis, these phenomena cannot be equated with the creation of the disorder itself.

It appears that culture may play a role in how DID manifests itself. Richeport (1992) observed that the popularity of possession trance states experienced in so many cultures may suggest that the multiplicity of selves may not always need to be considered pathological. Krippner (1986) has examined the treatment approaches to DID in Brazil, where the occurrence of DID has been traditionally viewed as a reflection of Brazilian "spiritism" and where the multiple self is created, defined, and systematically transformed by various aspects of Brazilian society. Bourguignon (1989) has also discussed the relationship between DID and possession trance states that are culturally defined, and Ronquillo (1991) examined the dynamics of the concept of "espiritismo" in relationship to the formation of DID in a 48-year-old Hispanic woman. Varma, Bouri, and Wig (1981) made comparisons with DID and what traditionally have been regarded as hysterical possession states in India. Ross and Joshi (1992), in a study of 502 Canadian
adults in the general population, drew the conclusion that paranormal experiences are reported more often by individuals who have been traumatized, especially by physical and sexual abuse. In some cases such paranormal experiences may be equated with special spiritual abilities.

Although most contemporary writers in North America view DID as a pathological condition, Richards (1990) reported that in some individuals DID may be a creative way to deal with life. Richeport (1992) discussed Watkin and Watkin's (1990) "ego states," Beahr's (1983) "co-consciousness," and Allison's (1985) "internal self的帮助" as illustrating positive aspects of DID. Watkins and Watkins (1990) theorized that ego states possess relatively permeable boundaries, like normal moods, but are less permeable in individuals with DID. Beahrs (1983) suggested that one state of being can be aware of the thoughts or consciousness of another state, but that this is less true in clients with DID. Allison (1985) found that one personality state may serve as an "inner self helper" and a guide in therapy for the DID clients and record and retain memories for the larger personality system.

Most contemporary theorists' tend to see DID as a pathological condition and as a posttraumatic stress disorder. Loewenstein (1991) defined DID as a "posttraumatic dissociative developmental disorder" beginning usually before the age of 5. Spiegel, who has written extensively on DID and dissociation (1984, 1986, 1988, 1989a, 1989b, 1990, 1991, 1993), viewed dissociation and splitting from both a post-traumatic and hypnotic model. He initially proposed (1963) a two-directional model of dissociation on a dissociation/association continuum, whereas repression was seen as unidirectional.

Whitman and Munkel (1991), like Loewenstein (1991), described DID as a creative, psychophysiological defense response to a relatively specific set of inescapable and uncontrollable experiences occurring within a circumscribed developmental time frame. There appears to be a growing body of literature on DID that relates histories of severe
repetitive, physical abuse and sexual trauma to the experience of uncontrolled
dissociation (Bliss, 1980; Braun, 1986; Braun & Sachs, 1985; Kluft, 1984; Spiegel,
1984). Adults with DID appear to experience more severe and chronic PTSD symptoms
when compared to other clinical groups (Braun, 1986; Kluft & Fine, 1993; Putnam, 1989;
Ross, 1989).

Kluft (1987) also reported that DID clients rarely present overt symptoms of
personality splitting when they seek out treatment, but they are often polysymptomatic.
DID appears to be a superordinate diagnosis that often overlaps with other disorders and
symptoms that may mask the DID condition (Bliss, 1980; Coons & Milstein, 1986;
Horevitz & Braun, 1984; Kluft, 1985; Putnam et al., 1986).

Putnam (1989) has reported that a number of different traumas have been reported in
the early-life histories of DID clients. Putnam has suggested that these traumas, if
occurring early in life, can lead to excessive dissociation in some individuals, and have an
effect on important development processes, like the development of a cohesive sense of
self. It appears, however, that developmental issues in regard to the formation of DID
have not been very fully explored in the research literature. There still appear to be a
number of unanswered questions regarding why one person might develop DID as a
result of traumatic events while another person might not.

Lynn and Rhue (1994) have pointed out that there continues to be a great deal of
controversy over just how dissociation operates as a defense mechanism and whether it
can be meaningfully distinguished from other defenses. Further research is needed to
substantiate a trauma-based model for DID, which over the years has been intuitively
appealing. Until the development of the DES by Bernstein and Putnam (1986) there were
no dissociative measures with established validity and reliability that could be used to
measure dissociation in DID clients, or incest survivors in general.
Summary of Research

In summary, the concepts of dissociation and splitting have often been used interchangeably in the literature, particularly in relationship to an understanding of DID. Early theorists like Janet (1889) and Freud (1912/1958) disagreed on what Freud labeled the "unconscious consciousness" in DID patients. After a flurry of interest in DID around the turn of the century there was a dramatic decline in interest in DID until the 1980s.

Beginning around 1933, Melanie Klein and other object-relations theorists began speculating on the role that early-life splitting might play in the development of later psychopathology. It appears that object-relations theory may shed some light on how this early-life intrapsychic mechanism might lead to the formation of alter personalities in some individuals. While a number of trauma-based models have been offered by contemporary theorists to explain how DID develops, there has been an absence of empirical research in this area. While theorists, like Putnam (1989), seem cognizant of the fact that early-life developmental processes, particularly the development of a cohesive self have been affected in DID clients, the process has not been very clearly delineated in the literature. A few writers like Confer and Ables (1983), Gruenewald (1977, 1978, 1986), and Crisp (1983, 1987) have suggested that there may be a connection between the formation of DID and early-life splitting processes.

Object-Relations Theory and Sexual Abuse

In the 1930s, object-relations theory became the major focus for the school of psychoanalysis, particularly in London. Melanie Klein (1933) formulated object-relations theory based on her observations of infants. Major contributions to object-relations theory by Klein included the concepts that internal objects are mental representations of instincts and that they are modified by internalizing the experiences of real objects in the infant's world. In recent years, object-relations theory has been...
regaining prominence as an important point of view in the field of psychology. The concepts associated with this theory are important not only to the development of the self (Posener, 1989; Krystal, 1990), but also to an understanding of affects (Sandler & Sandler, 1978), psychological defense mechanisms like depersonalization (Frances, Sacks, & Aronoff, 1977), the use of fantasy (Shane & Estelle, 1990), and sexuality (Kirkpatrick, 1990).

Since object-relations theory seems to provide a rich, comprehensive interpretation of early internal development, and conceptualizes psychological development as a continuous unfolding process with later stages built on earlier ones, it appears to provide a good model for trying to understand theoretically some of the long-term effects found in adult incest survivors. Although many of the comments about object-relations impairment in the incest literature appear to be anecdotal in nature, there appear to be a growing number of studies that have looked at the relationship between object-relations impairment and sexual abuse. Kaufman et al. (1954), in a study involving 11 girls who were incest victims, found an impairment in object relations. One 11-year-old in this study, who was living in a group placement, would puzzle staff when she suddenly would curl up in a ball, seem out of contact with reality, and would talk in a 3-year-old's tone of voice.

Cavillin (1966) provided case histories on 12 incestuous fathers he evaluated in a state-run diagnostic center. He found that they suffered from defective ego organization, characterized by a lack of synthesis in their early identification systems. The findings were based on psychosocial identity problems and ego deficits as identified through the MMPI. Lewis and Sarrel (1969), in five case studies on children, pointed out that there appeared to be object-relations impairment in the form of sadistic, ambivalent, and later seductive relationships with their parents. They speculated that a relationship may exist...
between object-relations impairment in childhood and later psychological symptom formation and disorders.

Green (1978) found overall impairment in ego functioning in a case study of 20 sexually and physically abused children. Their traumatic reactions were characterized by extreme anxiety states, primitive defense mechanisms, impaired impulse control, impaired self-concept, masochistic and self-destructive behavior, difficulties in separation, and difficulties in school adjustment. Green theorized that such object-relations impairment led later to a perceptual search for a "good object" to protect them from "bad objects."

The relationship between object-relations impairment and maladjustment is not always easy to determine. Rosenfeld (1979) found high levels of marital discord, sexual dissatisfaction, and characterological disturbance in six incest survivors who were later hospitalized. Although he did not control for other variables, he concluded that these problems were related to object-relations impairment.

Stolorow (1979) addressed the relationship between early-life sexual overstimulation and the consolidation of self and object representations. Stolorow noted that in order to have clear self-object differentiation, a child needs to have experienced normal sensual experiences and fantasies. This is needed in order to have appropriate boundaries between self and others as adults and can become disturbed in incest survivors. Cohen (1981), like Stolorow, saw sexual abuse as interfering with the incest survivor's development. Cohen reported that when sexual abuse occurs, "self-pathology" is the result.

Some exploratory research with infants seems to provide some evidence that supports the theoretical supposition that object-relations impairment can begin in infancy. Fraiberg (1982) studied a sample of 12 infants between the ages of 3 to 18 months who had experienced danger or severe emotional deprivation. Fraiberg noted that the infants
demonstrated pathological defense mechanisms of avoidance and freezing. These patterns of behaviors were identified by Fraiberg as demonstrating object-relations impairment in these infants.

Berner (1983) in a literature review on incest and object-relations theory found no primary sources that took an in-depth look at the effects of incest on female development. She concluded, however, after a review of relevant materials published over a 15-year period of time, and after examining Kernberg's (1976) view of development, that incest survivors do experience object-relations impairment because of the incest. She admitted that the exact nature of these effects is confounded by numerous other variables such as the parents' level of object-relations development, the girl's level of object-relations development prior to the incest, the nature, extent, and duration of the incest, and how and when the incest stopped.

The pre-Oedipal period is frequently referred to in object-relations literature as a period of time in infancy when damage to the ego can occur. Brooks (1983) reported a case study of a sexually abused child who seemed to have interpersonal difficulties relating to pre-Oedipal arrestment. Brooks (1985) also studied 29 sexually abused adolescents and found that there appeared to be two profiles, one of distressed adolescents and one of adolescents who reported no problems. The latter profile, however, appears based on repression and denial.

Madigan (1985), by administering the Rorschach Inkblot Technique to a group of 30 mothers of incest survivors and 30 mothers of non-incest survivors, found that the mothers of incest survivors scored significantly lower on impaired empathy, primitive interpersonal modes, and primitive defenses. Madigan speculated that the lower object-relations impairment in the mothers of incest survivors might explain why some mothers may deny the incest.

Wieder (1985) attempted to test the level of object representations of mothers and
their minor daughters in 15 incestuous and non-incestuous families using the Mayman's Early Memories Test and the Parental Description Test. Her hypothesis was supported that individuals who were receiving treatment for interpersonal difficulties stemming from incestuous relationships would be functioning at more primitive object-relations levels than those who had not been involved in incestuous relationships.

Mandel (1986) attempted to ascertain whether or not sexually abusive fathers, who were sexual abuse victims themselves, would display more object-relations impairment than nonabusive fathers in therapy and nonabusive fathers not in therapy. Although no significant differences were found between the groups on the two object-relations scales, there was a trend for the incest group to show more object-relations impairment than the other two groups.

Positive object relations were reported by Dewald (1988) in a case study of a middle-aged incest survivor being treated for anxiety. In spite of her incest, Dewald concluded that she was able to trust others and maintain sustained relationships. He attributes her capacity to do this to having a mother who nurtured the client during the client's pre-Oedipal period of development.

Research on incest and object-relations impairment prior to the mid-1980s seemed to be based mostly on projective tests. In the late 1980s research on incest and object-relations impairment has tended to use some objective and standardized measures. Katz (1989) investigated the long-term effects of incest in regard to levels of object relations, dyadic adjustment, and attitudes toward child-rearing. Thirty-two father-daughter incest survivors and 22 controls participated in this study. Incest survivors were found based on the Bell Object Relations Self-Report Scale to have more impaired object-relations than did the non-incest group. Katz hypothesized that the disturbances in object-relations and ego structure resulted either from blurred family boundaries prior to incest or from confusion of roles during incest.
Nifakis (1990) studied 17 female incest survivors who volunteered for her research. Using four object-relations scales and a rated interview, she found that adult survivors of incest were more compliant, hypervigilant, had more disturbances in boundaries, and had lower levels of object representations than a control group.

The term "primitive" is often used in object-relations literature to refer to a style of object-relations impairment that theoretically is linked to a pre-Oedipal period extending from early infancy to around 18 months. Westen (1989) challenged this assumption. Although Westen accepts the suppositions of object-relations theorists like Kernberg (1966, 1975, 1976) and self psychologists like Kohut (1971) that severe character pathology can originate from pre-Oedipal experiences, he theorizes that object-relations impairment is multiply-determined and can also occur later in life.

The use of the therapist as a "transitional object" is illustrated by Seinfeld (1989) who in a case study described doing therapy with a severely sexually abused girl. He indicated that this girl initially related to the therapist in non-human modes, treating the therapist like an inanimate doll. By using the therapist as a "transitional object" the child was eventually able to relive and work through the past abuse she experienced. As she improved, the child's relationship with the therapist changed and she was able to accept empathy and support.

Stovall and Craig (1990) found that in a comparison of mental object representations in 20 sexually and 20 physically abused females between the ages of 7 to 12, the mental representations did not differ. They found, however, that internal images of such representations did differ and concluded that impaired object relations is not simply a manifestation of family distress but reflects the type of abuse experienced.

Taylor (1990), based on a review of the literature and the study of 50 cases of adult sexual perpetrators in treatment over a 3-year period, found patterns of object-relations
"strivings" in men in this sample. He hypothesized that these patterns of object-relations strivings represented deficits in these men's personal relationships and may have explained their perpetration.

Object-relations impairment has been linked etiologically with the development of borderline personality disorder in which a history of sexual abuse is not uncommon. Saunders and Arnold (1991) have suggested that the good and bad aspects of experiences are not fully integrated in these clients due to splitting. Until integration occurs, object constancy will be a problem, with the client poorly tolerating stress and object loss.

Westen (1990) has theorized that sexual abuse victims have a more malevolent object world as adults and that their relationships with others are characterized by expectations of further victimization. He concluded that the malevolent quality of the representations can be exacerbated by projections of rage, splitting, masochistic reenactments, and other pathological defenses. Andreau (1991) described a 16-year-old African American female who was both sexually and physically abused, as well as neglected. This client seemed to reenact issues around her past abuse in therapy. It was not until she was able to project both good and bad objects (characteristics) onto her therapist that she could move from perceiving herself as a bad object to a good one.

It appears that individuals with incestuous backgrounds display a wide variety of psychological symptoms and disorders. Biebl (1991) found in a study of 33 women with a history of intrafamilial sexual abuse that there was not a typical "post-incest syndrome." He concluded that the broad range of psychopathological symptoms was related to "ego weakness" and led to anxiety, pseudomaturity, and narcissistic deficits in incest survivors.

Caffaro (1991) has offered insight into the role of object-relations impairment as it affects the treatment of incestuous fathers. He theorized that incestuous fathers have difficulty progressing in therapy since, from an object-relations perspective, they have
difficulty bonding with others as adults. As a result, he emphasizes the role of both interpersonal and intrapsychic processes in group therapy.

Elliott (1991) explored the relationship between incest and a number of long-term effects including ego impairment in a group of professional women. Out of 2,963 women, who responded to a mail questionnaire, approximately 29% of the women admitted to sexual molestation prior to the age of 16. Elliott found on a measure of ego functioning that the respondents had, in addition to a variety of PTSD symptoms, deficits in their capacity for object relations.

Wolf and Alpert (1991), in a review of the limited psychoanalytical literature on incest, concluded that those who have experienced incest have ongoing impairments of the ego, superego, and self, as well as primitive defense mechanisms and deficits in self-representation. Kinzl and Biebl (1992) came to a similar conclusion after studying several psychosocial, psychosomatic, and psychodynamic factors in 33 female psychiatric patients who had been victimized by childhood incest. Abuse was almost exclusively severe and prolonged and, in 75% of the sample, was done by biological fathers or stepfathers. Wingerson (1992) addressed the issue of "psychic loss." Like Kinzl and Biebl (1992), Wingerson viewed incest survivors as having difficulty with disturbed object relations, as well as problems in trust, empathy, and narcissistic hurt.

Although the incest literature frequently links an early history of sexual abuse with later psychiatric symptoms and personality disturbances. Frank (1992) investigated whether a particular pattern of psychopathology would emerge. Developmental and qualitative dimensions of object relations in college women, whose sexual abuse history had been associated with physical abuse, were compared with college women whose sexual abuse experiences were with peers. The former abusive group demonstrated significantly greater problems in object-relations impairment on the BORRTT's four interpersonal scales and on one of the reality-testing scales compared to the group who
had engaged only in sex play with peers. Three factors -- family relationship between the survivor and perpetrator, the presence of threat or force, and the age and frequency of the abuse -- all seemed to predict higher scores on the BORRTI and Thematic Apperception Test indices of object relations.

Grand and Alpert (1993), in a theoretical article on childhood sexual abuse, concluded that there is a relationship between this kind of abuse and object-relations impairment. The authors drew on Winnicott and other British object-relations theorists to demonstrate that the core trauma of incest relates to a disruption in attachment.

A qualitative study by Stern (1993) looked at the perceptions of eight sexually abused women toward their mother and how these perceptions might have impacted on how they experienced their sexual abuse as adults. Stern found a commonality within the internal object world of the subjects, which seemed to suggest an early disturbed mother-child relationship due to pathological projective identification. Stern concluded that the internal object world did seem to have an impact on the way in which the subjects experienced and processed their childhood sexual abuse.

Panucci (1992/1993) looked at the role of object-relations impairment in adult survivors of incest based on Bowlby's attachment theory. By administering the BORRTI and other measures to 52 adult females, Panucci found that a majority of the participants described their attachment style as being characterized by "insecure attachment." Those who did not demonstrate this problem with attachment had significantly less distortion in their object relations and reality testing.

The BORRTI was used by Silbert (1992/1993) who studied object-relations functioning in a clinical sample of 103 women sexually abused as children. Silbert found that the women reported more object-relations deficits in terms of expecting more malevolence, exploitation and betrayal, alienation, insecure attachment, social competence, and egocentricity. Overall, this study did not find a relationship between
specific abuse-related variables and object-relations impairment. Silvert concluded that while most of the specific abuse-related variables did not correlate with adult object-relations impairment, there was a relationship between some of the abuse variables and suicide, as well as hospitalizations.

A cross-cultural case study by Thrasher (1994) on the treatment of a West Indian female incest survivor documented a history of object-relations impairment. Thrasher found that, through therapy, the client was able to work through her sexual abuse and achieve ego integration. Hirsch (1994) noted that patients with factitious disorders sometimes have a history of severe physical and sexual abuse. Consequently they perceive their own bodies as an "external object," which they will treat in a self-destructive manner. Anorexia nervosa, hair pulling, and nail biting are cited as examples of self-destructive behaviors in these patients.

Reagan (1994) utilized a case study approach together with standardized instruments to examine the role of maturational processes associated with mother-daughter incest. Although her sample was quite small, she concluded, based on the Minnesota Multiphasic Personality Inventory and BORRTI, that incest survivors have a tendency to experience symptoms associated with psychosomatic and dissociative disorders and the development of object-relations impairment. She found the latter is characterized by relational styles marked by extreme anxiety over attachment problems with rejection and chronic doubts about personal perceptions of reality.

Sexton (1994) found, using the Rorschach in a group of 105 adult women who had been sexually abused, that there was a differential impact on the maturity of psychological structures. Disturbances in object-relations representations seemed to be predicted most by the severity of sexual abuse and by negative perceptions in the family-of-origin environment.
Riederle (1994) hypothesized that females who had been sexually abused by a biological father rather than by a non-biological father would have more object-relations impairment as adults. Riederle hypothesized that the disruption would be less severe with a non-biological parent, like a stepfather, since a stepparent often enters the home when the child is older and a firmer sense of self has been developed. In using the BORRTI, Riederle found no significant differences in object-relations functioning between survivors of incest by biological and non-biological fathers. Incest survivors in both groups showed moderate levels of object-relations impairment even after an average of at least 5 years of treatment in Alienation, Insecure Attachment, Egocentricity, and Social Incompetence.

Haviland, Sonne, and Woods (1995) examined the severity of PTSD symptoms and object-relations impairment in a group of 37 students (16 boys and 21 girls), ages 11-19, enrolled at a private residential school for children with a variety of conduct problems. Out of this group, 38% had experienced physical abuse only, 43% had experienced physical and sexual abuse, and 19% had experienced sexual abuse only. Although results were not analyzed based on type of abuse, the researchers found a positive correlation between the scales: Insecure Attachment, Egocentricity, Reality Distortion, Uncertainty of Perception, and Hallucinations and Delusions on the BORRTI and PTSD symptom severity. Haviland (personal communication, April 12, 1995) noted that there appeared to be a specific relationship between PTSD symptomatology and early age of abuse as well as abuse by a parental versus non-parental abuser.

Although Crisp (1983, 1987) has reviewed the concept of splitting as this process relates to DID individuals, only one researcher has empirically studied the relationship between DID and object-relations impairment in DID patients. Alpher (1991) found in using the BORRTI with one adult female inpatient that the host personality, Corinne, had
the greatest amount of ego strength, with no pathologically elevated scales when compared to her three alter personalities. Alpher suggested that this study provided some preliminary support for the proposition that the dissociative process in DID patients may function to maintain an effective, though maladaptive, core of ego functioning. Since, however, the patient in this study had been in treatment for some time, the ego stability found in the host personality may have been more of a reflection of improved ego functioning as a result of treatment, and may not be typical of the host personality of DID patients in general. While this study provides an interesting comparison of a DID patient’s host and alter personality states, the fact that only one subject was used in this study seriously affects its generalizability.

Alpher (1992a) in another study used the BORRTI to examine changes in the identity and self-organization in a 38-year-old male DID client over the course of intensive inpatient treatment. Alpher found after 4 months of treatment that there was a personality reorganization in the host and two alter personalities. The patient’s host personality showed a decrease on the Alienation scale, which is a broad-based indicator of overall object-relations impairment, and also showed a reduction in the Hallucinations and Delusions scale. The patient’s host personality, however, appeared to experience increased difficulties on the Uncertainty of Perceptions scale, suggesting the patient was feeling more distress or confusion over issues of reality and unreality. One alter personality showed a decrease in problems with hallucinations and delusions, while another alter personality showed an increase in problems relating to social competency.

A third study by Alpher (1992b) examined the personality structure of six DID patients (five female and one male) who were consecutively referred for psychological assessment at the time of their admission to an acute-care psychiatric unit. Alpher found that in doing a structural analysis of the social behavior of the host and alter personalities of these patients, that the host personalities and alter personalities differed in their
identity and self-organization. The host personalities seemed to show evidence of the internalization of abuse dynamics related to self-destructive trends. The alter personalities, who held memories of the abuse, however, did not manifest such dynamics.

Although Alpher's three studies (1991, 1992a, 1992b) suggest that host and alter personalities in DID patients appear to display differences in various aspects of object-relations functioning, that appear to change over time as the result of treatment, further research with larger samples is needed to replicate these studies. Since all three of these studies were done in inpatient settings, further research would also be needed to determine if similar changes in personality reorganization would result from outpatient psychotherapy.

All three of Alpher's studies involved individuals who had been sexually abused. In Alpher's 1991 study, the patient had been repeatedly sexually abused at the age of 4 for about a year by a friend of the family who had just been released from prison. The male patient studied by Alpher (1992a) through abreactive treatment was beginning to remember scenarios relating to chronic sexual and physical abuse rituals prior to being tested after 4 months of inpatient treatment. Alpher (1992b) reported that all of the five female patients and one male patient that he tested with the Structural Analysis of Social Behavior measurement system had experienced sexual and physical abuse.

Summary of Research

Although object-relations theorists have always looked at the impact that various events might have on the development of the self and object relations, only a few early case studies initially addressed the issue of incest and object-relations impairment. In fact, prior to 1983 Berner in a review of the literature on object relations found no primary sources that had explored the relationship between incest and object-relations impairment. She hypothesized that incest seemed to interfere with early-life object-
relations development. Starting around the mid-1980s, some empirical studies have examined the relationship between incest and object-relations impairment.

Because earlier research on incest and object-relations theory was based on case studies or used a variety of object-relations measures (frequently projective tests), it was hard to compare the findings of these studies to each other or to later studies. It appears, however, that the empirical research over the past 10 years does seem to support a relationship between various aspects of the incest experience and object-relations impairment. Further studies, however, are needed to draw any clear conclusions. Since the studies done to date are very preliminary in nature, it also appears important to critically evaluate the research literature in this area. It is possible that the object-relations impairment found in various empirical studies could be related to the incest experience itself, but could also be related to various other maltreatment factors, psychopathology in the family, neglect, or a number of other variables occurring prior to, during, or after the incest experience.

Although Alpher (1991, 1992a, 1992b) has done some interesting research on DID inpatients who have been sexually abused, in relationship to their level of object-relations impairment, these studies are in need of further replication. His preliminary studies do seem to suggest that personality reorganization can occur with DID individuals who have been in treatment.

Chapter Summary

The review of related literature that has been presented in chapter 2 suggests the following four ideas.

1. Long-term retroactive studies have provided rather extensive information about the long-term effects found in adult female survivors of childhood incest, especially from a PTSD model. There appears, however, to have been little attempt to compare the long-
term effects of incest survivors with personality splitting to those without personality splitting.

2. An etiological relationship between early-life sexual abuse and the long-term effects found in DID has been theorized in the literature, but that verification of this theory remains to be established.

3. A number of theories have been advanced concerning the nature of dissociation for over 100 years, especially as a posttraumatic phenomenon; however, empirical research was hampered until the late 1980s by the absence of a reliable and valid instrument designed to measure dissociation.

4. A relationship between incest and object-relations impairment has been hypothesized by some researchers, but the verification of this hypothesis has been established only in a very preliminary way through a few studies. This has been true in regard to research on incest survivors, in general, as well as research on DID individuals who were sexually abused as children.
CHAPTER III

METHODOLOGY OVERVIEW

Introduction

The following is a description of the population and sample, protection of human subjects, instrumentation, procedures, null hypotheses, and data analysis used in this study. This research was designed to investigate the relationship between dissociation and object-relations impairment in adult female incest survivors with DID (personality splitting) and adult female incest survivors without DID (no overt personality splitting). Second, it also examined whether there was a significant difference between these groups on the characteristics of dissociation and object-relations impairment. Although not a primary purpose of this study, a comparison was made between these two groups on a number of childhood maltreatment factors and on a number of adult traumatic factors.

Population and Sample

The population for this study included adult female incest survivors with and without personality splitting who at the time of the study were receiving outpatient therapy in Kalamazoo and surrounding geographic areas in Michigan and northern Indiana. Efforts were made to recruit individuals from a diversity of ethnic and racial backgrounds. All subjects participated on a voluntary basis. Clients who participated as volunteers in this study were drawn from a variety of outpatient treatment settings.

The sample for this study included adult female incest survivors at least 18 years of age, who were in outpatient treatment, and who met the criteria for "incest." Incest
survivors were included in the study if they self-reported any kind of sexual activity ranging from fondling to intercourse that had occurred before the age of 17 between themselves and any person who would be considered an ineligible partner because of his/her blood relationship and/or social ties (i.e., father, stepfather, grandfather, uncles, siblings, cousins, in-laws, and anyone who could be called a "quasi-family member" [i.e., mother's sexual partner living in the home]).

Clients were asked to volunteer for this study by their therapists. This was done to ensure that the clients would be appropriate for the study and would not suffer any negative consequences as a result of the study. I met with various outpatient staffs in southern Michigan and northern Indiana to identify potential research subjects who were being treated for their incest and either met or did not meet the diagnosis for DID. I also met with two regional support groups for therapists working with DID incest survivors to recruit DID clients since it was anticipated that it would be somewhat more difficult to find and recruit DID clients than non-DID clients for this study.

Adult male incest clients were not included in this study due to anticipated difficulties in recruiting adult male incest clients, especially with DID. Ross and Norton (1989) noted that the ratio of females to males with this disorder in patient populations is approximately 9:1 and that there are few differences in the characteristics found between women and men with this disorder. Hospitalized clients were not recruited for this study since it was felt that they would be less stable emotionally than outpatient clients and might have difficulty completing the research material.

Incest survivors who were manifesting covert signs of DID (Franklin, 1990) and did not meet clear-cut criteria for DID as described by the DSM-IV (APA, 1994) were also excluded from this study. DSM-IV criteria were used to determine if incest survivors should be assigned to the DID or non-DID group. Outside collaboration was provided by
me on one case where the therapist was uncertain whether or not the client met the DID diagnosis. Four DID clients being seen at the time of the study by this researcher were also included in the study.

**Protection of Human Subjects**

All potential subjects were required to provide written consent in order to participate in this study. A statement regarding the purpose of the study and issues pertaining to confidentiality was provided to clients on the Client Research and Consent to Release Confidential Information Form (Appendix A). In addition, subjects were informed that their desire not to participate or to withdraw from this study would in no way prejudice their future relationship with their therapist. They were also informed that their therapist could terminate the client's participation in this study at any point in time, if the therapist felt that the study was having a detrimental effect on the client's treatment. Prior to data collection, approval from Andrews University's committee for research involving human subjects was obtained.

Research subjects were assured that information obtained in connection with this research would remain confidential, within the constraints of the law, and would not be disclosed without client consent. All data collected were used for the purpose of statistical comparisons and analysis and were not associated with the research subjects' names. Participants were advised of any foreseeable risks as well as benefits that could be associated with this type of research (Appendix A).

When painful therapeutic material was elicited during the course of this investigation, it was the responsibility of the therapists and/or agency-treatment centers to help resolve these issues for the client within their treatment settings. No clients had to withdraw from the research; however, one client was unable to complete a few questions on the CMIS-SF regarding her childhood abuse because some questions stirred up too
many unpleasant memories for the client.

**Instrumentation**

The following instruments were used in this study: Dissociative Experience Scale (DES), Bell Object Relations Reality Testing Inventory (BORRTI), and Childhood Maltreatment Interview Schedule-Short Form (CMIS-SF).

**Dissociative Experience Scale (DES)**

**Purpose**

Until the development of the Dissociative Experience Scale (DES) (Bernstein & Putnam, 1986) (Appendix B), no reliable and valid instruments had been developed that would allow dissociative experiences to be quantified in normal and clinical populations. When the DES was originally developed respondents were asked to record the amount of time they spent dissociating by marking a 100-mm-line analogue scale. A simpler method of responding to items on the DES was later developed by Bernstein and Putnam, which involved circling the "percentage" of time spent in dissociation. This latter, simpler recording method was used in this research.

The DES was developed to provide a simple, easily administered instrument for investigating the contribution of dissociation to a variety of psychiatric disorders and for screening patients with major dissociative psychopathology. From a practical standpoint the DES was needed, in the opinion of its authors (Bernstein & Putnam, 1986), because dissociative disorders have been misdiagnosed in the past and have led to what they believe is the erroneous assumption that dissociative disorders are quite rare.

The DES has been used in a variety of research studies. For example, the DES has been used to measure the levels of dissociation in samples of PTSD patients (Branscomb, 1991; Bremner et al., 1992), eating disorder patients (Demitrack, Putnam, Brewerton, 1992).
Brandt, & Gold, 1990; Goldner, Cockhill, Bakan, & Birmingham, 1991) and borderline personality disorder patients (Herman, Perry, & van der Kolk, 1989). It has also been used to measure levels of dissociation in non-clinical populations such as the general population (Ross, Joshi, & Currie, 1990), and adolescents (Ross, Ryan, Anderson, Ross, & Hardy, 1989).

The DES has also been used to examine the relationship between dissociation and a variety of other variables including: physical and sexual abuse (Chu & Dill, 1990; Kirby et al., 1993; Ross, Norton, & Anderson, 1988; Ross, Miller, et al., 1990), aggression (Quimby, 1991), hypnotizability (Frischholz, Lipman, Braun, & Sachs, 1992), paranormal experiences (Ross & Joshi, 1992), and psychic experiences (Richards, 1991).

The DES has been used with DID populations to study the relationship between DID and complex seizures (Loewenstein & Putnam, 1988; Ross, Heber, Norton & Anderson, 1989), the overlap of DID with obsessive-compulsive disorder (Ross & Anderson, 1988), general characteristics of DID (Coons et al., 1988; Ross, Joshi, & Currie, 1990), DID as part of a dissociative continuum (Bernstein & Putnam, 1986), and differences between DID and other diagnostic groups (Bernstein & Putnam, 1986; Ross, Heber, Norton et al., 1989). Although the DES has been used to measure dissociation in non-clinical populations, this was not its intended purpose. Since non-clinical subjects typically score in a fairly narrow range at the low end of the scale on the DES, small differences among these subjects may not be meaningful. The DES was developed for use with adults age 18 or older.

The DES was not intended as a diagnostic instrument; however, many clinicians have used the DES as a screening device to identify high dissociators. A total score of 30 or above on this instrument has been found to correctly identify 74% of those with DID and correctly identify 80% of those who do not have DID (Carlson, Putnam, Ross, et al.)
In their analysis of the DES, 61% of those who scored 30 or above who were not diagnosed with DID had PTSD or a dissociative disorder other than DID. The median score for normals on the DES is 4.4 (Bernstein & Putnam, 1986).

Description

The DES is a 28-item self-report measure that permits the quantification of dissociative experiences by recording the frequency, and type of each experience. This quantification makes it possible to rank different diagnostic groups along a continuum of dissociation. The mean of all item scores ranging from 0 to 100 has been referred to in the literature as the "DES" score. In this study this score is referred to as the DES "frequency" of dissociative experiences score. A DES "type" score, which reflects the mean number of items endorsed by participants on this 28-item self-report measure, was also reported in this study. This score reflects the different "types" of dissociative experiences endorsed by participants and can range from 0 to 28.

The test items on the DES were formulated using clinical data and interviews, scales involving memory loss, and consultation with experts in dissociation. They were developed to measure disturbances in memory, identity, awareness, and cognition, and included experiences that have been labeled in the literature as amnesia, depersonalization, derealization, absorption, and imaginative involvement.

Experiences involving the dissociation of moods or impulses were excluded from the scale so that the items would not overlap with alterations in mood and impulses associated with affective disorders. Items were worded to be comprehensible to the widest possible range of individuals and to avoid implications of social undesirability.

The scale, when originally developed, was administered to between 10 and 39 subjects in each of the following populations: normal adults, late adolescent college students, as well as persons suffering from alcoholism, agoraphobia, phobic-anxious
disorders, PTSD, schizophrenia, and dissociative identity disorder. The scale has been proven effective in differentiating between subjects with and without clinical diagnoses of dissociative disorders.

The DES was conceptualized as a trait measure (as opposed to a state measure) and inquires about the frequency of dissociative experiences in the daily lives of subjects. A response scale using percentages was used to allow subjects to quantify their experiences for each item so that responses could reflect a wider range of dissociative symptomatology than possible if using a dichotomous (yes/no) format.

The following is an example of one of the items on the DES: "Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you."

The scale is a self-report measure and is self-administered. Through directions on the cover sheet of the scale, subjects are instructed to consider only those experiences that do not occur under the influence of drugs or alcohol when marking answers. In cases when the subject is illiterate or has difficulty reading, the instructions and questions can be read aloud and repeated and the subject can be assisted in circling an answer (percentage of time an experience occurs). It should be noted that scores on the DES do not always reflect psychopathology since many DES items ask about non-pathological forms of dissociation such as highway hypnosis or day-dreaming. Consequently, DES scores may have different meanings across clinical and non-clinical samples. Some information on correlations of DES scores with other measures is provided by Frischholz, Braun, Sachs, Hopkins et al. (1990) and Frischolz, Braun, Sachs, Schwartz et al. (1990).

Validity and reliability

Construct validity refers to an instrument's ability to measure a construct, which in the case of the DES is its ability to measure "dissociation." Item-scale score correlations
were all significant, indicating good internal consistency and construct validity (Bernstein & Putnam, 1986). The DES was also validated by Carlson et al. (1993). In this study a discriminant analysis was performed to classify 1,051 clients in a multicenter study done in Canada and the United States. The mean DES (frequency) score for subjects with DID in this study was 42.8 (N = 228) (SD = 19.2) and was substantially higher than subjects with other diagnoses. The discriminant analysis results show that the DES is capable of accurately classifying subjects into the categories of having or not having DID.

While there were no measures of dissociation available with established reliability and validity with which to compare the DES at the time of this study, convergent validity was studied by comparing the DES with a not-yet-validated Perceptual Alteration Scale. Frischholz, Braun, Sachs, Hopkins et al. (1990) reported a Pearson correlation of .52 between the DES and this scale.

Discriminant validity has been established by showing that the scores on the DES do not correlate highly with variables thought to be unrelated to the construct of dissociation. In the manual for the DES (Carlson & Putnam, 1993), a number of studies were cited that found no significant relationship between DES scores and socioeconomic status, sex, income level, employment status, education, religious affiliation, and race. There appeared to be low, negative correlations between DES scores and age. Additional construct validity on the DES was provided by a factor analysis of the items.

A Kruskal-Wallis test and post hoc comparisons of the scores of the eight populations initially used in the development of this scale provided evidence of the scale's criterion-referenced validity (how well the DES agrees with some criterion related to the construct being measured). The scale was able to distinguish between subjects with a dissociative disorder and all other subjects. In terms of concurrent validity (predictive capacity) an analysis of the DES yielded a specificity rate of 74% (proportion of DID
subjects correctly identified) and a specificity rate of 80% (proportion of non-DID subjects correctly identified) (Carlson et al., 1993).

The test-retest reliability coefficient on the DES was 0.84. The split-half reliability method was used to measure internal consistency. Using the Spearman-Brown formula, coefficients ranged from .71 for normal adults to .96 for phobic anxiety adults. For those diagnosed with DID, the coefficient was .92 (Bernstein & Putnam, 1986).

The Bell Object Relations and Reality Testing Inventory (BORRTI)

Purpose

Despite the theoretical robustness of object-relations and reality-testing constructs, research on object-relations theory has been limited in the past, like dissociation, by the absence of a standardized instrument with established reliability and validity. The BORRTI (Bell, 1991) (Appendix C) was developed to fill this gap. Through a factor analysis process, well-defined dimensions of object-relations impairment and reality testing deficits were identified by Bell, which eventually made up the seven scales on the BORRTI.

This self-report objective test eliminated the reliability problems of other methods used in the past to assess ego functioning that depended on individually administered projective tests or the judgment of raters. The BORRTI has been used with a large number of well-defined diagnostic groups to investigate four areas of interpersonal object-relations functioning and three areas of reality-testing functioning.

The BORRTI has been particularly helpful in the diagnosis and treatment of personality disorders and psychotic states. This seems to be the case since deficits in interpersonal functioning and reality testing seem to play an important role in more
characterological disorders. Treatment recommendations based on BORRTI scores can make it more likely that clients will receive appropriate clinical services.

Description

The BORRTI is a 90-item, self-report multifactorial inventory of ego functioning with a true-false format. It is based on the premise that personality develops from experiences in early childhood through relationships that produce internal self-representations. Psychopathology is seen as a disruption of this pattern of psychological growth that can result in an arrest in development of a particular ego state. Like dissociation, object relations is viewed as falling on a developmental continuum, from normal to pathological.

The four object-relations (OR) scales on the BORRTI (Alienation, Insecure Attachment, Egocentricity, and Social Incompetence) were developed from an earlier version of this instrument, the Bell Object Relations Inventory (BORI) (Bell, Billington, & Becker, 1986) and deal with general object-relations interpersonal functioning. Bell defines object relations as the capacity for experiencing human relatedness. Believing that object relations is multidimensional. Bell et al. (1986) used a factor analytic approach to develop these four interpersonal scales. Three reality testing (RT) scales -- Reality Distortion, Uncertainty of Perceptions, and Hallucinations and Delusions -- were not included in the BORI but were added in the BORRTI to measure problems in reality testing.

The Alienation scale deals with basic trust. Those who score high on this scale have difficulty getting close to others and do not have much hope of entering or maintaining a satisfying, stable, intimate relationship. A high score may also suggest difficulty in separating one's needs and impulses from those of others, and may point to ego-boundary disturbances.
The Insecure Attachment scale can reflect an inordinate need for closeness in relationships as well as a low tolerance for rejection, separation, and loss. High scorers may see relationships as having a painful quality but generally attain a higher level of object relatedness than those who score high on the Alienation scale.

High scorers on the Egocentricity scale have a mistrust of others' motivations, seeing others as existing only in relationship to oneself. They see others as being manipulated for one's own self-centered aims. This scale may indicate severe disturbances in ego boundaries, with differentiation of self from others being extremely poor.

The Social Incompetence scale has to do with difficulty in establishing friendships, social insecurity, a lack of close interpersonal relationships, and poor sexual adjustment. High scorers are likely to experience shyness, anxiety, and uncertainty regarding interactions with members of the opposite sex.

Of the three reality-testing scales, the Reality Distortion scale may suggest the presence of delusions, thought withdrawal, thought broadcasting, and various depressive and grandiose beliefs. The Uncertainty of Perceptions scale is a measure of a person's self-awareness and grasp on reality. It involves doubts about perceptions of internal and external events, confusion about one's feelings of others, and extreme ambivalence in relationships. However, even those who score highly on this scale seem able to maintain some degree of ego functioning.

High elevations on the Hallucinations and Delusions scale suggest the presence of hallucinatory experiences and paranoid delusions of various types. High scorers are most commonly found among schizophrenic and schizoaffective samples, with some borderline patients also receiving elevated scores. In the case of DID clients, however, it has been suggested by Alpher (1992a) that this scale is more likely to capture the nature of passive influence phenomena in DID clients. As a result, a high score on this scale...
should not be assumed to be measuring traditional psychotic processes when the BORRTI is used with DID clients.

Additional interpretations of the BORRTI scale scores can be made also by examining various scale scores in relationship to other scale scores. If computer-scored, a printout also provides the examiner with a listing of items endorsed in the pathological direction. Critical items are marked as being either "Object Relations" or "Reality Testing" in nature and may be helpful in identifying clinically subtle but important differences in the meaning of a particular profile pattern.

The following are statements that are typical of those on the BORRTI: "I have at least one stable and satisfying relationship"; "Sometimes I think I have been possessed by the devil"; "It is hard for me to get close to anyone"; "No matter how hard I try to avoid them, the same difficulties crop up in my most important relationships"; "People are never honest with each other"; "I feel shy about meeting or talking with members of the opposite sex"; "I feel that my thoughts are being taken away from me by an external force"; "I know my own feelings"; "I hear voices that others do not hear which keep up a running commentary on my behavior and thoughts."

The simplicity of the BORRTI minimizes the need for special test administration. It has been administered by mail, in large classroom settings, in small groups of psychiatric patients, and in one-to-one clinical situations. In the latter approach, which was used in this study, subjects were asked to complete the test using the "true/false" format.

There are two principal sources of invalidity in the BORRTI: unscorable items (left blank or marked both "true" and "false") and exaggerated reporting (positive or negative). If the subject has difficulty deciding whether the item is true or false, the test administrator can assist the person to refer to the "most recent experience" as the test instructions say, or to "give the answer that seems most descriptive" even though both answers are sometimes true. When respondents in clinical settings exaggerate their
response patterns, this tendency will often also appear in other aspects of the interaction. This may represent a misunderstanding of the purpose or meaning of the inventory or may convey some other message, such as a "cry for help." The test administrator should be alert to such threats to validity.

This instrument may be hand- or computer-scored. Computer scoring is recommended since 800 arithmetic operations are involved in hand-scoring. Also, the microcomputer program written in Microsoft BASIC (IBM-compatible) code allows exact computation of factor scores that can be compared with non-pathological norms (N = 934) provided with the program.

Validity and reliability

The BORRTI was derived from an explicit framework of ego functioning (Bell et al., 1986; Bell, 1994). The internal structural validity was found to be strong given the high degree of factorial invariance. The external validity of the BORRTI has been established based on the use of this instrument in a wide variety of applications. Such experience has been accruing over the past 10 years as clinicians and researchers have begun publishing results of the BORRTI in investigating a variety of psychiatric disorders, psychosocial factors in medical illness, and issues of personality and development.

Bell (1991) reported on a number of studies that have demonstrated discriminant, concurrent, and predictive validity among various groups such as schizophrenics, substance abusers, nightmare sufferers, and cross-dressers. The BORRTI has also been used with DID clients (Alpher, 1991, 1992a) and normal samples. In addition, the BORRTI has also been used in the study of groups like: mother-daughter dyads, personalities of twins, sexual decision making in college students, gender-identity formation, single women who choose motherhood, and patterns of early adolescent
relatedness to parents. The BORRTI has also been used as an outcome measure in at least two clinical studies, and its construct validity has been explored in several studies described in the prepublication manual (Bell, 1991). In a review of the BORRTI's psychometric characteristics, Alpher (1991) concluded that it is a reliable and valid instrument for the assessment of object-relations and reality testing.

The BORRTI scales are relatively free of response bias due to age or sex although men tend to show higher scores on the Social Incompetence scale (Bell, 1991). Internal consistency and split-half reliability for all scales appear to be good (Cronbach's alpha: .78 to .90 range; Spearman split-half: .77 to .90 range).

Test-retest reliability for the BORRTI has been assessed with psychiatric samples over 8 weeks, 13 weeks, and 26 weeks. Since the instructions of the BORRTI are to describe "your most recent experience," state changes should be reflected with re-testing correlations. Psychiatric samples undergoing treatment in particular would be expected to show fluctuations in BORRTI scores over time. Thus, one would expect to see test-retest correlations that are neither too high nor too low (Bell, 1991).

Classification reliability appeared to be good when cut-off scale scores were examined for a schizophrenic sample 26 weeks after initial evaluation on the seven scales (percentage of agreement ranged from 69.8 to 84.9). Intercorrelations among scales have varied considerably depending on the sample of subjects. A thorough review of the theoretical, structural, and external validity of the BORRTI is provided by Bell (1994). In addition to citing additional research with the BORRTI with a number of other psychiatric groups, Bell has found the external validity of the BORRTI supported by its relationship with other well-known self-report instruments and clinical ratings.

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The Child Maltreatment Interview Schedule - Short Form (CMIS-SF)

The CMIS-SF (Briere, 1992) (Appendix D) has been developed for research use. The CMIS-SF is an abbreviated form of the CMIS. The CMIS is a comprehensive questionnaire designed for clinical purposes to elicit pertinent background information, particularly maltreatment factors that may be of etiological significance in examining the long-term clinical correlates of childhood sexual victimization. Briere (1992) advises that for research purposes the "further information" sections on the CMIS should be deleted from each item, along with the topic headings.

The purpose of using the CMIS-SF in this study was to assess differences between the DID and non-DID incest survivor groups on various maltreatment factors. Putnam (1993) reported that it has been believed by those treating DID clients that they have, on the average, experienced more trauma than non-DID childhood abuse and trauma victims. This belief, however, has not been empirically tested. The main utility in using the CMIS-SF is in its ability to obtain standardized information that may be of value in the replication, extension, or comparison of this study's results with other studies in the incest literature. The CMIS-SF also includes questions on traumatic events that have occurred in adult life.

Procedures

Procedures for Obtaining Subjects

Twenty-nine female adult survivors of incest with personality splitting and 31 adult female incest survivors with no overt splitting (18 years or older) volunteered for this study. There were also two integrated DID clients who participated in this research. The results on these two clients are reported separately in chapter 4. While collecting data, I attended staff meetings and DID therapist-support network meetings in southern Michigan and northern Indiana to recruit incest survivors with and without DID for this
study. Questions were answered about the study, and a Therapist/Agency Letter (Appendix E) that briefly explained the nature of the research was discussed as well as other issues that might have been of concern to therapists who might want to participate.

As names of therapists were identified through the above process (and general networking activities), I met individually with therapists who requested additional information regarding the nature of the study. In agencies where individual therapists provided outpatient counseling to incest survivors, appropriate agency supervisory personnel were contacted to get their approval for the research. In such situations both supervisory personnel and individual therapists were asked to sign the Therapist/Agency Consent Form (Appendix F). This form, which explained the general nature of the study, was signed prior to the collection of any data.

Once individual therapist and appropriate agency personnel had signed this form, individual therapists who expressed an interest in assisting in the collection of data on one or more of their incest clients were given additional information in a handout entitled Therapist Guidelines (Appendix G). This material outlined the responsibilities of therapists in this study and provided them with the necessary information to participate with their clients in this research.

Therapists were also given a Client Diagnostic Confirmation Form (Appendix H). Therapists were encouraged to try to enlist incest survivors from their current case loads whom they felt would be emotionally stable enough to participate in this research. The Client Diagnostic Confirmation Form also provided information on the criteria for this study. Therapists were asked to use this form to make a diagnosis of the client (DID or non-DID) and also were asked to rate their level of confidence in their diagnosis on a 5-point Likert scale. This form also provided therapists an opportunity to describe some of the clinical characteristics of their DID clients. To be included in this study clients were
required to meet the following criteria: (1) be a female, (2) be at least 18 years of age, and (3) be an incest survivor as described in this research (see definition, chapter 1). To ensure that clients met the diagnosis for DID or non-DID, therapists were provided with the diagnostic criteria for DID based on the DSM-IV (APA, 1994) on this form.

Clients who completed this research were not given any financial remuneration for their participation but were told that information obtained from this study might eventually benefit other incest survivors in the future. A summary of the clients' test results on the DES and BORRTI was provided to all therapists in this study. Therapists were asked to share the test results with their clients if they felt this would be diagnostically helpful to the client.

Clients who were interested in volunteering their time for this study were informed at the time they consented to participate that they could notify me if they wished a summary of the research at a later date. Confidentiality was maintained in this research by the assignment of the client's first four digits of their social security number to the material they were required to turn in for the study. The names of clients were not used in the publication of research data.

Clients were asked to fill out a Personal Data Sheet (Appendix I) once it had been determined that they met the criteria for inclusion in this study and had signed the Client Research and Consent to Release Confidential Information Form (Appendix A). The Personal Data Sheet provided basic demographic information, psychological treatment history, and information on the client's "Incest Memories." Because of recent controversy in the news media and by some researchers over the accuracy and reality of repressed memories in incest survivors (Loftus, 1993), the clients were asked to answer questions regarding their incest memories. It was hoped that the information obtained would add to our basic understanding of repressed memories in adult incest survivors by asking them directly about these memories.
Data Collection Procedures

Once clients had completed the Client Research and Consent to Release Confidential Information Form (Appendix A) and Personal Data Sheet (Appendix I), it was recommended that outpatient therapists have them complete the CMIS-SF (Appendix D) at the agency or office where the client was being seen for services. This was suggested so that if upsetting memories or feelings were elicited by the CMIS-SF in regard to childhood abuse, the therapists would be in a position to deal with whatever negative feelings or memories might surface for the client.

Therapists were given some latitude on whether clients completed the Personal Data Sheet, CMIS-SF, DES, and BORRTI in one or two settings; however, therapists were encouraged to have the clients complete all of the research material within 1 month after signing the Client Research and Consent to Release Confidential Information Form (Appendix A). Most clients were able to complete the research material in less than 2 hours and in one sitting. It was recommended that the clients complete the research material in a quiet office in the counseling setting where clients were receiving services. This was to ensure that the two self-report measures and CMIS-SF were completed by the client in an adequately controlled testing situation. It was also felt that this procedure would maximize the full cooperation and attention of the client. Both the 28 items on the DES and the 90 "true/false" items on the BORRTI were read to clients who had difficulties reading or understanding the material.

Although adult clients with DID have been known to dissociate and "switch personalities" under stressful situations, including testing situations, not much is known about how this process might influence the findings in DID research. Even less is known about incest survivors who do not manifest overt switching, but may still dissociate during testing. In this study no effort was made to control for the effects of personality switching or dissociation. "All parts" of the client (alter personalities) were encouraged to participate in completing the research material as a holistic approach to testing.
This decision to not control for the effects of personality switching and dissociation in test administration was based on testing procedures recommended by Armstrong and Loewenstein (1990) for DID clients. Armstrong and Loewenstein suggested that all alter personalities be invited to participate in testings so that the results provide a broad-based picture of the client's functioning at the time of testing. It is recognized in this study that there may have been some personality switching or the co-presence, or co-consciousness, of some personality states. Armstrong and Loewenstein are in agreement with Coons (1984) who stated that: "Only taken together can all the personality states (in dissociative disorders and DID) be considered a whole 'personality'" (p. 53). Rather than regarding the shifting states of alters as confounding the test results, the instructions recommended by Armstrong and Loewenstein enlist the participation of the greatest number of personality states in any given testing situation. In this research, it was hoped that these procedures moved beyond surface manifestations to the core phenomenology of the disorder and thus provided a more complete picture of the personality structure, range of abilities, and information available to DID clients.

Since adult incest survivors with and without personality splitting were tested in this study, a slight adaptation of Armstrong and Loewenstein's (1990) recommended procedure was used. This was done so that the same administration instructions could be used with both the DID and non-DID incest survivors. The following testing instructions (Appendix J) were provided to all subjects prior to the completion of the DES and BORRTI:

"Testing was designed to be useful for people who sometimes feel as if they have different parts to themselves and/or feel very divided. Although this may or may not be true for you, you are invited to allow all parts or aspects of yourself to participate in the testing if this is comfortable."
Since no effort was made to control for the effects of alter personalities in clients with DID, the test results are being offered as a global representation of their overall functioning and response to the test situation.

**Null Hypotheses**

Null Hypothesis 1: There is no relationship between scores of dissociation and object-relations impairment in adult female incest survivors diagnosed with DID (no splitting) and those not diagnosed with DID (no overt splitting).

Null Hypothesis 2: There are no significant differences between adult female incest survivors diagnosed with DID (splitting) and those not diagnosed with DID (no overt splitting) on a measure of dissociation.

Null Hypothesis 3: There are no significant differences between adult female incest survivors diagnosed with DID (splitting) and those not diagnosed with DID (no overt splitting) on a measure of object-relations impairment.

**Data Analysis**

The DES was hand-scored and two scores were obtained in this research. The DES score named in this study as the "frequency" of dissociative experiences score is the primary score usually reported in the research literature when the DES has been used. This score refers to the mean amount of time spent in dissociative experiences. A second DES score, which is less commonly reported in the research literature and named in this study the "type" of dissociative experiences score, refers to the mean number of different types of dissociative experiences endorsed by the clients.

BORRTI data were analyzed through a computer program. Computer scoring provided exact computation of scale scores. These scores were compared with nonpathological norms to generate standard score profiles. The nonpathological normative sample (N = 934) consisted of 60 community-active adults (members of the...
board of directors of a social service agency and a business organization; ranging in age from 19-79 years old; M = 38.47). The remainder of the group consisted of students (ranging in age from 18 to 48 years old; M = 25.86).

Tentative interpretative statements for high-point scale scores are included in the BORRTI manual (Bell, 1991). These statements are derived from extensive research with the BORRTI in diverse clinical samples validated with current research-based diagnostic procedures (Bell, 1991; Bell et al., 1986). Bell has recommended that individual scale t-scores on the BORRTI be regarded as clinically elevated if t-scores are over 60 on the first six scales (Alienation, Insecure Attachment, Egocentricity, Social Incompetence, Reality Distortion, and Uncertainty of Perception) or over 65 on the Hallucinations and Delusions scale. The t-scores were plotted against norms to produce a standard score profile for the four interpersonal object-relations (OR) scales and three reality-testing (RT) scales measured by the BORRTI.

A Pearson's product correlation (two-tailed) was used to test hypothesis 1. It was predicted in this study that there would be a positive correlation between the amount of time adult incest survivors spend dissociating (as measured by the DES "frequency" score) and the degree of object-relations impairment as measured by the BORRTI Alienation scale score. This BORRTI scale score was pre-selected to test hypothesis 1 since this BORRTI scale score appears to represent the broadest dimension of object-relations impairment on the BORRTI compared to other scale scores. Although the six other BORRTI scale scores were not pre-selected to test hypothesis 1, Pearson correlations were also run between the DES "frequency" score and these six BORRTI scale scores to see if there would also be a relationship between the mean amount of time spent in dissociative experiences and these six scales. Also, although it had not been hypothesized in chapter 1 that there would be a relationship between the DES "type" score (mean number of endorsed items on the DES) and the seven BORRTI scale scores.
Pearson correlations were also run to see if there would be significant positive correlations between these scores. It was felt that if there were, it might be possible to draw the additional conclusion that the mean number of different "types" of dissociative experiences is also significantly related to object-relations impairment in adult incest survivors. This would mean that as adult incest survivors dissociate more, they would also have to employ more different types of dissociative experiences as part of an ego-defense strategy.

The t-tests for independent samples were run to test hypothesis 2 for the two groups in this study to see if the DID incest survivor group differed significantly from the non-DID incest survivor group. It was predicted that the DID incest survivor group (due to higher levels of childhood traumatization) would score significantly higher than the non-DID incest survivor group on both the "frequency" and "type" of dissociative experience scores on the DES. It was expected that the DID group would spend a greater amount of time dissociating and would also endorse a greater number of dissociative experiences than the non-DID group.

The t-tests for independent samples were also run to test hypothesis 3 for the two groups in this study to see if the DID incest survivor group would score significantly higher than the non-DID group on seven BORRTI scale scores. It was predicted that the DID incest survivor group (due to higher levels of childhood traumatization) would score significantly higher than the non-DID incest survivor group on all seven BORRTI scales. A .05 level of significance was used to test all these hypotheses.

The CMIS-SF was used to get background information on both groups in the sample on the incidence of various childhood maltreatment factors. It was assumed this information on childhood maltreatment factors could be used to determine if the DID group was, in fact, traumatized more during childhood through various kinds of
maltreatment than the non-DID group. Since being traumatized as adults could also have a cumulative effect on the level of traumatization experienced by both the DID and non-DID groups (which could also influence scores on the DES and BORRTI in adult incest survivors in this sample), the CMIS-SF was also used to get information on both groups in regard to the incidence of adult traumatic experiences reported. It was expected that the DID group (based on a general review of the literature) would have experienced a greater incidence of childhood maltreatment, including incest, than the non-DID group. It was also expected that the DID group might also report a higher incidence of adult traumatic experiences than the non-DID group because the DID group might be more prone to re-enact abuse experiences as adults, experience more revictimization, or due to diminished ego strength, view events as more traumatic.

A multivariate discriminant analysis was also performed on the DES and BORRTI scale scores for the two groups in this study to ascertain whether the two groups could be classified based on these test scores.
CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

Introduction

The purpose of this study has been to investigate whether there is a relationship between dissociation and object-relations impairment in adult female incest survivors diagnosed with "dissociative identity disorder" and those not diagnosed with this disorder. It has also been designed to examine whether there is a difference between the DID group and non-DID group on the characteristics of dissociation, as measured by the Dissociative Experience Scale (DES), and on the characteristic of object-relations impairment, as measured by the Bell Object Relations Reality Testing Inventory (BORRTI).

Although not a major focus of this research, information has also been obtained on a number of background variables using the Child Maltreatment Interview Schedule--Short Form (CMIS-SF). Since there appear to have been no studies that have compared the backgrounds of DID incest survivors with the backgrounds of non-DID incest survivors, comparisons were made between these two groups on a number of childhood maltreatment factors and a few adult traumatic factors.

The results of the data analysis are presented in this chapter. The first section describes the demographic characteristics of the sample. This is followed by a description of the clinical characteristics of the sample, CMIS-SF results, and statistical analyses of the findings in relationship to the three research questions. Finally, a brief description of two integrated DID clients and a summary of the findings will be provided at the end of this chapter.
Description of Sample

Demographic Characteristics

The sample consisted of 60 adult female clients, 18 years or older, who were receiving outpatient therapy for the long-term effects of childhood incest occurring before age 17. The sample was drawn on a volunteer basis from the client caseloads of 31 different outpatient therapists (25 female and 6 male). The group of therapists who participated in the study included Ph.D. psychologists, master's level psychologists, social workers, licensed professional counselors, and two doctoral-level students in counseling psychology. Sixty-five percent of the sample were being treated in private practice settings, 30% in community agency settings, and 5% in university counseling settings.

Twenty-nine women in the sample constituted one group. This group, named the "DID group," was made up of adult, female incest survivor clients in outpatient therapy, who met the diagnosis for "Dissociative Identity Disorder," based on DSM-IV (APA, 1994) criteria, and volunteered for the study. Thirty-one women in the sample constituted the second group, which was named the "non-DID group." This group was also made up of adult, female incest survivor clients who were in outpatient therapy, but who did not meet the diagnosis for DID. Two additional clients, who had in the past met the diagnosis for DID, but who appeared to be integrated at the time of this study, were excluded from the DID group. The findings on these two clients are reported separately and they were not included in the sample. It was felt that the results of these two subjects would have biased the findings in the DID group but might provide some interesting data on integrated individuals still in therapy.

The entire sample of incest survivors was drawn from six counties in Michigan and one county in northern Indiana and included both urban and rural areas. Therapists
working with adult female incest survivors both with and without DID were identified through informal networking activities so that clients could be approached by their therapists regarding their willingness to participate in this study.

The racial composition of the sample is described in Table 1 and was very similar for both the DID and non-DID groups. Ninety percent of both groups were Caucasian. Ten percent of the DID group were made up of African Americans. Three percent of the non-DID group were made up of African Americans, and another 7% identified themselves as multi-racial (Caucasian and Native American Indian, and Mexican and Native American Indian). Although an effort was made to recruit minorities in this study, research restrictions at some community-based counseling centers made it difficult to obtain a racially diversified sample.

Table 1

Racial Composition of Sample

<table>
<thead>
<tr>
<th>Group</th>
<th>Caucasian</th>
<th>African American</th>
<th>Multi-Racial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a</td>
<td>%</td>
<td>a</td>
</tr>
<tr>
<td>DID</td>
<td>26</td>
<td>89.70</td>
<td>3</td>
</tr>
<tr>
<td>Non-DID</td>
<td>28</td>
<td>90.32</td>
<td>1</td>
</tr>
</tbody>
</table>

Note. N = 60 for sample, 29 for DID group and 31 for Non-DID group. Percentages reflect the proportion of incest survivors in each group in the sample falling into the various racial groups represented in this study.

aOne subject was Caucasian and Native American Indian and one was Mexican and Native American Indian.
Table 2 shows the age distribution for the sample that was similar for both groups. The average age of the DID incest survivor group was 39.3 years (SD 10.00) with a range of 25-63 years. The average age of the non-DID incest survivor group was 36.1 (SD 8.71) with a range of 19-55 years. The majority of clients in both groups fell in the 30-49-year-old range; however, there were more non-DID incest survivors in the young adult range of 18-29 years. There were also no non-DID incest survivors in the 60-69 year age group.

Table 2

<table>
<thead>
<tr>
<th>Age Range</th>
<th>DID (N = 29)</th>
<th>Non-DID (N = 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a</td>
<td>%</td>
</tr>
<tr>
<td>18 - 29</td>
<td>5</td>
<td>17.24</td>
</tr>
<tr>
<td>30 - 39</td>
<td>10</td>
<td>34.48</td>
</tr>
<tr>
<td>40 - 49</td>
<td>10</td>
<td>34.48</td>
</tr>
<tr>
<td>50 - 59</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>60 - 69</td>
<td>2</td>
<td>6.90</td>
</tr>
</tbody>
</table>

Note. Percentages reflect the proportion of incest survivors in each group in the sample falling into the various age ranges.

As with the racial composition and age of the sample, the DID and non-DID incest survivor groups were quite similar in regard to marital status (Table 3). Both the DID and non-DID groups were somewhat equally distributed among being married, divorced, or widowed. There were slightly more single individuals in the non-DID group compared to
the DID group and slightly more separated individuals in the DID group compared to the non-DID group. The average number of children of women in the DID group was 1.9 (SD 1.75) with a range of 0-6 children, while the average number of children of subjects in the non-DID Group was 1.6 (SD 1.80) with a range of 0-7 children.

Table 3

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>DID (N = 29)</th>
<th>Non-DID (N = 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a</td>
<td>%</td>
</tr>
<tr>
<td>Single</td>
<td>8</td>
<td>27.59</td>
</tr>
<tr>
<td>Married</td>
<td>9</td>
<td>31.03</td>
</tr>
<tr>
<td>Separated</td>
<td>4</td>
<td>13.79</td>
</tr>
<tr>
<td>Divorced</td>
<td>7</td>
<td>24.13</td>
</tr>
<tr>
<td>Widowed</td>
<td>1</td>
<td>3.45</td>
</tr>
</tbody>
</table>

Note. Percentages reflect the proportion of incest survivors in each group in the sample in each of the marital categories.

The educational level of the DID and non-DID incest survivors in the sample was fairly high for both groups (Table 4). In the DID group there were no incest survivors with less than a high-school education, and only 10% in the non-DID group had less than a high-school education. As a whole the sample appears fairly well-educated with approximately 75% of both groups having obtained at least some college or graduate school education. Two individuals in the DID group and one individual in the non-DID group had obtained a Ph.D. The relatively high educational level may reflect the fact that
at least 61% of the sample was drawn from an area where there is a major university, a 2-year community college, and other institutions of higher learning. The fact that 21% of the DID group had either attended 1-3 years of graduate school or obtained a Ph.D. seems consistent with Kluft's observation (1986a) that there appears to be a subset of highly educated professionals among DID clients.

Table 4

Educational Level of Sample

<table>
<thead>
<tr>
<th>Academic Level</th>
<th>DID (N = 29)</th>
<th>Non-DID (N = 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>High School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than</td>
<td>3</td>
<td>9.68</td>
</tr>
<tr>
<td>Some</td>
<td>2</td>
<td>6.90</td>
</tr>
<tr>
<td>Graduate</td>
<td>5</td>
<td>17.24</td>
</tr>
<tr>
<td><strong>College</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some</td>
<td>10</td>
<td>34.48</td>
</tr>
<tr>
<td>Graduate</td>
<td>6</td>
<td>20.69</td>
</tr>
<tr>
<td><strong>Post-graduate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 - 3 years</td>
<td>4</td>
<td>13.79</td>
</tr>
<tr>
<td>Ph.D.</td>
<td>2</td>
<td>6.90</td>
</tr>
</tbody>
</table>

*Note.* Percentages reflect the proportion of incest survivors in each group in the sample completing the various levels of education.

Although the findings in this study suggest a relatively high level of academic accomplishment in the sample as a whole, this is not matched by income level. The
average income of the DID incest survivor group was $10,400.00 (SD 13.90) with a
range of $0 to $50,000. The average income in the non-Did incest survivor group was
$17,200.00 (SD 16.02) with a range of $0 to $60,000. Twenty-eight percent of incest
survivors in the DID group reported no income, while only 10% of incest survivors in the
non-DID group reported no income. Given the assumption that the job opportunities for
both groups were the same, the lower mean income for the DID group, together with the
relatively larger number of individuals in the DID group with no income, could reflect
more difficulties on the part of the DID group in securing or maintaining employment
due to the seriousness of their disorder.

Clinical Characteristics of the Sample

Diagnostic Information

A Client Diagnostic Confirmation Form (Appendix H) was completed by all
outpatient therapists on the clients who participated in this study (Table 5). All of the
clients who were recruited by their outpatient therapist were female, 18 years or older, and
met the criteria for being an "incest survivor" defined in chapter 1. Forty-eight percent of
the sample met the criteria for "Dissociative Identity Disorder" (DID), while 52% did not
meet these criteria. Only one therapist was initially unsure about whether one of her
clients met the diagnosis for DID. After consulting with this researcher and obtaining
additional past treatment information on the client, the diagnosis of DID was confirmed.
As mentioned previously, two DID clients, who were reported as integrated, were not
included in the sample and formal results of this study.

Most of the therapists participating in this study were experienced clinicians and
have worked for a number of years with incest survivors in general or with incest
survivors diagnosed with DID. Four DID incest survivors and one non-DID incest
survivor in this study were clients of this researcher at the time the study was conducted.
Since some researchers like Beitchman et al. (1992) have questioned whether some

Table 5

Client Diagnostic Confirmation Form

<table>
<thead>
<tr>
<th>Characteristics of sample&lt;sup&gt;a&lt;/sup&gt;</th>
<th>n</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>60</td>
<td>100.00</td>
<td></td>
</tr>
<tr>
<td>18 years or older</td>
<td>60</td>
<td>100.00</td>
<td></td>
</tr>
<tr>
<td>Incest survivors</td>
<td>60</td>
<td>100.00</td>
<td></td>
</tr>
<tr>
<td>DID</td>
<td>29</td>
<td>48.33</td>
<td>51.66</td>
</tr>
</tbody>
</table>

<sup>aN</sup> = 60.

incest survivors reported in the literature have met the diagnosis for DID. Therapists in this study were asked to rate the confidence level of their diagnosis. Therapists used a 5-point Likert scale with "1" being "not confident," "3" "moderately confident," and "5" "extremely confident." The mean confidence level assessed by therapists diagnosing the DID group was 4.76 with a standard deviation of 0.58. The lowest rating assigned any DID diagnosis was a "3" (Table 6). This suggests that therapists overall were fairly sure of their diagnoses.

Alter Personalities

Although the therapists in this study were sometimes quite specific in the number of "known" alter personalities they reported in their DID clients, a number of therapists, including this researcher, were sometimes able to provide only broad estimates of the number of alter personalities based on observations in the office or the self-report of the
Table 6

Characteristics of DID Groupa

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Diagnostic Confidence</td>
<td>4.76</td>
<td>0.58</td>
<td>3 - 5</td>
</tr>
<tr>
<td>Alter Personalities</td>
<td>54.90</td>
<td>165.60</td>
<td>2 - 896</td>
</tr>
</tbody>
</table>

aN = 29.

client. Since individuals with DID do not always let family members or others know of the existence of their alter personalities, no attempt was made in the study to substantiate the number of alter personalities reported by therapists. Also, there may have been some clients who were not completely aware of how many alter personalities they had. As a result, it is possible that some DID clients could have had more alter personalities than were reported or observed at the time of the study.

Braun (1986, pp. xii-xiii) makes the distinction between alter personalities, fragments, memory trace fragments, presenting personalities, and host personalities. Due to some of the practical difficulties in making these distinctions, the number of alter personalities reported in this study should be regarded as a broad "estimate" and may include any combination of the above mentioned types of personality states.

One therapist, for example, commented that her client was a survivor of ritual abuse and had 174 alters. The client had, however, integrated 50 alter personalities, but was continuing to develop new alters while in treatment. The number of alter personalities estimated by therapists ranged from 2 to 896. Since the mean number of alter personalities in this study appeared skewed because of three DID clients with more than 100 reported alter personalities (and probable personality fragments), the median number

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of 15 may provide a more accurate picture of the typical number of alter personalities in the DID group (Table 6).

The reporting of fairly large numbers of alter personalities or personality fragments has sometimes appeared in the literature and usually is associated with particularly horrendous types of abuse, especially ritual abuse. In this study, 21% of the DID group reported the involvement of a cult member or religious person in sexual abuse involving kissing and fondling, and 24% reported this type of sexual abuse when intercourse was involved. No one in the non-DID group cited a cult member or religious person involved in their sexual abuse.

The median number of 15 alter personalities in this study appears consistent with previous research. Putnam et al. (1986), for example, in a study of 100 patients, reported an average of 13 personalities. Ross, Norton, and Wozney (1989) found an average of 16 alter personalities in a sample of 236 patients. When therapists were asked about whether or not their DID client appeared to be integrating, 55% stated "yes," 24% "no," and 21% were "unsure." When asked about whether the client's "host" or main personality was co-conscious with alter personalities at least part of the time, 79% stated "yes," 7% "no," and 14% were "unsure." Although there appear to be no previous data in the research literature on rates of integration or co-consciousness in DID clients, the relatively large percentages of clients in this study who appeared to be integrating, or whose host seemed to be co-conscious at least part of the time, could be a reflection of the fairly long period of time the DID clients in this study have been in treatment.

**Treatment History**

In looking at both the prior and current treatment histories reported by clients on the Personal Data Sheet (Appendix I), there appeared to be important differences between the two groups (Tables 7 and 8). The DID group as a whole spent more time in both prior and
current treatment than the non-DID group. The DID group spent on the average 41.1 months (SD 52.2) in prior treatment compared to 26.6 months (SD 31.8) for the non-DID group. The DID group spent on the average 43.1 months in current treatment with their outpatient therapist compared to 17.9 months in the non-DID group. The greater amount of total time spent in treatment by the DID group, compared to the non-DID group in this study, might appear to provide some indirect evidence that the incest survivors in the DID group were experiencing more serious long-term psychological problems than the non-DID group. Since, however, the research literature suggests that DID clients have often spent considerably longer periods of time in treatment (sometimes years) than most clients before being correctly diagnosed, the longer treatment times in the DID group could be, at least in part, a reflection of this latter problem.

In examining the issue of prior treatment, it should be noted that some of the clients in this study, especially those with DID, appeared to have provided somewhat broad estimates of how much time they spent in prior treatment (sometimes expressed in years). The group as a whole appeared to have complex prior treatment histories with a number of DID clients anecdotally reporting hospitalization or other treatment modalities. One client in the DID group, for example, reported that she had worked in the past with 12 different therapists.

Because of the broad estimates given by some of the DID clients regarding the amount of time they spent in prior treatment and because of what appeared to be sometimes complex prior treatment histories, the average amount of time reported in this study for prior treatment for the DID group may not be very precise. Overall, however, based on the estimates that were given, it appears safe to assume that the DID clients, as a whole, spent much more time in both prior and current treatment than the non-DID group.

Incest survivors in this study were also asked whether their prior treatment (Table 7) and current treatment histories (Table 8) reflected only individual therapy, only group
Table 7

Prior Treatment History

<table>
<thead>
<tr>
<th>Months in Treatment</th>
<th>DID (N = 29)</th>
<th>Non-DID (N = 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>51.70</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>52.22</td>
</tr>
<tr>
<td>Range</td>
<td>0-180</td>
<td>0.96</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of Treatment</th>
<th>DID (N = 29)</th>
<th>Non-DID (N = 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modality</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Individual</td>
<td>15</td>
<td>51.72</td>
</tr>
<tr>
<td>Group</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Individual and Group</td>
<td>11</td>
<td>37.93</td>
</tr>
<tr>
<td>None</td>
<td>2</td>
<td>6.90</td>
</tr>
</tbody>
</table>

Note. Percentages reflect proportion of incest survivors involved in each treatment modality for each of the two groups.
Table 8

**Current Treatment History**

<table>
<thead>
<tr>
<th>Months in Treatment</th>
<th>DID (N = 29)</th>
<th>Non-DID (N = 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>M</strong></td>
<td>46.52</td>
<td>17.90</td>
</tr>
<tr>
<td><strong>SD</strong></td>
<td>36.95</td>
<td>16.27</td>
</tr>
<tr>
<td><strong>Range</strong></td>
<td>3-144</td>
<td>1-70</td>
</tr>
</tbody>
</table>

**Types of Treatment**

<table>
<thead>
<tr>
<th>Modality</th>
<th>DID (N = 29)</th>
<th>Non-DID (N = 31)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Individual</td>
<td>18</td>
<td>62.10</td>
</tr>
<tr>
<td>Group</td>
<td>1</td>
<td>3.45</td>
</tr>
<tr>
<td>Individual and Group</td>
<td>10</td>
<td>34.48</td>
</tr>
</tbody>
</table>

*Note.* Percentages reflect proportion of incest survivors involved in each treatment modality for each of the two groups.
therapy, or a combination of individual and group therapy. Approximately half of the DID group and a third of the non-DID group reported receiving only individual therapy as part of their prior treatment (Table 7). Only one person in the DID group and no one in the non-DID group reported receiving only group therapy; however, 32% in the non-DID group reported receiving only group therapy as part of their prior treatment. Thirty-eight percent of the DID group and 32% of the non-DID group reported receiving a combination of individual and group therapy as part of their prior treatment.

Also, in the DID group only 7% compared to 32% in the non-DID group reported having had no prior treatment before working with their current therapist. Assuming that services were equally accessible to both groups, these figures might also suggest that incest survivors in the DID group required more counseling services over the course of their lifetime than the non-DID group due to their condition. In regard to current treatment (Table 8), more than half of both groups reported receiving individual therapy only. Only a small percentage in both groups reported receiving only group therapy, and over a third of both groups reported receiving both individual and group therapy as part of their current treatment. In regard to both prior and current treatment, individual therapy appeared to play a prominent role in both groups. A combination of individual and group therapy was the second most frequent treatment modality used by both groups.

**Incest Memories Questionnaire**

On the Personal Data Sheet (Appendix I) individuals in the sample were asked to answer 11 questions concerning an Incest Memories Questionnaire. The findings are reported in Table 9. These questions were included in this study to provide an opportunity for incest survivors themselves to report on their perceptions regarding the accuracy and stability of their memories since the presence and accuracy of repressed memories in
adult incest survivors has been challenged by some (Loftus, 1993).

Although Walker (1994) reported that the incest literature, as a whole, seems to support the concept of repressed memories as a legitimate sequel to childhood sexual abuse, a great deal is still not known about how this occurs. Walker (1994, p. 95) suggested, as others have, that dissociation may interfere with the acquiring of memories especially in children. She indicated that such memories may be stored subcortically through visual and kinesthetic somatization rather than through cognitive attention. As a result, affective states, similar to the ones experienced by children during their abuse, could later bring about the recall of some memories even if the abuse was pre-verbal.

All subjects recruited for this study were required to meet the criterion for being an "incest survivor" described in chapter 1 of this study. Since all the clients who volunteered for this study were asked to participate based on this pre-established criterion, it is not surprising that 100% in the sample reported on the Personal Data Sheet (Appendix I) that they believed they were sexually abused before the age of 17 (question 1) (Table 9). Subjects were asked this question, however, so that if some incest survivors questioned this assumption, they would be given an opportunity to state whether they did. Slightly more DID incest survivors, 69% compared to 52% of the non-DID incest survivors, reported that someone in their family had confirmed their abuse (question 2).

Seventy-nine percent of the DID group, compared to 84% of the non-DID group, stated that some of their memories of childhood sexual abuse appeared blocked or vague (question 3). The fact that a smaller percentage of the DID group reported blocked memories may be a reflection of their longer time in treatment (prior and current) than the non-DID group. It should be pointed out, however, that the 5% difference between the percentage in the DID group and non-DID group reporting blocked or vague memories
may not be statistically significant, and the difference could be attributed to chance or other factors besides actual group differences.

Question 4 on the Personal Data Sheet deals with the issue of suggestibility and denial in relation to one's incest memories. Of those subjects whose sexual abuse had been confirmed by family or others, at least 93% of the DID group and 97% of the non-DID group did not question the outside corroboration of their sexual abuse. None of the incest survivors in this study felt their therapist had "implanted ideas" in their mind by telling them that they had been sexually abused (question 5). It would appear that if therapists were trying to implant ideas of sexual abuse in their clients, that at least some of the clients in this relatively highly educated sample would have reported that they suspected this was occurring.

Among the incest survivors in this sample, 62% in the DID group and 74% in the non-DID group reported retrieving memories of sexual abuse prior to getting into therapy (question 6). However, more than twice as many DID incest survivors than non-DID incest survivors reported retrieving memories of sexual abuse since getting into therapy (question 7). Although other factors could be responsible for the larger number of DID clients reporting the retrieval of sexual abuse memories since getting into therapy, these figures could suggest a differential response pattern to outpatient treatment by these two groups. The differences could also relate to the considerably longer time spent in treatment by the DID group in which there would have been more opportunity to retrieve repressed memories.

In the sample 90% of the DID incest survivors compared to 68% of the non-DID incest survivors felt at the time of this study that "there may be incidents of sexual abuse which have been blocked" from their memory (question 8). This question is similar to question 3 but asks incest survivors about specific incidents of sexual abuse being
Table 9

**Incest Memories Questionnaire**

<table>
<thead>
<tr>
<th>Item</th>
<th>Group(^a)</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you believe you were sexually abused before the age of 17?</td>
<td>1</td>
<td>100.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>100.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has anyone in your family confirmed that you were sexually abused before the age of 17?</td>
<td>1</td>
<td>68.97</td>
<td>20.69</td>
<td>10.34</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>51.61</td>
<td>41.94</td>
<td>6.45</td>
</tr>
<tr>
<td>3. Do some of your memories of childhood sexual abuse appear blocked or vague?</td>
<td>1</td>
<td>79.31</td>
<td>6.90</td>
<td>13.79</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>83.87</td>
<td>6.45</td>
<td>9.68</td>
</tr>
<tr>
<td>4. Do you feel that you were not sexually abused even though family or others have told you you were?</td>
<td>1</td>
<td>6.90</td>
<td>93.10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>3.23</td>
<td>96.77</td>
<td></td>
</tr>
<tr>
<td>5. Do you feel your therapist has planted ideas in your mind by telling you that you have been sexually abused?</td>
<td>1</td>
<td></td>
<td></td>
<td>100.00</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td>100.00</td>
</tr>
<tr>
<td>6. Did you retrieve memories of sexual abuse prior to getting into therapy?</td>
<td>1</td>
<td>62.07</td>
<td>27.59</td>
<td>10.34</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>77.42</td>
<td>19.35</td>
<td>3.23</td>
</tr>
<tr>
<td>7. Did you retrieve memories of sexual abuse since getting into therapy?</td>
<td>1</td>
<td>96.55</td>
<td></td>
<td>3.45</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>38.71</td>
<td>6.90</td>
<td>67.74</td>
</tr>
<tr>
<td>8. Do you feel that there may be incidents of sexual abuse which have been blocked from your memory?</td>
<td>1</td>
<td>89.66</td>
<td>6.90</td>
<td>3.45</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>67.74</td>
<td>3.23</td>
<td>29.03</td>
</tr>
<tr>
<td>9. Do you feel that your memories of sexual abuse, if you have them, are accurate?</td>
<td>1</td>
<td>65.52</td>
<td></td>
<td>34.48</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>87.10</td>
<td></td>
<td>12.90</td>
</tr>
<tr>
<td>10. My memories of sexual abuse vary from day to day.</td>
<td>1</td>
<td>37.93</td>
<td>51.72</td>
<td>10.34</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>16.13</td>
<td>77.42</td>
<td>6.45</td>
</tr>
<tr>
<td>11. At the present time I feel that I am currently able to remember ____ of my sexual abuse</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. Percentages reflect the proportion of incest survivors in each group responding to the Incest Memories Questionnaire.

\(^{a1}\) = DID group. \(N = 29\). \(^{2}\) = Non-DID group. \(N = 31\).
blocked, versus memories in general. Since one of the primary characteristics of DID is amnesia, it is not surprising that the DID group would report more specific events in their lives being blocked from their memory.

In terms of the accuracy of incest memories (question 9), 66% of the DID group compared to 87% of the non-DID group felt their incest memories were "accurate." No one in the sample felt their memories were "inaccurate." There were, however, almost three times as many in the DID group versus the non-DID group who were "unsure" about the accuracy of their memories. As in some of the other questions relating to incest memories, the increased amnesic barriers found in DID clients might explain why a greater percentage of DID versus non-DID clients reported being unsure of the accuracy of their memories.

Question 10 asked the incest survivors in this study whether or not they felt their memories of sexual abuse would "vary from day to day." More DID incest survivors than non-DID incest survivors felt that their memories varied from day to day. Half or more, however, of the incest survivors in both groups said their memories did not vary from day to day. Less than 10% in both groups were "unsure" about whether their memories varied from day to day. The responses to question 10 suggest that there might be more daily variability among DID incest survivors' memories than non-DID incest survivors in this study.

Memories may vary in DID clients at any given time depending on the degree of co-consciousness between specific alter personalities and the host personality, and whether or not an alter personality or the host personality has executive control. Although it would be difficult to draw any firm conclusions about the variability of incest memories based on only this item, responses to this question and others on the Incest Memories Questionnaire seem to suggest that there are some differences between the DID and non-DID group on how memories are remembered on a day-to-day basis.
When asked about how much of their sexual abuse incest survivors were able to remember at the time of this study (question 11), about half of the DID group reported being able to remember "some" of their abuse, while about half of the non-DID group reported being able to remember "most" of their sexual abuse. These percentages could reflect that the DID group as a whole has more amnesia, overall, regarding their childhood sexual abuse than the non-DID group, even though at the time of this study the DID group had been in treatment longer. It appears, however, that both groups seem to have some awareness that they do not know everything about their abuse.

**CMIS-SF Results**

*Childhood Maltreatment Factors*

The CMIS-SF developed by Briere (1992) provides information on the incidence of various types of childhood maltreatment and adult traumatic factors. The childhood maltreatment factors have been organized by the type of abuse, the ages at which the abuse occurred, the characteristics of the abusers, the characteristics of the two types of sexual abuse - kissing and fondling and intercourse, and the frequency of the physical abuse. The adult traumatic factors have been organized by type of traumatic event and mean ages when the adult traumatic events occurred (Tables 10 - 16). Individuals completing the CMIS-SF were asked to report any kind of childhood maltreatment occurring prior to age 17 and adult traumatic events occurring after age 17.

The CMIS-SF includes seven childhood maltreatment factors (Table 10). These include: (1) Parental Substance Abuse; (2) Parental Domestic Violence; (3) Parental Physical Abuse; (4) Sexual Abuse (Kissing and Fondling); (5) Sexual Abuse (Intercourse); (6) Parental Psychological Unavailability (Table 11); and (7) Parental Psychological Abuse (Table 12). The CMIS-SF also asks respondents to indicate whether they felt they were sexually abused or physically abused in general (Table 10).
When examining all five types of childhood maltreatment on the CMIS-SF (Table 10), both groups in the study displayed a fairly similar pattern of maltreatment in regard to incidence. The most frequently reported type of maltreatment for both groups was sexual abuse through "kissing and fondling." Briere defined kissing and fondling as having someone kiss or touch you in a sexual way, or make you touch the other person's sexual parts. All of the clients in this study reported experiencing this type of sexual abuse since incest was used as a criterion for this study. When this type of abuse was defined as occurring with "someone 5 years or older," a definition used in some sexual abuse research, 97% of both groups reported being kissed and fondled.

The second most frequent type of maltreatment reported by both groups was sexual abuse through "intercourse." This was defined on the CMIS-SF as involving oral, anal, or vaginal intercourse. Besides penile penetration, intercourse could also include the insertion of a finger or object into the anus or vagina. Eighty-three percent of the DID group and 72% of the non-DID group reported this type of sexual abuse. Ninety percent of the non-DID group and 74% of the non-DID group reported intercourse with a family member. When this type of abuse was defined as occurring with "someone 5 years or older," the incidence was 83% for the DID group and 77% for the non-DID group.

The third most frequently reported type of maltreatment by both groups was "parental physical abuse." This was defined as involving at least one parental figure, or adult in charge, who did something on purpose to hurt the incest survivor as a child. This could involve, for example, being hit, punched, cut, or pushed down. To qualify for physical abuse on the CMIS-SF, the injuries would have had to been severe enough to lead to bleeding, bruises, or broken bones or teeth. Seventy-nine percent of the DID group and 52% of the non-DID group reported this type of maltreatment. Thirty-one percent of the DID group in this sample, and 23% of the non-DID group reported injuries severe enough to also require being taken to a doctor or a hospital.
Table 10

Incidence of Five Childhood Maltreatment Factors

<table>
<thead>
<tr>
<th>Maltreatment Factors</th>
<th>Group a</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
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</thead>
<tbody>
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<td>Parental Substance Abuse</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
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<td></td>
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<tr>
<td>Parental Domestic Violence Abuse</td>
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<td></td>
</tr>
<tr>
<td>Medical Care or Police</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Parental Physical Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Care or Police</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Abuse - Kissing &amp; Fondling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Member</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Someone 5 years or older</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Force</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Abuse (Intercourse)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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</tr>
<tr>
<td>Force</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Abuse (General)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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The fourth most frequently reported type of maltreatment for the DID group was "parental domestic violence." Domestic violence was defined as witnessing a parent hit or beat up by another parent. Sixty-six percent of the DID group reported witnessing domestic violence. This was the least frequently reported type of maltreatment by the non-DID group. Forty-two percent of the non-DID group reported this type of maltreatment.

The least frequent type of maltreatment reported by the DID group was parental substance abuse. Parental substance abuse was defined on the CMIS-SF as having a parental figure who had problems with alcohol significant enough to lead to medical problems, divorce, separation, being fired from work, or being arrested for intoxication in public or while driving. Forty-eight percent of the DID group reported this type of maltreatment. This was the fourth most frequently reported type of maltreatment by the non-DID group with 45% reporting this type of maltreatment.

On the five types of childhood maltreatment factors found in Table 10, the DID group reported higher incidences on all of the categories of abuse. The only exception was Sexual Abuse (kissing and fondling), which was the same for both groups. In examining other aspects of childhood maltreatment found on Table 10, the DID group reported a higher incidence. In regard to parental domestic violence, 41% of the DID
group compared to 26% of the non-DID group indicated that on at least one or more
occaisions someone required medical care or the police had to be called.

In regard to "force" during sexual abuse (kissing and fondling), 90% of the DID
group, compared to 48% of the non-DID group, reported that force was used. In regard to
"force" during intercourse, 83% of the DID group and 52% of the non-DID group
reported that force was used.

The findings on the CMIS-SF suggest that the DID experienced a higher incidence
of all five types of childhood maltreatment compared to the non-DID group. The
substance abuse was reported as being more continuous, the parental domestic violence
more severe, the physical abuse more harmful, and force more often used during the
sexual abuse.

There were two childhood maltreatment factors on the CMIS-SF that dealt with the
psychological environment in the home: (1) Parental Psychological Unavailability (Table
11); and (2) Parental Psychological Abuse (Table 12). These factors seem conceptually
to fall more on a continuum rather than being dichotomous events (being present or not).
Both of these factors may also be viewed as possibly setting an emotional "tone" in the
home.

In regard to "parental psychological unavailability" there appears to have been some
differences between the two groups (Table 11). A greater percentage of the non-DID
group compared to the DID group reported being loved by their fathers "not at all"
(before age 8). However, a greater percentage of the DID group compared to the non-
DID group reported being loved by their mother "not at all" (before age 8). In regard to
feeling that they were loved "not at all" from age 8 to age 16 by their fathers, the DID and
non-DID groups were quite similar in their self-reports. In regard, however, to feeling
loved "not at all" from age 8 to age 16 by their mothers, 52% of the DID group compared
to 13% of the non-DID group reported this type of parental psychological unavailability.
In regard to the Parental Psychological Abuse Factor (Table 12) more DID incest survivors than non-DID incest survivors reported being psychologically abused in all seven categories. The categories included: being yelled at, insulted, criticized, made to feel guilty, ridiculed, embarrassed, or made to feel they were a bad person. The findings on the Parental Psychological Abuse Factor appear to provide additional evidence that the DID incest survivors were treated more poorly as children than the non-DID group of incest survivors. Further research regarding the nature of these differences is needed. A very large percentage of incest survivors in both groups indicated that they had been abused "over 20" times a year.

Ages of Abuse

In examining age as a variable related to the childhood maltreatment factors of parental substance abuse, domestic violence, physical abuse, and sexual abuse, it was found that the DID group experienced all forms of these types of maltreatment factors at an earlier mean starting age than the non-DID group except for one type of abuse (Kissing and fondling where the abuse was negligible)(Table 13). When averaging the mean starting age at which all types of abuse occurred in the DID group, the mean starting age for the DID group was 6.0 years. This compares to a mean starting age for all types of abuse in the non-DID group of 8.7 years. When averaging the mean ages at which the abuse stopped for all types of abuse, the mean stopping age for the DID group was 13.5 years and 12.4 years for the non-DID group. Overall, the abuse in the DID group started earlier than the non-DID group and lasted longer. It is possible that the sexual abuse in this sample (both kissing and fondling, and intercourse) stopped with the onset of puberty when the chances of becoming pregnant could occur. Girls at this age might also become more aware of the inappropriateness of their sexual abuse through the increased contact with peers that often occurs around this age.
### Parental Psychological Unavailability Factor

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<th>Parent</th>
<th>DID (N = 29)</th>
<th>Non-DID (N = 31)</th>
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<tr>
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<td>4</td>
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<td>5</td>
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<tr>
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<table>
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<tr>
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<th>From age 8 through age 16</th>
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<td>n</td>
<td>%</td>
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<td>4</td>
<td>13.79</td>
<td>4</td>
<td>12.90</td>
<td></td>
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</tr>
</tbody>
</table>

**Note.** Likert Scale (1) = "Not all" to (4) "very much." Percentages reflect proportion of DID and Non-DID groups reporting how much they felt loved and cared for by each parent.
<table>
<thead>
<tr>
<th>Type</th>
<th>Group&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Never</th>
<th>Once</th>
<th>Twice</th>
<th>3 - 5</th>
<th>6 - 10</th>
<th>11 - 20</th>
<th>Over 20</th>
</tr>
</thead>
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<td>Yell at you</td>
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<td>0.00</td>
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<td>3.45</td>
<td>3.45</td>
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<td>82.76</td>
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<td>Insult you</td>
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<td>0.00</td>
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<td>6.90</td>
<td>3.45</td>
<td>82.76</td>
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<td>12.90</td>
<td>16.13</td>
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<td>48.39</td>
</tr>
<tr>
<td>Criticize you</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>3.45</td>
<td>10.34</td>
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<td>3.23</td>
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<td>0.00</td>
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<td>3.45</td>
<td>0.00</td>
<td>6.90</td>
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<td>0.00</td>
<td>6.45</td>
<td>9.68</td>
<td>67.74</td>
</tr>
<tr>
<td>Ridicule or humiliate you</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>10.34</td>
<td>6.90</td>
<td>82.76</td>
</tr>
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<td>6.45</td>
<td>6.45</td>
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<td>41.94</td>
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<td>Emanual you in front of others</td>
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<td>16.13</td>
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<td>Make you feel you're a bad person</td>
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<td>3.23</td>
<td>6.45</td>
<td>6.45</td>
<td>58.06</td>
</tr>
</tbody>
</table>

Note. The percentages reflect the proportion of incest survivors in each group endorsing each type of psychological abuse.

<sup>a</sup> 1 = DID group, N = 29: Group 2 = Non-DID group, N = 31.
The mean age at which various types of abuse stopped seemed to vary somewhat between the groups depending on who the abuser was. There were, however, eight categories in which the mean age was somewhat greater for the DID group and five categories in which the mean stopping age was somewhat greater for the non-DID group. There were three categories where comparisons in the age at which the abuse stopped could not be made since the non-DID group did not report any sexual abuse in terms of "intercourse" by a professional, babysitter, or other person.

In looking at the mean ages at which the sexual abuse (kissing and fondling) started and stopped for the two groups, this type of abuse started earlier for the DID group (6.7 years) compared to the non-DID group (9.9 years). The age at which the kissing and fondling stopped was the same for the two groups (12.3 years). In regard to intercourse, the mean age at which this type of sexual abuse started was earlier for the DID group (6.2 years) compared to the non-DID group (8.2 years). The age at which the intercourse stopped was slightly later for the DID group (12.3 years) compared to 11.4 years for the non-DID group. The duration of both kissing and fondling and intercourse was about twice as long, on the average, for the DID group compared to the non-DID group. Further research is needed to determine the importance and relevance of the different mean starting and stopping ages, and duration of various abuses for groups such as these.

Characteristics of Abusers

Data on the characteristics of the abusers in this study are provided in Table 14. In looking at what type of parental figure experienced a substance abuse problem, 45% of both the DID and non-DID groups reported substance abuse by a biological parent. In addition, 3% of the DID group reported substance abuse by "multiple" parental figures. This latter category involves a substance abuse problem by more than one parental figure.
Table 13

Ages of Abuse

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<th>Types</th>
<th>Group</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
<th>Start Age</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
<th>Stop Age</th>
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Note. A - Abuser at least five years older than incest survivor as a child when the abuse occurred.

a1 - DID, N = 29; 2 - Non-DID, N = 31.
This might involve substance abuse by any combination of biological, step, foster, or other person serving as a parental figure in the home.

In examining the issue of domestic violence, 66% of the DID group, compared to 36% of the non-DID group saw their father hit their mother, while 48% of the DID group compared to 32% of the non-DID group saw their mother hit their father.

In looking at the issue of parental physical abuse, the parental figure reported most frequently involved in this type of abuse in both the DID group and non-DID group was a biological parent. Twenty-four percent of the DID group, however, reported being

Table 14  
**Characteristics of Abusers**

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<thead>
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<th>Non-DID (N = 31)</th>
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<sup>a</sup> "Multiple" reflects abuse by more than one category of abuser within each category of maltreatment.
<br>
<sup>b</sup> "Other" reflects quasi-parent or other adult functioning in the role of a parent.
<br>
<sup>c</sup> Abuser is at least five years older than the incest survivor as a child when the abuse occurred.
<br>
<sup>d</sup> "Other person" is any non-family not included in any other category of abuse.
physically abused by multiple parental figures, while only 3% of the non-DID group reported being physically abused by multiple parental figures.

In identifying by rank order the family members most frequently involved in sexual abuse (kissing and fondling) in the DID group, the family member(s) identified as most often involved were: multiple family members, followed by fathers, extended family member, mothers, brothers, sisters, and quasi-family members. The rank order of abusers was the same for the DID group when the incest survivors were asked who was involved in their abuse who was "five or more years older" when the abuse occurred. The pattern of abusers was somewhat different for the non-DID group. In this group, extended family members were reported as being most frequently involved in kissing and fondling. This was followed by: fathers, multiple family members, brothers, mothers, quasi-family members, and sisters. The rank order of abusers was the same for the non-DID group when the abuser was "five or more years older" when the abuse occurred.

In identifying by rank order the family members most frequently involved in sexual abuse (intercourse) in the DID group, the family member(s) identified as most often involved were: fathers, multiple family members, mothers, extended family members, brothers, sisters, and quasi-family. This rank order of abusers was the same when the DID group was asked who was involved in their abuse who was "five or more years older" than them when the abuse occurred. In the non-DID group the family member(s) identified as most often involved in intercourse were: extended family members, brothers, multiple family members, fathers, mothers, and quasi-family members. No sisters were identified. The pattern of abusers seemed to change slightly when the non-DID group was asked who was involved in intercourse who was "five or more years older" than them when the abuse occurred. Extended family members were most frequently reported. This was followed by fathers, multiple family members, brothers, mothers, and quasi-family
members. No sisters were identified as abusers through intercourse when the criteria of "five years or older" was used.

In examining the overall pattern of abusers in this study, the DID group in most categories of abusers reported a higher percentage of abuse by various family members than the non-DID group. Multiple family members played the most prominent role in familial sexual abuse (kissing and fondling) and father in familial sexual abuse (intercourse) in the DID group. In the non-DID group, sexual abuse (kissing and fondling and intercourse) was most often reported by extended family members.

Two groups of non-familial abusers are identified on the CMIS-SF and included "professionals" and "other non-family." The DID group reported being kissed and fondled by teachers, doctors, other professionals, or by multiple professionals. The non-DID group reported no sexual fondling by teachers, doctors, or multiple professionals, but a very small percentage identified being kissed and fondled by the category of "other" professionals. In terms of being kissed or fondled by "other non-family," the DID and non-DID groups were somewhat similar in that both groups reported some abuse by friends, strangers, babysitters, and other persons. The DID group, however, reported a higher incidence of abuse than the non-DID group in the various "other non-family" categories.

Characteristics of Abuse

Table 15 includes information on the frequency of the sexual abuse (kissing and fondling and intercourse) in this sample. Sixty-six percent of the DID group and 29% of the non-DID group indicated that they were kissed and fondled "100 plus" times (or too many times to remember). Forty-five percent of the non-DID group, however, reported being kissed and fondled "1 - 49" times. A fairly small percentage of both groups reported being kissed and fondled "50 - 99" times.
In regard to intercourse the two groups were fairly similar in regard to how frequently they experienced this type of abuse. Fifty-nine percent of the DID group, however, and 48% of the non-DID group reported experiencing this type of sexual abuse "100 plus" times (or too many times to remember). A higher percentage of the DID group, when compared to the non-DID group, reported both sexual abuse through kissing and fondling and intercourse as occurring "100 plus" times (or too many to remember).

Table 15

Frequency of Abuse

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<td>n</td>
<td>%</td>
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*Note.* Percentages reflect the proportion of incest survivors in each group for each category of "number of times" sexually abused.

*a* "100 plus" = being sexually abused 100 or more times or "too many times to remember."
sexually abused by "someone 5 or more years older" through kissing and fondling) stated there were "too many people" to remember. Also 21% of the 24 DID incest survivors (who reported being sexually abused by "someone 5 or more years older" through intercourse) stated there were "too many people" to remember.

No one in the non-DID group had problems estimating how many people had abused them through kissing and fondling and intercourse. Among the 30 non-DID incest survivors (who reported being sexually abused by "someone 5 or more years older" through kissing and fondling), the range was 1 - 6 people, with a mean of 2.1 people.

In regard to intercourse among the 24 incest survivors in the non-DID group (who were abused in this way by "someone 5 or more years older"), the range was 1 - 8 people, with a mean of 2.2 people.

Among the 22 DID incest survivors who were able to provide an estimate of how many people sexually abused them through kissing and fondling, the range was 1 - 31 people, with a mean of 6.6 people. In regard to intercourse, among the 19 DID incest survivors who were able to provide an estimate of how many people abused them in this manner, the range was 1 - 45 people, with a mean of 5.7 people. It should be noted that the one DID incest survivor in this study who reported 896 alter personalities (Table 6), and was a cult victim, was the client who reported being sexually abused through intercourse by approximately 45 different people. In addition to the cult abuse reported by this DID incest survivor, the large number of alter personalities may also be a reflection of the very large number of people who abused this client through intercourse.

An effort was also made in this study to determine how frequently DID and non-DID incest survivors were physically abused. As was the case in reporting the total number of people involved sexually with each incest survivor, 78% of the 23 DID incest survivors who were physically abused, indicated the abuse occurred "100 plus" times or "too many" times to remember. Thirty-eight percent of the 16 non-DID incest survivors
who were physically abused also indicated the abuse occurred "100 plus" times or "too many" times to remember. Although a number of factors might explain why incest survivors in this study had difficulty reporting how many people sexually abused them, and how many times they were sexually and physically abused, it is possible that dissociation may have, at least in part, accounted for some of the memory problems. It appears fairly clear, however, that the DID group, as a whole, experienced sexual abuse on a more frequent basis, had more people involved in the sexual abuse, and was physically abused more often than the non-DID group.

**Adult Traumatic Factors**

Table 16 summarizes the six adult traumatic factors that are found on the CMIS-SF. These include (1) Rape or Sexual Assault; (2) Battering in a Sexual/Romantic Relationship; (3) Physical Assault; (4) Combat Duty; (5) Experiencing a Life-Threatening or Injurious Event; and (6) Observing Someone Being Assaulted, Injured, or Killed. The results on the six adult traumatic factors are similar to the results on the childhood traumatic factors. In all categories of adult trauma (except for "combat duty," which was not reported by anyone in the sample) the DID group reported experiencing them on a more frequent basis than the non-DID group. Since children who have been sexually or physically abused sometimes appear to re-enact those experiences as adults, or may be more vulnerable to re-victimization, it is not surprising that the DID group reported higher incidences of adult traumatic events on the CMIS-SF. It is also possible that DID incest survivors may have a greater tendency to view upsetting incidents as adults from a traumatic frame of reference because of past traumatizations or poor ego-strength stemming from object-relations impairment.
Table 16

Incidence of Adult Traumatic Factors

<table>
<thead>
<tr>
<th>Traumatic Factors</th>
<th>Groupa</th>
<th>N</th>
<th>Incidence</th>
<th>Ageb</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape or Sexual Assault</td>
<td>1</td>
<td>29</td>
<td>66.70</td>
<td>29.9</td>
<td>8.38</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>31</td>
<td>51.60</td>
<td>24.4</td>
<td>6.80</td>
</tr>
<tr>
<td>Battering in a Sexual or Romantic Relationship</td>
<td>1</td>
<td>29</td>
<td>48.10</td>
<td>33.2</td>
<td>8.21</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>31</td>
<td>45.20</td>
<td>26.3</td>
<td>5.79</td>
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<tr>
<td>Physical Assault</td>
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<td>44.40</td>
<td>32.5</td>
<td>10.67</td>
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<td></td>
<td>2</td>
<td>31</td>
<td>16.10</td>
<td>23.0</td>
<td>5.29</td>
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<tr>
<td>Combat Duty</td>
<td>1</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experiencing a Life-Threatening Event or Injurious Event</td>
<td>1</td>
<td>29</td>
<td>51.90</td>
<td>30.6</td>
<td>19 - 55</td>
</tr>
<tr>
<td>Type of Event</td>
<td>2</td>
<td>31</td>
<td>41.90</td>
<td>28.2</td>
<td>9.71</td>
</tr>
<tr>
<td>Auto Accident</td>
<td>1</td>
<td>15</td>
<td>64.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>13</td>
<td>53.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire</td>
<td>1</td>
<td>15</td>
<td>14.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>13</td>
<td>7.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Earthquake</td>
<td>1</td>
<td>15</td>
<td>0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>13</td>
<td>7.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traumatic Factors</td>
<td>Group&lt;sup&gt;a&lt;/sup&gt;</td>
<td>N</td>
<td>Incidence</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------</td>
<td>----</td>
<td>-----------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>15</td>
<td>14.30</td>
<td>85.70</td>
<td></td>
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<tr>
<td></td>
<td>2</td>
<td>13</td>
<td>15.40</td>
<td>84.60</td>
<td></td>
</tr>
<tr>
<td>Multiple Events</td>
<td>1</td>
<td>15</td>
<td>7.10</td>
<td>92.90</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>13</td>
<td>15.40</td>
<td>84.60</td>
<td></td>
</tr>
<tr>
<td>Observing Someone Being Assaulted, Injured or Killed</td>
<td>1</td>
<td>29</td>
<td>40.70</td>
<td>59.30</td>
<td>32.8</td>
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<tr>
<td></td>
<td>2</td>
<td>31</td>
<td>22.60</td>
<td>77.40</td>
<td>29.0</td>
</tr>
</tbody>
</table>

<sup>a</sup>1 - DID, N = 29; 2 - Non-DID N = 31.

<sup>b</sup>Age of last occurrence.
Statistical Analysis

Research Question 1: Is there a relationship between scores of dissociation and object-relations impairment in adult female incest survivors diagnosed with DID (splitting) and those not diagnosed with DID (no overt splitting)?

A Pearson's product-moment correlation (r; two tailed) was used to test the relationship between the DES score ("frequency" of dissociative experiences) and the BORRTI Alienation scale score to answer this research question. Since this latter score contains loadings from the greatest number of items on the BORRTI, it was pre-selected as a test for this hypothesis. Based on personal communication with its developer (M.D. Bell, personal communication, April 12, 1995), it is believed that the Alienation scale represents the broadest dimension of object-relations impairment measured by this test.

The "frequency" of dissociative experiences score, rather than the "type" of dissociative experiences score, was also pre-selected to test this hypothesis, since the amount of time spent in a dissociative state has been theorized in this study to lead to a pathological use of dissociation by adult incest survivors, especially those with DID.

A summary of the correlations between the DES "frequency" of dissociative experiences score (ranging from 0-100) and the DES "type" of dissociation experiences score (ranging from 0-28), and the seven BORRTI object-relations scale scores (ranging from 30-80) for the sample are presented in Table 17. The seven BORRTI scales include: Alienation, Insecure Attachment, Egocentricity, Social Incompetence, Reality Distortion, Uncertainty of Perception, and Hallucinations and Delusions. The first four of these seven BORRTI scales measure deficits in the interpersonal domain of Object Relations impairment (OR) and the last three measure Reality Testing deficits (RT). Chapter 3 provides a detailed description of these seven scales. Correlations between the DES and BORRTI were considered significant if they were less than 0.05.
A positive and significant correlation between both "frequency" and "type" of dissociative experiences as measured by the DES and the BORRTI Alienation scale in the sample supported the hypothesis that there would be a relationship between dissociation and object-relations impairment in this sample ($r = .49, p = 0.0001$, and $r = .43, p = 0.0007$) respectively (Table 17). Although the "type" of dissociative experiences score was not pre-selected to test this hypothesis, the "type" score appeared to provide additional support for the hypothesis. The "frequency" DES score indicates what percentage of time a person might spend on the average in dissociative experiences. The "type" score provides the mean number of items endorsed by the person.

Table 17

<table>
<thead>
<tr>
<th>BORRTI Scale</th>
<th>M</th>
<th>SD</th>
<th>$r^a$</th>
<th>Prob.</th>
<th>$r^b$</th>
<th>Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alienation</td>
<td>63.23</td>
<td>10.62</td>
<td>0.49*</td>
<td>0.0001</td>
<td>0.43*</td>
<td>0.0007</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>57.27</td>
<td>12.01</td>
<td>0.23</td>
<td>0.0825</td>
<td>0.21</td>
<td>0.1095</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>57.72</td>
<td>9.75</td>
<td>0.35*</td>
<td>0.0065</td>
<td>0.32*</td>
<td>0.0117</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>57.98</td>
<td>10.06</td>
<td>0.30*</td>
<td>0.0209</td>
<td>0.33*</td>
<td>0.0089</td>
</tr>
<tr>
<td>Reality Distortion</td>
<td>55.87</td>
<td>10.16</td>
<td>0.51*</td>
<td>0.0001</td>
<td>0.45*</td>
<td>0.0003</td>
</tr>
<tr>
<td>Uncertainty of Perception</td>
<td>61.28</td>
<td>12.24</td>
<td>0.53*</td>
<td>0.0001</td>
<td>0.51*</td>
<td>0.0001</td>
</tr>
<tr>
<td>Hallucinations and Delusions</td>
<td>58.70</td>
<td>13.05</td>
<td>0.63*</td>
<td>0.0001</td>
<td>0.71*</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

Note. $N = 60$; $r^a =$ DES frequency score; $r^b =$ DES type score. $p < .05$. 

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The Alienation scale reflects problems with a basic lack of trust in relationships that are found to be unstable, ungratifying, lacking in intimacy, and superficial. It can also suggest problems in suspiciousness, guardedness, isolation, and withdrawal from others in an angry and hostile way (Bell, 1991).

Another source of evidence in this study, which supported the hypothesis that there would be a relationship between dissociation and object-relations impairment in incest survivors in the sample, came from an examination of the correlations between both "frequency" and "type" of dissociative experiences on the DES and the six other BORRTI scales in the sample (Table 17). All of the BORRTI scales except for the Insecure Attachment scale correlated with both "frequency" and "type" of dissociative experiences.

The results indicate that incest survivors in this study who spend more time in dissociative experiences and report more different types of dissociative experiences are likely to also experience other problems, in addition to having difficulty maintaining close and stable relationships with others. They are likely to have problems with egocentricity where they view themselves as omnipotent and the center of the universe, or as powerless and under the control of some indomitable force. Incest survivors with higher scores on the DES are also likely to feel socially incompetent. They can be expected to have difficulty not only with the opposite sex but have problems making friends. They are likely to find interpersonal relationships bewildering, unpredictable, and anxiety-provoking and as a result may try to relieve anxiety by avoidance and escape from others.

Incest survivors who scored higher on the DES are also likely to have more difficulties with reality distortion. They are likely to have distortions of internal reality which may lead to somatic concerns, confusion between waking and dream states, understanding their own feelings and the feelings of others. Another area of disturbance includes uncertainty about perceptions. Questioning their perceptions of both internal
and external reality, the incest survivors in this study with higher scores are likely to question the reality of flashbacks, dreams, or retrieved memories regarding their abuse, and worry at times if they are only making their memories up. On the positive side, however, they may have sufficient resiliency to later be aware of lapses in reality testing and the passage of time associated with their dissociative episodes and affirm what is real.

Although incest survivors in this study demonstrated a relationship also between dissociation and the Hallucinations and Delusions scale on the BORRTI, the exact nature of this relationship is more difficult to ascertain. Bell noted (1991) that higher scores on this scale are often found in schizophrenics, schizoaffective samples, and some borderline patients. Although dissociative disordered clients sometimes show overlapping characteristics with these and other diagnostic groups, the higher scores on this scale may reflect hallucinatory or delusion-like symptoms that may mimic psychotic disorders but, in fact, be quite different in many ways.

The Insecure Attachment scale on the BORRTI may not have shown a positive correlation with "type" and "frequency" of dissociative experiences on the DES in incest survivors in this sample since this scale suggests a level of object-relations self-representations that is somewhat higher and better integrated than that found in some of the other scales on the BORRTI (Bell, 1991). Also incest survivors frequently display a pseudomaturity in regard to interpersonal relationships. In a sense they may have responded to the BORRTI in a way that might have masked some of their difficulties in personal rejection measured by this BORRTI scale. Bell (1991) has noted, however, that the Insecure Attachment scale is one on which high functioning adults and students were most likely to receive elevated scores, as well as psychiatric outpatients with less severe character disorders. If this scale had been correlated with dissociation, it would suggest being overly sensitive to rejection and feeling easily hurt by others.
When the sample of adult female incest survivors was divided into two groups, the DID and non-DID group, there was also a positive and significant correlation between "frequency" of dissociative experiences on the DES and the Alienation scale in the DID group ($r^a = 0.44$, $p = 0.0163$) (Table 18). This also provided support for the hypothesis that there would be a relationship between dissociation and object-relations impairment in this study in DID incest survivors. The positive correlation that was found between dissociation and the Alienation scale in the DID group appears to provide some preliminary support for the theory proposed in chapter 1 of this study that individuals with DID spend more time dissociating as children because of traumatic events or other adverse experiences at a very young age and as a result have more object-relations impairment later as adults.

Table 18

<table>
<thead>
<tr>
<th>BORRTI Scale</th>
<th>M</th>
<th>SD</th>
<th>$r^a$</th>
<th>Prob.</th>
<th>$r^b$</th>
<th>Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alienation</td>
<td>66.31</td>
<td>9.08</td>
<td>0.44*</td>
<td>0.0163</td>
<td>0.09</td>
<td>0.6567</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>58.93</td>
<td>11.42</td>
<td>0.17</td>
<td>0.3815</td>
<td>0.08</td>
<td>0.6835</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>60.45</td>
<td>9.47</td>
<td>0.04</td>
<td>0.8416</td>
<td>0.02</td>
<td>0.3707</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>59.52</td>
<td>10.14</td>
<td>0.10</td>
<td>0.6187</td>
<td>0.20</td>
<td>0.3082</td>
</tr>
<tr>
<td>Reality Distortion</td>
<td>58.59</td>
<td>10.72</td>
<td>0.55*</td>
<td>0.0019</td>
<td>0.45*</td>
<td>0.0145</td>
</tr>
<tr>
<td>Uncertainty of Perception</td>
<td>66.66</td>
<td>9.81</td>
<td>0.42*</td>
<td>0.0241</td>
<td>0.32</td>
<td>0.0915</td>
</tr>
<tr>
<td>Hallucinations and Delusions</td>
<td>67.83</td>
<td>8.66</td>
<td>0.32</td>
<td>0.0858</td>
<td>0.27</td>
<td>0.1535</td>
</tr>
</tbody>
</table>

Note. $N = 29$; $r^a$ = DES frequency score; $r^b$ = DES type score. $* p < .05$. 

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In the DID group only the Reality Distortion scale on the BORRTI showed a positive and significant correlation between both "frequency" and "type" of dissociative experiences on the DES ($r^a = .55, p = 0.0019, r^b = .45, p = 0.0145$) (Table 18). This finding may be useful clinically in explaining why individuals with DID have distortions in reality testing (i.e., the perceptual disturbance of subjectively feeling and sometimes seeing alter personalities, which are not seen by other people). As a result, they often report alter personality states that perceived from a phenomenological standpoint seem real to DID individuals but would be regarded by others as aberrant or unusual.

There was also in the DID group a positive and significant correlation ($r^3 = 42, p = 0.0241$) between "frequency" of dissociative experiences on the DES and the Uncertainty of Perceptions scale on the BORRTI (Table 18). This finding would theoretically make sense since individuals with DID, because of dissociation, seem to frequently question their perceptions of what is "real" and "unreal." The Uncertainty of Perceptions scale also appears to be similar to the F scale on the MMPI and higher elevations may be seen as a "cry for help." This may stem from inner turmoil and distress arising out of a more poorly differentiated level of object relations.

The fact that three out of four of the BORRTI scales in the DID group were positively correlated with "frequency" of dissociative experiences on the DES and only one correlated with "type" (Table 18) appears to provide additional support for the theory proposed in this study that the amount of time spent dissociating may be more related to object-relations impairment in DID clients than the total number of different types of dissociative experiences reported.

The positive correlation between the "frequency" of dissociative experience on the DES and the BORRTI scales of Alienation and Reality Distortion (Table 18) may shed further light on our theoretical understanding of DID. Bell (1991) reported that when the Reality Distortion scale is elevated with the Alienation scale on the BORRTI, then
distortions in perceptions of self and others may characterize the person's style of interpersonal relationships. DID clients may not only distort their sense of self and inner reality but are more likely to view others in a distorted manner.

It is interesting to note that there was a reversal in the size of the correlations within the Reality Distortion scale when one compares the DID and non-DID groups on the two different scores of dissociative experiences, "frequency" and "type" on the DES (Tables 18 and 19). There was a larger correlation between "frequency" of dissociative experiences and Reality Distortion than "type" of dissociative experiences and Reality Distortion in the DID group ($r^a = .55, p = 0.0019; r^b = .45, p = 0.0145$) (Table 18).

Table 19

<table>
<thead>
<tr>
<th>BORRTI Scales</th>
<th>M</th>
<th>SD</th>
<th>$r^a$</th>
<th>Prob.</th>
<th>$r^b$</th>
<th>Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alienation</td>
<td>60.35</td>
<td>11.28</td>
<td>0.49*</td>
<td>0.0051</td>
<td>0.47*</td>
<td>0.0083</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>55.71</td>
<td>12.52</td>
<td>0.23</td>
<td>0.2111</td>
<td>0.22</td>
<td>0.2340</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>55.16</td>
<td>9.44</td>
<td>0.50*</td>
<td>0.0040</td>
<td>0.37*</td>
<td>0.0433</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>56.54</td>
<td>9.93</td>
<td>0.57*</td>
<td>0.0008</td>
<td>0.49*</td>
<td>0.0056</td>
</tr>
<tr>
<td>Reality Distortion</td>
<td>53.32</td>
<td>9.05</td>
<td>0.38*</td>
<td>0.0374</td>
<td>0.47*</td>
<td>0.0083</td>
</tr>
<tr>
<td>Uncertainty of Perception</td>
<td>56.26</td>
<td>12.28</td>
<td>0.33</td>
<td>0.0728</td>
<td>0.32</td>
<td>0.0762</td>
</tr>
<tr>
<td>Hallucinations and Delusions</td>
<td>50.16</td>
<td>10.45</td>
<td>0.19</td>
<td>0.3182</td>
<td>0.41*</td>
<td>0.0218</td>
</tr>
</tbody>
</table>

Note. $N = 31; r^a = \text{DES frequency score;} r^b = \text{DES type score.}$

$^* p < .05$. 

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The opposite was true in the non-DID group in which there was a smaller correlation between "frequency" of dissociative experience and Reality Distortion ($r^a = .38, p = 0.0374; r^b = .47, p = 0.0083$) and a larger correlation between that scale and "type" (Table 19). Although statistically it would appear difficult to draw any firm conclusions from the above correlation patterns, the different patterns might reflect some subtle differences in the manner in which DID and non-DID incest survivors use dissociation in terms of dealing with reality.

Other evidence supporting the hypothesis that there is a relationship between dissociation and object-relations impairment in incest survivors comes from an examination of the correlations between dissociation and object-relations impairment in the non-DID group. There was a positive and significant correlation between both "frequency" and "type" of dissociative experiences on the DES and Alienation in the non-DID group ($r^a = .49, p = 0.0051, r^b = .47, p = 0.0083$) (Table 19).

Additional evidence supporting the hypothesis was also found in the positive and significant correlations between "frequency" of dissociative experiences on the DES and the BORRTI scales of Egocentricity, Social Incompetence, and Reality Distortion. There were also positive and significant correlations between "type" of dissociative experiences on the DES and the BORRTI scales of Egocentricity, Social Incompetence, Reality Distortion, and Hallucinations and Delusions (Table 19). It appears that the more the non-DID group dissociated, the more this group experienced problems in these object-relations areas.

While it is not completely clear from a theoretical standpoint why the non-DID group displayed more significant correlations and a different pattern of correlations than the non-DID group (Tables 18 and 19), it is possible that incest survivors in the non-DID group may be in less denial about some object-relations problems because overall they dissociate less than DID incest survivors (Table 20).
In comparing the size of the correlations between the DID and non-DID groups, the largest significant correlation in the DID group (Table 18) was between the "frequency" of dissociative experience score on the DES and the Reality Distortion scale on the BORRTI. The largest significant correlation in the non-DID group (Table 19) was between the "frequency" of dissociative experience score on the DES and the Social Incompetence scale on the BORRTI. The findings would appear to suggest that there may be more of a relationship between dissociation and reality disturbances in the DID group, while in the non-DID group dissociation may tend to manifest itself more as a way to relieve anxiety or avoid and escape bewildering and confusing social situations (Bell, 1991).

**Question 2:** Is there a significant difference between adult female incest survivors diagnosed with DID (splitting) and those not diagnosed with DID (no overt splitting) on a measure of dissociation?

A t-test for two independent samples was conducted to answer this research question. Table 20 shows the results of this analysis. Probabilities associated with the t-values were considered significant if they were less than 0.05. As can be seen from the table, adult female incest survivors in the DID group differed significantly from incest survivors in the non-DID group on both "frequency" and "type" of dissociative experiences scores on the DES.

In comparing the mean DES "frequency" scores for the two groups in the sample, the DID group had a mean "frequency" score of 43.1 out of a total possible score of 100, compared to a mean "frequency" score 12.7 in the non-DID group. These mean scores were significantly different (p = 0.0000) (Table 20). In comparing the mean DES "type" scores for the two groups in the sample, the DID group had a mean "type" score of 24.9 out of a total possible score of 28, compared to a mean "type" score of 12.5 in the non-DID group. These mean scores were significantly different (p = 0.0001). This suggests...
Table 20

Summary of t-test Results on Dissociation

<table>
<thead>
<tr>
<th>Factor</th>
<th>Group&lt;sup&gt;a&lt;/sup&gt;</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>Prob</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociation (frequency)</td>
<td>1</td>
<td>43.10</td>
<td>16.46</td>
<td>8.52*</td>
<td>58</td>
<td>0.0000</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>12.67</td>
<td>10.78</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissociation (type)</td>
<td>1</td>
<td>24.90</td>
<td>2.92</td>
<td>10.60*</td>
<td>58</td>
<td>0.0001</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>12.48</td>
<td>5.64</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>a</sup> 1 = DID group; N = 29; 2 = Non-DID group; N = 31.

* p < .05.
the DID group dissociates more often and uses a larger number of dissociate mechanisms than the non-DID group.

**Question 3:** Is there a significant difference between adult female incest survivors diagnosed with DID (splitting) and those not diagnosed with DID (no overt splitting) on a measure of object-relations impairment? A t-test for two independent samples was conducted to answer this research question. Probabilities associated with t-scores were considered significant if less than .05. Table 21 shows the results of this analysis.

As can be seen from Table 21, adult female incest survivors in the DID group differed significantly from incest survivors in the non-DID group on the BORRTI Alienation scale score. This scale was pre-selected to test the hypothesis prior to data analysis (see also question 1) since this scale appears to represent the broadest dimension of object-relations impairment measured by this test.

Additional evidence in support of this hypothesis is found in Table 21. Four other BORRTI object-relations scales scores, in addition to the Alienation scale, were found to be significantly different between the DID and non-DID groups. These four scales included Egocentricity, Reality Distortion, Uncertainty of Perceptions, and Hallucinations and Delusions. It appears that the DID and non-DID groups, based on a univariate analysis of the data, seem to differ most on scales that reflect problems with overall alienation, narcissistic hurt (Egocentricity), and the three Reality Distortion scales.

Two BORRTI Object Relations scales -- Insecure Attachment and Social Incompetence -- were not found to be significantly different and did not provide additional support for the hypothesis. Elevated scores on the Insecure Attachment scales seem to reflect attitudes and personality traits most commonly associated with avoidant, dependent, compulsive, or passive-aggressive personality disorders (DSM-III, 1987) and according to Bell (1991) may not be so severe as to cause serious social dysfunction.
Table 21

Summary of t-test Results on Object-Relations Impairment

<table>
<thead>
<tr>
<th>Scale</th>
<th>Groupa</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>t</th>
<th>df</th>
<th>Prob</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alienation</td>
<td>1</td>
<td>29</td>
<td>66.31a</td>
<td>9.08</td>
<td>2.24*</td>
<td>57</td>
<td>0.028</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>31</td>
<td>60.35</td>
<td>11.28</td>
<td></td>
<td></td>
<td>0.029</td>
</tr>
<tr>
<td>Insecure Attachment</td>
<td>1</td>
<td>29</td>
<td>58.93</td>
<td>11.42</td>
<td>1.04</td>
<td>58</td>
<td>0.302</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>31</td>
<td>55.71</td>
<td>12.52</td>
<td></td>
<td></td>
<td>0.303</td>
</tr>
<tr>
<td>Egocentricity</td>
<td>1</td>
<td>29</td>
<td>60.45</td>
<td>9.47</td>
<td>2.16*</td>
<td>58</td>
<td>0.035</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>31</td>
<td>55.16</td>
<td>9.44</td>
<td></td>
<td></td>
<td>0.035</td>
</tr>
<tr>
<td>Social Incompetence</td>
<td>1</td>
<td>29</td>
<td>59.52</td>
<td>10.14</td>
<td>1.15</td>
<td>58</td>
<td>0.257</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>31</td>
<td>56.55</td>
<td>9.93</td>
<td></td>
<td></td>
<td>0.257</td>
</tr>
<tr>
<td>Reality Distortion</td>
<td>1</td>
<td>29</td>
<td>58.59</td>
<td>10.72</td>
<td>2.06*</td>
<td>58</td>
<td>0.045</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>31</td>
<td>53.32</td>
<td>9.05</td>
<td></td>
<td></td>
<td>0.044</td>
</tr>
<tr>
<td>Uncertainty of Perception</td>
<td>1</td>
<td>29</td>
<td>66.66a</td>
<td>9.81</td>
<td>3.61*</td>
<td>58</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>31</td>
<td>56.26</td>
<td>12.28</td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
<tr>
<td>Hallucinations and Delusions</td>
<td>1</td>
<td>29</td>
<td>67.83a</td>
<td>8.66</td>
<td>7.10*</td>
<td>58</td>
<td>0.000</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>31</td>
<td>50.16</td>
<td>10.45</td>
<td></td>
<td></td>
<td>0.000</td>
</tr>
</tbody>
</table>

Note. t-scores greater than 60 on the BORRTI subscales are suggestive of psychopathology except on the Hallucinations and Delusions subscale which requires a t-score greater than 65.

a 1 - DID group, N = 29; 2 - non-DID group, N = 31.

* p < .05.
Elevated scores on the Social Incompetence scale signify a high degree of social anxiety. Persons with higher scores would tend to withdraw from social interactions. Based on univariate analysis it appears that the DID and non-DID groups differ more on BORRTI scales, that reflect more characterological problems like those suggested by Alienation and Egocentricity scales and disturbances in reality testing areas like that found on the Uncertainty of Perception and Hallucinations and Delusions scales. The two groups are not significantly different on the two scales on the BORRTI that suggest less serious psychopathology (Insecure Attachment and Social Incompetence scales).

On all seven of the BORRTI scales the DID group scored higher than the non-DID group, based on mean t-scores, suggesting that the DID incest survivors as a group had more difficulties in all the areas measured by these scales (Table 21).

Since the findings of this study seem to support the hypothesis that there is a relationship between dissociation and object-relations impairment in incest survivors, both with and without DID, there appeared to be some value in determining if one or more of the BORRTI's seven object-relations scale scores and the DES "frequency" and "type" scores could be used to distinguish between the two groups. To address this issue, a multivariate, direct discriminant analysis was used. In this procedure, all discriminating variables were examined simultaneously to ascertain the nature of group differences.

Table 22 shows the canonical discriminant function when all seven BORRTI scale scores and the two DES scores were entered into the equation simultaneously. The eigenvalue, which is the ratio between group variability to within group variability, was 2.98 suggesting the discriminant function was quite good at discriminating the DID and non-DID group. The percentage of variance, which refers to the proportion of the total between group variability accounted for by the discriminant function in a two-group situation, is always 100% (Klecka, 1980; Norusis, 1985). The cumulative percentage is
the running total of the percentage of variance and is also 100% in a two-group case (Diekhoff, 1992).

The canonical correlation of 0.87 is a measure of association that summarizes the degree of relatedness between the two groups. This suggests a rather high relationship between the groups and the discriminant function (Diekhoff, 1992; Klecka, 1980; Norusis, 1985). When squared, approximately 75% of the total variance due to group differences was explained by the discriminant function. The small Wilks’s lambda indicates 0.25 of the total variance was accounted for by group differences. Small lambdas are generally associated with functions that have much variability between the groups and little variability within groups.

In this study it was concluded that the seven BORRTI scale scores and the two DES scores when taken together can significantly differentiate between membership in the DID and non-DID group. The discriminant function appears to be quite effective in classifying group membership. In relation to actual group membership, there were no

<table>
<thead>
<tr>
<th>Function</th>
<th>Eigenvalue</th>
<th>Percentage of Variance</th>
<th>Cumulative Percentage</th>
<th>Canonical Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.9803</td>
<td>100.00</td>
<td>100.00</td>
<td>0.87</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Function</th>
<th>Wilks's Lambda</th>
<th>Chi-squared</th>
<th>df</th>
<th>sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>25</td>
<td>73.90</td>
<td>9</td>
<td>.0000</td>
</tr>
</tbody>
</table>

Table 22

Canonical Discriminant Function

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DID clients misclassified, while only three non-DID clients were misclassified. This results in a 100.0% classification rate for the DID group, and a 93.3% classification rate for the non-DID group. There was an overall correct classification rate of 95% in the sample as a whole.

Table 23 shows the unstandardized coefficients and structure matrix that represent the importance of the variables relative to each other. They provide information on how much or little these variables contribute to the differentiation between the two groups in this study. According to Tabachnick and Fidell (1989), the meaning of the function is inferred by a researcher from the pattern of correlations between the function and the predictors which is indicated by the structure matrix. By convention correlations of plus or minus .30 may be considered eligible for interpretation (Tabachnick & Fidell, 1989).

In examining Table 23 three variables in combination significantly differentiate between the DID and non-DID groups. These include: Hallucinations and Delusions, "type" of dissociation, and "frequency" of dissociation. These three variables all make a positive contribution to the discriminant analysis function. Individuals in the DID group can be expected to be most different than the non-DID group based on higher Hallucinations and Delusions scores on the BORRTI and higher "frequency" and "type" scores on the DES. The DID group centroid is 1.75490 and the non-DID group centroid is -1.64168.

**Integrated DID Clients**

At the time of this study two clients who participated in this study were reported as "integrated" by their outpatient therapists in the Kalamazoo area. One client, a 36-year-old Caucasian, married with no children, had approximately 5 years of college, and no
Table 23

**Unstandardized Canonical Discriminant Function Coefficients and Structure Matrix for the Two Groups in the Sample**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Weight</th>
<th>Structure Matrix</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Alienation</td>
<td>-0.020</td>
<td>0.171</td>
</tr>
<tr>
<td>B. Insecure Attachment</td>
<td>0.006</td>
<td>0.079</td>
</tr>
<tr>
<td>C. Egocentricity</td>
<td>0.024</td>
<td>0.165</td>
</tr>
<tr>
<td>D. Social Incompetence</td>
<td>-0.025</td>
<td>0.087</td>
</tr>
<tr>
<td>E. Reality Distortion</td>
<td>-0.062</td>
<td>0.157</td>
</tr>
<tr>
<td>F. Uncertainty of Perception</td>
<td>0.025</td>
<td>0.274</td>
</tr>
<tr>
<td>G. Hallucinations and Delusions</td>
<td>0.040</td>
<td>0.540*</td>
</tr>
<tr>
<td>H. &quot;Type&quot; of Dissociation</td>
<td>0.152</td>
<td>0.806*</td>
</tr>
<tr>
<td>I. &quot;Frequency&quot; of Dissociation</td>
<td>0.029</td>
<td>0.648*</td>
</tr>
</tbody>
</table>

Note. *Coefficients of plus or minus .30 or greater were chosen to differentiate the DID and non-DID groups.
reported income. Her therapist indicated that this client had integrated in April 1994, six months prior to participating in this study. Her therapist, who has had a great deal of experience working with DID clients, rated her confidence level in the client's DID diagnosis on a 5-point scale as being a "5," extremely confident. The client's diagnosis had also been confirmed by two physicians and three therapists. This client had been in individual therapy for 3 years prior to working with her current therapist, and has been in therapy with her current therapist for 3 years and 4 months. The therapist reports that prior to integration this client had nine main alter personalities with many personality fragments. This client obtained a DES "frequency" score of 9.3 and a DES "type" score of 11.0. This integrated client obtained a clinically elevated score on only one of the BORRTI scales, Egocentricity, with a t-score of 68.

Another Caucasian client, age 30, single, with no children, had 2 years of college and reported an income of $28,000. Her therapist indicated that this client had seemed to integrate approximately 1 1/2 years prior to this study, but this integration was not maintained due to some life stressors. This client then integrated for the second time approximately 4 months prior to this study and has maintained her integrated state. Her therapist, who is also experienced in working with dissociative disorders and presently doing research in this area, rated her confidence in the client's DID diagnosis as "extremely confident." No prior treatment history was reported. This client has been in individual therapy with her current therapist for 8 years. The therapist reported that prior to integration this client had more than 100 alter personalities and had obtained a DES "frequency" score of 20.2 and a DES "type" score of 22.0. This integrated DID client at the time of this study obtained a DES "frequency" score of 4.6 and a DES "type" score of 6.0. The client also at the time of this study obtained only one clinically elevated score on the BORRTI. This was on the Social Incompetence scale with a t-score of 62.
Based on the test findings on these two clients, it appears that integrated DID clients appear to experience a dramatic reduction in both dissociative symptomatology and object-relations impairment following integration. The post-integration mean scores for these two integrated clients on the DES ("frequency" = 7.0, "type" = 8.5) were both below the mean DES scores for the non-integrated DID clients in this study ("frequency" = 43.1, "type" = 24.9). These two integrated DID clients also each obtained clinical elevations on only one BORRTI scale compared to the non-integrated DID clients in this study, who as a group, obtained clinically elevated scores on the three BORRTI scales of: Alienation, Uncertainty of Perception, and Hallucinations and Delusions.

**Chapter Summary**

The sample consisted of 60 adult female incest survivor clients. Twenty-nine out of the sample made up the group of incest survivors with personality splitting (DID group). Thirty-one out of the sample made up the group of incest survivors without overt personality splitting (non-DID group). There was a significant and positive relationship between dissociation and object-relations impairment in the sample, as a whole, and in both groups.

In this study there was also significant difference between the two groups on the frequency and type of dissociation as measured by two scores on the DES. The DID group had higher mean scores as a group on both "frequency" and "type" of dissociative experiences as measured by the DES than the non-DID group. This finding suggests that DID incest survivor clients spend more time dissociating than non-DID incest survivor clients and use more different types of dissociative coping mechanisms than non-DID incest survivors.

There was also a significant difference between the two groups in this study on the
characteristics of object-relations impairment. The DID group had significantly higher mean scale scores than the non-DID group on five out of seven of the BORRTI scales including: Alienation (which measures the broadest dimension of object-relations impairment on the BORRTI), Egocentricity, Reality Distortion, Uncertainty of Perceptions, and Hallucinations and Delusions. The findings suggest that DID clients as a group have more impairment in these areas measured by these scales than the non-DID group in this study.

While none of the mean scale scores on the seven BORRTI scales were clinically elevated in the non-DID group, three of the mean scale scores were clinically elevated in the DID group. These scale elevations were on the object-relations scale of Alienation, and two reality-testing scales: Uncertainty of Perceptions and Hallucinations and Delusions. The remaining four BORRTI mean scale scores for the DID group were also very close to being clinically elevated. The results suggest that DID clients may have more object-relations impairment than the non-DID group in the areas measured by these scales.

In doing a discriminant analysis of the two DES scores and seven BORRTI scale scores in the sample, the results indicated that DID incest survivors can be distinguished from non-DID incest survivors in that they spend more time dissociating and utilize more different types of dissociative mechanisms. DID incest survivors are also more likely to have problems with hallucinations and delusions.

The clinical description of two integrated DID clients in this study illustrates the important role that personality integration may play in the reduction of both dissociative symptomatology and object-relations impairment. The possible link between severe and repetitive childhood physical and sexual abuse, parental substance abuse, parental domestic violence, and the formation of DID is suggested by the background information obtained on the sample on the CMIS-SF. The DID group consistently displayed higher
incidences on both childhood maltreatment factors and adult traumatization factors than the non-DID group.

In addition the DID group, as a whole, reported earlier mean starting ages and later mean stopping ages for childhood maltreatment (sexual and non-sexual) than the non-DID group. Both the DID and non-DID groups as a whole reported sexual abuse (kissing and fondling) by both familial and non-familial abusers. The DID group, however, as a whole reported a higher incidence of sexual abuse by various abusers than the non-DID group and by multiple abusers. At least 21% of the DID group also reported abuse by cult members or other religious persons in the form of kissing and fondling (and 24% in the case of intercourse), while no one in the non-DID group reported this type of abuse.

In regard to psychological maltreatment, more incest survivors in the DID group reported not being loved "at all" by their mothers throughout childhood. More incest survivors, however, in the non-DID group reported not being "loved at all" by their fathers, especially before age 8. The DID group reported a higher incidence than the non-DID group on seven different types of psychological abuse.

In looking at the characteristics of the sexual abuse reported by incest survivors in this study, the DID group more often reported the use of force, and being abused more frequently and by more people, on the average, than the non-DID group. The DID group also reported more physical abuse than the non-DID group. While the two groups were quite similar in regard to demographic characteristics, the DID group had been involved longer in various types of treatment than the non-DID group and was earning less income on the average.

In examining the memories of DID and non-DID incest survivors, there appear to be a number of important differences between these two groups, with DID clients typically experiencing what appears to be more amnesia for specific abuse events in their past and
more variability in their day-to-day memories of their childhood sexual abuse experiences. Both groups, however, seem to have a fair amount of confidence in the overall accuracy of their sexual abuse memories.
CHAPTER V

SUMMARY, DISCUSSION OF FINDINGS, AND IMPLICATIONS

This chapter presents a summary of the study, a discussion of the findings, and implications for treatment and further research.

Summary

Purpose of the Study

This study was undertaken with the purpose of examining the relationship between dissociation and object-relations impairment in adult female incest survivors being treated in outpatient settings. From a theoretical standpoint it was hypothesized that there would be a relationship between dissociation and object-relations impairment in the sample, and that adult incest survivors, who dissociate more, would also have more object-relations impairment. It was also hypothesized that the DID group would have significantly higher levels of dissociation and object-relations impairment than the non-DID group of incest survivors with no evidence of overt personality splitting. Object-relations theory, within the broader context of a PTSD model, was offered as a possible explanation for the personality splitting observed in adult incest survivors with DID and was seen as possibly having implications for the treatment of incest survivors in general.

Overview of Related Literature

A review of the literature presented in chapter 2 suggested that long-term retroactive studies have provided extensive information about the characteristics of adult female survivors of childhood sexual abuse from a PTSD model. Some writers, however, have questioned whether the PTSD model adequately accounts for the many long-term
negative effects found in adult incest survivor clients. They have suggested that it may not be the sexual abuse per se, but perhaps sexual abuse in combination with other types of maltreatment or other factors in the home environment that lead to later psychological adjustment problems in many adult female incest survivors. There appear to be no studies that have specifically compared the long-term effects of incest in DID clients with incest survivors who do not meet the criteria for DID.

A review of the literature on sexual abuse and DID showed that sexual abuse, especially incest, was frequently mentioned in case studies on clients with this disorder. Incest was not, however, cited as a possible factor in the development of DID in early review articles on DID in this country. It was not until the 1970s and 1980s that a link was clearly drawn between childhood incest and other types of abuse and the formation of DID.

Some have theorized that extremely sadistic sexual abuse, physical abuse, and other kinds of early-life traumatic events may lead to DID. In the 1980s a number of retrospective studies were conducted with large groups of DID patients. In these studies it was found that sexual and physical abuse were reported by almost all of the DID patients who were questioned about their childhood history. Like the incest literature in general, it appears that a number of writers in the DID literature have speculated that childhood sexual abuse may be an important factor that predisposes an individual to many of the long-term effects found in adults with this disorder, including personality splitting.

Few writers have suggested in either the incest literature, or DID literature, that early-life object-relations impairment during the first year or two of life might be the factor that predisposes an individual to later long-term psychiatric problems, especially personality splitting. Most writers have recognized the role of various maltreatment factors in the development of later psychopathology, especially DID. It is difficult.
however, in retroactive studies to determine what types of adversive conditions may have existed in the early lives of children that could have set the stage for the development of alter personality states. One thing that appears clear, based on the literature, is that DID appears to originate in childhood and does not seem to develop in response to only adult trauma. This would seem to lend support to the object-relation model discussed in this study.

While it makes sense that sexual and physical abuse or other traumatic events after the age of 2, might lead to a number of the long-term negative effects found in incest survivors with and without DID, it is possible that earlier life developmental factors have possibly been overlooked by many researchers in drawing conclusions about the long-term effects of incest. It may be that a neglectful, harsh, or abusive environment before age 2 may already predispose an individual to disturbances in identity, ego strength, and basic coping mechanisms that can lead to later life psychiatric problems and the need for treatment.

It is possible that impaired object-relations functioning during the first 2 years of life, when splitting is used as a defense mechanism, and when important self-representations are formed, may cause a person to be especially vulnerable to developing DID. In fact, it is possible that some individuals may develop DID while others may not because of the type of environment that is present during the first 2 years of life. If this is true, it does not negate the fact that later childhood abuse, neglect, or a harsh or overwhelming environment probably results in additional psychological harm and more and more extensive personality splitting.

Since the late 1980s and early 1990s some researchers have begun to investigate the role of dissociation and object-relations impairment in adult incest survivor clients with DID and adult incest survivors who do not appear to have any overt personality splitting. Although it appears that there have been no past studies that have examined the
relationship between dissociation and object-relations impairment in adult incest survivors, it has been hypothesized in this study that there may be a relationship between these two phenomena. It has been hypothesized that young children, who dissociate more frequently, will be in less contact with important "objects" in their external world and as a result will have more impaired interpersonal relationships and reality testing than children who do not dissociate very much early in life. It is also possible that alter personalities represent an arrestment in the splitting process and that some individuals develop DID because adequate self-representations are not formed within the first year or two of life.

As more research is done in the area of dissociation, it may be possible to isolate what specific characteristics of very early childhood (before age 2) or other negative environmental factors after age 2 (like physical, sexual, and psychological abuse, or emotional or physical neglect) may be most damaging in terms of long-term effects. It is possible that the tendency to dissociate is closely connected in infancy to an arrestment in the developmental stage of splitting when this latter process has to be over-used as a way of organizing and defending against overwhelming life experiences. When this occurs, mental representations in the form of alter personality states are formed which form the basis for further organizing or defending against other overwhelming or stimulating events like incest and physical abuse later in life.

The incest experience has usually been viewed as "traumatic" in nature and blamed for the many long-term negative effects found in adult survivors with and without DID. It is possible that other factors, like family violence, poverty, parental mental illness, or alcoholism, may contribute singly or in combination to some of the damaging effects found in many incest survivors.

A theoretical overview of the concepts of dissociation and splitting in DID clients has been also presented in chapter 2 together with an overview of research on object-
relations :mpairment and sexual abuse. Although there have been only a limited number of studies that have examined the role of object-relations impairment in adult incest survivors with DID, it is possible that object-relations theory may eventually enhance our understanding of how this disorder develops.

Sample and Instrumentation

The sample consisted of 60 adult females who were sexually abused prior to the age of 17 and were in outpatient treatment. Forty-eight percent of the sample was made up of incest survivors with DID, compared to 52% who were also incest survivors but who did not meet the criteria for this diagnosis.

The study was conducted in southwestern Michigan, but was expanded to include other areas in Michigan and northern Indiana in order to obtain an adequate sample size of DID and non-DID incest survivors. In order to investigate the characteristics of dissociation and object-relations impairment as a long-term effect in incest survivors, participants were asked to complete a Personal Data Sheet, the Dissociative Experience Scale (DES), the Bell Object Relations and Reality Testing Inventory (BORRTI), as well as the Child Maltreatment Interview Schedule—Short Form (CMIS-SF) developed by Briere (1992). Therapists were also asked to complete a Client Diagnostic Confirmation Form on their clients.

A simple two-group design was used to investigate the relationship between object-relations impairment and dissociation in the sample. The adult female incest survivors were assigned to either the DID or non-DID group based on whether or not they met the diagnosis for DID based on DSM-IV criteria (APA, 1994). Because of the use of these criteria, it was assumed that the two groups would differ on the characteristic of personality "splitting" as defined in chapter 1 (Braun, 1986).
Since the characteristic of splitting as it refers to non-DID incest survivors has not been empirically investigated, it was assumed in this study that the non-DID incest survivor would not have any "overt" personality splitting. It is possible that this group may have had some covert personality splitting and that personality splitting may exist on a continuum.

The two groups were very similar in terms of demographic characteristics. The two groups varied somewhat in their description of their incest memories and on a number of other clinical characteristics. A larger number of DID versus non-DID incest survivors reported having incidents of childhood sexual abuse blocked from their memory. A larger percentage of DID clients than non-DID clients, however, reported retrieving more memories of their sexual abuse since getting into treatment.

Forty-eight percent of the sample was made up of DID incest survivors. The median number of alter personality states reported by DID incest survivors was 15. At least 55% of the DID clients were reported by their outpatient therapist as experiencing some degree of integration, and 79% reported some degree of co-consciousness between their host personality and alter personality states. The DID group as a whole had been in treatment much longer than the non-DID group (both prior and current treatment) and had experienced more parental substance abuse, domestic violence, physical abuse, and sexual abuse (intercourse). The DID group also reported a higher incidence of psychological abuse, and a larger percentage in the DID group did not feel loved “at all” by their mothers.

The mean age at which parental substance abuse, physical abuse, and sexual abuse started was earlier for the DID group than the non-DID group and lasted longer on the average. The DID group reported a higher incidence of sexual abuse by family, friends, strangers, professionals, babysitters, and other non-family persons than the non-DID group. In terms of the incest experience, abuse by a variety of family and non-family
individuals was experienced by both groups. The DID group reported, in general, a higher incidence of sexual abuse (intercourse) than the non-DID group. This group also reported that in regard to their sexual abuse (kissing and fondling and intercourse) force was used more, the sexual abuse was more frequent, and more abusers were involved. The DID group was also physically abused more frequently. The DID group also consistently reported a higher incidence of adult traumatic experiences compared to the non-DID group.

Data on two integrated DID clients, which were not included in the data on the sample, seemed to suggest that personality integration may lead to lower mean scores in dissociation and a significant reduction in object-relations impairment compared to non-integrated DID clients.

Delimitations described in chapter 1 in regard to this study included: (1) the inclusion of only adult female incest survivors, at least 18 years or older, and living in the Midwest; (2) the outpatient nature of the sample; and (3) the volunteer nature of the sample. Limitations in the study included the difficulty of generalizing the findings to populations other than the population included in this study. Although a study by Ross and Norton (1989) suggests that DID manifests itself in a similar way in men and women, further research is needed in this area. It is anticipated that the results of a study such as this might differ for adults versus children outpatient clients versus clients who are involved in other treatment modalities and volunteers versus non-volunteers. Incest survivors who are not in treatment might not display the dissociative and object-relations symptomatology found in this sample.

Other limitations described in chapter 1 related to: the absence of a matched control group, a somewhat limited sample size, and problems in obtaining a racially diversified sample. Although subjects were able to provide rather extensive information about their childhood abuse and seemed to have little difficulty completing the DES and BORRTI, it
was apparent that the DID group had more difficulty remembering and reporting some details about their childhood physical and sexual abuse than the non-DID group. This may have been related to dissociation and as well as to the sexual and physical abuse that were often reported as occurring "too many times" to remember. Although the alter personality states of DID clients were encouraged to participate in this research, it is difficult to know how much personality switching, memory problems, or the covert influence of alter personality states may have affected the results of this study.

Attempts were made in this study to assure clients that their identities would remain confidential. A number of clients expressed concern over this issue with their outpatient therapist but agreed to participate. Due to the sensitivity of the topic, it is possible that some clients may not have felt comfortable reporting the full extent of their childhood abuse and, as a result, could have underreported their abuse.

As an incentive to the client, the therapist of each subject was given the client's results on the DES and BORRTI with an interpretation of the findings to aid in subsequent treatment. It was felt this encouraged fuller participation on the part of the client and resulted in clients putting forth a concerted effort to provide information in this study. Although clients were not financially remunerated for their participation in this study, they appeared interested in learning more about themselves and were informed that the information they provided might expand our general understanding about the long-term effects of incest.

In general, due to the exploratory nature of this research and some of the above limitations, it is recommended that the results be considered preliminary in nature and in need of further replication. Although the study covered a fairly broad geographic area and variety of treatment settings, it is recommended, because of the relatively small sample size and absence of a control group, that caution be exercised in the generalization of the
findings. It should also be noted that self-report measures are somewhat more vulnerable to bias based on the response set of the person completing the measure, and as a result, the findings should be interpreted accordingly.

**Discussion of Findings**

This section presents a summary of the findings of the research related to the three main hypotheses. A Pearson's product-moment correlation (two tailed) was used to test null hypothesis 1. A t-test for independent samples was used to test null hypotheses 2 and 3. A .05 level of significance was established to test all three of these research hypotheses. A multivariate discriminant analysis was performed to ascertain what scores on the DES and BORRTI might be helpful in distinguishing between these two groups.

A comparison of the two groups was also made in regard to clinical characteristics based on data obtained from the CMIS-SF. The two groups were compared on a number of childhood and adult maltreatment factors, the ages at which the abuse occurred, the characteristics of the abusers, and the characteristics of the abuse experiences. The two groups appeared quite similar in regard to demographic characteristics; however, the DID group reported much longer periods of prior and current treatments and lower income. The DID group, as a whole, seemed to be experiencing a fair degree of integration and co-consciousness. The DID group reported a median of 15 alter personalities. DID individuals reported more variability in their day-to-day memories of traumatic events than the non-DID group and a larger percentage reported recovering traumatic memories since getting into treatment. Overall, the DID group reported a higher incidence of childhood maltreatment and adult traumatization than the non-DID group. Their maltreatment started earlier and lasted longer. The DID group was more likely to experience force when being sexually abused, and were sexually abused by more people
than the non-DID group. They were sexually and physically abused more often.

Three statistical research hypotheses were tested in this study:

**Null Hypothesis 1**: There is no relationship between scores of dissociation and object-relations impairment in adult female incest survivors diagnosed with DID (splitting) and those not diagnosed with DID (no overt splitting).

This research hypothesis was rejected. The results show that there was a significant and positive correlation between dissociation and object-relations scores in the total sample of adult female incest survivor clients. Using a Pearson's product moment correlation, there was a positive correlation between both the "frequency" and "type" of dissociative experiences on the DES and six BORRTI object-relations subscales: Alienation, Egocentricity, Social Incompetence, Reality Distortion, Uncertainty of Perceptions, Reality Distortion, and Hallucinations and Delusions. The only BORRTI scale in which there was not a significant positive correlation between the two types of dissociation was Insecure Attachment. Those subjects in the total sample who had high dissociation scores also tended to have high scores on object-relations impairment in most areas. The findings suggest that incest survivors who dissociate more often and employ a greater number of different types of dissociation mechanisms, will experience more problems in a number of interpersonal areas of functioning and in some cases even in reality testing.

In the DID group, there was also a significant and positive correlation between "frequency" of dissociative experiences and three BORRTI scales: Alienation, Reality Distortion, and Uncertainty of Perception. In the DID group there was also a positive correlation between "type" of dissociative experience and reality distortion. The findings suggest that DID clients, because of the amount of time they dissociate, can be expected to have more problems with overall object-relations impairment as measured by the
Alienation scale on the BORRTI, as well as in reality distortion and uncertainty about their perceptions of reality. It appears that there may also be a relationship in the DID group between problems in reality distortion and the use of multiple types of dissociation. In this study 24 different types of dissociative experiences out of a total of 28 types were endorsed by DID incest survivors.

In the non-DID group, there was a significant and positive correlation between "frequency" of dissociative experiences and four BORRTI scales: Alienation, Egocentricity, Social Incompetence, and Reality Distortion. There was also a significant and positive correlation between "type" of dissociative experiences and five BORRTI scales—Alienation, Egocentricity, Social Incompetence, Reality Distortion, and Hallucinations and Delusions. It is possible that the non-DID group had significant correlations in these areas because as a group they tended to dissociate less than the DID clients and use different types of defenses.

Although there is no prior empirical research that specifically addressed the relationship between dissociation and object-relations impairment in DID and non-DID incest populations, the findings of this study appear to support the theory offered in this research that there would be a relationship between these two characteristics in adult incest survivors. Although such a relationship does not necessarily mean that there is a cause and effect relationship between dissociation and object-relations impairment, the findings may suggest that adult incest survivors, who have a pattern of frequent dissociative responses to life situations and who engage in a variety of different types of dissociative experiences, may do so based on poor ego strength and an inability to face life stressors without resorting to such dissociative mechanisms.

As was previously hypothesized in this study, it is possible that the processes of dissociation and object-relations are interactive. At a very early age a child growing up in an adverse environment develops an arrestment in the splitting process, which under
more normal conditions serves to organize and make more manageable overstimulating or overwhelming experiences. Dissociation then continues as a more primitive defense mechanism and then interferes with the integration of life experiences that would normally lead to a healthier and more unified ego. Incest survivors who experience such an arrestment in ego development are probably more likely to develop DID.

Based on Spiegel (1993), such maladaptive dissociative responses are often overlearned and can be triggered in adults prone to dissociation. This might also explain why a higher percentage of the DID group in this study reported incidents of sexual abuse that had been blocked from memory, felt their memories were less accurate, and felt memories of their sexual abuse varied more from day to day than the non-DID group.

In looking at the relationship between dissociation and object-relations impairment in research, it is important to examine whether other variables might have been responsible for explaining the relationship between the two variables. Braun (1990, chap. 11), for example, has noted that incest in the history of a patient with dissociative disorder should be taken as an indicator that "something worse" may have happened to account for the psychopathology. It is possible that factors prior to the incest experience of the clients in this sample (like early-life personality arrestment) might be responsible for explaining why many incest survivors (both those with and without DID), manifest so many psychiatric disorders, or have problems coping with life stressors in general.

The relationship between dissociation and object-relations impairment found in this study might also reflect the possibility that these survivors have experienced what might be termed "chronic" versus "acute" PTSD because of various childhood maltreatment variables. Rahe (1993) noted that individuals who experience acute PTSD have a high likelihood of recovery, generally have had more enriching early-life experiences, use psychological defense mechanisms to a moderate degree, and demonstrate ample coping capabilities. Individuals who go on to experience chronic PTSD, however, have a poorer
prognosis, report impoverished early-life experiences, use psychological defenses to an extreme degree, and show a paucity of coping skills. It is possible that the incest survivors (both DID and non-DID) in this study are experiencing more chronic PTSD and may not typify all incest survivors. Both the DID and non-DID incest survivors in this study reported a variety of childhood maltreatment over a relatively long period of time during childhood. They were also revictimized by various traumatic events as adults.

**Null Hypothesis 2:** There is no significant difference between adult female incest survivors diagnosed with DID (splitting) and those not diagnosed with DID (no overt splitting) on a measure of dissociation.

Using a t-test for two independent samples, this hypothesis was rejected. The findings suggest that there is a significant difference in dissociation between adult incest survivors diagnosed with DID and those who are not diagnosed with DID. Mean scores on dissociation as measured by the DES, including both "frequency" and "type" of dissociative experiences, were significantly higher for the DID than the non-DID group.

The results relating to this hypothesis are consistent with previous research in the area of dissociation. Ross, Miller, et al. (1990) found in a sample of 102 DID clients that their mean "frequency" of dissociative experience score was 41.4. This compares with a mean "frequency" dissociative score of 43.1 for the DID group in this sample. The non-DID group in this study had a mean "frequency" of dissociative experience score of 12.7, which is higher than that found in normal populations.

The findings in this study also appear somewhat consistent with other studies on dissociation. Carlson and Putnam (1993) reported in a review of studies using the DES that the mean "frequency" of experience score ranged from 3.7 to 7.8 in normal populations and from 42.8 and 55.0 in DID populations. They noted that a total score of 30 or above will correctly identify among severely dissociative individuals 74% of those
who meet the criteria for DID.

While there appear to be no studies that specifically compare the DES scores of DID incest survivors with non-DID incest survivors, Bernstein and Putnam (1986) found that DID patients scored higher on the DES when compared to normals and a number of patient groups, including those with PTSD. Since individuals with DID have consistently obtained the highest scores on the DES compared to other groups, it is not surprising that the DID group in this study had a significantly higher mean score on both "frequency" and "type" of dissociative experiences than the non-DID group. While this research did not use a control group, the data seem to support the idea that dissociation falls on a continuum (Bernstein & Putnam, 1986). In this research the DES "frequency" score of 12.7 for the non-DID group is higher than that reported by Putnam (1993) for normals (3.7 to 7.8), but not as high as the 43.1 reported by DID clients in this research, the 42.8 to 55.0 reported by DID individuals in Putnam's (1993) review or the 41.4 reported by Ross, Joshi, & Currie (1990).

The concept of a dissociative continuum appears to not only exist in regard to how much time individuals spend dissociating but also in regard to how many different types of dissociative experiences they report. In looking at the mean DES "type" score of 12.5 in this study for the non-DID group, it is greater than the 11 reported by Bernstein and Putnam (1986) for normal individuals, but less than the 28.0 reported by Bernstein and Putnam for DID individuals, and the 24.9 reported by DID clients in this research.

A number of factors may have accounted for the differences in DES mean scores for the DID and non-DID group in this research. Briere (1988), for example, found that extended sexual abuse, victimization involving bizarre acts, multiple perpetrators, and concomitant physical abuse may produce a variety of psychological problems. He also found that sexual intercourse during the abuse may result in especially high levels of
dissociation and suicidality. The DID group compared to the non-DID group in this study reported a higher incidence of a variety of childhood maltreatment factors, a more extended period of sexual abuse, more abusers, and a higher level of concomitant physical abuse. The DID group also reported more incidents of kissing and fondling, intercourse, using of force, and sexual abuse by a greater number of people than the non-DID group.

Although the differential effects of various types of abuse in relation to dissociation were not examined in this study, the DID group, as a whole, reported a higher incidence of parental alcoholism, domestic violence, physical abuse, sexual abuse (intercourse), parental psychological unavailability, and psychological abuse than the non-DID group. Briere and Runtz (1988a) found that psychological abuse by the father and physical maltreatment by the mother were associated with more dissociation than sexual abuse variables.

Chu and Dill (1990), Strick and Wilcoxon (1991), and Sablatura (1991/1993) all reported somewhat higher levels of dissociation in inpatients who have been sexually abused compared to inpatients who have been physically abused. Maynes (1993) also found in a sample of 226 adult survivors of sexual abuse that the sexual abuse experience was positively correlated with acute and chronic dissociation. Sexual abuse was the most frequently reported type of maltreatment reported by both groups in this study.

Since the DID group in this research reported higher incidences on a variety of maltreatment factors such as parental substance abuse, domestic violence, and physical abuse than the non-DID group, it is possible that these factors had an additive effect leading to higher scores on the DES in regard to the amount of time incest survivors dissociate as well as necessitating a variety of dissociative coping mechanisms.

Dexter-Carrell (1993), for example, found a significant difference between physically and sexually abused subjects and non-abused subjects on the DES, with
abused subjects obtaining higher scores. Fink and Golinkoff (1990) also found that a group of DID patients could be differentiated from patients with borderline personality disorder on measures of physical abuse, sexual abuse, and dissociation, with DID patients scoring higher on dissociation. A study by Reichhold-Caruso (1990) found that adult nonoffending male incest survivors obtained a significantly higher mean score on dissociation than a non-abused group. This study seems to provide some preliminary evidence that male incest survivors, like the female incest survivors, experience more dissociative symptomatology than non-incest survivors.

In this research approximately one out of five incest survivors in the DID group had experienced sexual abuse by a cult member or other religious person. This compared to no victimization by cults or a religious person in the non-DID group. The presence of cult abuse leading to higher scores on dissociation has been reported in at least three studies (Bensinger, 1990; Tamura, 1989; Young et al., 1991) and may also explain why the DID group in this study had higher mean scores on dissociation.

A relationship between violence and dissociation was also reported in a study by Paley (1988) in which five women who used dissociation as a major defense had histories of chaotic and violent backgrounds. In this current research the DID group reported a higher incidence in the use of force in regard to being sexually abused than the non-DID group. Keaney (1993) also found that the use of force was predictive of higher scores on the DES, and Tamura (1989) found that higher levels of dissociation are associated with more invasive sexual acts. Sanders, McRoberts, and Tollefson (1989) found a relationship between unpredictable physical violence experienced in childhood or early adolescence and later DES scores in a sample of 337 undergraduates. The elevated DES scores were positively correlated with both physical and psychological abuse.

In this research the DID clients reported a higher incidence on all five childhood maltreatment factors, two psychological maltreatment factors, and five adult traumatic
factors on the CMIS-SF than the non-DID group. The mean onset of the abuses was also earlier, the duration longer, and the variety of abusers more diversified in the DID group. The DID group was also more likely than the non-DID group to have experienced force in regard to their sexual abuse, more frequent sexual abuse, intercourse by a larger number of people, and episodes of domestic violence. Although more research is needed on how these variables may relate to dissociation, it appears, based on this research, that a multifactorial model may be needed to explain the relationship between all of these variables and the long-term effect of dissociation found in different diagnostic groups.

**Null Hypothesis 3:** There is no significant difference between adult female incest survivors diagnosed with DID (splitting) and those not diagnosed with DID (no overt splitting) on a measure of object-relations impairment.

Using a t-test for two independent samples, this hypothesis was rejected. The findings indicate that there is a significant difference between adult incest survivors diagnosed with DID as a group and those who are not, on the long-term effect of object-relations impairment. The two groups in this study had significantly different scores on the BORRTI Alienation scale, which was pre-selected to test this hypothesis since the Alienation scale appears to represent the broadest dimension of object-relations impairment on this test. Additional support for the hypothesis was found when four other BORRTI object-relation scales were found to be significantly different (Egocentricity, Reality Distortion, Uncertainty of Perceptions, and Hallucinations and Delusions) between the two groups.

It is possible that the DID and non-DID groups were significantly different on these BORRTI scales since all five of these scales can be seen as possibly reflecting more serious disturbances of the self than the two BORRTI scales of Insecure Attachment and Social Incompetence, which were not significantly different. Bell (1991) has noted that
the Insecure Attachment scale is more likely to be elevated by psychiatric outpatients with less severe character disorders. Bell has also noted that the Social Incompetence scale reflects problems, especially with interactions with the opposite sex and in making friends, and may also reflect less serious psychopathology.

In contrast, Egocentricity, which was significantly different for both groups, seems to reflect problems with narcissistic hurt and is more frequently found in individuals with personality disorders. Reality Distortion, Uncertainty of Perceptions, and Hallucinations and Delusions are scales that tend to reflect more serious psychiatric disturbances. Since the research literature, on the whole, suggests that DID individuals experience more psychiatric disorders and serious problems in functioning than other groups, it is not surprising that the DID and non-DID groups were significantly different on the five BORRTI scales that seem to reflect more serious psychopathology.

From a clinical standpoint, mean scale scores for all seven of the BORRTI scales were also higher in the DID than the non-DID group, suggesting that the DID group, as a whole, may have experienced more difficulties with the four interpersonal object-relations scales on the BORRTI as well as the three reality-testing scales on this self-report measure.

The findings suggest that DID incest survivors, based on an elevation of the Alienation scale, may be more likely than non-DID clients to be guarded, suspicious, isolative, angry, hostile, or withdrawn. Empathy also may be more difficult for DID incest survivors. In regard to Insecure Attachment, DID incest survivors are more likely than non-DID incest survivors to feel easily rejected by others. Although they may have a desperate need for closeness, separations, losses, and loneliness may be more poorly tolerated. Guilt, jealousy, and anxiety may lead to sado-masochistic relationships, which serve to re-enact early-life masochistic relationships and contribute to feelings of re-
victimization in adulthood. Upsetting events in adult life may also be perceived as being more traumatic by DID incest survivors.

In regard to Egocentricity, DID incest survivors are more likely than non-DID incest survivors to have a need to control other people and events out of a sense of internal helplessness or feelings at times of inner chaos. They may, without realizing it, be controlling and demanding, and have difficulty delaying gratification. Due to the narcissistic hurt they have endured, they may be more reactive to actual or perceived re-victimization and project onto others malicious motives and intents. In regard to Social Incompetence, DID incest survivors are more likely than non-DID incest survivors to have gender identity confusion. They may tend to be gregarious and superficially confident about their ability to relate to others. Others may relate in a remote and distant manner. In general, a pseudomature attitude may mask more serious problems with feelings of social inadequacy.

The above five BORRTI scales deal with broad-based object-relations impairment in the interpersonal sphere. DID incest survivors in this research also displayed more difficulties than non-DID incest survivors in the realm of reality disturbances. The three scales which deal with this on the BORRTI are: Reality Distortion, Uncertainty of Perception, and Hallucinations and Delusions. Since there has not been much research with the BORRTI in relationship to dissociative disorders, and because disturbances in reality testing have not been very fully explored in the DID literature, caution needs to be exercised in too literally applying the traditional meaning of reality disturbances to DID incest survivors in this study.

Bell (1994) found, however, in a sample of 45 psychiatric inpatients at a V.A. Medical Center, that Reality Distortion was very highly correlated with the F scale on the MMPI. Since the F scale on the MMPI has frequently been associated with degree of psychopathology with higher scores often suggesting greater psychopathology. an
inference might be drawn in this study that the DID group may have demonstrated greater psychopathology as a group than the non-DID group. This inference appears to be supported by the results since the DID group not only obtained higher mean t-scores on the Reality Distortion scale on the BORRTI than the non-DID group but on all the other BORRTI scales. This psychopathology may not only relate to the incest experience itself, which in this research involved for the DID group more violence, intercourse, and a greater frequency of sexual abuse, but also more domestic violence, physical abuse, psychological abuse, and feelings of being unloved by mothers. It appears that the incest experience was not a "benign" experience, especially for the DID group. The higher use of alcohol by the parental figures in the DID group may also be a risk factor that predisposed this group to what appears to be the development of more serious psychopathology than the non-DID group.

The increased psychopathology in the DID group also seemed especially evident in higher elevations on the Reality Distortion, Uncertainty of Perception, and Hallucinations and Delusions scales of the BORRTI than the non-DID group. The scales represent a variety of reality disturbance symptomatology. DID incest survivors in this research appear more likely to experience more problems than the non-DID group with confusion regarding reality, unreality, and depersonalization, thought disturbances, and first-rank symptoms of schizophrenia. The passive influence of alter personality states and intrusive thoughts may also be present. Uncertainty of Perceptions has been linked by Bell (1991) to a variety of problems in functioning and is associated with doubts about one's perception of internal and external reality. Bell noted that dissociative reactions may be reflected in elevations on this scale and may also reflect a "cry for help" in some individuals.

The last reality distortion scale on which the DID scored higher than the non-DID group was the Hallucinations and Delusions scale. Elevations on this scale often
represent problems in functioning, which involves severe breaks with reality. In the DID incest survivors in this research, however, this may more likely represent the dissociative withdrawal response in which DID individuals often report voices, hypnogogic dream states, out-of-body experiences, flashbacks, somatic and sensory body memories, the presence of alter personalities, perceptual disturbances, or other types of thinking or experiencing that would not usually be regarded as normal.

The multivariate discriminant analysis of the data in this research seems to delineate the differences between the DID and non-DID groups in regard to hallucinations and delusions, the amount of time individuals in the DID group spent in dissociation, and the greater number of different types of dissociative experiences endorsed compared to the non-DID group. It makes intuitive sense that DID incest survivors who engage in dissociative activities like day-dreaming, escape into fantasy, lost periods of time, self-induced hypnosis, and other types of self-absorption activities, are more likely to be seen as experiencing hallucinations and delusions than the non-DID group. Flashbacks and abreactive experiences in which the DID incest survivors experience confusion over time, place, and person may also be factors contributing to a higher score on the BORRTI Hallucination and Delusions scale.

From a practical standpoint, based on the discriminant analysis, the BORRTI appears to have some potential for screening incest survivors, in general, and could be helpful in identifying incest survivors who might meet the diagnosis for DID. The DES already has been proven to be a reliable test for identifying "high dissociators" and screening individuals who might have DID.

Although a number of theoretical articles on splitting have been written that conceptually explain how incest may be related to object-relations impairment, there have been only a few studies that have examined the issue of object-relations impairment in DID individuals (Alpher, 1991, 1992a, 1992b). Some of the studies that have been done
on object-relations impairment in incest survivors have used various projective tests and
other non-standardized object-relations measures, which makes it difficult to compare the
results of this research with those studies.

McGovern (1986) noted in a review of empirical studies on object-relations theory
that the empirical investigation of object-relations theor- has lagged behind theory.
Object-relations theory, however, as a whole, seems to shed light on the psychodynamic
processes and an understanding of interpersonal relationships. The intrapsychic self-representations that are formed in the context of early-life experiences with significant
individuals may later predispose incest survivors, including DID incest survivors, to a
variety of psychiatric symptoms and disorders in adult life, especially DID.

Wendt (1993/1994) found in studying women who were sexually abused, with
sisters in the same families who were not abused, that the non-molested sisters did not
differ significantly from their abused sisters as adults in the realm of interpersonal
functioning. Wendt’s study points to a distinction made earlier in this chapter that
object-relations impairment in adult incest survivors may be related more to other factors
besides the incest experience per se. It is possible that there are factors within the homes
of both DID and non-DID incest survivors that predispose a child to object-relations
impairment even before a child is sexually abused.

If it is true that incest survivors with DID have had more severe object-relations
impairment due to early-life trauma, overwhelming, overstimulating, or aversive
environments than incest survivors without DID, then the findings of this research may
provide some preliminary support for a theoretical model that suggests that DID may be
related to an arrestment in early-life splitting. Although more research is needed to
support such a model, the theory described in this research may have some heuristic value
in guiding further practice and research. Most object-relations research has looked at the

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relationship between sexual abuse and later object-relations impairment, and not at early-life developmental issues. There are various studies that suggest that incest survivors do have more impaired object relations than non-incest survivors (Elliott, 1991; Green, 1978; Katz, 1989; Nifakis, 1990; Reagan, 1994; Riederle, 1994; Rosenfeld, 1979; Sexton, 1994; Silbert, 1992/1993; Stem, 1993).

Overall, it appears difficult to control for the effects of object-relations impairment in research since impaired object-relations functioning can have an indirect effect or be interrelated with so many other long-term effects that have been reported in the literature in regard to incest survivors. Cole and Putnam (1992) report that since incest can be damaging to both a sense of self and social functioning, any incest model should take into account the various developmental stages from infancy to middle adulthood in examining the long-term effects of incest.

Although there appear to be no studies that examine how object-relations impairment may vary over the life span, Kluft (1988b) has suggested that the capacity to dissociate may decline with age. He noted that the stability of dissociative defenses and structures (such as alter personalities) may be compromised as individuals with DID grow older. Coons (1986) has also reported that studies on the natural history of DID seem to indicate that although a number of DID patients remain floridly dissociated and switch frequently throughout their lives, in many others there is a marked reduction in the frequency and overttness of their personality switching over time. If dissociative symptoms decrease over the lifespan, it is possible that object relations in both the interpersonal sphere and reality-distortion sphere may also change over time. It would appear important in analyzing any research on dissociation and object-relations impairment that norms be established for various age groups so that deviations from these norms can be used in establishing general criteria for what might be considered a pathological deviation.
Implications for Treatment and Further Research

For Treatment

Since theory often guides practice, this study appears to have important implications for treatment. Because DID clients in the past have spent years in treatment before being correctly diagnosed, this study may provide a conceptual framework for more quickly identifying clients who might be experiencing DID. A discriminant analysis of both the DES and BORRTI suggests that both of these instruments may have utility in identifying incest survivors, in general, from incest survivors with DID. Further research, however, is needed on the BORRTI to determine if incest survivors as a group display characteristic profiles.

In the past, abreaction has played an important role in the treatment of DID clients. Although it is expected that abreactions will continue to play an important role in working toward personality integration and the reduction of symptomatology in DID clients, other aspects of the treatment process may need to be better delineated. Based on this study and my experience in working with a number of DID clients, it appears that more attention may need to be given to the problem of impaired object relations and the developmental impact that such impairment can have on the client and on the treatment process.

Many DID clients appear to have difficulty handling the absence of their outpatient therapist during normal vacations or when the client is feeling in a state of crisis. DID clients also appear to respond poorly in many cases to having to transfer to a new therapist and may become suicidal if they feel "abandoned" by their therapist for a variety of reasons. From an object-relations perspective, it appears important to recognize that a therapist who works closely with DID clients may serve as a "transitional object" for the client. Winnicott (1971), an object-relations theorist, noted that transitional objects become important when the self and others are not clearly differentiated in young
children. If there is a developmental disruption in the transitional object phase, the process may continue to be maintained in a hidden way later on in life. Relational issues may be especially important in the early stages of treatment to enhance ego strength. Developmentally the client may need to identify with the therapist and other significant individuals in their lives before any meaningful reduction in symptoms can occur.

If the goal is to work toward personality integration with DID clients, the client may need to experience a certain amount of security in the relationship with the therapist before the client is ready to give up the client's system of alter personalities. The alter personalities may themselves be seen as transitional objects (Fink, 1993) that the client has adopted as substitutes for real people who have disappointed the client during early childhood.

Seinfeld (1993) has reported on the function of the therapist in working with clients who have deficits in object relations and has indicated that both the processes of "interpreting" and "holding" are important. While "interpreting" is a commonly understood term in psychoanalytic literature, "holding" is a less commonly used term originally coined by Winnicott (1971). It is a process whereby a core self is formed through the responsiveness of other people (objects) in a person's life. Therapeutically, this term refers to a process in which the client is supported emotionally and understood within the framework of transferences and counter-transferences.

Because DID clients have, based on their history, often been emotionally dependent on external "objects" (people) who have frustrated and rejected them, the relationship with the therapist provides a new and restorative opportunity for DID clients to learn how to be in a relationship with a "good enough object" (the therapist). Over time, the client may then be able to develop the personal security needed to give up the system of alter personalities and take risks with real people in the real world.
Seinfeld (1990) also has reported on the handling of what might be termed the "bad object" in the therapeutic relationship. According to Seinfeld, the bad object is comprised of the actual negative attributes of parental figures, together with later significant others resembling them, so that the client fantasizes about these figures. The client often will split off the most awesome and frightening aspects of these figures and project these aspects onto the therapist. A better understanding of these projections can help a therapist working with DID clients handle some of the strong and negative therapeutic reactions found in many DID clients. On the other end of the spectrum, overly idealized compensatory projections of the "good object" will also need to be addressed in therapy.

For Research

In general, although a great deal of research has been done on the long-term effects of incest, it appears that there is a need for research that looks at other factors that can affect the long-term psychosocial adjustment of a person. It is possible that many of the serious long-term effects, which have been attributed to the "trauma" of incest, may in fact relate to a "trauma" in infancy. This study has drawn the conclusion that at least some of the long-term negative effects of incest may be associated with early-life object-relations impairment and dissociation, especially in the case of DID. It has been hypothesized that later problems in adjustment may stem from an arrest in an early-life splitting process, and in the case of DID, difficulties in forming cohesive, reality-based self-representations.

Some areas of research that might be useful to pursue include:

1. Well-controlled studies that attempt to conceptualize the long-term effects of childhood incest from a multifactorial object-relations, developmental model (Such studies may in the future prevent, reduce, or ameliorate some of the long-term deleterious effects found in many adult survivors.)
2. The expansion of current research into the processes of childhood splitting and dissociation in childhood so that there is less reliance on retrospective studies. (Such retrospective studies are useful but may miss important factors that may be more obvious in studies with children.)

3. The extension of research by Alpher (1992a, 1992b), which examines the personality reorganization that appears to occur as the result of treatment in DID clients. (This may help elucidate what factors are helpful in promoting personality integration.)

4. Exploratory research into the nature of co-consciousness and integration in clients and the impact of these processes on traumatic memories. (Again, exploring the issues of memory or repression in children may expand our knowledge about what contributes most to the blocking and unblocking of memories in incest survivors.)

5. Environmental studies that explore the overall impact of various ecological factors on infants, particularly those factors that might impair object-relations functioning or overall ego strength.

6. Outcome research on various treatment models that have been used effectively to treat DID and non-DID incest survivors. (This might be useful in determining which treatment models are most effective.)

7. Research on the continued development and validation of child and adult screening measures quantifying dissociative and object-relations constructs that could be used as part of standard clinical interview or as additional scales on the MMPI-2.

8. Research that provides additional normative data on how dissociation and object-relations impairment is experienced over the life span. This is important so that the relationship between dissociation, object-relations impairment, and other factors affecting overall psychosocial adjustment can be better understood.
APPENDIX A

CLIENT RESEARCH AND CONSENT TO RELEASE

CONFIDENTIAL INFORMATION FORM
CLIENT RESEARCH AND CONSENT TO RELEASE
CONFIDENTIAL INFORMATION FORM

ANDREWS UNIVERSITY
DEPARTMENT OF EDUCATIONAL AND
COUNSELING PSYCHOLOGY
Berrien Springs, Michigan 49104

Please sign and date this form if you agree to take part in this study. Place one copy
in the envelope provided. Keep one copy for your own information. Do not answer any
questions in this study until you have done this.

This research has been designed to obtain information on the effects of incest in adult
survivors and will be conducted at the outpatient office or agency where you receive
counseling. The information you are being asked to provide will be shared with your
therapist. This information may be of some help to your outpatient therapist in your
counseling and will hopefully enhance our understanding of incest survivors in general.
By answering the information in this research you will be helping those who treat incest
to learn more about this problem. Over the next few weeks, you will be asked to
complete a personal data sheet, child-maltreatment questionnaire, and two brief self-
report inventories.

Please note that your participation in this study is voluntary and no compensation
will be provided. By signing this form you agree to have your therapist release
confidential information on your diagnosis and treatment for research purposes. You
agree to serve as a research participant and authorize Linda Stuppy, and the Dept. Of
Educational and Counseling Psychology at Andrews University, to keep, preserve, use,
and dispose of the findings of this research with the provision that your name will not be
associated with any of the results.

The information handled in this study will be handled confidentially. This will be
the only form you will be required to complete which will include your first and last
name. A numerical code will be used to protect your confidentiality on information you
supply. Some of the information you will be asked to provide is highly personal and may
trigger unpleasant thoughts, memories, or feelings. If you decide at any point in time not
to continue with this research, this will in no way prejudice your future relationship with
your therapist. Also, if your therapist feels that this research is having a detrimental
effect on you, or your counseling, your therapist has the right to terminate your
participation in this research.
You have the right to withdraw from this research at any time and should notify your therapist in writing if you would like to do so. I understand that if I have further questions regarding my participation, I may contact:

Linda Stuppy, M.A. or Dr. J. Kijai
Counseling Associates Andrews University
601 Comerica Building Bell Hall
Kalamazoo, MI 49007 Berrien Springs, MI 49104
(616) 388-3330 (616) 471-6240

I consent to participate in the research described above. I have read and understand this statement and I had all my questions answered.

_________________________________________  ___________________________
Participant's Signature                         Date

_________________________________________
Participant's Name (please print)

_________________________________________
Witness's Signature                           Date

_________________________________________
Researcher's Signature                        Date

I also consent to have Linda Stuppy release the information I provide in this study to my outpatient therapist for use in my counseling.

_________________________________________  ___________________________
Participant's Signature                         Date

_________________________________________
Witness's Signature                           Date
APPENDIX B

DISSOCIATIVE EXPERIENCE SCALE
PLEASE NOTE

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

Appendix B
DES
Pages 194-195

UMI
APPENDIX C

BELL OBJECT RELATIONS REALITY TESTING INVENTORY
PLEASE NOTE

Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

Appendix C
BORRTI
Pages 196-197

UMI
Childhood Maltreatment Interview Schedule - Short Form

CMIS-SF

John Briere, Ph.D.
Department of Psychiatry
University of Southern California School of Medicine

1991


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CODE NUMBER __________  DATE ________________

Age __________

Sex: Male ___  Female ___

Race: Caucasian/White ___  Black ___  Asian ___
Hispanic ___  Other ___

Are you currently receiving psychotherapy or psychiatric treatment?

Yes ________  No ________

The following survey asks about things that may have happened to you in the past. Please answer all of the questions that you can, as honestly as possible.

1) Before age 17, did any parent, step-parent, or foster-parent ever have problems with drugs or alcohol that lead to medical problems, divorce or separation, being fired from work, or being arrested for intoxication in public or while driving?

yes ___  no ___

If yes, who? _____________________________________

About how old were you when it started? __

About how old were you when it stopped? _______
[Check here if it hasn't stopped yet ___]

2) Before age 17, did you ever see one of your parents hit or beat up your other parent?

yes ___  no ___

If yes, how many times can you recall this happening?

_____ times

Did your father ever hit your mother? Yes ___  No _______

Did your mother ever hit your father? Yes ___  No _______

Did one or more of these times result in someone needing medical care or the police being called?  Yes ___  No ___
3) On average, before age 8, how much did you feel that your father/step-father/foster-father loved and cared about you?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

4) On average, before age 8, how much did you feel that your mother/step-mother/foster-mother loved and cared about you?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

5) On average, from age 8 through age 16, how much did you feel that your father/step-father/foster-father loved and cared about you?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

6) On average, from age 8 through age 16, how much did you feel that your mother/step-mother/foster-mother loved and cared about you?

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

7) When you were 16 or younger, how often did the following happen to you in the average year? Answer for your parents or stepparents or fosterparents or other adult in charge of you as a child:

<table>
<thead>
<tr>
<th>Event</th>
<th>Never</th>
<th>Once a year</th>
<th>Twice a year</th>
<th>3-5 times a year</th>
<th>6-10 times a year</th>
<th>11-20 times a year</th>
<th>Over 20 times a year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yell at you</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Insult you</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Criticize you</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Try to make you feel guilty</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Ridicule or humiliate you</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Embarrass you in front of others</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Make you feel like you were a bad person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
8) Before age 17, did a parent, step-parent, foster-parent, or other adult in charge of you as a child ever do something to you on purpose (for example, hit or punch or cut you, or push you down) that made you bleed or gave you bruises or scratches, or that broke bones or teeth?

   yes ___ no ___

   If yes, who did this? ________________________________

   how often before age 17? ___ times

   How old were you the first time? ___ years

   How old were you the last time (before age 17)? ___ years

   Were you ever hurt so badly that you had to see a doctor or go to the hospital?

   yes ___ no ___

9) Before you were age 17, did anyone ever kiss you in a sexual way, or touch your body in a sexual way, or make you touch their sexual parts?

   yes ___ no ___

   Did this ever happen with a family member? yes ___ no _______

   If yes, with who? ________________________________

   Did this ever happen with someone 5 or more years older than you were?

   yes ___ no ___

   If yes, with who (check all that apply):

   _____ A friend

   (at what ages? _____)

   _____ A stranger

   (at what ages? _____)
202

_____ A family member

(who? ____________ )
(at what ages? _____)

_____ A teacher, doctor, or other professional

(who? ____________ )
(at what ages? _____)

_____ A babysitter or nanny

(at what ages? _____)

_____ Someone else not mentioned above

(who? ____________ )
(at what ages _____)

Did anyone ever use physical force on any of these occasions?
Yes __ No ___ If yes, who? ______________

Overall, about how many times were you kissed or touched in a sexual way or made

to touch someone else's sexual parts by someone five or more years older before age 17?

_____ times

Overall, how many people (five or more years older than you) did this?

_____ people

10) Before you were age 17, did anyone ever have oral, anal, or vaginal intercourse with

you, or insert a finger or object in your anus or vagina?

yes ___ no ___

Did this ever happen with a family member?

yes ___ no ___

If yes, with who? ____________________________

(At what ages? ____________)
Did this ever happen with someone 5 of more years older than you were?

yes ___ no ___

If yes, with who (check all that apply):

_____ A friend
(at what ages? ______)

_____ A stranger
(at what ages? ______)

_____ A family member
(who? _____________)
(at what ages? ______)

_____ A teacher, doctor, or other professional
(who? _____________)
(at what ages? ______)

_____ A babysitter or nanny
(at what age? ______)

_____ Someone else not mentioned above
(who? _____________)
(at what ages? ______)

Did anyone ever use physical force on any of these occasions?

yes ___ no ___ If yes, who? _______________________

About how many times did anyone five or more years older have oral, anal, or vaginal intercourse with you before age 17, or insert a finger or object in your anus or vagina?

_____ times
Overall, how many people (five or more years older than you) did this?  

_____ people

11) To the best of your knowledge, before age 17, were you ever

**Sexually abused?** Yes ___ No ___

**Physically abused?** Yes ___ No ___

12) Since age 17, have you experienced any of the following?

A) Rape or sexual assault?

Yes ___ No ___

If yes, how old were you the last time it happened? ___ years old

B) Being beaten or hit or battered in a sexual or romantic relationship?

Yes ___ No ___

If yes, how old were the last time it happened? _____ years old

C) Physically attacked or assaulted by someone who wasn't a sex partner or husband/wife?

Yes ___ No ___

If yes, how old were you the last time it happened? ___ years old

D) Combat or battle as a member of the U.S. Armed Forces?

Yes ___ No ___

If yes, how old were you the last time it happened? ___ years old

E) Involved in an auto accident, fire, earthquake, or other event that caused you to fear for your life and/or to be physically injured?

Yes ___ No ___

If yes, what was the event? __________________________________________________________

If yes, how old were you the last time it happened? _____ years old

F) Being present when someone else was assaulted, injured, or killed?

Yes ___ No ___

If yes, how old were you the last time it happened? _____ years old

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Dear Therapist/Agency:

I am a doctoral student in the Counseling Psychology Department at Andrews University. I am conducting research on the long-term effects of incest in adult female survivors, who are at least 18 years of age, and are in outpatient therapy. The research will focus on the long-term effects of incest in women who have personality splitting (Dissociative Identity Disorder—formerly called "Multiple Personality Disorder") and those without personality splitting who may be receiving treatment and have other diagnoses.

Enclosed is a packet of information, including Therapist Guidelines, designed to explain the criteria for this study as well as procedures. Also enclosed is information which will need to be completed by any adult female outpatient client who would like to volunteer for this study. It is anticipated that it will take only a few minutes of the therapist's time to complete a brief form confirming the client's diagnosis and to have the client complete the following:

- Research and Consent to Release Confidential Information Form
- Personal Data Sheet
- Child Maltreatment Interview Schedule-Short Form
- Dissociative Experience Scale-II
- Bell Object Relations Reality Testing Inventory

All of the above items should be able to be completed by the client in two hours or less although some clients may need slightly more time. Although participation in this study is voluntary and no clients or agencies will be reimbursed for their participation, the Child Maltreatment Interview Schedule-Short Form may provide information helpful in assessing the client's treatment needs. All of the information will be confidential and the names of clients will not be published in the final research.

If, as an outpatient therapist, you would like to participate in this study by gathering information on one or more of your clients, please sign the attached consent form. If additional approval for such research is required by your practice or agency, please secure the necessary signature(s). I would like to thank you in advance for your participation. It is hoped this study will expand our understanding about the long-term effects of incest.

Sincerely,

Linda Stuppy, M.A.
Doctoral Student
If you have any additional questions or concerns about this study, you may contact:

Linda Stuppy, M.A. or Dr. J. Kijai
Counseling Associates Andrews University
601 Comerica Building Bell Hall
Kalamazoo, MI 49007 Berrien Springs, MI 49104
(616) 388-3330 (616) 471-6240
Therapist/Agency Consent Form

ANDREWS UNIVERSITY
DEPARTMENT OF EDUCATIONAL AND COUNSELING PSYCHOLOGY
Berrien Springs, Michigan 49104

Please sign and date this form if you agree to take part in this study. Place one copy in the envelope provided. Keep one copy for your files. Do not answer any questions in this study until you have done this.

This research has been designed to obtain information on the effects of incest in adult female survivors and will be conducted at the outpatient office or agency where you provide counseling. The information you are being asked to provide may be of some help to the adult female survivors you treat. By answering the information in this research you will be helping those who treat incest to learn more about this problem. Over the next few weeks you will be asked to complete a Client Diagnostic Confirmation Form on your client, and have your client complete a Personal Data Sheet, a Child Maltreatment Interview Schedule-Short Form, and two self-report inventories: one on dissociation (Dissociative Experience Scale-II) and one on object relations impairment (Bell Object Relations Reality Testing Inventory). Please note that any client who wishes to participate in this study must sign the "Client Research and Consent to Release Confidential Information Form" prior to answering any questions. If your agency requires an additional consent form to release information, please have the client complete this form for your records.

Please note that your participation in this study is voluntary and no compensation will be provided for your participation or the participation of your client. By signing this consent form you agree to serve as a research participant and authorize Linda Stuppy to keep, preserve, use, and dispose of the findings of this research with the provision that the name of the client will not be associated with the results. The information in this study will be handled confidentially. The only form the client will be required to complete with their name on it will be the Client Research and Consent to Release Information Form. A numerical code will be used on all other information to protect confidentiality.

Some of the information your client will be asked to provide is highly personal and may trigger unpleasant thoughts, memories, or feelings. Clients will be advised that they can withdraw from this research at any time by writing you of their intent to do so without prejudice to their future relationship with you as therapist. As their outpatient therapist, you may also withdraw from this study at any time, especially if you feel the study is having a negative effect on your client's treatment or emotional well-being.
I understand that if I have further question about this research, I can contact:

Linda Stuppy, M.A. or Dr. J. Kijai
Counseling Associates Andrews University
601 Comerica Building Bell Hall
Kalamazoo, MI 49007 Berrien Springs, MI 49104
(616) 388-3330 (616) 471-6240

As therapist I consent to participate in the research described above. If additional approval for research with clients is required at my practice or agency, I have secured the necessary signatures below. I have read, understood, and received a copy of this statement, and have had all my questions answered.

Therapist Signature

Date

Witness for Therapist

Date

Authorizing Agency Personnel

Date

Witness for Agency Personnel

Date

Researcher

Date
APPENDIX G

THERAPIST GUIDELINES
Dear therapist,

Thank you for your participation in this research. The following describes the criteria that clients must meet to participate in this research.

**Criteria for this Study:** All outpatient clients who would like to participate in this study must be female, at least 18 years of age, and meet the criterion for "incest" as described in the **Client Diagnostic Confirmation Form**.

**Procedures:**

1) **Client Research and Consent to Release Confidential Information Form:** Once you have determined if a client meets the criteria for this study, please ask the client to read and complete this form in your presence after approaching the client about participating in this study. If your practice, or agency requires your own release of information form, please complete this in addition to the above form for your records. Clients who agree to participate in this study have the option of withdrawing at any time. Please witness the client's signature on this form and return the original with the information gathered on this client. It is suggested this form be completed at an intake interview, if this is a new client, or during an outpatient session, if you are already seeing the client in therapy. This will ensure that any questions or concerns can be answered prior to the client's signing of this form.

2) **Client Diagnostic Confirmation Form:** Once a client has agreed to participate in this study, please complete this form. You will be asked to rate the level of confidence in your diagnostic impressions of this client if the client appears to meet DSM-IV criteria for Dissociative Identity Disorder (formerly called "Multiple Personality Disorder").

3) **Personal Data Sheet and Child Maltreatment Interview Schedule-Short Form (CMIS-SF):** Since this information is of a highly personal nature and may be upsetting to some clients, it is recommended that these two items be completed at your office prior to the client's next outpatient session and should not be sent home with the client. This will ensure that the client will have time to process her feelings after completing this information, especially if it triggers unpleasant memories. The CMIS-SF may also be helpful in further identifying the treatment needs of the client if discussed in a session after it is completed by the client. It is anticipated that the client will be able to complete both the Personal Data Sheet and CMIS-SF in less than one hour.

4) **Dissociative Experience Scale-II (DES-II) and Bell Object Relations Reality Testing Inventory (BORRTI):** It is recommended that the client complete these two self-report inventories in a quiet room at your practice, or agency, and not be sent home with the client. It is also recommended that they be completed within one month after the completion of the Personal Data Sheet and CMIS-SF if possible. This procedure will ensure that these inventories are completed by the client in an adequately controlled testing situation, will maximize the full cooperation and attention of the client, and result in the inventories being completed in a timely fashion. Both of these inventories may be
read to the client if reading is a problem or the client does not have at least a sixth grade education. Since some of the clients who will be taking these inventories may have personality splitting, special Instructions for Psychological Testing will be provided to enhance the full participation of any alter personality. Please use these instructions, however, with any client who participates in this study, regardless of their diagnosis.

**Final Comments:** If any of the above materials are not completely filled out by your client, I would appreciate it if you would see that this is done before returning the materials in the enclosed envelope. If you, or your client, would like a summary of this research after it is completed, please let me know. If you have any questions at any time while you are participating in this study, please call me at: (616) 388-3330. Please mail any research folders which have been completed on subjects to:

Linda Stuppy, M.A.
Counseling Associates
601 Comerica Building
Kalamazoo, MI 49007
APPENDIX H

CLIENT DIAGNOSTIC CONFIRMATION FORM
CLIENT DIAGNOSTIC CONFIRMATION FORM

THERAPIST'S NAME: __________________________
TODAY'S DATE: _________________________________
CLIENTS' CODE NUMBER: ________________________

1) Is this client a female? ___ Yes _____ No

2) Is this client 18 years, or older? ___ Yes _____ No

3) Does this client meet the criteria of being an incest survivor as described below? _____ Yes ______ No
   Undecided: (explain)
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

For this purpose of this study "incest" will be defined as any self-reported sexual contact (ranging from fondling to intercourse) between a child before the age of 17 with a person who would be considered an ineligible partner because of his blood relationship and/or social ties (i.e. father, stepfather, grandfather, uncles, siblings, cousins, in-laws, and what might be called "quasi-family" (i.e. mother's sexual partner living in the home)).

4) Does this client meet the DSM-IV criteria for Dissociative Identity Disorder (DID) (formerly called "Multiple Personality Disorder")?
   Yes ___ No

DSM-IV Criteria:

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behavior.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g. blackouts or chaotic behavior during Alcohol Intoxication) or a general medical condition (e.g. complex partial seizures).
Please indicate your level of confidence that this client has, or does not have Dissociative Identity Disorder.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Confident</td>
<td>Moderately Confident</td>
<td>Extremely Confident</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: If your level of confidence rating is a 1 or 2, please contact me further regarding confirmation of the diagnosis. You may continue with the research in the meantime.

5) If you client has DID, please list
   Number of known alter personalities: ___

6) Does this client appear to be integrating?
   _____ Yes   _____ No   _____ Unsure

7) Is the client’s host, or main personality co-conscious with alter personalities at least part of the time?
   _____ Yes   _____ No   _____ Unsure

8) How long has this person been in treatment with you?
   ________ (months)
   For: _____ Individual   _____ Group
   Other ________
   Explain: ______________________________________________________

Comments: ______________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

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APPENDIX I

PERSONAL DATA SHEET
PERSONAL DATA SHEET

TODAY'S DATE: ____________
CLIENT'S CODE NUMBER: ____________

SEX: _______ DOB: _____________ AGE: ____________

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOWED (CIRCLE ONE)

NUMBER OF CHILDREN (IF APPLICABLE): _______

EDUCATION: _____ GRADE LEVEL: ________ OR YEARS/COLLEGE

CURRENT ANNUAL INCOME: ______________

NUMBER OF MONTHS IN THERAPY WITH CURRENT THERAPIST? ____ months

TYPE OF CURRENT THERAPY? INDIVIDUAL: GROUP: OTHER? (DESCRIBE) ______________________________________

TYPE OF PRIOR THERAPY? INDIVIDUAL: GROUP: OTHER? (DESCRIBE) ______________________________________

INCEST MEMORIES Please circle answer.

1) Do you believe you were sexually abused before the age of 17?
   Yes    No    Unsure

2) Has anyone in your family confirmed that you were sexually abused before the age of 17?
   Yes    No    Unsure

3) Do some of your memories of childhood sexual abuse appear blocked or vague?
   Yes    No    Unsure

4) Do you feel that you were not sexually abused even though family or others have told you were?
   Yes    No    Unsure
5) Do you feel your therapist has planted ideas in your mind by telling you that you have been sexually abused?
   Yes  No  Unsure

6) Did you retrieve memories of sexual abuse prior to getting into therapy?
   Yes  No  Unsure

7) Did you retrieve memories of sexual abuse since getting into therapy?
   Yes  No  Unsure

8) Do you feel that there may be incidents of sexual abuse which have been blocked from your memory?
   Yes  No  Unsure

9) Do you feel that your memories of sexual abuse, if you have them, are accurate?

10) My memories of sexual abuse very from day to day
    Yes  No  Unsure

11) At the present time I feel that I am currently able to remember: (check one)
    _______ Most of my sexual abuse
    _______ Some of my sexual abuse
    _______ Very little of my sexual abuse
    _______ None of my sexual abuse
INSTRUCTIONS FOR PSYCHOLOGICAL TESTING

Testing was designed to be useful for people who sometimes feel as if they have different parts to themselves and/or feel very divided. Although this may, or may not be true for you, you are invited to allow all parts or aspects of yourself to participate in the testing if this is comfortable.

Please complete all test items and do not leave any blank. Thank you.
REFERENCE LIST


Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence from domestic abuse to political terror*. New York: Basic Books.


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