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Women's Auto/Biography and Dissociative Identity Disorder: Implications for Mental Health Practice

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Abstract Dissociative Identity Disorder (DID) is an uncommon disorder that has long been associated with exposure to traumatic stressors exceeding manageable levels commonly encompassing physical, psychological and sexual abuse in childhood that is prolonged and severe in nature. In DID, dissociation continues after the traumatic experience and produces a disruption in identity where distinct personality states develop. These personalities are accompanied by variations in behaviour, emotions, memory, perception and cognition. The use of literature in psychiatry can enrich comprehension over the subjective experience of a disorder, and the utilisation of 'illness narratives' in nursing research have been considered a way of improving knowledge about nursing care and theory development. This research explores experiences of DID through close textual reading and thematic analysis of five biographical and autobiographical texts, discussing the lived experience of the disorder. This narrative approach aims to inform empathetic understanding and support the facilitation of therapeutic alliances in mental healthcare for those experiencing the potentially debilitating and distressing symptoms of DID. Although controversies surrounding the biomedical diagnosis of DID are important to consider, the lived experiences of those who mental health nurses encounter should be priority.

Keywords Dissociative Identity Disorder · Autobiography · Mental health practice · Nursing · Psychiatry · Lived experience

Introduction

This article samples five biographical and autobiographical texts discussing the lived experience of individuals with Dissociate Identity Disorder (DID) with the aim of thematically

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analysing these accounts. The objective of this work is to consider how themes and consistencies raised can provide textual understanding of how DID is subjectively experienced and how this could aid in the objective understanding of the mental health nurse and other practitioners. DID has provided widespread controversy and uncertainty, which for the most part has led to potential ignorance amongst professionals (Stickley and Nickeas 2006). The rationale for this research is to provide a qualitative study of a selection of published narratives on DID to inform nursing professionals' understanding of the lived experience of DID. There is an established tradition of this type of work (Oyebode 2009) and using narratives in this way can highlight individual, personal perspectives in the aim of examining subjective experience without laying claim to universal truth.

Background

Disciplinary context: Literature and psychiatry

Literary approaches to healthcare are in tandem with a biopsychosocial approach (Engel 1977); actively seeking to understand what role individual experience plays within an illness and gain a more rounded, enriched picture (Cawley 1993; Downie 1994). Kleinman (1988) details a conflict between the view of the service-user, who considers the effects of their symptoms and resulting impact on their life and the clinician, who views their problems as a disease or disorder to be fixed. Biopsychosocial approaches to medicine and medical research appear a more inclusive model of practice that appreciates the intricacy of illness (Adler 2009; Deacon 2013). Fava and Sonino (2008) detail this approach as viewing illness as encompassing persons, their body and their environment as essential components, appreciating that psychosocial factors may assist, protract or alter the course of an illness and that these effects are varied between each person and each illness.

Methods of research are influential on the way a practitioner may organise her knowledge and approach individuals, and it has been suggested that healthcare students could benefit from education encompassing the humanistic aspects of care, committing equal focus to the care and perceptions of those who are ill in addition to the treatment of disease (Beveridge 2009; Crawford and Baker 2009; Hawkins 1993; Hawkins 1999), although this is not a commonly utilised approach (Oyebode 2009). Beveridge (2003) discusses some of the benefits of reading literature within psychiatry to encourage ethical and moral reflection within decision-making and the application of literary contrivances to the clinical environment. In addition, the sourcing of creative devices provided by the arts and humanities within education can encourage reflection that is creative (Crawford, Brown et al. 2015), and approaches to care, particularly within psychiatry, may frequently require a creative approach. Although each healthcare professional may not gain the same benefits from including literary-based study into nurse education (Crawford and Baker 2009), it has a valid and potentially significant role within the shaping of many professional practices (Gergen and Gergen 2006).

Narratives can be defined as different ways of telling events (Bruner 1988) and provide the vehicle through which the unique meaning of words and actions for those experiencing them can be portrayed, all within the cultural and social paradigms of a community (Overcash 2004). Through taking note of individual perspectives, insight into the experiences of living with a particular illness can be gained (Charon 2006; Evans 2009; Oyebode 2009). Additionally the ways in which an individual may interpret her situation and then adapt to make sense of it can also

be understood more fully from a subjective, human perspective (Crawford and Baker 2009; Kleinman 1988). Narrative based medicine can provide a way for professionals to gain a deeper understanding and mould or challenge assumptions (Greenhalgh and Hurwitz 1998). As Oyebode (2009) details, individuals can make sense of their experience by producing a narrative account that is a disclosure of their experience, and illness pathographies may aid in maintain a sense of identity in a time where identity is often threatened (Bury 2001). Above all, the *person's* voice is represented by pathographies (Crawford, Brown et al. 2015).

DID: Diagnosis, disorder and disagreements

Dissociation can be defined as a disturbance in the functioning of consciousness related to a detachment from reality (Dell 2006). Dissociation is commonly experienced non-pathologically as an everyday process, for example daydreaming whilst driving, and is also employed as a coping mechanism during experiences of trauma (Lynn and Rhue 1994). The most extensive experience of dissociation is related to DID where identity construction and recall ability that normally integrate to provide a sense of reality is impacted through prolonged exposure to traumatic stressors (Ringrose 2012; Simeon et al. 2002). The Diagnostic and Statistical Manual of Mental Disorders, now in its fifth edition (DSM-V), describes DID as a "disruption of identity characterized by two or more distinct personality states [...] the disruption in identity involves marked discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behaviour, consciousness, memory, perception, cognition, and/or sensory-motor functioning" (American Psychiatric Association 2013, 292-294). The disorder is "associated with overwhelming experience, traumatic events, and/or abuse occurring in childhood" (294). The International Classification of Diseases and Related Health Problems, now in its fourth edition (ICD-10), differs in the detailing of DID as essentially the "apparent existence of two or more distinct personalities within an individual, with only one of them being evident at a time. Each personality is complete, with its own memories, behaviour, and preferences," furthermore change "from one personality to another in the first instance is usually sudden and closely associated with traumatic events. Subsequent changes are often limited to dramatic or stressful events, or occur during sessions with a therapist that involve relaxation, hypnosis, or abreaction" (World Health Organisation 2010, 160).

DID is an extreme, rare dissociative disorder, and it is uncommon for an individual with DID not to have experienced trauma in the form of physical, psychological or sexual abuse in childhood (Dell and Eisenhower 1990; Shipman and Taussig 2009). Talbott (1988) suggests that 97-98% of those with DID report these forms of abuse. The remainder may have experienced trauma in other forms such as near death experiences or observing extreme violence to others (Steele 1989). During trauma the mind will split off or disconnect to attempt some normality in functioning (Brenner 1994; Lasky 1978), and this will continue after the traumatic experience where observable alterations in identity, as per above diagnostic criterions, appear (Spiegel and Cardena 1991; Steinberg and Steinberg 1995). DID has become controversial since initial documentation in the nineteenth century (Putnam 1991) with the diagnosis ebbing in and out of use and labelled a medical 'fad' (Paris 2012). Professionals are divided in a polarised fashion, and minimal existing research provides contradictions in abundance.

Piper and Merskey (2004) suggest that the relationship between child abuse and DID diagnosis is puzzling as abuse has been a reality for much longer than the existence of DID; thus if DID is a product of abuse there would have been potential for the establishment of DID sooner. Furthermore some suggest DID actually exists as a variation of other disorders, particularly so-called 'Borderline Personality Disorder' as a form of posttraumatic stress

response (Buck 1983; McLean and Gallop 2003) and also conversion disorder as a functional neurological symptom (Paris 2012; Brown et al. 2007; McHugh 2013). Evidence to suggest a relationship between conversion disorders and childhood trauma provides further grounds for considering a conversion disorder where DID diagnosis is currently in place (Roelofs et al. 2002). There has also been inquiry over the validity and reliability of DID diagnostic criteria and whether DID should be included within psychiatry (Gleaves 1996; Pope et al. 1999). Although this has continued over time DID remains within diagnostic manuals (Dell 2001; Piper and Merskey 2004).

DID has been considered a sociocultural creation (Spanos 1996). This argument is based on the large increase in DID diagnosis following notable and widely read publications of DID, such as *Sybil* (Schreiber 1973), that were given large amounts of media attention (Dale 1999). In this way DID is viewed as context-bound and elements of the disorder will change over time to meet shifts in expectations and the cultural formulation of the disorder (Spanos 1994). Additionally having a first-degree relative diagnosed with DID is considered a risk factor (Kaplan and Sadock, 2008).

DID has been labelled as *iatrogenic* in nature, that is created by therapists (Coons 1991; Dale 1999). This viewpoint is predominantly focused on small numbers of practitioners in North America with a large numbers of individuals with diagnosed DID on their case load (Fahy 1988; Merskey 1995; Showalter 1998). Prevalence in other countries has also been demonstrated to be considerably lower (Fujii et al. 1998; Xiao et al. 2006). Consequences are considered to surpass the clinical setting with inappropriate use of DID diagnosis including the simulation of DID as a legal defence on grounds of diminished responsibility (James 1998; Stanley 1983). DID orientated therapy has also been criticised as intentionally escalating elements of the disorder and producing overdependence (Dale 1999). Some theory has suggested that the symptoms of DID can be encouraged by suggestion in those predisposed to use dissociative defences (Bowers 1991). The therapist provides an all-encompassing, ideological 'DID belief system' where the manifestation of new personalities and the search for repressed memories are sought (Ofshe and Watters 1995). Mulhern (1994) discussed a sociohistorical approach where there had been a growth of between 25-50% of practitioners reporting patients with DID were recovering traumatic memories from childhood, in the previous decade to publication. Ofshe (1992) suggests that when such memories cannot be verified, the individual is left to deal with the suffering of a social construction, provided by therapists often predisposed to find such outcomes. Consequently the potential issue of false memories has been intertwined within the field of DID, suggesting a causal link between therapeutic approaches and the recovery of memories after amnesic periods of time (Brandon et al. 1998; Walker and Antony-Black 1999). Different approaches to concepts of memory have also been illustrated between Western Europe and North America (Lebow 2008).

Opposing these considerations, there is no substantial, consistent data to support fully the assumption that DID is a variation of 'Borderline Personality Disorder' (Golier et al. 2003; Heffernan and Cloitre 2000) or that child abuse predates DID (Walker and Antony-Black 1999). Although not classed as a common condition (Dorahy and Lewis 2002), DID has been and is increasingly observed as experienced by individuals and is present internationally within psychiatric services and private establishments through growing research literature (Boon and Draijer 1993; Martinez-Taboas et al. 2013). Biological evidence for the existence of DID has been displayed through observable smaller hippocampal and amygdalar volumes in those with DID, compared to those who did not have DID (Vermetten et al. 2006). A genetic analysis sampling of 579 siblings, adopted siblings and identical and fraternal twins showed possible

genetic factors contributing to dissociative tendencies (Becker-Blease et al. 2004). Although potential environmental factors were also implicated here, sociocultural influences within a mental illness do not explicitly imply iatrogenesis (Bhugra and Bhui 2007). Additionally diagnostic reliability and validity has been demonstrated by verification of past traumatic experiences in patients with DID (Coons 1994). Positive results for those receiving a tailored treatment for the disorder such as decreased dissociation, depression, distress and rates of self-injury have also been documented (Brand et al. 2009; Brand et al. 2012). Such findings provide a case at this time for the continued inclusion of DID within diagnostic manuals and future editions until DID is further investigated (Ross 2009). The adaptive nature of memory can cause problems when considering reliability due to mechanisms such as misattribution, bias and suggestibility (Schacter 1999) – however, there is cause to consider that traumatic and non-traumatic memories differ distinctly and the association of them as being the same memory type is not accurate (Berntsen 2001; Porter and Birt 2001). It has been suggested increased divisions of personality are witnessed within the course of therapy as the environment provides re-evocation of past experiences (Davies and Frawley 1994).

There is as good a cause to reject the criticisms relating to the existence of DID as there is to consider them. This debate has left many questions and criticisms unanswered, and there are large gaps within the literature concerning DID. Boysen and VanBergsen (2013) investigated published research concerning DID during the period 2000-2010 and found only twenty-one case studies and eighty empirical studies. The authors noted that in the cases of schizophrenia and anorexia nervosa there had been an increase in levels of research over the time period, while this was not observed with DID. This suggests that approaches to research are not providing driven, evidence-based levels of investigation which are required to expand the knowledge base and tackle unexamined experiences. Aside from this it cannot be denied that the symptoms attributed to DID are both debilitating and distressing for those experiencing them, with the 'host' person often having no power over the dissociation and is left unable to recall periods of time where alternate personalities take control (Jasper 2013). Those suffering from severe dissociative disorders such as DID have increased rates of attempted suicide compared to those with posttraumatic stress disorder and substance abuse who do not experience dissociation (Foote et al. 2008). Consequently, attention needs to be given to this disorder, its roots and its potentially distressing consequences.

Methodology and analysis

Research design

The research is a literary narrative inquiry, an approach concerned with personal accounts of a particular subject area and how these experiences have been interpreted by the individual (Polkinghorne 1988). Although quantitative investigations of DID are increasing, this design has been selected, as it provides an approach which may highlight something different than that which statistics and epidemiology can provide— an exploration of the subjective experience (Car 1994; Charon 2006; Oyebode 2009). Nursing practice goes above and beyond the application of empirical research conclusions (Johnson 1994); coupled with an appreciation of treatment experiences can positively inform the planning and implementation of care, multi-professional team communication and the future education of professionals (Holloway and Freshwater 2007a; 2007b). This is particularly relevant to DID due to discussed confusion and unawareness of the

condition amongst professionals. The importance of listening to individual perspectives and wishes in care provision has long been emphasised, a patient-centred approach (Rogers 1951) demonstrated to be desired by patients (Little et al. 2001; Williams et al. 1995). Stewart (2001) suggests that patient centeredness is often poorly understood, and qualitative research may provide a means for better understanding the qualities of this type of care.

Within narrative inquiry sample size is not extensive, as cases selected provide data rich in content, allowing narrow inclusion criteria (Holloway and Freshwater 2007a); Patton 2002). A homogenous sampling approach included similar data for purpose of investigation and for consistency in the sample (Holloway and Freshwater 2007a). Focus was placed on biographical and autobiographical narratives presented in published books. The personal experiences at the centre of these narratives were focused on females with DID, as diagnosis is more probable in females with a ratio of 9:1 (Lewis-Hall et al. 2002) and therefore a higher prevalence of females with DID are encountered in adult clinical settings (American Psychiatric Association 2013, 295). It should be noted that a small number of accounts by males with DID do exist, for example *A Fractured Mind: My Life with Multiple Personality Disorder* (Oxnam 2005), *First Person Plural: My Life As a Multiple* (West 1999) and *The Minds of Billy Milligan* (Keyes 1994), and future research could aim to explore the male perspective. The sample chosen for this research aims to cover a wide time span; texts are both biographical and autobiographical allowing for analysis of a cross-section of subjective perspectives and experiences. This broad approach does not aim to be exhaustive; rather to consider commonly noted accounts and to consider commonalities across time and place (See Appendix).

Sample: Biographical	Sample: Autobiographical
The Three Faces of Eve (Thigpen & Cleckley 1957)	*When Rabbit Howls* (Chase 1987)
Sybil (Schreiber 1973)	*Fractured* (Dee 2009)
	Today I'm Alice (Jamieson 2009)

Analysis

An initial reading of the five texts was carried out to check for inclusion, to discover broad themes around DID and to establish the sample. This also worked to inform understanding of the experience of DID and related empathic understanding. In this way the effects of 'emotional reading' were allowed for and implications of the literature, for example whether the text was biographical or autobiographical, were noted for later consideration (see Ethics, below). Following a second reading of the texts a thematic approach was taken for analysis of the data. This is a form of qualitative examination that is developmental in nature, not based on a specialised theory or structure but instead allowing the researchers to immerse themselves within the data and let this shape the path of analysis (Holloway and Freshwater 2007a). Owen (1984) identified some common reference points to employ whilst identifying notions or themes within data as recurrence, repetition and forcefulness of concepts. Analysis of the narratives sampled identified emerging themes reflecting the experience of each author, in the aim of highlighting any collective significances (Josselson and Lieblich 2001).

Themes were established by detailed, close textual reading of the material into categories that formed a type of reference framework within a focused context (Gibbs 2007). The analysis was flexible, and focus was given to the identification and definition of robust themes that the initial readings had highlighted (Howitt and Cramer 2007). Existing research literature highlights several concepts that are intertwined within the study of DID, for example trauma often

specific to childhood abuse and the central notion of dissociation with observable change in elements of personality. Due to this, emphasis was placed, wherever possible, on not allowing pre-selected knowledge to influence the development of themes during analysis. As referenced, Owen's (1984) concepts of the recurrence, repetition and forcefulness of themes, establishing these as robust, not superficial. Each paragraph was considered in terms of what was being portrayed and the meaning of this which included establishing any similarities or constants in experience between texts, as well as any different aspects of an experience and any ideas or issues that were considered important or highlighted by the author.

These concepts constituted a grouping of common elements into different categories that allowed for the emergence of four predominant themes:

1. The process of dissociation
2. The experience of abuse or trauma
3. Social elements of abuse
4. The role and experience of healthcare and diagnosis

Ethical approach

Access to the sample for analysis provided no ethical implications; however, it was important to consider the role of reader or researcher emotions and potential for bias throughout the research. Emotional responses may be elicited from narrative accounts that could prospectively taint interpretation and application of the knowledge provided and impair professional performance (Coulehan 1995). It is suggested that to possess 'emotional intelligence' requires self-awareness and an awareness of others and can be utilised to produce best practice in healthcare settings (Jordan and Troth 2002; Reeves 2005). This *self-reflexive* approach to research and practice is crucial to the nursing professional. Blythe, Wilkes, Jackson and Halcomb (2013) suggest that the methodological implications of being a researcher within qualitative approaches can often include challenges in managing emotions and analytic objectivity but suggest that reflexivity can be a constructive strategy against these challenges. Credibility of qualitative research has been related to the ability of the researcher to be aware of their perspective and represent this accurately through analysis (Milne and Oberle 2005); however Frank (2000) observes that telling a story can establish a relationship and within research the belief that there needs to be a distance between researcher and participant is not always beneficial or correct (Dowling 2006).

Findings

The process of dissociation

All sampled discuss the experience of dissociation or the dissociation they have witnessed in their clients, frequently and in depth. In aiming to understand what it is like to dissociate the concept of memory loss is fundamental – in all texts the 'host' personality experiences a loss of time and a resulting dissociative fugue. Alice discusses her fragmented memory and distinguishing the difference between her dreams and memories, often confused if her recall was actually a memory: "I felt fully awake most of the time, but sometimes while I was awake it felt as if I were dreaming. In this dream state I didn't feel like me, the real me, I felt numb" (Jamieson, 70). What Alice is referring to here is her feeling of detachment or disorientation, later relating this to when she found herself in random destinations: "...I could be dreaming at that moment and might wake suddenly

and find myself somewhere else [...] I would remember sitting in my bedroom studying one moment, and then be walking through the shopping centre with music blasting in my ears the next" (40). Similarly Ruth found herself confused during her younger years, losing large gaps of time and having no idea where it had gone: "Other days were complete blanks. I would remember leaving for school and returning to the house but not what happened in between. I soon got a reputation for being erratic" (Dee, 125). These experiences are common throughout the sample and are depicted at times to be, understandably, very frightening and isolative, for example when others remembered whole conversations or activities which the individual has had no recollection of being part of. Considering what weight this concept has on the individual with DID is important for the nurse, as it may seem equally as bizarre to both parties.

An interesting consideration when trying to grasp the subjective experience of dissociating is the depiction of feeling disconnected from the core self or 'host personality', whether this be through loss of time and memory or through clearly hearing, conversing and experiencing visual representations of alternate personalities. Ruth portrays this by saying: "I have always been able to see myself through their eyes [...] one of the others would arrive unannounced [...] and would be beside rather than inside me. If they were inside me it meant that they had taken over [...] my body, completely" (17-18). In this way Ruth identifies a separation between herself and her alters and how this impacts on her experience of the world, which is replicated by all individuals sampled.

Alternate personalities logically differ among individuals; Truddi's case is intriguing as it is the only one sampled where the host is not portrayed as being present but 'asleep.' A mirror image was created in 'The Woman,' developed with the sole purpose of functioning in the outside world with no knowledge of the past horrors experienced. The alternate personalities within the sample are discussed as possessing different genders, accents, ages, abilities, appearances and purposes. Interestingly there is commonly one or several alters that appear to have full knowledge, whilst others, including the host, have limited or specific understanding. Truddi's 'Troops' provide a fascinating insight into what it would be like to experience subjectively the interplay between these personalities throughout the text, with passages like the following making the reader feel as if they were reading an interchange between a house full of completely different people: "Catherine demanded diet cola. The woman never bought soft drinks, she hated them...In a burst of affection for [a] teddy bear, Lamb Chop planted a kiss and a gob of butter on its nose. The butter came from the toast she had to have, even though dinner was being prepared [...] The one whose voice sounded like a duchess reclined in a chair at the kitchen table, with no sense of humour [...] over roars of protest, loaded her plate with cauliflower, brussel sprouts, and string beans. The others refused to eat. They hated vegetables" (Chase, 261-262). Narrative description of such an experience dares the reader to consider what this would be like.

The presence of physical symptoms in relation to dissociation is noted by several individuals sampled, and an association between chronic pain such as headaches and dissociative episodes has been suggested previously (Fishbain et al. 2001). In *The Three Faces of Eve*, Eve White experiences headaches and blackouts when Eve Black is active; this was associated with a period of dissociation: "The earlier headaches had been related to [...] the other Eve's efforts to gain control, and the blackouts had often represented this alternate's emergence into periods of activity" (Thigpen and Cleckley, 142). Before the emergence of the third personality Jane, Eve Black experiences the same amnesia as Eve White though does not experience the headaches, highlighting individual differences between somatic experiences for separate personalities.

Headaches are depicted in different ways and appear to not be affected by pain relief. The Woman in Chase's text has migraines ruled out by the doctor, and portrayal of the experience is more a fear of feeling the headache than actually experiencing any pain: "I sort of sense the

pounding...but it's from forty miles away and that makes me nervous. Because I know it's coming [...] I stay so busy that maybe I outrun it" (Chase, 20). For Eve White it is noted "she did not say the pain was "'unbearable,'" or that it was "'as if an axe were splitting her skull'" and that she "'without emphasis [...] described the attacks'" (Thigpen and Cleckley, 7). Pain amnesia has been found in those who have experienced trauma (Ebrinc 2002; Orbach et al. 1997) particularly in dissociative disorders where there is self harm (Putnam 1989). This is related to the intense changes experienced in terms of identity, memory and affect in those who dissociate (Saxe et al. 2002). In Alice's case she explains she suffered "migraines that lasted for days and did not respond to treatment or drugs" (Jamieson, 68) as part of several physical symptoms including a dry throat, numb shoulders and a tic in her neck. This concept is relatable to the controversy over DID and conversion disorders as discussed previously; if these headaches are not experienced in the traditional neuropathic sense and are not affected by pain relief, it is possible they are a somatoform symptom of dissociation. This can by no means be considered trivial. In mental health practice, dissociation will be encountered when working with those who have DID and holding, as best possible, an empathic understanding of this experience could be key to therapeutic interactions, reducing distress and working towards stability in mental wellbeing.

The experience of abuse or trauma

Within all texts analysed the individual in question experienced traumatic events within childhood; with the exception of Eve, this trauma has been severe, significant and predominantly in the form of abuse by family members and/or others. This was classed as a robust theme during analysis as it is intertwined with the need for dissociation *as a coping mechanism*, as Ruth comments: "Who can we turn to other than ourselves? How can we deal with this terror, other than to put it into little cupboards in our consciousness, than lock the doors firmly so that the terror does not contaminate the rest of us? Where this talent for self protection comes from, I don't know" (Dee, 59). Biographical accounts within the sample have also made these associations within the treatment of DID as seen with Sybil: "The selves, the doctor was now convinced, were not conflicting parts of the total self, struggling for identity, but rather defences against the intolerable environment that had produced the childhood traumas [...] Each self was younger than Sybil, with their ages shifting according to the time of the particular trauma that each had emerged to battle" (Schreiber, 283-343). This association provides the perception that the individual was separate, or protected from, the abuse as if it was not happening to the host, observable in the previous theme. On becoming aware that her persistent dreams were recollections of her own abuse, Alice attributes her unawareness to a coping strategy: "Without the emotional distance the other little girl provided, I came face to face with the alarming possibility that these were not dreams at all, but memories of something that had happened and I had somehow managed to bury them in the deepest depths of my subconscious [...] If my memories were real then I had been violated incestuously to a state of insanity by my own father [...] Not some strange little girl from my obscene memory. It was me" (Jamieson, 112-113). Such realisations may be particularly difficult, and nurse input may understandably be intensive and require patience and sensitivity. Within the sample, abuse accounts are highly upsetting and unsettling, spanning various forms. In allowing for empathic saturation the emotional effects of exploring these events are poignant and at certain points lead to the requirement of a break from exploring the texts, allowing time to process the textual content – use of the first 'emotional' read was beneficial here. Through both exploring narrative accounts and interacting with traumatised individuals clinically, the nurse is at risk of vicarious traumatisation or

even a compassion fatigue (Collins and Long 2003; Sabo 2006); clinical supervision could be very useful to combat or protect from such effects.

As noted, Eve had not experienced severe and enduring childhood abuse of any form. She had suffered a miscarriage not long before therapy began; however, within childhood there are two traumatic events that her therapists attribute to the development of dissociative mechanisms and DID. Eve witnessed a body being dragged from a watery ditch, and during a funeral her mother insisted she touch the corpse of her grandmother. Eve attributes horror and fear to both of these events but reports an "ordinary" childhood aside from this. As discussed previously the development of DID is not strictly related to trauma in the form of childhood abuse, and as a nurse the subjective experience of the distress should be as important as considering its source.

Although considering the need for dissociation in relation to severe childhood trauma is important in planning therapeutic interventions, the debilitating and disorientating effects of resulting dissociation on daily functioning is an important focus of care. Truddi encourages the reader to consider the long term impact that such abuse can have: "Incest leaves the victim with no real connection to him-or herself or anyone else [...] Incest is a thief; it steals more from its victims than you can ever imagine. Make no mistake-by whatever pretence— incest, child abuse, stinks out loud" (Chase, 327-328). It is largely unsurprising that throughout the sample and even when outwardly individuals have carried out a 'normal' life for some time, childhood abuse results in varied problems for the individual with DID. Childhood sexual abuse has been associated with significant increased risk of psychopathology (Molnar et al. 2001), which has been linked to depression, low self-esteem and substance misuse (Finkelhor and Browne, 1985; Putnam 2003) as well as increased suicidality (Bruffaerts et al. 2010; Bruwer et al. 2014).

Ruth and Alice particularly discuss their experiences of self-harm and of suicidality in depth, and the reader can get a sense of their hopelessness as they come to terms with the abuse they suffered and the lack of control dissociation brings. Alice highlights the interesting consideration that healthcare professionals did not understand that when she self-harmed, the behaviour was driven from the personalities within her, not from her own actions. In particular Alice possesses two alters who engage in self-harm as an expression of their pain and distress resulting from the traumatic memories they possess: "After every self-harming or overdosing incident I run the risk of being sectioned and returned to a psychiatric institution [...] So, why do I do it? I don't. If I had power over the alters, I'd stop them. I don't have that power. When they are out, they're out. I experience blank spells and lose time, consciousness, dignity" (Jamieson, 269-270). This may be particularly hard for professionals to grasp, but again it is the beliefs and the subjective experience of the individual that should be focused on. Although a difficult concept, it is a way of hoping to understand the complexities of this disorder.

It is understandable that the treatment process may be uncomfortable and reveal many deeply ingrained negative perceptions of the self. There has been an association between abuse experiences and subsequent feelings of disgust (Coyle et al. 2014), shame and guilt (Street and Arias, 2001). Shame-responses concerning body image are related to childhood abuse, and in turn this is related to chronic or recurrent depression (Andrews and Hunter 1997). Ruth and Truddi discuss that their siblings too were being abused in various forms, and guilt could be associated with these experiences, particularly as an older sibling, over a failure to protect them or protect themselves.

Although the *threat* of abuse may be long gone, the mechanism of dissociation is still utilised, and an individual may be hesitant to engage in everyday tasks and social contact for fear of dissociating and for what could happen during the time they lose. As her therapist details: "Eve White found herself severely handicapped in establishing simple friendships with others [...] It was difficult, too, for her to participate in little plans for diversion or ordinary

social life [...] She soon found that she must keep each new acquaintance at arm's length in order to avoid as much as possible, and for as long as possible, their discovering the unpredictable intrusions of the other manifestation" (Thigpen and Cleckley, 122). Considering this as a reader it is difficult to imagine but can be easily appreciated to be a frightening prospect. Alice explains that "I only discovered that one had been out when I lost time or found myself in the midst of some wacky occupation – finger-painting like a five-year-old, cutting my arms, wandering from shops with unwanted, unpaid for clutter" (Jamieson, 186). In this way the disorientating experience of DID can be considered, as well as a fear of repercussions, for example with shoplifting. This theme indicates that the experience of abuse or trauma during childhood is strongly connected to DID, producing a severe and enduring impact on the lives of those sampled.

Social elements of abuse

Within the sample, the approach towards childhood abuse within a sociocultural context is discussed, and often it is suggested that others outside the home knew these individuals were experiencing abuse but did nothing to intervene; in addition Ruth and Truddi could not seek refuge in another parent as both were involved in the abuse. In Alice and Sybil's case the non-abusive parent had no recognition any abuse was occurring or did not consider the possibility that it could be. As Sybil's therapist muses: "Her mother had tortured and frightened Sybil, and Sybil could do nothing about it [...] Sybil loved her grandmother, but she hadn't intervened...her father hadn't intervened, either [...] the neighbours [...] never came [...the doctor] who again and again saw that the [...] child had been hurt but didn't try to discover why. And later Sybil repressed rage at her teachers, who from time to time asked her what was wrong but never actually bothered to find out" (Schreiber, 209). The damaging effects of this ambivalence and the anger that Sybil held within are considerations that the nurse must make when caring for those with a history of abuse, and such deeply rooted emotions and resulting impact on views of the self will require careful address. Abuse also often involved other perpetrators outside of the home, and it is alarming to consider the enormity of engagement in this abuse. As Ruth pertinently reflects when her teacher's husband attempts to rape her: "How many other helpless girls had Mrs. Close sent over to her husband? How many families destroy their and other people's children in this way?" (Dee, 169-170). This is a poignant contemplation.

Walker (1999) suggests that child abuse has and continues to be widespread and is potentially ignored or denied to provide protection from the dire reality. She writes: "Perpetrators have an obvious vested interest in denying abuse [...] others also want to deny: the relatives of abuse survivors and others who may have known, or could have known, as well as all those who did not intervene and who could have done, including significant numbers employed as professional carers. And in general it is not comfortable to know about such nastiness – it challenges the illusion that the world is sufficiently safe and benign" (Walker, 3-4). Ruth addresses that this denial often encompasses class systems within society, commenting: "We are lead to believe that people from poor and uneducated backgrounds don't know any better [...] When it comes to rearing children, to drug and sexual abuse, it is the working classes that tend to attract most attention" (Dee, 210). Ruth is from a middle-class background, suggesting mistruth for these viewpoints and the damage such assumptions can have.

Moulding the sociocultural approach to the issue of childhood abuse is important within the context of DID and nursing practice as well as within a wider perspective, particularly as childhood abuse has been shown to remain common and seemingly increasing in frequency

(Keane and Chapman 2008). It should be noted that increased reports of or referrals for child protection could be a sign of increased vigilance or attention to this area. This theme highlights the potential magnitude of childhood abuse and how those sampled were largely unprotected by those with the power to do so. As a nurse there is high importance placed on a duty of care and safeguarding vulnerable individuals (Nursing and Midwifery Council 2008). It is unsettling as a reader that so many professionals from different fields were largely dismissive that abuse was occurring, particularly as experiencing abuse in childhood is not only related to DID but has various mental and physical health consequences (Afifi et al. 2007). Within and beyond DID, this is an important contemplation for the protection of vulnerable persons within wider society.

The role and experience of healthcare and diagnosis

Within the sample, contact with healthcare services and obtaining diagnoses are discussed. Alice in particular portrays a view that is filled with disappointment, a feeling of being let down throughout her life by healthcare services. When discussing her abuse of alcohol as a teenager at school she comments: "[...] the head of the year [...] gave me a cutting from the local newspaper about children who had parents with drinking problems. He had assumed I was imitating my parents, the first in a lifetime of wrong assumptions, misdiagnoses, of missing the point" (Jamieson, 24). Alice refers to her experience of a ten-year involvement with services from childhood, including being detained in various hospitals, being labelled with conditions like Obsessive Compulsive Disorder and Paranoid Schizophrenia, and taking the compulsory medication that came with these labels. During this period and without specific tailored approaches, Alice was left in a cycle of self harm, illicit substance and alcohol abuse, overdoses and depression.

As with any case of misdiagnosis, the individual in question may suffer as a result, and as treatment for DID is suggested to be very specific and tailored, diagnosis appears to provide comfort and clarity to individuals like Alice and Ruth. With diagnosis Eve appears to transform her life, ending her unhappy marriage and focusing on herself and her daughter through working towards recovery. In comparison Sybil is portrayed as particularly fearful of the diagnosis and resistant to exploring her alternate personalities for a substantial period. In the long term, diagnosis leads to positive outcomes for all within the sample as interventions begin.

Iatrogenesis is referenced within the texts, whether it be through the rejection of this by the individual who feel their experiences have been lifelong previous to therapeutic intervention or through the therapist who carefully considered their conclusion of DID. This is harder to experience through the biographical texts where rejection of iatrogenesis is based in the fact that Eve and Sybil lack knowledge over the existence of their possessed personalities, seeking help from services due to loss of memory, affective symptoms or fear over unfathomable occurrences experienced by themselves and others: "Sybil knew that she would have to tell the doctor about the end-of-the-rope feeling" about the "strange, incomprehensible things" that "were not new, [but] had in fact occurred since she was three and a half" (Schreiber, 51). None of the sample specifies desiring the diagnosis of DID as a reason for seeking treatment, and commonly there is a desire to *hide* the existence of their alter personalities for fear of being labelled mentally ill or not being able to make sense of what they are experiencing. As Ruth explains: "I had not known exactly what they were or why they were there, now that the abuse had long gone [...] I saw and conversed with other versions of me that I knew weren't really there. The only people I'd heard about who saw things had been diagnosed as schizophrenics and therefore in the eyes of the world were 'mad.' They believed that the things they saw were

there. I knew mine weren't." (Dee, 268). Taking the role of iatrogenesis into account may be difficult when travelling the journey of the author or with the service-user. Regardless of personal interpretation, invalidating service-user experiences by disbelieving authenticity is not appropriate when aiming to understand the subjective.

Due to the nature of DID, engaging in communication concerning origin and purpose of other personalities may be interpreted as an intrusion and a great deal of secrecy may be present. A fascinating example is found in *When Rabbit Howls* where beginning therapy with Stanley effects the internal organisation of the Troops and stimulates conversation between personalities who were not before aware of each other: "That first questioning penetrated the walls of the Troop Formation. The threat posed by talking to Stanley – the first person with whom they'd ever shared so much and contemplated sharing more – the mechanism keeping so many unaware of each other since birth was a strong one, but the tremor had been felt [...] the emotional reactions of the other Troop members were now single and separate and piercing" (Chase, 22-23).

When exploring the inner communication and decision making processes of the host and/or the other personalities detailed within the texts, the requirement of trust is highlighted and is particularly relatable to disclosing childhood abuse. As Alice details, she had the chance to discuss her experiences of dissociation and the relation of this to her 'dreams' of abuse but avoided this: "As a teenager I played the game to win and told her [psychologist] as little as possible" (Jamieson, 58). Morse (1991) suggests that until the nurse is committed to the service-user and the service-user is willing to trust her, complex behaviours will manifest and a beneficial relationship cannot be established. This theme indicates there is a great deal of consideration when applying this label and perceived misdiagnosis. This is not unanticipated when considering the controversy and lack of detailed diagnostic criterion surrounding DID, yet can produce negative consequences for the individual. From a nursing perspective, experiences of healthcare are paramount, including an appreciation of the difficulties surrounding this diagnosis.

Discussion: Clinical application of textual analysis

Issues of amnesia and disorientation associated with dissociation are potentially problematic within therapeutic interactions as establishing stable, continuous communication from which to build on may be difficult (Jasper 2013). Working through this together to form an acceptance of the circumstances may be beneficial within the therapeutic relationship and working towards stability. This is also relevant when considering the disconnection or separation between the host and alters, the mental health practitioner may need to try and understand how this may feel and work to recognise when the host has been 'taken over,' aiming to reduce potential negative influences on the individual. Additionally the depiction of physical pain associated with dissociation, particularly headaches as a precursor to dissociation, could be indicative prior to diagnosis, working to avoid misdiagnosis. Here, grounding work could also be implemented by the nurse to potentially reduce the frequency of dissociative fugues.

A nurse approaching experiences of trauma in DID may require time to explore the individual's view and association of attachment to the experience. Appropriate care planning and risk assessment should be implemented and updated if therapeutic input allows for a shift in perception, that is that they suffered the abuse not another. The depth of impact and sensitive nature of this topic will require a strong, supportive relationship between nurse and service-user. Trust has been acknowledged as central in developing an effective therapeutic relationship (Belcher and Jones 2009; Hupcey et al. 2001); a trusting relationship with the nurse

allows for directed focus on recovery through achieving the most appropriate interventions (Hams 1997; McQueen 2000). This may be particularly relevant to those who have experienced an exploitation of their trust as a child. In relation to hopelessness and harmful behaviours, risk assessment, as within all areas of mental health, is crucial for nursing somebody with DID. If certain personalities are more inclined to carry out these behaviours, the nurse may need to take time to recognise differing characteristics of these personalities and the behaviours associated with them. Specific risk and care plans could be produced in the hope of de-escalation and minimising risk. In working with those who experience these feelings it could be important for the nurse to try understand the origin of these beliefs and the potential barriers they may present in working towards recovery.

Stereotypical generalisations concerning abuse, for example that it is class-specific, need to be strictly avoided. Nurses are in a good position to be vigilant over abuse and can hope to reduce the impact of distress and protect from further ill-treatment through this vigilance (Chihak 2009). Research into the factors influencing recognition and reporting of childhood abuse by nurses has been conducted across culture;, this has suggested requirements for professional preparation and an emphasis on the extensive impact abuse can have within nursing education (Feng and Levine 2005; Fraser et al. 2010). In addition a multi-professional, collaborative approach for reporting abuse has been suggested (Feng et al. 2010) as well as shared databases within organisations to encourage this (Sanders and Cobley 2005). It could be suitable for nurses to receive specialist training and supervision in the area of abuse to enable better communication and work to reduce the fear of disclosure inherent in DID (Day et al. 2003).

Although misdiagnosis is never completely unavoidable, in a clinical world where many professionals are sceptical over DID validity (Cormier and Thelen 1998; Leonard et al. 2005) and due to the complex nature of DID creating challenges in accurate diagnosis (Labott and Wallachm 2002), it is logical that the incidence of misdiagnosis within DID has been shown to be amplified (Chu 1991). A delayed diagnosis or misdiagnosis and the provision of inappropriate care are not likely to foster a trust filled, positive experience with clinicians. This theme is clearly important to the nurse as traditionally applied diagnosis directs the pathway of care and *appropriate* treatments implemented by the nurse. Nurses may find it beneficial to consider a more biopsychosocial approach to care provision, not only centred on applied diagnosis, working with the individual and the likely varied influences on subjective experience. Taking the time to increase knowledge surrounding DID is also beneficial, as more constructive or positive approaches towards DID are correlated with increased knowledge about the disorder (Frankel and Spain 2000) and thus potentially decreased risk of misdiagnosis. There is cause to reject controversies surrounding DID for the purpose of interaction and relationship building with a service-user; if the nurse cannot commit to the interaction and is restrained by disbelief or ruled by controversy, a relationship cannot be forged and empathy is not achievable.

Critical considerations and limitations

The limitations of any research design must be considered when discussing implications for practice, and the conclusions drawn from this research are necessarily tentative and in some senses incomplete. The aim here is not to state definitively that the accounts are universally representative or to investigate their veracity; rather, to acknowledge the importance of a person's subjective experiences at a specific moment in time, as portrayed through the text. Thus our exploration is taken with acknowledgment of the difficulties around taking objectively reported 'truth' (which can never be fully representative of a person's whole experience)

and subjective 'truth.' particularly in the case of DID where there may be difficulties in recalling the perspectives of alters by the very nature of the experiences. As Holloway and Freshwater (2007a) suggest, if a researcher identifies with ideas presented to them by the author, she can expand her knowledge over the experience. From an interdisciplinary perspective, the use of these pathographies in this context allowed for a discovery of the subjectively reported experience of dissociation, particularly in exploring the presence and characteristics of alternate personalities. While the accounts cannot and should not be taken as representative, generalisable or 'objectively' accurate, they do portray a timely reminder to consider the person's subjective experience as primary in the clinical encounter, particularly where objective 'truth' cannot be located and / or is of lesser importance than prioritising the person's needs, wishes and beliefs.

Furthermore, narrative accounts have been more widely critiqued in terms of their applicability and validity in relation to issues of memory. Hawkins (1993) comments that through the act of writing, the author can reorder or recreate the past, and this may become theatrical in nature. It has also been suggested that autobiographical memory is influenced, structured and constructed through the overall culture and social context of that individual, including sociocultural myths (Brockmeier 2002; Nelson 2003). If autobiographical memory is a representation of these influences and of an individual's inner and outer world (Bluck 2003), confabulation, even unintentionally, may be unavoidable. Yet as Hamkins (2013) details, the combination of the clinician and the service-user working to explore individual narratives can lead to discovery of the self, individual construction of meaning and values and cultivate personal strength. This approach in the broadest sense can subsequently inform decision-making clinically and shape recovery. Clinical suggestions reached through analysis of the sample could be utilised in this way by the practitioner, and in this sense the uniqueness of experience is valuable without need for consideration of the veracity of the text, particularly for those autobiographical accounts whereby the subjective world is primary, as it is in any psychiatric encounter.

Despite the positives discussed previously for the use of narrative approaches within psychiatry, there are some who do not consider it beneficial. Literary critic Harold Bloom describes reading as selfish, expanding only personal intellect, not developing altruism or sensitivity to others, and approaching literature with the sole purpose of achieving a gain clinically has been argued against (Bamforth 2001). Beveridge (2003) outlines criticisms that suggest reading for this purpose may not be utilised by professionals, perceiving it no substitute for clinical experience where the individual in question may not even wish to be "examined personally" (Evans 2009, 19). There have also been criticisms of the sampled texts too, and such critiques of the sampled texts are important when considering the relevance and application of such material in clinical practice. *The Three Faces of Eve* and *Sybil* have faced steep allegations of being fabricated accounts. Nathan (2011) provides a particularly thorough 'expose' of the confabulation surrounding Sybil in the introduction of *'Sybil Exposed.'* Schreiber's archived papers revealed the manifestation of Sybil's personalities were not spontaneous but "provoked over many years of rogue treatment that violated practically every ethical standard of practice for mental health practitioners"; in this way "Dr Wilbur had approached Sybil's health problems with a predetermined diagnosis that brooked no alternative explanations. In her therapy she had made extravagant, sadistic use of habit-forming, mind-bending drugs" (2011, xviii). Nathan discusses how "the woman who became Sybil fell in with a psychiatrist and a journalist, and the three saw their project, a path-breaking book about female mental suffering, burst upon the world with perfect timing. They

were a blessed sisterhood" (2011, xx). In this sense the production of this text provided not only large financial gain but also represented these women as forerunners within an exciting field of psychiatry. Similarly Eve's case has come under scrutiny from even Eve herself, who published texts under her real name, Chris Costner Sizemore; *I'm Eve* (1977) and *A Mind of My Own* (1989) discuss her true experience of DID. Within these texts she writes of feeling exploited by the high levels of media attention she received following the work of Thigpen and Cleckley. Furthermore, she was not in possession of only three personalities and 'cured' as her therapist's suggested but over twenty personalities that were not integrated at the time of publication of *The Three Faces of Eve*. Carlin (1995) notes that *When Rabbit Howls* provides the reader with narrative truth because it "possesses not one, but two endings, each self-consciously scripted as a fiction" which recognise the horror of endured abuse and forces the reader to enter into a world that cannot be fully understood. This provides the "continuity and closure" necessary when "a certain experience has been captured to our satisfaction." Even though these endings are fictitious representations of the alters revenge and closure, it is what they deemed a necessary 'finale' as a subjective truth to them, open for the reader to explore.

Conclusion

This paper has explored the experience of DID as portrayed in a selection of five narratives, aiming to utilise findings to develop empathic understanding of the subjective experience. Findings suggest the experience of DID stems from abuse or trauma in childhood that was often ignored by those in positions to end maltreatment. In reaching and receiving a diagnosis the disabling and frightening experience of frequent dissociation and the existence of varied personalities over which the individual has no control, continues to impact heavily on people's day to day life. While focus largely has been on implications of this data for the therapeutic alliance within the diagnosis of DID, it is felt that this approach can be applied throughout psychiatry to beneficial effect, encouraging professionals to consider the lived experience of the individual under their care, giving focus to empathetic abilities and capacity for compassion. Further investigation in this area may look to conduct detailed close textual reading on other narratives concerning DID, including male authors. This may be beneficial in observing potential applicability of the themes highlighted in this research to wider texts, further expand knowledge surrounding the experience of this disorder and remove a solitary focus on the controversies of DID. Through avoiding or limiting conversation with service-users, by not fostering a person's strengths and views and encouraging their support systems and through not guarding against personal bias, assumptions or fixed beliefs, recovery can be compromised. Care planning and implementation can become directed and one dimensional, almost falsifying the therapeutic alliance and the basic concepts of compassion and empathy could become a fading ideal. It is these outcomes that narrative research and the health humanities can strive to help avoid.

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Appendix: Text synopsis

The Three Faces of Eve (Thigpen and Cleckley 1957)

Drs. Thigpen and Cleckley document an account of their client Eve White; a shy, modest lady referred for psychiatric consultation following severe headaches and blackouts. During initial consultation and through a subsequent lengthy therapy process the fun-loving Eve Black and the curious, caring Jane manifest, leading to a diagnosis of DID and an exploration of terror and grief within childhood that is applied to the creation of these different personalities. Eventually these 'incomplete' personalities combine into a reunited self 'Evelyn White,' a spontaneously integrated active personality.

Sybil (Schreiber 1973)

Schrieber, a professional journalist in Psychiatry, details the journey of Sybil and her psychoanalyst through initial treatment for social anxiety and loss of memory to the manifestation of sixteen personalities. Through prolonged contact, the therapist encourages discussion with these personalities who reveal a childhood of horrific abuse at the hands of Sybil's mentally unwell mother and their role in protecting Sybil from an intolerable upbringing.

When Rabbit Howls (Chase 1987)

This autobiographical account, constructed by the various personalities of Truddi Chase, was at the time of publication the only book written by a victim of childhood abuse who developed DID. Uniquely, Truddi is portrayed as sleeping since the beginning of the severe and enduring physical, emotional and sexual abuse suffered from the age of two by her stepfather. During psychotherapy and the production of the manuscript that eventually became this publication, an awareness of ninety-two different functioning personalities was eventually encountered by therapist and the personality created to function in everyday life without knowledge of the past horrors experienced.

Fractured (Dee 2009)

Ruth Dee tells her story of severe childhood sexual abuse, beginning with her grandfather and spanning to her father, other family members and his friends as well as constant physical and emotional abuse by her mentally unwell mother. Ruth splintered off into different selves from her early years to help her cope with what she had to endure and takes the reader through her life, her struggles and her work towards eventual integration as she came to terms with her past.

Today I'm Alice (Jamieson 2009)

Alice describes her journey of a life full of lost time, horrific nightmares of abuse, severe self harm and illicit substance misuse that lead to years of hospitalisation and wrong diagnoses before it became apparent she possessed alternate personalities. As time goes on Alice explains how she came to discover, through the memories of her alters, that her nightmares were actually a true history of prolonged childhood abuse at the hands of her father and others. The reader is privy to her efforts to confront her father and the abuse she suffered and how she came to live with her many selves.

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