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A

DISSOCIATION AND CRIME:  
ABUSE, MENTAL ILLNESS, AND VIOLENCE IN THE LIVES OF  
INCARCERATED MEN

by

ABBY STEIN

A dissertation submitted to the Graduate Faculty in  
Criminal Justice in partial fulfillment of the requirements  
for the degree of Doctor of Philosophy, The City University  
of New York

2000

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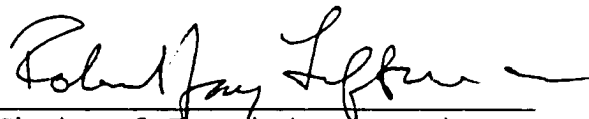
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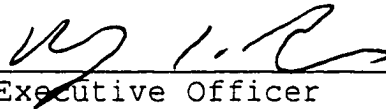
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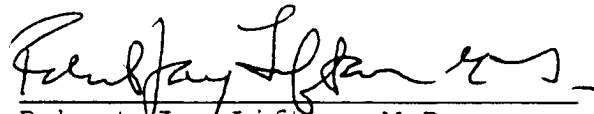
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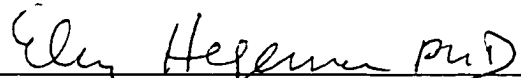
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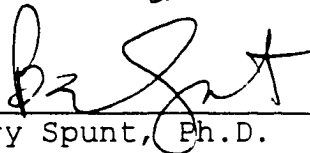
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Abstract

DISSOCIATION AND CRIME: ABUSE, MENTAL ILLNESS, AND VIOLENCE  
IN THE LIVES OF INCARCERATED MEN

by

Abby Stein

Advisor: Robert Jay Lifton, M.D.

This dissertation investigates the nature and scope of dissociative events experienced by a sample of sixty-four incarcerated men, hospitalized for either psychiatric or medical evaluation. Information gleaned from extensive interviews with the *Juvenile Justice Assessment Instrument*, modified for use with an adult population, questionnaire data culled from the *Dissociative Experiences Scale*, and official records where available, were used to explore the relationships between and among childhood trauma, dissociation, mental illness, and violent criminal outcome.

One third of the incarcerated men in this study were found to have elevated dissociation scores, while over a fifth met the criteria for pathological dissociation. As expected, horrific abuse during childhood, especially when

accompanied by sexual abuse, was found to be a common antecedent of dissociation.

Dissociation appeared most pathological in individuals with underlying psychiatric or neurological vulnerabilities, suggesting that responses to trauma are likely shaped and intensified by mental illness and/or that mental illness may be exacerbated by traumatic experiences. Interestingly, despite lengthy psychiatric histories, not one of the fourteen subjects meeting the criteria for severe dissociation had ever been diagnosed with a dissociative disorder.

These violent men often committed their crimes in dissociated states. Of great interest, over seventy percent of severely dissociative inmates professed amnesia for their offenses, although none claimed to be innocent of the crimes with which they were charged. Thus, in stark contrast to their non-dissociative counterparts, who often denied their offenses, dissociative men were abundantly willing to assume guilt even when they were unaware of what they had done.

The dissertation provides an overview and analysis of salient issues in the assessment, diagnosis, and treatment of dissociation in an inmate population as well as offering a discussion of the legal ramifications of dissociative

diagnoses for criminal defendants. In a more theoretical vein, the dissertation synthesizes psychoanalytic, cognitive, and trauma models of dissociation to suggest an alternative paradigm for the study of dissociation as a character pathology.

## Acknowledgements

My thanks go out to all of those who supported me intellectually, emotionally and financially through the long process of shaping this dissertation.

First, this research could not have been undertaken without the close supervision of Dorothy Otnow Lewis, M.D., a true pioneer on the twin frontiers of dissociation and violence. Dr. Lewis has been, by turns: teacher, friend, mentor and muse. She taught me that a good social scientist needs both brains and a heart - the brains to find something and the heart to stand by what she has found. I hope that this work makes her proud.

The writing of this dissertation was guided by three powerful scholars.

The chair of my committee, Robert Jay Lifton, M.D., is the keenest of listeners, the gentlest of critics, and the most sage of advisors. I will be forever grateful that such a formidable scholar lent his time and his support to this effort.

Elizabeth Hegeman, Ph.D., offered both insight and inspiration: her considerable clinical expertise in the area of dissociative disorders provided a cross-check on my theoretical constructions; her considerable kindness kept me believing that the work was worthwhile.

Barry Spunt, Ph.D. held me here on earth. Without his pragmatism and clear thinking I have no doubt that the dissertation might have been more stream of consciousness and less consciously scientific. My thanks for his help in organizing both my thoughts and my writing.

My thanks to all of my John Jay College colleagues in the interdisciplinary Thematic Studies Program I've called home for the last five years. What I've learned in teaching with you has informed this work immeasurably. I owe a special debt of gratitude to my department chair, Michael Blitz, Ph.D., on three counts. One, he is a great friend. Two, his own work on the subjective sense of self has emboldened and enlightened my analyses. Three, he made sure that I never had to share my office with another adjunct professor, which meant I could finish this dissertation.

My gratitude to all those who have resided in the executive suite: Tony Simpson for bringing me on board, Jim Levine for believing in me, Mary Gibson for her encouragement and, of course, Christina Czechowicz, troubleshooter extraordinaire.

My love and thanks to my husband, Bobby, who has helped make all of my dreams - including this one - come true. Thanks also to my children, Izzy and Sadie, who have been sharing their mommy with a computer for the last two years. My undying gratitude to that most important of family members, Andrea Balascak, without whom this work could not have been completed.

My profound appreciation to Melissa Ritter, who has supported me in the recognition and integration of my own fractured narratives.

Finally, my thanks to all of the incarcerated men who participated in this study. I hope that I have amplified your voices loudly enough that someone will hear you.

This dissertation is dedicated to the memory of my father and the year he spent in prison.

CONTENTS

ABSTRACT . . . . . iv  
ACKNOWLEDGMENTS . . . . . vii  
LIST OF TABLES . . . . . xv  
Chapter . . . . . Page  
1. INTRODUCTION . . . . . 1

PART I

DISSOCIATION: DIMENSIONS, QUESTIONS,  
AND STRATEGIES

2. THE PROBLEM . . . . . 9  
3. RESEARCH QUESTIONS AND HYPOTHESES . . . . . 20  
4. METHODOLOGICAL ISSUES . . . . . 26  
    Collecting Data . . . . . 27  
    The Semi-Structured Format . . . . . 28  
    The Reconstruction of Traumatic Events . . . . . 31  
    Validity . . . . . 34  
5. METHOD . . . . . 37  
    Study Participants. . . . . 37  
    Data Collection. . . . . 37  
    The Juvenile Justice Assessment Instrument . . . . . 38  
    The Dissociative Experiences Scale . . . . . 43  
6. THEORETICAL FRAME . . . . . 45

PART II  
QUALITATIVE ANALYSIS

Chapter	Page
7. DREAMING WHILE AWAKE: THE USE OF TRANCE TO BYPASS THREAT . . . . .	53
Danger . . . . .	53
Annihilation Realized . . . . .	56
Dissociative Process . . . . .	60
Controlling the Body: Ongoing Trauma and Dissociation . . . . .	71
8. DOUBLESPEAK: TRAUMA AND THE CREATION OF DUELING NARRATIVES . . . . .	76
Trauma and Memory . . . . .	78
9. PERSONAE NON GRATA: DISSOCIATION AND THE TRANSFER OF GUILT . . . . .	87
Personality Fusion in Normal Development . . . . .	87
The Effect of Maltreatment . . . . .	89
Memory and Guilt . . . . .	91
10. FALSE SELVES . . . . .	96
Petrifaction: The Lost Narrative . . . . .	97
Putrefaction: The Vengeful Narrative . . . . .	104
Purification: The Redemptive Narrative . . . . .	110

Chapter	Page
11. SUMMARY: THE DEVELOPMENT OF THE DISSOCIATED RESPONSE . . . . .	115

PART III  
QUANTITATIVE ANALYSIS

12. DEMOGRAPHIC PROFILE. . . . .	120
13. ADULT CRIME AND VIOLENCE . . . . .	124
Youthful Aggression . . . . .	126
Domestic Violence . . . . .	128
14. CHILD MALTREATMENT . . . . .	130
Physical Abuse . . . . .	130
Sexual Abuse . . . . .	132
15. DISSOCIATIVE SIGNS, SYMPTOMS, AND EXPERIENCES .	133
Derealization/Depersonalization . . . . .	133
Losing Time . . . . .	135
Identity Confusion/Radical Identity Alteration . . . . .	136
16. DISSOCIATION AND PSYCHIATRIC DIAGNOSES . . . . .	138
Prevalence of Dissociative Pathology . . . . .	138
Psychiatric Status of Pathologically Dissociative Inmates . . . . .	142
The Diagnostic Profile . . . . .	143
Adjustment Disorder . . . . .	143

Chapter	Page
Borderline Personality Disorder . . . . .	144
Epilepsy . . . . .	147
Schizophrenia . . . . .	149
Depression . . . . .	152
Malingering . . . . .	152
Other Diagnoses . . . . .	153
17. DISSOCIATION AND ABUSE . . . . .	155
18. DISSOCIATION AND AMNESIA FOR CURRENT OFFENSE . . . . .	157
19. DISSOCIATION AND VIOLENCE . . . . .	159
20. SUMMARY OF QUANTITATIVE FINDINGS . . . . .	161
Prevalence of Pathological Dissociation . . . . .	161
Dissociation and Psychiatric Status . . . . .	162
Dissociation and Child Abuse . . . . .	164
Dissociation and Violence . . . . .	165
Dissociation and Amnesia for Current Offense . . . . .	167
Statistical Regression . . . . .	166
PART IV	
DISCUSSION AND CONCLUSION	
21. SUMMARY AND DISCUSSION . . . . .	170
22. CONCLUSION . . . . .	186
REFERENCES . . . . .	238

Appendix

A	JUVENILE JUSTICE ASSESSMENT INSTRUMENT. . . . .	.187
B	DISSOCIATIVE EXPERIENCES SCALE. . . . .	.234

TABLES

Table	Page
I. Table of Legal Cases . . . . .	18
II. Distribution of Current Offenses . . . . .	123
III. Distribution of Dissociative Symptoms by Admission Status . . . . .	142
IV. Offense Histories of Severely Dissociative Subjects . . . . .	160

## CHAPTER 1

### INTRODUCTION

Almost everyone dissociates occasionally. Upon hearing bad news, we go numb. During emotionally charged actions, we feel remote, as if we were watching a movie. In stressful moments, we space out momentarily and lose contact with our surroundings. We completely forget an important episode from childhood. We all compartmentalize thoughts, feelings, and behaviors in the service of everyday functioning.

People utilize dissociation, along with myriad other psychological defenses, to protect their core sense of self from threatening material. Minor, infrequent episodes of derealization, depersonalization, and even amnesia fall within an acceptable range of psychological reactions to anxiety. As long as the resort to dissociative defenses does not in itself engender pain or dysfunction, individuals are assumed to be integrating their experiences normally and responding to events in a relatively appropriate way.

However, for some individuals, in the face of anxiety there seems to be a characterological propensity to rely primarily, or even exclusively, on a range of dissociative defenses. At one end of the dysfunctional spectrum are those who have a moderate, or borderline, level of dissociative organization: they struggle with issues of separation, of autonomy, of identity. Yet, despite a fairly significant degree of psychological impairment, they remain reality based and well oriented to time, person, and place.

On the other end of the continuum are those with full-blown dissociative psychopathologies: such individuals may meet the criteria for *Dissociative Identity Disorder*. The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) defines Dissociative Identity Disorder (DID) as (1) the presence of two or more distinct identities or personality states, which can (2) "take control" of one's behavior, accompanied by (3) an inability to recall [personal information] too extensive to be explained by ordinary forgetfulness. The definition differs only marginally from DID's earlier formulation in DSM III-R, where it was referred to as Multiple Personality Disorder (MPD).

Abuse during childhood, particularly of a sexual

nature, is thought to be the most common antecedent of the dissociative disorders. Over the last decade, the diagnosis of dissociative signs and symptoms in the general population, particularly in adult survivors of physical and sexual abuse, has increased exponentially (Schaefer, 1986; Ross 1989). In clinical settings, females have been more likely to receive dissociative diagnoses than males, in part because they are more likely to seek treatment for symptoms and/or support for coping with traumatic histories.

Ralph Allison (1981-1982), a psychiatrist working in the criminal justice system, was one of the first theorists to wonder where all the *male* dissociators were hiding. He speculated that dissociative men, more likely to be legally sanctioned for erratic or aggressive behavior than their female counterparts, might be lurking somewhere, undetected, in our jails and prisons. Since that time, many researchers (Steinberg, Bancroft and Buchanan, 1993; Saks, 1994; Lewis, 1991) have hypothesized that overt abuse in the backgrounds of some violent male offenders, coupled with a purported lack of recall for their crimes, make these criminals likely candidates for a dissociative

diagnosis. Unfortunately, there has been little in the way of empirical substantiation for this claim.

To date, there has been only one study attempting to document the prevalence of dissociative symptoms in a sample of criminal offenders (Snow, Beckman and Brack, 1996). Using a representative sample of 298 male and female jail inmates, Snow and her colleagues were able to document that dissociative symptoms are much more prevalent in a jail population than in the population at large. However, since this study of offenders used primarily self-administered checklists to tap dissociative phenomena, it provided more in the way of descriptive statistics than it did in the way of rich, dynamic explanations for dissociated thought and behavior<sup>1</sup>. Because of this dearth of

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<sup>1</sup>Other studies, using semi-structured clinical interview protocols, have enumerated dissociative symptoms in groups of sex offenders (Bliss, 1986), documented pre-homicide histories of dissociative symptomatology and verified abuse histories in murderers diagnosed with DID (Lewis, Augur, Swica, Pincus & Lewis, 1997; Carlisle, 1991), and qualitatively described the dissociative symptoms of violent felons (Carlisle, 1991). The groups in all of these studies were small (33 rapists; 12 murderers; 14 murderers; and 20 violent felons in the four studies, respectively). Only Bliss's subjects were randomly chosen from an incarcerated population; the other investigators chose their subjects based on either a previous diagnosis of dissociative disorder or a subject generated claim of dissociative symptomatology.

information on dissociation and crime, I decided to investigate the nature and scope of dissociative events as they are experienced by incarcerated men.

In the early nineties when I interviewed a number of incarcerated juveniles and adults I was continually struck by the degree of psychological disconnection exhibited by criminals, particularly violent ones. Their narratives seemed scripted and yet oddly without detail: it was as if the stories were being told by an uninvolved third party. Histories of nightmarish maltreatment were blandly recited and absurdly interpreted, if indeed the abusive events of childhood were remembered at all (sometimes only the old scars and burn marks on a man's back, or a yellowing abuse and neglect petition in his file, survived to tell the story). Criminal pasts were likewise rendered inaccessible by a strange combination of memory gaps, historical revisionism, and what appeared to be a kind of existential absenteeism on the part of the narrator. I set out to explore the connections between dissociation and crime. Toward this end, my colleagues and I interviewed sixty-four male inmates from Riker's jail and the Bronx House of Detention. The men were interviewed at length on the forensic ward at Bellevue Hospital in New York City, where

they had been referred for either psychiatric or medical evaluation. Through a series of intensely focused interviews we were able to elicit rich life histories. Together with our subjects, my fellow interviewers and I traversed the rocky terrain of childhood dread, adult rage, disembodied action, and fractured identity. Later, in my office, I tried to make some holistic sense of what appeared at first to be a bunch of disjointed narratives, notable as much for what they hid as for what they revealed. Through myriad and sometimes anguished re-readings, these frustrating narratives eventually converged into a single nuanced story. The story of these violent, mentally ill men is a story about the horrific lengths to which one will go in order to survive a terrifying childhood, and the ways in which "ghosts from the nursery" (Karr-Morse and Wiley, 1997) both inhabit and infect a lifetime.

The primary purpose of the investigation is to elucidate the relationships between and among childhood trauma, mental illness, dissociative phenomena, and violent criminal outcome in a sample of male inmates. A second, related purpose is to reexamine the relevance of the

diagnosis of Dissociative Identity Disorder to legal issues of consciousness, volition, and sanity.

It is my hope that this research will shed some light on one dark pathway toward violence and suggest some appropriate interventions for those who travel there.

PART I  
DISSOCIATION: DIMENSIONS, QUESTIONS,  
AND STRATEGIES

## CHAPTER 2

### THE PROBLEM

Dissociation has become a hot topic, a medico-legal football of sorts. Yet, the idea of dissociation isn't new. Pierre Janet (1888) was perhaps the first to articulate detailed theories of "automatism," where dissociated parts of the personality developed independently (Ellenberger, 1970), and to link these psychological manifestations to a history of trauma. The discreteness that Janet attributed to these "successive existences," or alternate personalities, is questionable: there is probably more co-consciousness among split off aspects of the self than he intuited. Still, his basic description of dissociative process remains a valuable framework for examining issues of psychological compartmentalization among survivors of childhood maltreatment, particularly when the symptoms under discussion are quite severe.

Freud, in 1894, parted conceptually with Janet by characterizing dissociation as just another defense

mechanism, akin to repression, where real or *imagined* threats to the ego were split off from conscious awareness. Indeed, he used the terms splitting and dissociation interchangeably. Freud rejected the notion that the dissociated parts (which include both memory for events and their accompanying affects) could assume a consciousness of their own that would function in an executive capacity, as Janet had believed. In reformulating his theory of dissociation, Freud opened the door to viewing dissociative symptoms on a continuum of severity and allowed for the possibility that they might be caused by something other than actual trauma.

Later psychoanalysts, like Melanie Klein and Harry Stack Sullivan, deviated from Orthodox Freudian positions, choosing to emphasize interpersonal, rather than instinctual, factors in psychological development. These neo-Freudians continued to write quite eloquently about dissociation as a defense mechanism, even when they, like Freud, rejected the idea of full-blown dissociated personalities. Harry Stack Sullivan, for example, called dissociation a "prolonged state of dreaming while awake," a tool devised to avoid recognition of one's own

powerlessness. Melanie Klein articulated the struggle to remain intact and integrated (as opposed to dissociated) even under optimal developmental circumstances. Robert J. Lifton (1996) has discussed the role of "psychic numbing" in the development of mental illness and as a defensive strategy formed in response to traumatic experience. R.D. Laing described many of his patients as having "unembodied" or "false" selves that they presented to the world so that their real selves would not be engulfed by others.

Still, over the years, rather than exploring the more minor dissociations of everyday life or even the function of dissociation as a defense in more serious mental illness, most investigations of dissociation have concentrated on only the most bizarre and theatrical accounts of multiplicity (Prince, 1906; Thigpen and Cleckley, 1957; Scribeber, 1973; Bliss, 1985). Understandably, the narrow focus on particularly fantastic case histories gave rise to a skeptical backlash against any claim of dissociative experience. Indeed, so distrusted were most clinical assertions about dissociative patients that Multiple Personality Disorder did not even make it into the Diagnostic and Statistical Manual until 1980.

Thus, criminal defendants may have suffered dissociative episodes prior to 1980, but because such experiences were not formerly recognized by the psychiatric profession, dissociation was never diagnosed or used as part of a legal defense. As mentioned earlier, today the diagnosis continues to arouse great suspicion, especially among legal analysts<sup>1</sup>.

Yet, research has consistently suggested that criminal offenders are likely candidates for dissociative disorders. Bliss (1986), for example, found a high percentage of DID sufferers (22 of 33 subjects) in a sample of male sex offenders. Lewis and colleagues (1997) have provided objective documentation of a (prehomicide) history of dissociative symptoms and have verified child abuse histories for twelve murderers. Similarly, ten of twenty women on death row have been diagnosed with dissociative

---

<sup>1</sup>In regard to the credibility of DID accounts, Nancy McWilliams makes an astute observation: "...philosophical efforts to grapple with multiple personality disorder have leaned toward a category mistake to the effect that there are actually different personalities involved, not one person with the subjective sense of multiplicity." She suggests that those who doubt the legitimacy of the construct question whether DID is truly "any more peculiar than people who starve themselves to death based on a false conviction that they are fat".

disorders (Slovenko 1991). Snow and her colleagues had 298 jail inmates fill out the Dissociative Experiences Scale (Bernstein & Putnam, 1986). They found that 25% of the inmates had elevated scores on dissociation measures and over 15% of inmates had scores high enough to be considered for a diagnosis of DID.

While it is true that most people suffering from dissociative disorders do maintain a fragile veneer of normality, it is also true that an estimated 20 to 45% of dissociative patients carry a concurrent diagnosis of antisocial personality disorder (Dinwiddle, North, and Yutzy, 1993). Why are dissociative individuals so often wolves in sheep's clothing? What links exist between dissociative disorders and antisocial behavior, particularly violent criminality?

One possible answer lies in the suggested etiology of dissociative disorders. A history of severe physical and sexual abuse during early childhood has been reported in the vast majority of dissociative patients. In most cases the reported abuse has not only been chronic, it has been

of a particularly bizarre and sadistic nature<sup>2</sup>.

We do know that severely abused children, whether or not they dissociate, are more likely to have criminal outcomes than their nonabused counterparts. The differences between adults abused as children and non-abused controls are particularly significant on measures of violent offending (Widom, 1989).

This vicious circle of violent behavior can be explained in several ways. First, children may simply model the violent actions of their caretakers. Second, abused children may sustain injuries to the central nervous system that make it more difficult for them to moderate impulsive behaviors. Third, a child who cannot effectively retaliate against a bigger, stronger persecutor may be destined to become an adult who seeks out weaker prey to victimize.

---

<sup>2</sup>Unfortunately, most of our information about the antecedents of dissociative disorders comes to us by way of patients who receive the diagnosis in therapy and then retrospectively reconstruct trauma histories. No prospective studies exist to tell us whether dissociative outcomes are likely given single or repeated episodes of physical or psychological trauma, or whether the appearance of dissociative symptoms is triggered or exacerbated by other factors (e.g., mental illness; neurological disorder; chronic drug use). The current study attempts to discern the relative contributions of such factors to dissociative events.

The study of dissociative experiences among jail inmates may help to clarify a fourth mechanism for the transgenerational transmission of violence. It is commonly argued that certain individuals indulge in a kind of self-hypnosis in order to escape the pain of abuse (Bliss, 1980; Bliss, 1986)<sup>3</sup>. In the most extreme cases, the victimized self is shunted aside and replaced by stronger, often violent, selves, better able to sustain in the face of threats to survival. Eventually, dissociation becomes a preferred coping strategy and new facets of the self take center stage in the face of even minor stressors. Because precipitating traumas are so completely compartmentalized, they may be only partially accessible even in the psyches

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<sup>3</sup>The "self-hypnosis" theory of symptom formation is currently the most popular amongst dissociation theorists. Other persuasive arguments have been made for dissociationism as (1) a loss of cohesion between normally occurring subsets of self (Erdelyi, 1994); (2) a type of culturally or socially cued behavior (Spanos and Burgess, 1994); (3) a type of psychological shock that prevents or distorts information processing (van der Kolk, Hart & Marmer, 1996); or (4) a kind of elaborated fantasy role playing (Pynoss, Steinberg, and Goenjian, 1996). Severe dissociative pathologies are likely engendered by a combination of these factors.

of "alternate" selves<sup>4</sup>. The original person may not remember the assaults s/he has endured. The created, violent personality may not remember the assaults s/he has perpetrated.

While the courts have thus far largely rejected the idea that dissociative disorders so violate the necessary conditions for consciousness and volition that *mens rea* cannot exist (See *Table of Legal Cases*, below, for a listing of key cases), forensic clinicians must continue to investigate the extent to which dissociation might bear on issues of competency or provide mitigation of criminal responsibility. Mindful that legal experts have largely dismissed the DID defense as just another "trendy alibi" (Radwin, 1991), forensic researchers and clinicians should work toward the refinement of evaluative instruments that can detect dissociative symptoms, differentiate dissociative disorders from other mental illnesses, and screen for malingered symptoms. Clearer diagnostic

---

<sup>4</sup>Billy Milligan, one of the few defendants to successfully utilize a dissociative diagnosis in gaining an insanity acquittal, harbored twenty-three separate personalities. His lesbian alter, "Adalana," was purported to have asked "Do you know what it's like ... not to know the meaning of love?" while she was raping an Ohio University student (Keyes, 1981).

guidelines will hopefully temper the controversies that dissociative diagnoses currently invite.

Even in cases where dissociation is not so extreme as to produce discrete personalities, there may be habitual resort to a defensive posture that amplifies self-preservation at the expense of right action, splits affect from behavior, and produces only a *partial* consciousness of the self's activities. To what extent should the person thus dissociated receive legal or moral exculpation? To what degree could such a question be obviated by an earlier and more astute intervention in the lives of abused children and mentally ill adults? The following research may provide some answers.

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**TABLE I. TABLE OF LEGAL CASES**

<b>CASE</b>	<b>CHARGE</b>	<b>LEGAL ISSUE</b>	<b>FINDING</b>
<b>State v. Badger</b>	<b>Attempted burglary</b>	can the defendant be found competent if: a) only an alter can assist atty. because only alter remembers crime? b) only an alter is present at trial, rendering def. amnesic for trial proceedings?	a) amnesia is no bar to competence  b) def. can be informed later about proceedings for which s/he is amnesic
<b>Michigan v. Foley</b>	<b>Murder</b>	can a defendant testify under hypnosis to elicit an alter?	No
<b>Dekaplaney v. Enomoto</b>	<b>Murder</b>	can an alter enter a guilty plea knowingly?	Yes
<b>Stinyard v. Dugger</b>	<b>robbery; kidnapping, murder</b>	same issue	Yes
<b>People v. Wade</b>	<b>torture, murder</b>	can a defendant found to have multiple personalities claim that counsel is ineffective on the basis that an insanity defense was not mounted?	No

**TABLE I. TABLE OF LEGAL CASES (continued)**

<b>CASE</b>	<b>CHARGE</b>	<b>LEGAL ISSUE</b>	<b>FINDING</b>
<b>Ohio v. Grimsley</b>	<b>drunk driving</b>	<b>can the actions of a criminal alter be considered conscious and volitional?</b>	<b>Yes</b>
<b>Kirkland v. Georgia</b>	<b>bank robbery</b>	<b>can a person be held responsible for the actions of a criminal alter?</b>	<b>yes, if the alter a) had intent and b) knows the difference between right and wrong</b>
<b>California v. Miskiman</b>	<b>murder</b>	<b>same issue</b>	<b>no, if the person cannot control the actions of the alter</b>
<b>Hawaii v. Rodriguez</b>	<b>Rape</b>	<b>does evidence of multiple personalities automatically equate with incompetence or insanity?</b>	<b>yes (trial court) no (appellate court): each personality must be tested for competence/sanity under ALI standards</b>
<b>State v. Darnall</b>	<b>Murder</b>	<b>same issue</b>	<b>no: jury must decide</b>
<b>Ohio v. Milligan</b>	<b>robbery, assault, rape</b>	<b>same issue</b>	<b>yes: those suffering from multiple personality disorder are insane</b>

CHAPTER 3  
RESEARCH QUESTIONS AND HYPOTHESES

The **qualitative** section of this dissertation describes the nature of dissociative episodes among a sample of male inmates referred to the forensic unit of Bellevue Hospital for medical and psychiatric evaluation, and attempts to develop a theory regarding the genesis of dissociative symptoms and disorders. The links between and among dissociation, child abuse, mental illness, and criminal offenses are discussed.

The **quantitative** section of this dissertation documents the prevalence of dissociative signs, symptoms, and experiences in this same sample; examines issues relevant to appropriate psychiatric screening and diagnosis; and discuss co-morbidity, misdiagnosis, and malingering. The quantitative section also examines abuse factors as contributors to dissociative outcome, the role of dissociation in violent offending, and the relationship of claims of amnesia for criminal offenses to dissociative history.

The dissertation attempts to answer the following questions and validate the following hypotheses:

### **I. Dissociative Signs, Symptoms, and Experiences**

1. What percentage of jailed offenders has any history of dissociative signs, symptoms, or experiences, i.e., amnesia, depersonalization, derealization, radical identity confusion, or identity alteration?

2. What is the nature of these dissociative episodes?

3. Are dissociative signs, symptoms, and experiences found more frequently in offenders referred for psychiatric evaluation than in offenders referred for medical evaluation (a population more representative of the general inmate population)?

4. Are dissociative symptoms, signs, and experiences more common in forensic populations than previously thought?

#### Hypothesis

Interview responses for 64 inmates were analyzed and the frequency and nature of the dissociative events they experienced are described in the following chapters. I expected to find some cases where dissociative symptoms, and even multiple personalities, seemed to have been

invented by malingering defendants or iatrogenically created by clinicians. Still, I hypothesized that, by and large, dissociative symptoms in forensic populations are missed far more frequently than they are invented or imagined.

## **II. Pathological Dissociation and Psychiatric Diagnoses**

1. What percentage of jailed offenders seem likely candidates for a diagnosis of Dissociative Identity Disorder (i.e., apparently meet the diagnostic criteria for Dissociative Identity Disorder as outlined in the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (1994)?

2. Does the presence of a psychiatric or neurological illness, other than DID, appear to engender or exacerbate dissociative symptoms?

### Hypothesis

The psychiatric group was compared to the medical group on measures of dissociation. I suspected that the greatest frequency and severity of dissociative symptoms would be found among inmates already recognized as suffering from other mental disorders, rather than be evenly distributed among the general population of inmates.

Thus, while the dissociative spectrum of symptoms these inmates exhibit has probably been missed or misinterpreted by criminal justice personnel, chances are that other psychiatric symptoms have brought the inmates to the attention of mental health liaisons within the criminal justice system. If true, this suggests that their cases are already being clinically evaluated, which is positive. However, it also indicates that the magnitude and import of these inmates' psychopathology is not being recognized, with potentially serious implications for adjudication, disposition, and treatment. In a more theoretical vein, it suggests that the co-morbidity of dissociative disorders with other mental disorders could signal that dissociation is sometimes a manifestation of other mental illnesses and only occasionally is so severe in and of itself that a full-fledged diagnosis of Dissociative Identity Disorder is warranted. In this way, many dissociative symptoms could be construed much as paranoid symptoms, which are seen in many mental and neurological disorders, but rarely are so dominant as to justify a diagnosis of Paranoid Personality Disorder.

### **III. Dissociation and Abuse**

1. Does child abuse engender or exacerbate dissociative

symptoms?

2. Is the experience of sexual trauma during one's childhood either a sufficient or a necessary condition for the presence of dissociative symptoms?

#### Hypothesis

For those subjects reporting a history of severe or chronic dissociation, a number of variables that are thought to engender or exacerbate dissociative phenomena are examined. I hypothesized that while sexual trauma is a decisive factor in severe dissociation it plays a lesser etiological role, perhaps only an exacerbatory one, in the formation of milder dissociative symptomatology.

#### **IV. Dissociation and Violence**

Are there links between severe dissociation in an individual and his or her level of violence?

#### Hypothesis

The number and severity of violent acts committed by jail inmates who report a history of chronic or severe dissociation are reported. I hypothesized that many acts of violence will have been committed during dissociated states of consciousness. It is also assumed that those with the most profound histories of trauma will exhibit the most

severe dissociative symptoms and hence will also be the most violent.

### V. Dissociation and Amnesia

How are claims of amnesia for criminal activity related to dissociative disorders?

#### Hypothesis

In the light of research that indicates that 10% of violent male criminals claim no memory for their crimes (Taylor & Koppelman, 1984; Parwatiker, et al, 1985) and 50% of male murderers may be amnesiac for their homicides (Bradford and Smith, 1979; O'Connell, 1960, Holcomb and Daniel, 1968) it seems appropriate to explore whether these amnesiac males might suffer from dissociative disorders. I expected that while many inmates would have been amnesiac for particular crimes of violence they'd committed, these amnesiac experiences would not necessarily be linked to a history of other dissociative symptoms, suggesting that amnesia for a particular crime may not be particularly indicative of the presence of a dissociative disorder.

## CHAPTER 4

### METHODOLOGICAL ISSUES

The "findings" of any study are, in essence, the tabulation and analysis of answers to a researcher's questions. This is equally true whether one is documenting galvanic skin responses to noxious stimuli, observing the food foraging behaviors of homeless men, or polling Americans for their opinion on the existence of angels. Although most criminal justice researchers will allow space for unanticipated observations, findings are, by and large, products of the vision articulated by researchers through the questions they choose to raise and the methods they employ to get answers to those questions.

This study used a semistructured depth interview to elicit information from subjects. The rationale for choosing this method is articulated below. A detailed description of the actual protocol is provided in Chapter 5, "Method," and a full copy of the instrument appears in Appendix A.

## Collecting Data

Traditionally, criminal justice researchers have relied on official records, structured questionnaires, and, more recently, self report instruments to cull information. Interviewing is difficult and time consuming. Why use it at all, when these other methods of data collection are available?

Although superficially efficient, using official records to learn about the activities of criminals is like using a dimestore magnifying glass to examine protozoa. Official records offer only the grossest estimates of complex behaviors. Closed-ended questionnaires are good exploratory tools, but they don't provide a forum for intimate disclosures. Even open-ended self report instruments may lack the sensitivity to tap truly accurate data regarding behavior, particularly when it is of an antisocial nature. It is in response to these inadequacies in traditional data gathering methods that depth interviewing has gained popularity as a tool for exploring issues in criminal justice (Petersilla, 1977).

A depth interview should:

1. Rely on a series of questions and probes designed to elicit information about the physical, psychological, and social circumstances of childhood.

2. Make use of the subject's spontaneous utterances as a technique for discovering latent meanings.

3. Ask for detailed descriptive information regarding the social network in which the subject is currently embedded.

4. Obtain numerous examples of current activities.

5. Attempt to determine the subject's feelings regarding past and present relationships and events.

Comprehensive data can be constructed from the raw facts revealed in such an interview. Because the interview reflects the reciprocity of sociological and psychological theories, it yields material pertinent to both realms of discovery.

### **The Semi-Structured Format**

The semi-structured interview is one of the most important investigative tools employed by researchers. In particular, it is a singularly profitable way of examining material that rests beyond the easy fraternity of mere conversation. Many interviewers have traditionally adopted a passive role, allowing subjects to set the conversational agenda,

interrupting only for clarifications of language or meaning, and relying on subjects' spontaneous revelations to inform analysis. Others have tended to use very rigid interview formats that "artificially [constrain] or force the character" (McCracken, 1988) of the stories that are elicited.

Much can be learned when the flow of information remains unrestricted, but such a method has definite limitations (McCracken, 1988; McKinnon and Michaels, 1971; Kruttschnit and Dornfeld, 1992; Della Femina, Yeager & Lewis, 1990; Stein & Lewis, 1992). First, left to their own devices, subjects will leave out information they perceive as irrelevant but which may, in fact, be integral to analysis. Second, subjects may consciously suppress information which is painful to remember, difficult to articulate, or which, if revealed, might have deleterious consequences in the real world. Finally, the most salient clues are often the most strongly repressed. In the absence of repeated probes, such experiential markers may never surface, depriving us of true insight into individual perceptions and motivations. Sensitive material is always difficult to uncover. This is all the more true in

investigations into the genesis of criminal activities, which by their very nature are secreted.

Thus, an interview must have a carefully scripted format, but one which can accommodate the insertion of alternate nuggets of information, and take them down separate predesigned paths. Much like interactive novellas for the computer, the interview should allow the writing of a story with twists, turns, and false endings, but one that moves inexorably onward.

In this research, my colleagues and I found it useful to work with a topically arranged "cheat sheet" which offered us numerous routes toward a common destination. The use of this type of scripted format, with predetermined phraseology and designated pathways, helped alleviate a reliability problem encountered in interviewing. It is no secret that interviewers will elicit disparate amounts of information, depending on their particular skills. This makes it difficult to compare information gathered by various team members, and nearly impossible for other researchers to replicate findings. We believe that "the extent to which the interview can shape the interviewer's attitude, rather than the converse, will determine its

consistency in successfully eliciting information" (Stein & Lewis, 1992).

In this regard, the importance of follow-up questions cannot be overstated. Questions as posed may be misunderstood, respondents may not easily remember certain events, the sought-after material may be of a highly sensitive nature and not easily shared. For all these reasons, people may not be forthcoming upon initial query. The use of multiple prompts, prods, and probes in this study surely facilitated both memory for events and comfort with storytelling.

Follow-ups were written into the interview rather than left to the discretion of the interviewer. It is a common human tendency, especially upon hearing shocking or sordid information about child abuse or criminal violence, to assume that one has "heard everything" and prematurely leave a particular line of questioning. The extent to which probes are explicitly embedded in the interview structure is, in many cases, the extent to which they are prosperously employed.

### **The Reconstruction of Traumatic Events**

Only occasionally is trauma remembered close to verbatim; more often it is remembered as an amalgam of

experience and the continual reinterpretation of experience. Thus, we have not only the old Freudian dilemma of the historical truth of abuse allegations versus their narrative or perceived truth, but the added distraction of "received" truth: a personal history rescripted by others. Michael Schudson (1995) has gone so far as to assert that "there is no such thing as individual memory" because all memory operates through the intermediary forces of language, social cueing, and patterned recall. In this light, some degree of memory distortion is virtually inevitable for all of us.

In Chapter 10, "False Selves," I discuss petrification as a defensive response to trauma. The metaphor becomes even more suitable when extended to dramatize the refractory nature of historical material. One recalls the tale of Perseus who, following divine orders to look away from the head of Medusa, avoids petrification by spying Medusa's reflection in his shield instead. The story highlights the distortion of reality, most especially as it pertains to the perception of traumatizing encounters. Although Perseus manages to behead Medusa, he never confronts her directly. And so this may be the case with the retrospective reconstructions of abuse elicited by

research protocols; we can never directly "see" the abuse, the abuser, or even the abused.

According to van der Kolk (1996, p.282) "terrifying experiences may be remembered with extreme vividness, or may totally resist integration." Thus, clinicians and researchers who deal with abuse survivors always discern the outlines of the traumatized self as it is refracted in a highly biased lens. Where caretakers have purposely conspired to alter or negate children's memories of traumatic events, for the investigator, the lack of cohesiveness in the victim's narrative is doubly frustrating. We struggle with how best to reassemble the story of a self, interrupted. We become in equal parts confessors and detectives. Detectives seek out evidence; for the researcher this means the verification of abuse stories through official records, the independent corroboration of traumatic events by witnesses, the painstaking documentation of the physical and psychological sequelae of abuse, and an ongoing analysis of the interviewer's influence on the subject's narrative. Thus, though it may be a jagged trajectory from the subject's "experience" to the researcher's datum, the depth interview is still an indispensable way to uncover the truth of

abusive experiences as they are/were perceived by the individuals who endured them.

### **Validity**

Semi-structured interviews increase validity in some ways, but they offer no panacea (Petersilla, 1977). It stands to reason that the more detailed the stories we elicit the greater the likelihood that we are measuring what we set out to measure. Still, information from interviews must be cross-checked whenever possible. I have tried whenever feasible to obtain information from other quarters, e.g., arrest records, hospital charts, social service records, and other official reports to support or illuminate the stories told by inmates.

Second, I have tried to be aware of my own impact on the "construction" of data in the interview process. These "autobiographies initiated by others" as Watson and Watson-Franke (1985) have called interview data, may have more in common with biographies than with diaries. They are retrospective accounts encouraged by an outsider, not ongoing, self-initiated disclosures. The dialogue between the interviewer and the respondent produces the data; data is constructed rather than merely revealed (Briggs, 1986;

Stoller, 1985). Frank (1979, p. 85) goes so far as to say that the information gleaned through the interview process "blends together the consciousness of the investigator and the subject, perhaps to the point where it is not possible to disentangle them."

There is probably no way to cure the problems that ensue when the research instrument is one's self. Nor, perhaps, should we attempt to rub out the human factors that supposedly distort our findings. Although the search for purer data has often led us to impose additional filters between the interviewer and the respondent (tests, techniques, and other means) such artifices rarely produce the desired effect. For example, even the most structured pen and paper psychological test will elicit more sexual responses when the proctor is young and attractive, rather than older or unappealing (Devereux, 1967).

In this study, I made no attempt to negate my influence on the men I interviewed. I did try to remain aware of my stimulus potential for subjects, as well as the subjects' effects on me, and to account for these factors when I studied the interview data. Freud believed that the transference of affect was the most important bit of datum to emerge in an analysis. Devereaux (1967) goes Freud one

better in stating that the interviewer's counter-transference of affective attitude offers even greater opportunity for understanding the subject's inner world.

So, rather than adopting a mantle of scientific dispassion during this work, I tried to listen to my own feelings about the men who shared this tough information with me. As I followed some clues not necessarily accessible through logical deduction, I think that I was able to use my feelings in the service of science rather than to its detriment. I trusted the intuition of R.A. Sweder (1985) who contends that this kind of "subjective science" is not only possible, but preferable.

## CHAPTER 5

### METHOD

#### Study participants

The subjects in this study were 39 male psychiatric patients and 25 male medical patients, referred to the forensic unit of Bellevue Hospital from Riker's Island and The Bronx House of Detention. A complete demographic profile of these subjects can be found in Chapter 12.

#### Data collection

Three sources of data were utilized in this research. A version of the Juvenile Justice Assessment Instrument (Stein, Lewis & Augur 1993), modified for use with adult populations, was administered to all subjects. In addition, the Dissociative Experiences Scale (Bernstein and Putnam, 1986) was administered to eighteen subjects: nine medical admissions, and nine psychiatric admissions. Finally, whenever possible, historical information on subjects was gathered from police reports, social service agency records, hospital records, and family interviews.

## I. The Juvenile Justice Assessment Instrument

The Juvenile Justice Assessment Instrument (JJAI) is a semistructured interview protocol, composed of 80 questions (See Appendix A). The interview takes approximately three hours to administer. The JJAI addresses the following areas:

### The Offense

Initial questions focus on circumstances surrounding the offense (e.g., "Was the incident planned or was it committed on the spur of the moment?"; "Were drugs or alcohol involved?"). The individual's frame of mind at the time of the offense is explored, particularly if the offense was violent (e.g., "Did you know it was going to happen beforehand?"; "Did you stop by yourself, or did you have to be pulled off?"). Special attention is given to memories surrounding the offense. Inability to remember all, or part, of the offense provides clues to the individual's neurological and psychiatric status at the time of the offense. In addition, a history of other offenses is taken, regardless of whether or not the offenses ever came to official attention.

### Aggressive Acts

Particular attention is paid to the number, nature, precipitants, and aftermaths of violent acts (e.g., "Have you ever had the experience of thinking that someone said something bad about you and you turned around ready to fight, but the person claimed that they hadn't said anything?"; "How do you feel after a fight? Sleepy? Sick? Dizzy?"). As with questions regarding the nature of the specific offense, special attention is given to memories surrounding fights, since these data help determine whether violent acts are related to organic factors (e.g., intoxication, seizures) or psychodynamic factors (e.g., dissociative states).

### Chronology of Living Situations

The JJAI explores placements outside the home throughout the person's life (e.g., group homes, psychiatric residences, correctional placements) and takes a detailed history of changes in domestic situations (e.g., foster homes, changes in family membership). Also included are questions regarding possible maltreatment at each placement or at the hands of any caretakers.

### Family Medical, Psychiatric, and Behavioral History

Aspects of family history are explored (e.g., has anyone in the family had a problem with their nerves?"; "What happened when Mom or Dad had a drink too many?"; "Has anyone in the family had trouble with the law?"). Interviewers inquire specifically about aunts, uncles, cousins, grandparents, and siblings, as well as about parents.

### Physical Abuse and Witnessing Family Violence

Issues of abuse and violence are tapped in a variety of different contexts (e.g., "Did alcohol ever make anyone in the family really angry? What would happen?"; "Who did the punishing in the house? Did they ever lose their cool and go farther than they meant to?" "Were you ever hit with a belt? A belt buckle? An extension cord?"; "Were you ever burned? Punched?; Knocked unconscious?"). Attempts are made to determine the degree and chronicity of abuse, and the number of perpetrators involved.

### Sexual Abuse

Questions explore sexual abuse, both inside and outside the home. In addition to direct questions about

possible molestations, responses relevant to sex abuse issues are also elicited during the course of routine medical questioning (e.g., "As a child, did you ever have bleeding when you moved your bowels? Do you know what caused it?"; Did you ever have a sexually transmitted disease? How old were you?") and during the course of taking a social history (e.g., "Have you ever had sex with someone much older than you?"; "Who taught you about sex?").

#### Psychological\Neurological\Medical History

Questions are included that tap information about a range of possible psychiatric disorders (e.g., schizophrenia, bipolar disorder) and several psychiatric symptoms (e.g., suicidality, hallucinations, delusions). An effort is made to obtain a history of psychiatric hospitalizations, diagnoses, therapeutic interventions, and psychopharmacological treatments. In addition, specific questions are posed regarding all accidents, injuries, illnesses, and their sequelae, particularly as regards possible damage to the central nervous system.

### Psychomotor/Dissociative Symptoms

Included are questions pertaining to episodic amnesias (e.g., "After a fight, do you always remember what happened?"; "Do you ever find things in your room, like writing, that you don't remember doing, or don't recognize?"). In addition, questions are posed regarding any history of loss of fully conscious contact with reality (e.g., "Do you ever lose track of hours, or days, or even weeks of your life when you don't know what happened?"; "Have you ever been told that you cursed someone, or hit them, and you could swear you didn't do it?"); depersonalization (e.g., "Some people go outside their bodies and watch themselves do things. Have you ever done that?"); pain analgesia (e.g., "Are you ever able to block out pain?"); episodes of *deja vu*; dreamlike states; metamorphopsias; staring episodes; fugue states; olfactory and gustatory hallucinations; headaches; and other seemingly inexplicable phenomena (e.g., "Do people ever call you by another name and you don't know why?"; "Is your handwriting ever very different?"; "Have you ever found clothing in your closet that you don't remember buying?").

## Scars

One of the most valuable areas of inquiry involves scars. Interviewers are instructed to inquire about the origins of all visible or palpable scars on the head, face, and arms and then to ask "Are there any scars that I can't see?" Interviewers may also ask to examine the back and legs, when to do so is feasible and advisable, given the circumstances of the interview and the temperament of the subject. The examination is used both to document the veracity of subjects' responses and as a springboard for further inquiries regarding abuse, medical events, and dissociative experiences (e.g., "Have you ever found a really bad cut or bruise on your body that you didn't remember getting? Is there still a scar?").

## II. The Dissociative Experiences Scale

The Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986) is a twenty-eight item self report screening instrument that asks subjects to mark a line (with anchor points of 0 and 100) to indicate the degree to which they have experienced a particular dissociative event (e.g., amnesia, depersonalization, derealization, gaps in awareness, absorption, imaginative involvement), when they are not under the influence of alcohol or drugs (See

Appendix B). The scale takes about ten minutes to complete and yields items and total scores that range from 0 to 100. Studies have shown that the scale has good split half reliability (correlation coefficients ranging from .83 to .93) and good test-retest reliability (.84 to .96) (Pitblado and Sanders, 1991; Frischolz, et al, 1990; Ross, Norton and Anderson, 1988). The instrument has been shown to successfully distinguish dissociators from nondissociators, but yields a high false positive rate when attempting to distinguish those with dissociative identity disorder/multiple personality disorder from other psychiatrically ill patients with dissociative symptoms, such as patients suffering from post traumatic stress syndrome. For this reason, it is used only as a screening tool, not as a diagnostic instrument. In this study, it is used both as an adjunct to the JJAI, and as a check on the JJAI's validity.

## CHAPTER 6

### THEORETICAL FRAME

#### **Character and Defense**

This study employs a biaxial construct of character, based on Nancy McWilliams (1994) work on psychoanalytic diagnoses, as an interpretive framework for examining dissociative states, particularly as they apply to determinations of responsibility in criminal proceedings.

The first important distinction drawn by McWilliams is the one differentiating the type of person one is (i.e., one's characteristic or habitual ways of perceiving and interacting across time and situations) from that person's level of disorganization or degree of pathology (i.e., is the person normal/neurotic, borderline, or psychotic?).

#### **Character**

A psychological defense is a protective response (in thought, feeling, or action) that serves to shield a person from the awareness of anxiety-producing material. The way

that one perceives and reacts in the world can, in psychoanalytic terms, be inferred from an individual's preference for using certain defenses more than others. One indicator of healthy adaptation is the ability to rely upon a variety of defensive maneuvers depending on situational demands. The "sicker" the person, the more likely s/he will be to resort exclusively to a particular psychological strategy in the face of diverse threats. Many psychiatric patients will strongly favor a particular mode of defense in the face of threat. Hence, some mentally ill individuals tend toward suspiciousness and are termed paranoid; others may be overly concerned with minutiae and are considered obsessive-compulsive. Such individuals may employ defensive techniques that fall primarily into schizoid, depressive, narcissistic or hysterical categories (among myriad others) and are usually classified accordingly.

### **Pathology**

Each defensive style can appear at different levels of psychic organization/disorganization. The character labels are descriptive, not pejorative. For example, a paranoid personality functioning at the healthy/neurotic level might become a respected FBI agent; the paranoid character who is psychotic might falsely believe that the FBI is tapping his

telephone. An obsessive-compulsive can be punctilious and highly efficient or can be so driven by themes of unworthiness that s/he is completely dysfunctional. Someone with a psychopathic personality may be CEO or a murderer, depending upon their level of mental organization and life opportunities.

### ***Levels of Organization***

**Healthy/neurotic individuals** have a perception of self that is relatively consistent over time and across situations. Their identities seem stable and integrated—they appear to “know who they are,” even when feeling threatened, depressed or confused. They are able to assess people and situations, as well as their own strengths and weaknesses, realistically because of the presence of an “observing ego” that logically evaluates emotional experiences. Those falling along a normal/neurotic dimension appear to have separated from their caregivers well enough to become unique individuals, although their adjustment may be marred by other kinds of conflicts along the developmental continuum.

**Psychotics** evidence a high degree of internal disorganization, although they may not always behave in a

psychotic manner. In fact, the preoccupation with internality leaves scant energy for deciphering events realistically; there is no observing ego to comment on more experiential domains. Individuals who commit crimes while in a psychotic state may not be held legally responsible for their actions because they lack the ability to differentiate right from wrong, or because they cannot conform their behavior to the demands of law. Psychotics have severe identity problems accruing from a basic confusion over where they end and others begin or, indeed, whether or not they exist at all. A psychotic might believe himself to be Napoleon or Charlie McCarthy, or might insist that he was already dead. People at this level of mental organization seem fixed at a preverbal, prelogical stage where the relationship with caregivers was still wholly symbiotic.

**Borderlines**, although limited somewhat in their abilities to accurately assess themselves and others, are not unglued from reality in the sense that true psychotics are. Borderlines can entertain, albeit not for long, objective assessments of their own thoughts and actions. Accordingly, those with a borderline level of organization tend to suffer from identity confusions rather than

alterations, as a psychotic might. For example, borderlines may have a troubling ambivalence about gender identification or sexual orientation but they don't generally wake up on certain mornings insisting that they have magically become the opposite sex, as a psychotic might. Struggles are often fixed at the separation-individuation phase of development, with borderlines alternately terrified of being engulfed by or being abandoned by others.

#### **The Schema Applied to Dissociative Individuals**

Nancy McWilliams is the first textbook author to have included a chapter on dissociative character structure. Until quite recently, dissociative symptoms were considered so atypical that patients exhibiting them were deemed uniquely pathological. Such symptoms were understood as psychiatric anomalies rather than as manifestations of a relatively common defensive adaptation: "It has become abundantly clear, however, that many people dissociate frequently, and that some do it so frequently that dissociation can be said to be their prime mechanism for dealing with stress (McWilliams, 1994)."

Freud himself bears at least partial responsibility for the reclassification of many dissociative events as hysterical conversions caused by the repression of traumatic materials. What now seems almost certain, though, from the last decade's work with abuse survivors, is that in cases of unrelenting trauma, dissociation is a more common defensive style than repression. Dissociative characters tend to compartmentalize external and internal events and use trance to ward off perceived threats to the self.

Like any defense, dissociation is called into play by high anxiety. Therefore, a person who tends toward the use of dissociation by dint of history, but lives a relatively stable present life, will be unlikely to resort exclusively or pathologically to the use of this mechanism. Those who have both a traumatic past and a volatile present will be likely to engage the world from a dissociated stance. They may *derealize* threats by perceiving them from a dreamlike state that negates their intensity. Dissociators often *depersonalize* events, experiencing trauma as if it is happening to someone else. Because information so misperceived is not properly encoded, individuals are often *amnesiac* for what has happened to them or what they have

done. Finally, in its most pathological elaboration, dissociation so fractures the subjective sense of self that individuals experience a kind of *split consciousness* wherein they feel like separate people. Such people can be classified as suffering from Dissociative Identity Disorder, formerly known as Multiple Personality Disorder.

The subjects in the current study are, in many ways, perfect candidates for the borderline or pathological use of dissociative defenses. Eighty percent of the subjects were abused during childhood, almost half of them horrifically so. Moreover, their present lives are loaded with emotional triggers for dissociative response: checkered employment histories, marital discord, substance addiction, mental illness, dangerous neighborhoods, the tension associated with committing crimes, the constant threat of being caught.

I hypothesized that a high percentage of the inmates in the study would be dissociative and that their propensity to employ dissociative defenses would play a part in the commission of their crimes. What follows is an analysis, both quantitative and qualitative, of the interview responses of these men.

PART II  
QUALITATIVE ANALYSIS

## CHAPTER 7

### DREAMING WHILE AWAKE: THE USE OF TRANCE TO BYPASS THREAT

#### **Danger**

Crew is one of the more paranoid inmates here on 19 West. Earlier this day the twenty-year-old hit a ward nurse because he felt that "she was going to bite me." Crew claims that he has trusted no one since childhood, when even "a stuffed teddy bear seemed real and I had to break it." The medical chart indicates that Crew sometimes becomes rigid, almost catatonic, but when I ask him about his family he seems oddly relaxed. His speech is fluid and lucid:

My dad hit me with a garrison belt. He beat us for little things, like bad report cards. One time I ate the report card to avoid the beating. Lots of times. It was intense pain like you can't even imagine—everything you can think up. We had to stand on rice or kneel on a grater. He tied my brother and me up.

My stepfather started doing me when I was seven. You think that I like laying (sic) on the floor bleeding from both ends? He took pictures, porno shots, when I was like twelve, thirteen or fourteen...

I dreamed I saw people with gunshot wounds. I was a little kid that was driven to see things I shouldn't see. People falling. People can't get up. Step-brothers. They fall for trying to say an untruth.

I don't know what's real now. I lost hours. Not just hours, years. A lot of childhood. Too much childhood.

He thought he was making men but he was making robots.

According to S. Freud (1926), anxiety has two sources: actual trauma and the anticipation of trauma. Trauma is defined as a stimulation that the infant simply cannot obviate or disarm. Suffused as it is with "emergency" affects, trauma and its attendant anxiety can only be passively endured (Pynoss, 1996; Hurvich, 1989). This sense of being biologically overwhelmed translates psychologically as impending annihilation. The companion terror is that the self will dissolve, disintegrate, or disappear (Klein 1921/1984).

Humans are naturally averse to sensory overload. One of the earliest psychic functions is to avoid or neutralize the perceived threats from powerful stimuli. Anticipatory anxiety then, unlike the traumatic moment itself, is formative because it promotes schemas to circumvent or

forfeind danger. In the course of a normal childhood, this early warning system activates defensive postures that can protect the nascent self from dissolution. Crew literally becomes a "robot" when threatened; he exhibits signs of catatonia and has been diagnosed as schizophrenic. He also manages to dissociate that which would rightly haunt him: huge segments of Crew's childhood are missing. Portions of his adulthood are as well: he knows neither why he was arrested (drug possession) or how he ended up at Bellevue. However, he is quite willing when pressed to confabulate answers to both of these questions, which makes his narrative seem candid until further investigation proves it false. No wonder that, in addition to being labeled schizophrenic, Crew is considered by the staff to be an inveterate liar. No wonder that when he talks about the boyish alter personality "Vinnie" who shares his body, it is taken as further evidence of both schizophrenia and malingering, depending on who is doing the diagnosing.

In examining the abuse histories of men like Crew, I had to ask: if personality fusion in the child is the end product of nurturing, is personality *fragmentation* the unavoidable sequel to neglect? dissociation the inevitable outcome of abuse? Certainly, when abuse occurs, the stage

is well set for the development of conflicting subnarratives that interfere with core identity, although the degree of entrenchment of these warring self-systems is dependent upon numerous and elusive factors, from inborn temperament to organic illness to the availability of positive secondary caregivers. One can almost never argue that psychopathology is inevitable. Yet it is well established that inadequate or disordered parenting increases the likelihood of psychopathology in offspring.

Lifton (1996) has eloquently explicated how the powerful imagery of death equivalents like separation and stasis can inform, or deform, defensive structure. Apparently, the more deleterious the circumstances of one's upbringing, the more unavoidable are negative consequences. *When death images encountered by the child are not symbolic equivalents but real threats to life, mastery over them can only be attained through the most extreme measures.* The more threatened and corrupted the body, the more disembodied the self must become in order to survive.

### **Annihilation Realized**

Melanie Klein hypothesized that the fear of being obliterated was universal. The infant must initially protect itself from starvation, suffocation, lunacy and,

ultimately, psychic deconstruction. Later, the child will struggle to remain intact despite the threatened loss of body parts (phallic equivalents), body products (feces), and loved objects (caregivers). This, we are reminded by Dr. Klein, occurs even under optimal developmental circumstances. What happens when childhood trauma arises, not from imagined scenarios of parental abandonment and sadism, but from the very real persecutory actions of caretakers?

My father beat my mother and me. He hit her with an iron cord, sometimes a pan. He hit me with everything: a belt buckle, his hand, an extension cord. During beatings I was so scared—I just wanted it to be over.

He used to tie me up and leave me in the closet for the KKK. He said that I was too black.

Once he slit the dog's throat and left me in the closet with him for three hours. He told me "I'll do the same to you."

McClellan, age 30 (convicted of armed robbery)

In cases like McClellan's, a fault seems to form in the very foundation of self because of the pervasive sense of dread. Chances are that, even prior to abuse, the entire relationship in which the trauma eventually becomes embedded is itself so non-nutritive as to constitute a massive threat to survival. McClellan says that early on he

had trouble differentiating fantasy and reality because "my mother lied to me all the time." Myriad moments of neglect and trauma, coupled with the distorted sense of reality proffered by parents, likely sensitized the child to the anticipation of danger, and embed a tendency toward dissociated response: a selective inattention to threatening stimuli. This is how McClean described his frame of mind during his father's beatings:

I used to think "I'm laying dead on the ground" I'd be happy. I could close my eyes and make myself go across the street.

I felt nothing. Dead. I couldn't think right. I was so scared, my fear just stopped.

I could be across the street now. You just program yourself.

Shengold (1989) has dramatically termed the chronic overstimulation of child abuse, alternating as it does with emotional deprivation, "soul murder." "Soul," for our purposes, is interchangeable with "self." Again and again in these interviews it felt like subjects were without viscera; "soulless," in both the anthropological and the spiritual meaning of the word. McClean, like many of the inmates, appeared simultaneously dead and alive.

As McClean's conditioned response to anxiety is to take leave of his senses, he literally ceases to exist. But because such death is in the service of survival, McClean, as is discussed below, substitutes other selves to endure situations that he cannot. Robert Jay Lifton well describes this mutuality of death and immortality (1996, pp. 175 and 205):

In order to dissociate itself from grotesque death, the mind must cease to live, become itself deadened.

This kind of process was described even before Freud, by Janet, under the concept of dissociation. It includes not only stasis in the form of inactivation, but also disintegration in the sense of a coming apart of crucial components of the self.

We can say that this dissociative disintegration characterizes the psychic numbing of the traumatic syndrome, and is at the heart of that experience.

The numbing of this "sham death" serves to avoid threat. One "plays dead" in order to stay alive. []The vicious circle around meaning is something like this: Perceiving a variety of external situations and inner images as deadly, he cannot permit himself to feel. Equating such feeling with further threat, he wards it off via both mimetic deadness (including conversions) and explosive but superficial emotional outbursts, for there is also a deep fear of being "stilled".

Unfortunately, for McClean, the "emotional outbursts" he produced to counteract death were not always so superficial. McClean has been arrested over twenty-six

times. His list of offenses included assault, robbery and kidnapping. He is currently serving a life sentence for armed robbery.

### **Dissociative Process**

When Harry Stack Sullivan called dissociation "a prolonged state of dreaming while awake" he intuited the systemic shutdown that occurs in the face of trauma. Dissociation is the ultimate tool devised by the self to avoid recognition of one's own powerlessness in the face of a massive assault upon physical or psychic integrity. Much as an infant will suddenly fall asleep when its crying brings no relief from hunger, chill, or pain, a child schooled in the successful resolution of terror or anxiety through selective inattention to the fear-arousing circumstance will likewise find comfort in sleep.

My father tied me to a chin-up bar. I was whipped with a skinny leather belt with a small buckle. I got welts, scars. I was naked except for my underwear. I was just a little penguin. From seven to about ten [years old]. He didn't mean to beat me. It made me a man.

I can make my heart stop beating since I'm real small. Go ahead—get a stethoscope. Put me in a bathtub and cover it up real good. I bet I'll survive. Put three grenades under my bed. The bed will blow up, but I won't.

You know, I'm still sleeping, but I'm listening to

you.

Coates, age 36 (convicted of assaulting a police officer)

Far from being a static experience, the dissociator's "sleep" (sometimes referred to as self-hypnosis) is actually a dynamic process of vigilant awareness. Shengold, for instance, tells of a patient traumatized in childhood who could block out perception and emotion while remaining hyper-attuned to reality. As such, the individual's dissociative sleep serves a number of purposes. First, autohypnosis may function as a psychological aide to survival, much like a wild animal's "playing dead" occasionally outwits potential predators (Becker, 1973; Lifton, 1996). Second, "ignoring" the traumatic experience may provide a mechanism whereby painful material can be automatically "erased" from conscious awareness. Third, the total passivity that such feigned inertia implies allows one to avoid responsibility for having "provoked" the attack, as can be seen in the following narrative.

My brother trapped me in the attic and [we were fighting]. My mother made my brother go to his room and she beat him with a strap. She beat my brother's weenie with a belt until it bled. But when she beat *me* it was

like "Johnny" took the beating [Johnny is the subject's imaginary companion].

Wesley, age 25 (convicted of fraud)

Fourth, dissociative sleep lets one remain blind to the identity of the villain, particularly useful if the perpetrator is a much-needed caretaker.

I have no memories of my mother. I can't remember her name. I draw a blank. (The subject lived with his mother for the first twelve years of his life, when she abandoned the family.)

Steadman, age 37 (charged with grand larceny)

I think so, but I don't remember [about the molestation]. A building on the Eastside. Maybe I was five or six. It was a person inside the family. I don't know.

Fredo, age 29 (admits a double homicide)

Finally, autohypnosis grants one the opportunity to indulge the compulsion to repeat the original trauma in both its terrifying and seductive aspects, a phenomenon that Shengold calls *autofacilitation*. It is important for students of criminal justice to note that in this blind, compulsive reenactment, the dissociator may play perpetrator instead of victim (van der Kolk & McFarlane,

1996). In either case, the drama unfolds while the actor sleeps.

One day after school, my mom chased me into the room and got on top of me. I was twelve, no, younger. Maybe eight. After, I was screaming. The veins were hurting. It wasn't right.

It's like someone's awake and I'm asleep. I have to wake up by breaking a window and I don't want to. I space out for a few days. I just start daydreaming. My conscience tells me to do something to that lady.

I followed women home from the subway five or six times. I never raped them because they opened the door and got undressed. I can't see, I'm in a daze. One day the cops knock on my door and accuse me of rape. I said that I didn't rape them. Then the memories came back and I knew I was in trouble. That's when I just died.

Now I came back.

Matty, age 36 (convicted of robbery)

Matty envisages his life rather than living it; he has managed to cede control of his actions while maintaining the identity of the sleeper. Such psychic withdrawal constitutes a truncation of the process of constructive change that would accrue from assimilating one's experiences consciously. According to Sullivan, it "prevents one from discovering that a part of one's living is done without conscious awareness." For Matty, experiences remain no more than unelaborated, unintegrated

symbols. Sullivan calls this development a "parataxic distortion" and sees it as the base disorganization in mental disturbance. This is Matty's fifth psychiatric hospitalization.

Sullivan intuited the self-system as an organization of learning experiences created to avoid or minimize anxiety. The nascent system is built on the "personifications" of significant others (usually the mother, but not exclusively so) into a "good," or nurturing, entity and a "bad," or overture-rebuffing, entity. These secondary personifications of the good and bad caregiver form the basis for the rudimentary self-personas of "good me," "bad me," and "not me." "Good me" helps to birth a healthy ego-ideal; it accrues from equal measures of maternal consistency and unconditional warmth. "Bad me," conversely, is formed along a gradient of anxiety—the perception that one's needs will be ignored or even punished and that all attempts at need satisfaction will be thwarted. "Not me," unlike the other personifications, stands distinctly apart from the growing perception of one's physical integrity. In fact, "not me" is birthed under conditions of such extreme threat (real or perceived) that it cannot incorporate without risking eradication. This disconnected persona, in

the healthy adult, might hold paralyzing fears never owned up to, or murderous rage never realized. It emerges in our dreams and parapraxes (commonly called Freudian slips of the tongue) and sometimes in destructive life choices. Under stress it might even trigger minor dissociative episodes.

For most people, "good me," "bad me," and, even to a large extent, "not me" fuse as the developmental process moves forward. However, when anxiety and terror cannot be removed, destroyed, neutralized, or otherwise cancelled by the young child (as would be the case with ongoing physical or sexual abuse) it must be "ignored." Thus, a particularly potent adaptation in the face of ongoing terror is to dissociate experiences that are marked by what Sullivan calls "uncanny emotions": awe, dread, horror, and loathing. The dissociative individual's seeming apathy in the face of horrors both endured and perpetrated (what is often noted as "inappropriate affect" in the abused child or a "lack of remorse" in the violent criminal) is actually a form of somnolent detachment. The detachment arises from a sense of total powerlessness. When feelings of impotence are chronic, such selective inattention can be activated at the

slightest hint of anxiety. The sleepwalker is literally *not himself* a good deal of the time.

Thus, "not me," the cornerstone of dissociative process, is a primitive character, infused with dread, incapable of corporeality. "Not me" becomes acquainted with reality through experiences suffused with intense unremitting anxiety. As accurate learning cannot take place in such threatening circumstances (imagine learning your multiplication tables with a gun to your head, as one of the subjects had), the perception of reality is both unreal and unrealistic. Moreover, because the meting out of abusive punishments is arbitrary and capricious, the caretaker personification on which "not me" is based is itself inconsistent and nonsensical. Therefore, the actions of the "not me" persona are not founded on an understanding of cause and effect. Hence the dissociated self exhibits only the "rationality" of the dreamer; "not me" speaks in a private language and behaves in symbolic equivalents. For most of us this dissociated self is only evinced in nightmares. For an unlucky few, "not me" is a walking, talking parallel self.

McClellan, for instance said he had "a body living inside my body" that helped him to endure difficult or dangerous

circumstances. There must have been many such frightening moments in childhood, given the almost psychotic rages to which his father was prone (see above). As a child, McClean would

Get angry and throw chairs thinking about my father. I used to hit (people) as if they were my father, but I didn't know that.

At age fifteen, McClean was involved in a fight that resulted in the death of another teenager:

He stabbed me in the arm. I didn't know I had a knife in my arm. I was looking at the guy and it was like a dream.

McClean went on to describe several different characters that handled different situations for him:

I can talk to the other person inside. I can become the big guy. The bigger, stronger one is the good one. The bad one has no patience. Flame came first, then Robinson, Manny, Fence, and Eagle. Then Lori, who makes me feel five years old.

Some men acknowledged that their alternate selves housed emotions or performed tasks that they themselves were incapable of feeling or doing. They spoke of vicious,

uncontrollable personas who served to protect the self from real or imagined harm.

Shorna can set fires and sacrifice animals, but Barka is the violent one. Barka comes when I have to defend myself. I have to recede, he's stronger.

Andrew, age 25, arson

Andrew had named the entities within himself. He experienced them as powerful individuals living inside his body. On the other hand, Nick, whose father was a violent drunk, housed his rage in a separate space without naming it, explaining that "Only the part of me with a deep voice wants to decapitate people." Like Andrew's *Barca*, Nick's disembodied avenger could not always be contained. Nick had been picked up roaming the streets of the Bronx, indiscriminately firing an automatic weapon. Asked about his actions he related that he just "flipped" following the death of his young daughter from meningitis. "It really wasn't planned. I had just finished crying. I needed a shoulder to lean on." Despite numerous incidents of violence, including attacking a ward nurse at Bellevue and trying to kill his girlfriend by pushing her out of the window ("the guard rail saved her"), Nick described himself

as "by nature, a passive person." This seemed incongruous, unimaginable. Then one day an extremely suicidal inmate I'd privately nicknamed The Weatherman (for the odd meteorological expertise he had exhibited while in a dissociated state) begged to be taken to his "therapist," who turned out to be Nick. I watched Nick for nearly ten minutes as he quietly and lovingly counseled the Weatherman about hope and hanging on, before returning to the phone call he'd abruptly ended when he was informed that the Weatherman needed him. Nick had confided in me earlier in the day that "All of a sudden, I flip. Bang! I want to know how it feels to kill someone." It was hard to tell who was the "real" Nick. In fact, they both were. Although Nick did not seem to house individual "personalities" with historical continuity, i.e., he did not fit the criteria for a diagnosis of DID, he exemplified the extreme and unreconcilable multiplicity of selves so often seen in the group of subjects who were both mentally ill and horrendously mistreated during childhood.

Interestingly, when asked to what extent different aspects were perceived as being parts of themselves, subjects were usually quite adamant about their distinctiveness. Extremely dissociative individuals—those

meeting the criteria for DID—described their “other” selves as differently gendered; of other races, cultures, or ethnicities. But even those who were only moderately dissociative, like Nick, had a hard time accepting the idea that the violent, or passive, or even the spiritual sides of themselves were manifestations of a single psyche.

Hermie, who “don’t make no noise when I cry [because] when my father beat me, if I cry out, he hit me harder, until blood came out,” describes himself as “a lot of little people made out of sticks.” He is in for armed robbery but his memory of the crime is spotty. At times he imagines that he may have killed his victim (in actuality, no shots were fired). Before beginning his interview, I had to have Hermie sign a second consent form because he had signed the first as Juan Baez but then could not remember doing so, claiming “I never signed Juan Baez for me.” During the interview I surmise that Hermie sometimes blacks out and *becomes* Juan who, it seems, is pulled out of his violent persona only by other people’s crying.

I blacked out and started hitting my girl. She started crying. I saw and I said “oh my God.” I don’t know why I hit her. One time when my brother walked by and I stabbed him with a pencil. *When I came back to me I saw my brother crying. I don’t remember why I did it.*

Even confronted with the incontrovertible evidence of his own actions, Hermie simply refused to acknowledge that he could have been the one to perform them: "I am just *not* a person who likes to hurt people." Resolute and unbending, the firmness of Hermie's proclamations made me realize the extent of his psychic division.

Juan is not me. No, no, no, no, no.

I understood that no brief therapeutic conversation was likely to unify that which was so cleaved.

### **Controlling the Body: Ongoing Trauma and Dissociation**

R.D. Laing described many of his patients as "ontologically insecure," concerned mainly with preserving, rather than fulfilling, the self. As we know from interviews with abused children, in the aftermath of physical and sexual maltreatment there is a heightened concern with survival; a preoccupation with "being" over "becoming". Barbara Marcus (1989), in her clinical work with incest victims, has intuited that there is a disruption in the normal developmental sequence that

facilitates individuation and mature ego functioning. She tells us that the process of separation-individuation requires, initially, that the child can establish the illusion of control over the caretaker. Secondly, the process requires the capacity of the parents to a) relinquish control over the child's body and; b) to encourage mental, as well as physical, autonomy of the child. In abusive relationships, these requisite conditions are notably absent. Because the child's needs are subjugated to parental desires (for sex, physical dominance, or both) mastery over the self, vis-a-vis the internalization of the caretaking role, is never attained.

Worse than the rape even was that my father wouldn't let me take a shower after.

Fredo, age 29 (admits a double homicide)

My mother locked me in the closet. She said "Are you going to pee?" I cried "No mommy, no mommy." I was afraid but it stopped me from peeing on myself. I wouldn't call it punishment.

Alan, age 44 (charged with drug possession)

My mom to this day washes me. I cover here (subject cups his genitals) but she does it. She wants me that much, as her baby.

Shane, age 23 (charged with burglary)

Clearly, many of the natural weapons that children can enlist to fight annihilation fears are rendered impotent in the face of such parental control. Children like Hermie and Alan cannot discharge anxiety through screaming, crying out, or wetting themselves, for fear of inviting greater punishment. Children may even be physically restrained, like Crew, to the extent that they cannot attempt any motoric discharge of tension. If indeed abuse is perpetrated with the tacit approval or even the participation of several family members, there may be no other benign adults around to act as transitional other-than-abuser objects. This last was true for almost all of the abused subjects in this study, who were generally victimized by most family members.

When abuse is *sexual* in nature, anxieties are compounded, and thus, magnified. Particularly in an incestuous relationship, anxiety that would normally be neutralized as the Oedipal struggle is resolved, instead is exacerbated. By having sex with a biological parent, the child wins a victory of sorts, having apparently supplanted adult partners in their caregiver's affections (Diamond, 1989). Thus, rather than coming to the realization that one can never possess a parent romantically, the opposite

conclusion is reached, intensifying both confusion and guilt.

With any type of sexual molestation, the body may confound psychological defenses because it experiences as pleasurable events deemed inappropriate by the conscious mind. In this painful betrayal, even the body's own reflexive arousal triggers annihilation fears. Sexual fantasies of union with the caretaker, rather than being repressed, are expressed, bequeathing shame and self-recrimination (Diamond, 1989). Ultimately, one's own flesh, rather than forming a protective barrier against stimulus onslaught, yields to, and may even embrace, the trauma. The traumatic scene may be reenacted again and again with the original perpetrator or a stand-in (Herman, 1992). Even the body cannot be trusted. The physical self must be banished.

My mother would pick me up out of the crib and get sexual feelings. She would put me on her stomach and it was like an orgasm.

They said I pounded the wall. Did I do that? Where was that? My memory is like a spider web. It's like waking up in a nightmare. I can't trace back the steps.

Lenny, age 35 (convicted of attempted matricide)

I was nine and she [the babysitter] said she had something good for me to taste. It went on for about

six months. She abused me but I liked it. I would have a quasi orgasm with her. I didn't feel my pain.

Lawrence, age 50 (charged with drug possession)

Thus, in response to chronic abuse there is first a split between psyche and soma; the child self divorces the victim's body. One can then allow the body to be wounded or even destroyed with diminished threat to the "psychic nucleus," M.L. von Franz's apt term for the seat of self-organization. An example would be the rather common dissociative experience of seeing oneself floating above a dangerous scenario, witnessing the violation of one's body as if viewing a television movie; no affect is expressed and none is gained. For some people this is a dissociative moment, a temporary dislocation. For others, particularly if abuse occurs prior to the development of object and self-constancy, it may be the fissure that portends the chasm. Since it is the body that provides a sense of oneness, wholeness, and continuity over time, to disconnect from it is tantamount to death. As Laing eloquently reminds us: "To have no body is to be nobody."

I feel strange. I used to say: "I know I'm in here". I see myself inside my body looking out.

Saber, age 35 (charged with petty larceny)

## CHAPTER 8

### DOUBLESPEAK: TRAUMA AND THE CREATION OF DUELING NARRATIVES

For most people there is an unassailable experience of "I." I eat and sleep. I go to work. I get hurt. I fall in and out of love. Though philosophers debate whether the unitary "I" is largely an illusion, at most a loose organization of warring subsystems, our common experience indicates that our being in the world is enabled by the integration of such parts into a dynamic whole, a continuous person. Indeed, is not identity formation the process of articulating a cohesive narrative for oneself that provides both purposeful direction and historical continuity? Only if this is so can we attain a position of what R.D. Laing has called "ontological security," a firm conviction that we actually exist. Thus, although it may be true that "there are crowds of things which operate within ourselves without our will (Jung, 1935), the ability to maintain a measure of control over the discordant, even contradictory forces, within us is the hallmark of sanity.

Shengold observes that the mind is a "myth making and history making organ." Because of our intense need for cohesiveness and continuity, we "weave our memories into narrative, from which we construct our identities..."<sup>1</sup> If identity is, in whole or in part, made from memory, we must ask: how is memory deformed in cases of abuse? How might the deformation of memory alter identity?

There are at least two ways in which abuse interferes with the unfettered encoding of incoming information. First, an individual who is in a state of chronic overstimulation because s/he is experiencing constant anticipatory anxiety cannot distinguish relevant from nonrelevant stimuli, pain from pleasure, reality from fantasy (van der Kolk, Hart and Marmer, 1996). Second, complex symbolization, largely based on language ability, is obfuscated because language itself is corrupted by the

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<sup>1</sup>I have characterized the different substrates of personality perceived or exhibited by my subjects as *narratives* or *subnarratives*. I firmly believe that the supposed "personalities" in dissociative individuals have more in common with the reparatory stories that we all make up about ourselves than they do with personality constructs, which have far more complexity, variation, and depth than the alternate characters presented during dissociative states.

double meanings conveyed during abuse. In both cases, information is not encoded accurately, leading to memory lapses and distortions.

### **Trauma and Memory**

Under stress, the mind and body mobilize for survival. Under conditions of extreme stress, sensory, cognitive and affective experiences are not integrated. Because they are fragmented, they remain symbolically primitive. Whereas in a calm or mildly stressful situation individuals will tend to form meaningful images from the totality of an experience, when over-aroused they tend to pay attention to disparate stimuli in a haphazard way. For many of the impinging stimuli they remain unaffected bystanders, while to other stimuli they are superbly, but disproportionately, attuned. A victim therefore could have spotty or even absent memory for the trauma, while a particular sensory trigger might evoke an overwhelming negative affect or cue a particular behavior (Spiegel & Vermutten, 1994). If associated events are segregated from one another, memory is impaired.

Sonny is a case in point. He carried a diagnosis of *Psychosis Not Otherwise Specified* when he arrived at Bellevue for evaluation following a murder he claimed not

to remember having committed. Like all of the dissociative men in this study claiming amnesia for their crimes, Sonny never denied the murder.

They told me I stabbed him with a kitchen knife. I realized I did it, but I didn't know. I don't remember doing it.

Sonny has been hospitalized many times—for depression, anxiety, mania, hallucinations, suicidality, fugue. He has taken a long list of psychotropic drugs but none has helped his symptoms. Sonny presents a puzzle: he had been graduated from a community college, he seems a devoted family man. Yet his wife says that in contrast with his usual "calm, polite" demeanor, at times, Sonny becomes "a wild, different person who doesn't hear, doesn't respond." He has been telling doctors for years that his biggest fear is that he will lose control of his behavior. Now, the murder has made his premonition true.

Most of the doctors that have treated Sonny believe that his symptoms stem from a fourteen-month stint in Vietnam, during which time Sonny's closest army buddy hung himself. Sonny was discharged after being hit in the face with a machete by an enemy soldier. Only in the course of

my interviews with him did Sonny reveal that strange memory lapses and entrenched subnarratives had been with him since childhood, far antedating his wartime experiences. It is likely, however, that traumas experienced in Vietnam reignited defensive responses honed during childhood abuse. Finally, when Sonny found himself in a situation that he perceived threatened his secure home life he called upon "my protector" to obliterate the threat, by committing a second degree homicide.

Sonny had been helping Bobby, the murder victim, through a difficult time. Bobby told Sonny's wife that Sonny had given him permission to shower at their house one day. Sonny did not remember the conversation with Bobby, although Sonny's wife confirms that such an arrangement would not have been out of the ordinary. Upon arriving home to find Bobby there, Sonny grabbed a knife from a kitchen drawer and proceeded to stab Bobby, even as the victim begged for his life on the basis of their prior agreement. Bobby was dead when the police arrived. Sonny was dazed but compliant with the officers who arrested him.

Traumatic memory may not be continuous, resulting in amnesia (although with considerable leakage of salient

information) for life events. More typically, however, the result of such faulty encoding is a kind of transmogrified memory, where experiences and their accompanying affects are distorted or conflated. Moreover, because people so desperately want to make sense of these incompletely remembered experiences, they are particularly susceptible to suggestion and confabulation. They truly make up their lives as they go along, without relying on the inclusive and discriminating imagery that Robert Jay Lifton (1996) sees as central to the task of psychic survival and vitality and, I would add, a unified identity.

Sonny often loses time. Fifteen minutes here, twenty minutes there, sometimes he loses days:

I found myself in Jersey, camping out. I'd been gone for three days. It was me. I had a flashback, thinking I was back in Vietnam. I set up camp. I set up a perimeter and stayed there. I thought I was in enemy territory. Another time I found myself in Arthur Park in the Bronx. They said I was acting crazy.

He often relies on the accounts of others to supply the logical threads of his existence.

I'm not conscious. Other people tell me I've done things. They say I act like I'm in Vietnam. They say I

get crazy, violent. One time I almost choked somebody, a kid.

I find things. I found a wallet in my dresser with money last Thanksgiving. I knew it wasn't mine. I found a gun in one of my boots. I turned that into the police.

Sometimes people come up and call me by other names. They say they know me from the streets but I don't remember them.

Sonny envisages his self system as compartmentalized and controlled by others.

Junior is the strong part. He's a little kid, about sixteen years old. He makes me laugh. There's also a baby part that wants to be alone.

For example, when pressed for further details of the abuse he had endured at his father's hands, Sonny suggested that maybe Lawrence and Robert might remember. The memories are kept in a dark spot.

Lawrence and Robert watch over things. They don't want to share. If they do that, they would lose control of me.

"Robert" appears to embody Sonny's guilt and anger over abuse; Robert is the putrified part of himself. Robert is both self-abasing and vindictive toward others, tempting

Sonny toward suicide, and contributing, along with a healing persona, to the refinement of Sonny's "protector" narrative. Robert first appeared when Sonny was ten years old.

He talks about doing things right. When I do something wrong, he won't stop talking. He says "You should know better. You ain't shit. You shouldn't be alive, you should not be alive. Kill yourself."

Lawrence, on the other hand, counsels Sonny to "Straighten my life out. Go home, raise your kids, do things right." Sonny credits Lawrence with helping him to raise his daughters: a nurse, a teacher, and a servicewoman in the military. Lawrence works hard to purify Sonny.

Lawrence gives food to the homeless. He worked for the Church for over a year.

Lawrence cares about me. He tries to calm me down. Him and Robert get into arguments about me. Lawrence tells Robert to stop picking on me, to leave me alone.

They control the moods. But Robert is more in control than Lawrence. He has some aggressive behaviors. Sometimes he does it and other times he makes me do it. He hit someone in the head with a cane. They had to get stitches.

Like one time I got in a fight. I didn't want to. He gets in my head and takes control. It's hard for me not to do what he says. [The victim] and I were just talking. Then, Robert started arguing with him, "You think you're so smart" and so on. Me and him got into

a fight. Robert punched him a couple of times and then he ran away. Robert just ran away.

He came when my mother died. I didn't have no one. He started telling me what to do. In childhood and in Vietnam, where things were more confused. That's how things got started.

Sonny's mother died when he was ten. He was left in the care of his abusive father who "didn't tolerate nothing." Sonny was beaten with belts and extension cords and "punched in the face until I saw stars." His first "protector" character ("I don't want to say his name") came when Sonny was six years old. At times this protector is perceived by Sonny as existing only inside his head, while Robert and Lawrence have independent lives.

Junior, Protector, and the Baby don't take over. Only Robert and Lawrence. When they argue, that's when I get bad headaches, or a pain in my stomach, or in the back of my head. A lot of times I have scratches and I don't know where I got them.

Sometimes Sonny blames Bobby's murder on the Protector or fingers him as an accomplice. Sometimes he seems to be saying that the Protector only witnessed the murder.

He comes when I'm in physical danger. He came the night when I murdered somebody.

Most interestingly, Sonny, like other dissociative men in the study, spends a great deal of time trying to piece together the events of his life(s). Sonny often plays the role of a detective trying to solve the murder to which he has already confessed.

SONNY: I found some writing after the arrest. I had written on a piece of paper that I hadn't done what I was supposed to have done, but I knew who did it.

INTERVIEWER: Who did it?

SONNY: Robert. Sometimes he says he did it. I don't believe everything he says. **But I'm not a violent person.** I know something must have happened.

Sonny echoes the befuddlement of so many men in this study who failed to remember committing the crimes they so readily admitted to.

I was in the precinct. That's all I remember. The last thing before that was being in a White Castle with my wife. I don't remember robbing nobody. They say I was there, but I don't remember.

I only remember being home, in Manhattan with my family. My mother gave me money for Chinese food. Then I found myself here in the system. My sneaker laces were missing. I don't remember coming here. It's so scary.

A person who called me Tyrone (not the subject's name) claimed we did things together. He scared me because he said we robbed people for a few days.

Not one of these men claimed to be innocent despite the fact that they did not remember committing the crime with which they were charged. They all rejected the idea that a dissociative disorder might underlie their memory lapses, although they often voiced the idea that parts of themselves acted without the informed consent of other parts. Their cognitions seemed to constitute a kind of leaky, or partial consciousness of events, rather than the complete amnesia often associated with strict definitions of Dissociative Identity Disorder.

It is for this reason that I concluded that the stories told by the men were narratives constructed to fill in, and make sense of, events that had been encoded in a splintered fashion if, indeed, they had been encoded in memory at all.

The reader should not infer that I use the words "narrative" and "constructed" here to imply a willful fabrication to avoid responsibility. Rather, I wish to call attention to the degree to which one will go, *unconsciously*, to combat threats to the psyche, whether they come in the form of violence to the self or violence toward others.

## CHAPTER 9

### PERSONAE NON GRATA: DISSOCIATION AND THE TRANSFER OF GUILT

#### **Personality Fusion in Normal Development**

A child, in the course of normal development, must confront numerous "death equivalents": increased separation from caregivers, going to sleep at night, body parts that bruise and break, body products that get thrown or flushed away. Through psychological manipulation of these death symbols, the child can master fearful annihilative episodes by magically, imaginatively reversing their outcome (Lifton, 1983). The child begins to rehearse themes of *being* and *not being* as a prelude to truly understanding the separateness of "I." In earliest childhood, these are realized with games of peek a boo and hide-and-seek. Somewhat later, the child becomes immersed in small morality plays where all it takes to expunge bad guys is a

loud bang-bang. Still, with an alchemy left over from earlier developmental stages, the dead are only sleeping. Only much later, perhaps around the age of eight years, can a child begin to grasp the finality of death. Our understanding of death as merely separation (with a possibility of reunion) evolves into the knowledge that death is final and that the dead are irrevocably severed from us. Our understanding of death informs the process of separation and individuation because it reinforces the distinctness of each person's existence. To be aware of death is to recognize the uniqueness of life (Lifton, 1996).

Cognitive development facilitates emotional separation and integration. Slowly but surely, the child realizes that, not only is his being independent of his caregiver's being, but the overpowering feelings he experiences are only aspects of himself, not separate people. By late childhood, the self is recognized as a distinct entity. "I" may still be many faceted, but it is bounded. "I" no longer leaks over into "you" or "them." "I" does not transform into an uninvited, unrecognizable other. In the course of normal development, a core identity is formed that is at once singular and integrated; continuous and

finite, even as it remains plastic enough to accommodate new challenges.

### **The Effect of Maltreatment**

As we have already seen through the preceding narratives, the more that the body's integrity is compromised by internal and external forces, the more incorporeal the self must become in order to survive.

In survivors of maltreatment, the disembodied or "false" self(ves) become(s) almost hyperconscious, positing elaborate images to countervail abuse/death images. The images are what might be termed incipient personalities (Fagan & McMahon, 1984). They are created to interface with the world without risking the destruction of the psychic nucleus. Yet even one's own alternate personas are viewed as potential intruders who must be compartmentalized into discrete stalls of memory and consciousness. This way, alternate personas can never engulf the core self and, presumably, slate it for destruction. In fact, the alternate personalities of dissociative patients are often so hostile to one another that clinicians can successfully contravene suicide attempts only by having alternate personas individually contract to not kill one another (Lewis & Bard, 1991). Personas are so disconnected from any

organizing core that all experience is *depersonalized*. Bad things, in particular, happen to someone else.

Andrew, to whom the reader has already been introduced (see p.68), is in for arson. He has a history of vicious assaults and prostitution despite the fact that he holds a master's degree in education and has a very good job as a computer troubleshooter. In addition to having endured horrible physical abuse at the hands of his mother and grandfather, he was raped at the age of four by his sister's boyfriend "which kept going for some years." He is on protective watch for being sexually provocative with other inmates. The way that Andrew tells it, a counterfeit self was actually the one who was raped. Three other personas, two male and one female, endured the familial beatings. One of these others shares with me that "Andrew doesn't remember a lot of the bad memories."

The Weatherman is twenty-one, charged with a robbery that he does not remember committing. One of the Weatherman's ongoing subpersonas is Mark, born during a beating by the Weatherman's mother:

My mother was beating me with a belt. He (Mark) stopped me from feeling it. He took the beating for

me. I was hitting Constance (his sister) with a stick on her legs. My mother beat me. She was drinking.

Sometimes Mark is in my head. Sometimes he's just me. I don't see his face. If I think about him too much I get headaches, migraines.

Mark remembers [abuse] for me.

Like many of the men I spoke with, the Weatherman had not so much repressed traumatic memories as compartmentalized them. Many of the severely dissociative inmates I spoke with retained a subnarrator of abusive experiences to revivify incidents experienced from a deadened perspective and, frankly, to hold on to an illusion of wholeness.

### **Memory and Guilt**

The bad feelings from which the Weatherman needs to escape are not only caused by external circumstance but by internal struggles with traumatic guilt. His affect is clearly constricted in the manner of the severely depressed. The Weatherman enumerates his suicide attempts, which began when he was eight years old:

I took these pills, brown pills from the bathroom cabinet when I was "on punishment." No one knew.

I jumped in front of a car or bus in 1990 because my daughter's mother wanted to leave me. They took me to

Bronx Lebanon Hospital. I left that same night in a wheelchair. My legs and arms were cut and stitched.

I tried to cut myself with a razor here in jail. [Over] some garbage ... I tried to tell my lawyer.

I drank some bleach in 1991. I "hung up" in 1991 or 1992. I was sent to the clinic.

Sometimes I cut my arms or chest.

[Interviewer: *What do you think makes you do these things?*] It didn't sound like any other voice—maybe my voice, like 'do it or don't do it.' One time I was looking over a bridge and I heard a deep voice, a man's voice: 'Go ahead, you could do it—jump'. I thought it was my voice, maybe.

I could do it without feeling pain. On my own. I just don't think about it. It's unexplainable. I think about other stuff. Only if there's an open wound. I think about something exciting, like shooting a gun.

The Weatherman is diagnosed as an Anti-social Personality who malingers mental illness. He is at Bellevue for an evaluation of his current depressive symptoms which seem inexorably bound to his childhood sense of dread.

Depression and guilt are likely intertwined: here is Nancy McWilliams on the connection between the two:

The aggression-inward model [of depression] is consistent with observations that depressive people seldom feel spontaneous or unconflicted anger on their own behalf. Instead they feel guilt. Not the denial and defensively reinterpreted guilt of the paranoid person, but a conscious, ego-syntonic, pervasive sense of culpability.

It is in this context of accepting culpability that we can understand the proffered justifications of their own abuse offered by the subjects ("I was only beaten if I did something really wrong—like not eating".) It also explains their surprisingly easy acceptance of guilt when accused of crimes that they didn't remember committing. Harvey, eighteen years old, had experienced orchestrated group beatings by an ensemble cast that included his mother, aunt, and uncle. He was introduced to sex at the age of nine by a teenaged cousin:

He played with my butt and shit. When I was young I use to spend the night there and he kept fucking with my back and drawers.

He doesn't know why any of these things happened to him but he is as willing to accept responsibility for them as he is to accept it for the criminal violence whose perpetration he's dissociated.

A man said I took a VCR—I don't remember [but] it was in my hand. I was charged with assault for taking out a man's eye with a cane. I don't know if I hit him with it. Everybody said that they saw me swing the

cane. I just find myself somewhere with something else on my mind.

Sue Grand (1997) has discussed the mutual dissociation that occurs between perpetrators and victims of abuse whereby the perpetrator comes to see himself as innocent while the victim perceives of himself as guilty. While abuse is a strong external threat to survival, guilt is an internally generated threat just as powerful and destructive. Children tend to blame themselves for parental misdeeds, no matter how onerous. "I deserved it" is the usual message that is encoded. Children can minimize what has happened to them and handily exonerate the loved caretaker with this deft reinterpretation of events. This subject described his home life in an almost wistful tone:

I had more welts from a garrison belt ... my mother had to raise four kids by herself—she ran my father out with a knife. She once shoved a lit cigarette down my throat when she caught me smoking.

My mother was a beautiful person, so lovely. If I said no, she beat me from one end of the house to the other.

Indeed, it is guilt—along with the aforementioned terror—that the victim is trying to avoid through amnesia,

derealization, depersonalization, and the creation of alternative identities. Abuse and the internalization of guilt play formidable roles in the creation and entrenchment of subnarratives about abuse. They may equally inform the false selves that these fictive narratives engender, particularly the ones prone to violence. Men who believe they are bad do bad things.

## CHAPTER 10

### FALSE SELVES

I have elsewhere called attention to the almost generic quality of the false selves chosen by abused, dissociating individuals: an immobilized child; a "protector" character, often violent; and a shaman, or healer. Similarly, Dell and Eisenhower (1990) describe three core personality types in dissociative identity patients: fearful, protective, and avenging. Deidre Barrett (1994) also notes the caricatured nature of personality subtypes in dissociative individuals and likens them to the archetypes described by Carl Jung. She finds that Jung's main archetypes: Persona (the compliant host self), Shadow (the evil self), Puer (the child self), and Anima/us (the cross-gender self) appear with startling frequency in the personality constellations of dissociative patients. Both Fritz Perls and Carl Jung saw nighttime dream characters as dissociated parts of the self trying to be heard. Barrett asserts that it is "trauma that gives dream characters more

autonomy." In other words, it may be that abuse transmogrifies normally occurring unconscious themes and precipitates both their personification and their migration into discrete stalls of consciousness.

The three basic identity modes (immobilized baby, avenger/protector, healer) reflect three distinct psychic operations employed to obviate the consequences of abuse: petrification, putrefaction, and purification. I speculate that these three adaptations may represent players in the Oedipal triangle (pre-Oedipal child, powerful father, nurturing mother) or may be elaborations of the child's initial personifications of "not me," "bad me," and "good me."

#### **Petrification: The Lost Narrative**

M. L. von Fritz tells us that the self has long been symbolized as stone, or dead matter, signifying existence independent of affect. Petrification in response to trauma is akin to "playing dead"; it allows the victimized child to endure abusive episodes from a distance and may facilitate the kind of psychic numbing described by Lifton's adult trauma survivors.

Many maltreated children report being able to block the pain and terror of abuse through this kind of dissociative mechanism. The intense depersonalization is a game of hide and seek: a nine-year-old child once spoke to me of "icing" his body during abuse ("I believe I was mugged. It happened while I was dead.") and letting designated others (i.e., false selves) endure the pain. Eventually the created others escaped abuse as well ("Now we have code names so our father can't find us."). One of Marcus's (1989) clients offers an even more poignant illustration of the type:

[When my father molested me] I submitted and endured his advances by experiencing my body openings as graves. I felt nothing. I contained only dead, inanimate matter.

A subject introduced earlier, Coates (see p. 60-61), insisted that he could stop his heart from beating during abuse. Many research subjects shared with me that they become "disappeared" during maltreatment. Andrew "detached" while being sodomized, at age four-and-a-half, by his grandfather. He allowed the original self to be violated, but cut off all conscious awareness of the rape. The self

who endured this pain shared with no one what was happening to him because "If I told I'd be badly hurt."

Often, the abused self is retained in its childlike state. Andrew, a prostitute and arsonist, maintains a five-year-old self who witnessed the abuse. Wesley, in this time for fraud but carrying a history of brutal assaults, has preserved, in the left side of his head, the character of ten-year-old Jamie, who "does not write—he just makes up songs and rhymes. When my father banged my head, he [Jamie] made me laugh."<sup>1</sup> Crew, the paranoid, assaultive drug abuser who opened this analysis, introduced me to a boyish Kiki who told me "we share the same body, we have the same experiences. [During abuse] I helped him out." Crew's body also houses a girl and a boy of toddler age. Coates, usually quite grandiose, shares that "I'm thirty-six years old, but only in my body. I think the baby's coming out [now]. I bring him in my pocket." A murderer, Ezra, described those present at the scene when his father picked him up by the neck and tried to kill him: "Oh, the Boy was there, too. He passed away."

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<sup>1</sup> Wesley, interestingly enough, engages in much head banging (his own head) on the ward. He says he bangs his head to dislodge his father.

### The Anesthetizing Effect of Pain

Common sense dictates that physical pain is a consequence of bodily injury. Supposedly, the more massive the injury, the greater the resulting pain will be. In truth, the association between injury and pain is a puzzle: we can experience amorphous aches and pains when there is no clear-cut evidence of physical damage. Conversely, grievously injured individuals often report feeling no pain at all (Melzak, 1973). A parallel situation exists for psychic pain that is unacknowledged. When a person is seemingly oblivious to a massive emotional assault we say he or she has suppressed, repressed, denied, compartmentalized, or dissociated the painful experience. I have conceptualized this dissociative pain avoidance technique as *petrification*.

Petrification serves a dual purpose. In replacing one's humanness with inorganic matter, it allows the organism to endure pain without feeling. But in doing this, it also serves to protect the psychic center, as stone cannot be dissolved. Stone is the material from which fortresses are constructed. Petrification, on its surface a negation of the self, is actually an attempt to save the self from total

annihilation. Ludwig (1983) has speculated that such "sham deaths" may have great species survival value. The isolation of traumatic experiences acts to conserve physiological and psychological resources, thus allowing the organism to better defend against future violations.

### **The Adaptive Function of Pain and Pain Blocking**

The perception of pain helps us to survive an ever-dangerous environment. If a two-year-old did not experience the pain of touching a hot stove, he would simply leave his hand there to burn. Indeed the perception of pain is so integral to survival that people born with dysautonomia, a congenital insensitivity to pain, rarely live to adulthood. However, biology must also set boundaries on the ability to feel pain. While individuals may vary somewhat in their ability to withstand pain, at certain levels pain is simply intolerable for any organism to endure. Thus, the body has built in safeguards against insufferable pain. When signals from pain fibers reach the midbrain, the neurons of the periaqueductal gray (PAG) release their chemical messengers in a descending pathway, through the medulla, to the spinal column. These neurotransmitters cancel out some of the excitation from pain receptors (Graham, 1990). PAG also

manufactures its own opioids, similar to morphine, which can bind to various receptor sites in the central nervous system. The manufacture of these endogenous opioids, the neurotransmitters enkephalin and endorphin, are triggered by the threshold stimulation of pain fibers. They act to induce hypoalgesia, a partial suppression of pain (Roby-Brami et al, 1987). Clearly then, pain itself can produce a diminution in pain perception.

Psychology also plays an important role in triggering antipain systems. Animal studies indicate that pain suppression occurs only when there is no other way to avoid intense, prolonged pain. When rats can learn an avoidance response to electric shock their pain suppression systems do not go into gear. However, animals exposed to unavoidable, prolonged shock will eventually give up and not even attempt escape. Their "learned helplessness" is always accompanied by hypoalgesia for the administered shocks (Jackson, 1979). Moreover, when shocks are paired with a neutral stimulus, like a bell, the neutral stimulus will elicit the pain suppression response on its own. Therefore, it may be that the danger signal (bell) induces fear that, in turn, triggers hypoalgesia even before the injury occurs (Bolles and Fanselow, 1982). This may be the

physiological underpinning of the anticipatory anxiety that triggers dissociative response in the face of perceived threats to the self from abuse, even prior to the abusive event. The child literally "splits" whenever danger lurks. If one does not perceive the pain, one cannot consciously retrieve the memory of pain. In this way, traumatic episodes that have been dissociated are relegated to a strange never-never land: their recollection is alternately disjointed and affectless or is so theatricalized that memory itself is a sham. In either case, memory cannot be educative, which may explain why abused children tend to be revictimized repeatedly in adulthood (Herman, 1992) and why they show scant empathy for the pain of others (Straker & Jacobson, 1981; Main & George, 1985).

### **Linking Abuse and Violent Behavior**

Gelhorn and Kiely (1972) theorize that during the dissociative episodes suffered by abuse victims there is a disruption of the reciprocal relationship between the catecholaminergic system, which enables flight or fight responses, and the acetylcholinergic system, which acts to inhibit fear and block memory. Through the dissociative response, the child who can neither flee nor fight back can instead simply refuse to incorporate incoming information.

Interestingly enough, the same catecholamines (dopamine, epinephrine and norepinephrine) play an important role in the genesis and suppression of violent behaviors (Lewis, 1992). Additional studies of the physiological consequences of abuse may help to articulate a neurological pathway from abuse to violence over the bridge of dissociative process. One must wonder if it is the abused, dissociative child's observed tendency to remain oblivious to his own pain that fuels his oft-noted lack of empathy for others' pain. As Lewis (1992) queries: "Might the abused, aggressive child's [lack of remorse for his aggressive deeds] be a reflection of a centrally mediated expressive deficit (see Chapter 8, *Doublespeak*) coupled with a conditioned imperviousness to painful stimuli ...?". Indeed, if this neurophysiological corollary of abuse proves true it strongly augments psychological theories, providing a potent explanation for the link between abuse and violence.

### **Putrefaction: The Vengeful Narrative**

In order to treat others with concern and respect one must be capable of empathic response. Empathy involves an identification with others, but abused children tend to maintain egocentric views (Barahal et al, 1981) or incline toward identification only with aggressors (Wilber, 1985).

Of course, the caretakers of abused children are themselves egocentric, unempathetic, inconsistent, incapable of responding to their children's distress cues, and often overtly hostile (Straker and Jacobson, 1981). Hence, it is not surprising that maltreated children have difficulty interpreting emotional cues in others (Barahal, 1981). In fact, such a child's response to distress in others can be quite bizarre. For example, Main & George (1985) found that abused toddlers, when confronted with a crying or panic stricken agemate, responded with fear, anger, threats, or physical attacks. Not a single abused toddler in their sample responded with concern, or a helping behavior, to a crying or frightened peer. Howes and Espinoza (Feshback, 1989) observed children in both free play and structured situations and also found that abused children responded aggressively to playmates in distress. Moreover, they evidence no remorse in the aftermath of their hurtful behavior. Is this the stuff that adult predators are made of?

While petrification implies a calcification of the self—a paralysis that mimics death—putrefaction implies the devolution of the self into something half-rotted and potentially pernicious. This aggressive, vengeful

narrator's purpose may be to retain and reflect the "death imprint" (Lifton, 1979) that the petrified self has so conveniently forgotten. *It is this personality fragment that survives as testimony to the trauma.*

One unrepentant rapist I had evaluated prior to this study requested a cigarette during our interview, only to extinguish it on his wrist as proof of his invulnerability. In a subsequent session, the same man insisted on being tied to a chair and sedated lest he lose control and strike me during the interview (In this persona, the patient reports being tied to a tree during his father's frequent physical assaults). This inmate must reenact the paralyzing effect of his abuse by insisting on being manacled, while at the same time embracing his abusive experience by burning himself. The part of him that welcomes pain also blithely inflicts it: only in this persona does he brag of the rapes he has committed. The death equivalent, then, is on some level absorbed and reflected back through his antisocial behavior.

Subject after subject in this study talked about the "others" that did violent things that they themselves could never do. All of the men quoted below were maltreated during childhood. All carried psychiatric diagnoses.

He's big, red, mean, and angry. *I* never did anything wrong.

(arrested for weapons possession)

He fights for me.

(convicted of burglary)

He talks to the ladies and sets fires.

(committed arson)

One of the people inside is very violent. A person came up and called me T. (not the subject's name or nickname) and claimed we did things together. He scared me because he said we robbed people for a few days. T. is very violent.

(arrested for fraud)

I know I'm in there but I can't control him. I hurt my hand or do stuff. I hit someone the other day. I meant to say hello, but then I hit them.

(convicted of robbery)

The bad one has no patience.

(sentenced to life for armed robbery)

He's ugly; he screams for me.

(charged with assault with a deadly weapon)

Pioneers in dissociation, like Cornelia Wilber (1985), theorized that the violent personifications of the formerly abused were internalized representations (*introjects*) of their abusers. This is the object relationists extension of

the psychoanalytic idea that conscience, or superego, is the absorption or introjection of parental voices instructing one to behave appropriately. Interestingly, while so many have written of the apparent lack of superego in the criminal, Freud—although his musings on criminality are scant—held to the belief that aggressive criminality was the result of an overactive superego; the internalization of parental voices so harsh that the individual became overtly punitive toward self and others. The once-removed parental voices heard from the mouths of aggressive offspring encourage similar conclusions. Indeed, I have inferred from these subjects' monologues that the mantle of guilt worn by most abuse survivors directly feeds the poisoned stream of behavior that so often culminates in violence.

However, to disregard the self-aggrandizing purpose of introjected violence would be foolhardy. It is through voicing violent subnarratives that one can cheat the death dealers, triumph over the death threat, erase the death imprint left by child abuse. The frightening childhood is mastered with a power grab; by reenacting the suffering

with oneself as perpetrator, one's prior annihilation is magically reversed, and far more demonstrably than it is during mere fantasies of parricide. Presumably, the more violent the act, the more authenticated the role reversal. It is no accident that murder is referred to as the taking of a life; murderers often describe their acts as somehow reifying their own unfelt existence. Killing makes the killer both omnipotent and immortal - murderer and victim are eternally bound. Indeed, the leitmotif of "ownership" of the victim's body as well as the accumulation of "trophies" (personal belongings of victims) that runs through scenes of serial murder may be the eerie manifestation of life-affirming themes. In Patrick Suskind's novel, *Perfume*, a serial killer born with no body odor methodically murders in order to appropriate the scent of a lovable human being. The killer, Grenouille, distills human perfume from the skin and hair of his cherished victims in the hopes of becoming one of them. Less metaphorically, Ted Bundy offered the following treatise on the satisfactions of violent behavior:

[Murder] becomes possession. They are a part of you, and you [two] are forever one. Even after twenty or thirty it's the same thing, because you are the last one *there*. You *feel* the last bit of breath leaving

their body. You're looking into their eyes and, basically, a person in that situation is God! You then possess them and they shall forever be a part of you. (In Aynesworth & Michaud, 1983)

### **Purification: The Redemptive Narrative**

The sadism of the avenger self gives rise to guilt and a need to compensate for damages. These are accompanied by a crippling self-blame for the physical assaults for which the child fancies himself responsible. Guilt and shame combine to engender a remedial magical self. This version of the self is "all good," much like the idealized version of the mother that the child was unable to integrate with the other "bad mother," who either perpetrated—or did not protect the child from—abuse. Shengold (1989), in fact, views the vertical splitting of consciousness as beginning with a neurotic delusion of the rescuing parents. The absolute need for a good mother is, at first, compartmentalized as a mere fantasy-image. But, for the chronically abused, the initial fantasized image may anticipate a more pathological disengagement from the overarching self system. A new persona, an all-knowing soothsayer and healer, a symbolic representation of the gods, if you will, replaces the imaginary beneficent

mother. By performing good works, or by policing aspects of the self that would inflict punishment on others, this personality can both rescue and magically purify the child soiled by physical or sexual abuse.

Becker intuits the concept of heroism (a refusal to accept mortality) as embodying not only a meeting with death but a return from its embrace. In this light, the production of a "healer" character may be understood as a particularly resplendent symbol of life raised against the terrifying specter of childhood abuse. It is the redemptive narrative that most articulates a need to reconstitute a self riven by guilt.

Three of the eleven severely dissociative men in our study told of their "healer" sides. All eleven housed personas whose purported purpose was to do good, although they did not necessarily rise to shaman status. Andrew offered *Allah*, a wise old soul much like Matty's *Billy* "who tries to love everybody." Zip used the name *Mr. Whiteman* when involved with a healing ministry at the Assembly of God church.

Lifton (1996) tells us that the imagery of death (separation, disintegration, stasis) is always wedded to complementary images of life (connection, integrity,

movement). Even in abuse scenarios we see the simultaneous appearance of both kinds of imagery, the life equivalents and the death equivalents. During abuse, there is both the loss of the protector/nurturer and the connection/possession of the parent through a sexualized union (even abusive encounters that are not explicitly sexual in nature may become highly eroticized because of the intense physiological arousal that accompanies the aggressive physical intimacy of a beating). In actual sexual molestation, of course, the child may be in equal parts reviled and aroused, simultaneously anesthetized and orgasmic (the ultimate life affirmation).

An all-powerful, all-good persona is engaged in the perpetual ritualized *undoing*<sup>2</sup> of both the traumatic experience of the petrified child and the present day violent avenging of the protector character. The point of undoing is to compensate for past offenses, large and

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<sup>2</sup> The psychological defense of undoing is used to erase "bad," often murderous, thoughts and deeds. (Some common examples of undoing rituals are found in religious exercises, such as atoning for one's sins by fasting or prayer recitation, or in any number of superstitious actions. McWilliams [1994] observes that "the childhood game of avoiding stepping on sidewalk cracks lest one break one's mother's back is psychoanalytically comprehensible as the undoing of unconscious death wishes for the mother."

small, real and imaginary. Undoing hails from a place where bad thoughts and deeds are inseparable, where neither is accidental and where each must be magically expunged.

The healing subnarrative undoes both pain and guilt. For example, one of our violent dissociative inmates sometimes described himself as an old, blind priest (interestingly, many dissociators have "blind" personas reminiscent of the hysterically blind patients seen by Freud) whose duties included caring for a "baby" inside the subject and offering pastoral counseling to other inmates. He insisted that he could heal physical ills through a laying on of hands. His rituals were an atonement for the sins of having been a victim (in childhood) and a victimizer (in adulthood).

#### **A Brief Word about Cross-Gender Subnarratives**

Two of the three subjects with female subnarrators had been sodomized by male relatives as young children. While they were not the only men in the study to have been sexually molested by male perpetrators, they were the only two to have been victimized at such young ages (four and seven). The third subject with a female persona would not discuss sex and, in fact, claimed to have been a virgin

until the age of twenty-three. He did admit to having been horrendously maltreated by his father (see McClean's narrative, p.57)

I can draw no firm conclusions from the small numbers in this study. However, the findings associating feminine narration with the experience of sodomy by male perpetrators are suggestive. Since female alters appear with some regularity in males diagnosed with dissociative disorders, it would be of interest, for future researchers, to ascertain whether female personas derive from early homosexual rape.

## CHAPTER 11

### SUMMARY: THE DEVELOPMENT OF THE DISSOCIATED RESPONSE

1. Infant/child lives in a non-nutritive environment and/or is organically/temperamentally ill-equipped to handle impinging stimuli.
2. The non-nutritive environment, *even absent abuse*, is one in which chronic overstimulation alternates with emotional deprivation.
3. The child learns to deal with anxiety and anticipatory anxiety through selective inattention to experiences.
4. Experiences are not elaborated; they remain unintegrated symbols. Thus, there is a parataxic distortion, or a dissociation of thoughts and emotions that are normally integrated.
5. Rudimentary personifications of the self modeled on caregivers—"good me," "bad me," "not me"—don't fuse as they would in normal development. It is too threatening to view the alternately withholding and overstimulating caregiver as a single entity; it follows that the child

cannot tolerate his own ambivalent reactions to the caretaker.

6. It is more adaptive to keep personifications and their experiences separate.
7. Myriad non-nutritive moments have sensitized the child to impending danger; a tendency toward dissociated response is embedded.
8. If there is actual parental sadism, healthy separation-individuation cannot occur. The conditions which encourage the child's autonomy and the internalization of the caretaking role are absent because the parent cannot relinquish control over the child's body. A magical, internal and pathological separation takes place instead, as the self retreats into a psychic nucleus, leaving the job of interacting with reality to other "false" selves.
9. If there is chronic and brutal abuse, especially if it is accompanied by sexual assault, eventually, any type of autonomic arousal will trigger annihilation fears and further dissociations.

Consequently ...

10. Traumatic experiences must be *derealized*. An alternate reality is created where caretakers can remain idealized and the self remain safe. Caretakers encourage this

distortion of reality through their own linguistic denial or through the subversive retelling of events.

11. Traumatic experiences and the guilt that they evoke are split off from conscious awareness. These experiences are wholly or partially forgotten and the person evidences *amnesia* for critical life events.
12. The traumatized self must become disembodied to stay alive. Relationships of the traumatized self to others, to aspects of itself, and to ongoing events, are highly *depersonalized*; one develops the fixed idea that everything is somehow happening to someone else.
13. Initial personifications are (a) the victimized, petrified self; (b) the avenging, protector self; and (c) the healer/purified self. These may give birth to additional subpersonifications. The individual may experience *radical identity confusion* as one or the other aspect of the self asserts itself.
14. In the most extreme manifestation of a dissociated response to environmental stimuli, the aspects of the self seem to the host person, and to onlookers, to be autonomous, discrete entities. Each entity has a well-developed life narrative based upon a certain segment of the experiences of the host personality. There is the

sense that the person cannot always exert control over the behaviors of these "other" narrators. At this stage, the person is said to suffer from Dissociative Identity Disorder, and to exhibit observable *alterations in identity*.

PART III  
QUANTITATIVE ANALYSIS

CHAPTER 12  
DEMOGRAPHIC PROFILE

During the summer of 1993, data was gathered on 41 male psychiatric patients and 26 male medical patients, consecutively admitted to the forensic unit at Bellevue Hospital. The study used male subjects exclusively rather than a mixed sex sample, for the following reason. A noticeable absence of male dissociators in clinical populations has led many authors to speculate that male dissociators are being shunted into the criminal justice system while their female counterparts are receiving psychiatric attention. The nature of this sample allowed an examination of whether there is, indeed, a hidden subset of mentally ill offenders, namely male dissociators, among the incarcerated.

The 41 psychiatric patients were jail inmates, from Riker's Island and the Bronx House of Detention, referred for evaluations and diagnoses, or for competency determinations. The responses of two psychiatric patients

had to be excluded, as they were too incoherent to be analyzed. Therefore the actual psychiatric sample consisted of 39 subjects.

The 26 subjects in the medical group consisted of jail inmates referred to the hospital for injuries or illnesses sustained during incarceration. One subject was dropped from the study because he was transferred back to jail before the interview was completed. Therefore, the actual medical sample consisted of 25 subjects.

The mean and median age of the total group (n=64) was 31 years, with an age range from 16 to 50 years. The group was 60.3% Black, 30.2% Hispanic and 9.5% White. The mean age and racial/ethnic makeup of the general inmate population in New York City jails in the summer of 1993 was only negligibly different from our sample. In New York City jails (n = 16,270) the average age in 1993 was 30.5 years. The race/ethnic breakdown was as follows: 54% Black, 38% Hispanic, 6% White, and 2% Other (Department of Justice, 1996).

The mean number of school grades completed by subjects was 11.5 years, although over one-third (34.5%) had only completed tenth grade. Nine subjects had GEDs. Five subjects had finished college, with two subjects going on

to complete master's degrees; one in education and the other in music. The psychiatric group was, on average, less educated ( $\underline{M} = 10.7$ , s.d. = 2.69) than the medical group ( $\underline{M} = 12.4$ , s.d. = 2.83),  $\underline{t}$  (df=48) = -2.07, p. = .044.

The vast majority of subjects was single (62.9% never married, 12.9% divorced or separated, 1.6% widowed). Roughly 50% of the group were childless, with the remaining half having an average of 2.2 children. Psychiatric patients had fewer children ( $\underline{M} = 2.00$ , s.d. = 2.63) than the medical group ( $\underline{M} = 0.74$ , s.d. = 1.03),  $\underline{t}$  (df = 26.16) = -2.20, p. = .037.

The distribution of current offenses, for subjects where such information was verified (n=60), can be seen in the table below.

TABLE II. DISTRIBUTION OF CURRENT OFFENSES

Current offense	Number of subjects charged
Drug Possession	12
Burglary	6
Weapons Possession	6
Robbery	5
Armed Robbery	4
Grand Larceny	4
Petty Larceny	4
Trespassing	2
Homicide	2
Double Homicide	1
Aggravated Assault	1
Attempted Murder	1
Arson	1
Assault (simple)	1
Loitering	1
Sodomy/sex abuse	1
Drunk Driving	1
Possession of stolen property	1
Swallowing heroin	1
Violating protection order	1
Driving stolen vehicle	1
Fraud	1
Computer tampering	1
Criminal mischief	1

## CHAPTER 13

### ADULT CRIME AND VIOLENCE

#### **Aggression and Criminality**

Interview responses and official arrest records, when available, were used to determine subjects' levels of violence and to support a descriptive picture of their criminal activities.

Level of violence was determined by tabulating offense histories, self-reported criminal acts for which there had been no arrests, and self-reported acts of aggression in adulthood.

The following behaviors/offenses were defined as *nonviolent*: Loitering, vagrancy, disorderly conduct, petty larceny, grand larceny, fraud, computer tampering, possession of stolen property, weapons possession, drug possession. Sixteen subjects, 25% of total group (n=64), were considered nonviolent.

The following behaviors/offenses were considered *violent*: Arson, robbery (armed and unarmed), assault

(simple and aggravated), and burglary. One individual kidnapped his own child during a custody dispute: this was classified as a violent crime. Thirty-one subjects, 48% of the total group (n=64), were considered violent.

Only subjects committing the most heinous of acts were placed in the *extremely violent* group. This group included men committing the following acts: double homicide, homicide, attempted homicide, serial rape, and child sodomy. Seventeen subjects, 27% of the total group (n=64), were considered extremely violent.

There were no significant differences in violence levels between those admitted for psychiatric evaluation and those receiving medical attention ( $\chi^2(2) = 3.59, n.s.$ ). However, as violence levels increased, the proportion of psychiatric patients increased: the vast majority (71%) of extremely violent subjects had a history of mentally illness.

### Criminal History

In this sample, 92.2% of subjects had committed one or more crimes previous to the current charge. Only five men were first-time offenders. Moreover, there appeared to be no particular pattern of crime commission and no specialization in criminal areas, with 57.8% of criminals

sampled committing at least three different types of crimes prior to the current offense (Range 1 - 7; mean = 3, mode = 3).

Fifty-six subjects, or 87.5% of the total sample (n = 64) admitted to having possessed drugs at one time or another, making it far and away the most frequent criminal activity. About one-fifth of the sample (18.8%) were charged with drug possession at the time of these interviews. Following drug possession, the next most frequent crime admitted to was simple assault, followed by unarmed robbery. Burglary was in fourth place, with weapons possession being the fifth most frequently committed crime acknowledged by subjects.

#### Youthful Aggression

Subjects were queried about their aggressive activities during childhood and adolescence. Responses were coded for the following areas: cruelty toward animals, fire-setting, violent assaults, and aggressive acts not otherwise specified. Nearly half (48.4%) of the total group (n = 64) were aggressive on at least one of these measures during childhood or adolescence.

Eight subjects, or 12.5% of the total group (n=64), described episodes of cruelty toward animals. There were no

significant differences between psychiatric patients and medical patients in this regard (Fisher's exact test = .709, n.s.).

Eleven subjects, or 17.2% of the total group (n = 64), described having set fires during childhood and adolescence. There were no significant differences between psychiatric patients and medical patients in this regard (Fisher's exact test = .439, n.s.)

Fifteen subjects, or 23.4% of the total group (n=64), committed violent assaults in childhood or adolescence. There were no significant differences between psychiatric patients and medical patients in this regard ( $\chi^2(1) = .007$ , n.s.).

Ten subjects, or 15.6% of the total group (n = 64), committed other types of youthful violence not otherwise specified. These acts included acquaintance rape, throwing a desk out of a window and injuring a passerby, acting as an accessory to a stabbing, and getting into frequent (more than three) fistfights during childhood or adolescence. There were no significant differences between psychiatric patients and medical patients in this regard (Fisher's exact test = .494).

### Domestic Violence

Six subjects, or 9.4% of the total group, admitted to battering their partners. One subject admitted to assaulting his sister. One subject admitted to beating his child. There were no significant differences in domestic violence between psychiatric patients and medical patients (Fisher's exact test = 1.00, n.s.).

Considering the national figures on domestic assault, the known aggressiveness of this group, and the men's own histories of witnessing or experiencing violence in the home, it is unlikely that this small figure is truly reflective of domestic violence rates for the sample.

In some cases, shame may have underlaid the reluctance to admit to assaulting one's partner or child. In other instances, more frighteningly, the men may have reconfigured their aggression in the home as a deserved corrective for the misbehavior of wives and children, much as they rationalized their own parents' motives for abusive behavior. Upon closer questioning, however, it seems that in most cases the men were simply not in the home often enough to perpetrate much abuse. Thus, impressively low rates of spouse- and child-battering in this group may

actually reflect male absenteeism rather than indicate the presence of masculine self-restraint.

CHAPTER 14  
CHILD MALTREATMENT

**Physical Abuse**

The definitions of physical abuse employed by this study were deliberately conservative. Even given the narrow guidelines, most subjects easily met, indeed far exceeded, the stated criteria for having been abused. Indeed, 80% of *subjects in this study were physically abused* (51 of 64 subjects).

Subjects were considered *not abused* if they had been hit on the buttocks with an open hand or slapped across the face, with no resultant injury. A common punishment, being made to kneel on rice for short periods of time (i.e., less than fifteen minutes) was not considered abusive either. Verbal harangues, no matter how often they occurred or how odious the content, were not counted as maltreatment. Only twelve subjects, 19% of the sample, were not abused.

Subjects were considered *moderately abused* if they were hit on the buttocks or upper thighs with objects,

rather than an open hand (e.g., belts, switches, shoes), or slapped across the face until swelling occurred. Twenty subjects (31% of the sample) fit the criteria for having been moderately abused.

Subjects were considered *severely* abused if they were punched or hit on areas of the body other than the buttocks with belts, whips, switches, extension cords, or boards; and if they were deliberately burned or beaten to the point where limbs were broken, bleeding occurred, or they lost consciousness. Subjects were also considered severely abused if caregivers threatened them with guns or knives, or had actually attempted to murder them. Thirty-one subjects, *nearly half of the sample* (48.4%), had experienced these types of beatings and/or threatening behaviors by caretakers.

One subject refused to answer questions regarding maltreatment during childhood.

Fourteen subjects (21.8% of the sample) also witnessed significant family violence, including the intrafamilial use of punching, kicking, or weapons during arguments.

There were no significant differences between the psychiatric group and the medical group on measures of either abuse ( $X^2(1) = 2.16$ , n.s.) or witnessing family violence ( $X^2(1) = .04$ , n.s.).

Males (i.e., fathers, stepfathers, foster fathers, brothers, uncles, cousins, and mothers' boyfriends) were more often the perpetrators of abuse than were females (i.e., mothers, grandmothers, and aunts). There were 53 male abusers versus 35 female abusers. Although most subjects experienced violence at the hands of both sexes, male perpetrators were consistently more brutal. By roughly a two-to-one ratio, male perpetrators accounted for the kind of maltreatment that landed subjects in the most severe category of abuse ( $\chi^2(1) = 3.90, p. < .05$ ).

### **Sexual Abuse**

A subject was considered to be sexually abused if he engaged in sexual contact of any sort (i.e., digital, oral, anal, genital) prior to the age of fifteen, with a person at least four years older.

Twenty-two subjects, over a third of the sample, reported incidents of sexual abuse during childhood. Psychiatric subjects were somewhat more likely to report episodes meeting the criteria for sexual abuse than were those admitted for medical observation ( $\chi^2(1) = .579, n.s.$ ). Of the twenty-two subjects reporting a history of sexual abuse, twenty had also been physically abused in childhood.

## CHAPTER 15

### DISSOCIATIVE SIGNS, SYMPTOMS, AND EXPERIENCES

- What percentage of jailed offenders has any history of dissociative signs, symptoms, or experiences (i.e., amnesia, depersonalization, derealization, radical identity confusion, or identity alteration?)
- What is the nature of these dissociative episodes?
- Are dissociative signs, symptoms, and experiences found more frequently in offenders referred for psychiatric evaluation than in offenders referred for medical evaluation (a population more representative of the general inmate population)?
- Are dissociative symptoms, signs, and experiences more common in forensic populations than previously thought?

#### **Derealization/Depersonalization**

*Derealization* is an alteration in the perception of one's environment whereby reality seems to have slipped away. Some people may watch the ongoing action as if they were in a movie, others, from out of a fog. Still others describe a sense of almost hyper-realism, where events unfold in slow motion, actions are telegraphed, and movements are choreographed.

Typical states of derealization can include flashbacks, dream states, trances, feelings of unreality, and the inability to recognize familiar people or surroundings. Twenty-seven subjects (42.2% of the sample) experienced serious episodes of derealization by virtue of their intensity, frequency, or duration. Subjects undergoing psychiatric evaluations were significantly more likely to have episodic derealizations than were those admitted for medical evaluations ( $\chi^2(1) = 8.28069$ ,  $p = .004$ ). Indeed, 81.5% (22 of 27) of derealizers were being psychiatrically evaluated.

*Depersonalization* is a loss of contact with one's physical or mental self. Depersonalization encompasses feelings of disconnection from the self or from specific body parts; automatism or dissociated control; strange bodily perceptions; out-of-body experiences; and analgesia for pain.

Twenty-two subjects (34.4% of the sample) experienced serious episodes of depersonalization, either by virtue of their intensity, duration, or frequency. Psychiatric subjects were significantly more likely to experience these episodes than were medical subjects ( $\chi^2=9.104$ ,  $p. = .003$ ).

Nineteen of twenty-two, or 86.4%, of depersonalizers were psychiatrically hospitalized.

### **Losing Time**

*Losing time* was defined as significant episodes of amnesia, experienced when the subject was not under the influence of alcohol or drugs, and where no specific neurological event was cited as the triggering agent. Included were partial or complete amnesias for discrete events (such as not remembering the commission of a crime for which one has been charged); memory problems surrounding important historical information (e.g., not remembering one's date of birth or the names of one's family members), and longer periods of time for which memory is extremely spotty or totally absent (e.g., not remembering any of the sixth grade).

Over half of the subjects interviewed (53.1%) reported memory problems that rated as significant either because of their frequency, their duration, or the gravity of the forgotten event. Psychiatric subjects were significantly more likely to report amnesiac episodes than were medical subjects ( $X^2(1) = 18.07, p. = .0002$ ). Indeed, 85.3% (29 of 34) of subjects experiencing significant time loss were in the psychiatric group.

### Radical Identity Confusion/Identity Alteration

The most extreme form of depersonalization involves confusion over the basic components of one's identity, such as being unsure of one's age, sex, or race. At the greatest level of severity, individuals go beyond confusion to alterations in identity, insisting that they are actually other people.

Fourteen subjects, all of them psychiatric patients, experienced episodes of radical identity confusion. Thus, radical identity confusion was significantly associated with admission status ( $\chi^2(1) = 11.487, p. = 0007$ ).

Eleven subjects (9 psychiatric patients and 2 medical patients) reported episodic alterations in identity.

Of note, one of the medical patients experiencing these alterations had a history of particularly severe neurological trauma. At age five, the subject fell off a carnival ride, breaking his arm and losing consciousness. At age twelve he hit his head and lost consciousness while swimming, requiring stitches. The following year he fell off a horse and again lost consciousness. At sixteen years of age, the subject fell from a fire escape, breaking both legs and an arm, and again losing consciousness. As an adult, he was shot in the head during a gun sale.

The other medical patient experiencing shifts in identity had been previously hospitalized for psychosis, and at the time of the study was taking a number of antianxiety and antipsychotic medications.

## CHAPTER 16

### DISSOCIATION AND PSYCHIATRIC DIAGNOSES

- What percentage of jailed offenders seems likely candidates for a diagnosis of Dissociative Identity Disorder (i.e., apparently meet the diagnostic criteria for Dissociative Identity Disorder as outlined in the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (1994))?
- Are dissociative disorders being correctly diagnosed by mental health professionals working in the jails?
- Are self-administered questionnaires useful in the diagnosis of dissociative disorders in this population?
- What relevant links exist between other mental illnesses and dissociative phenomena?

#### **Prevalence of Dissociative Pathology**

Fourteen patients evidenced at least four of the following dissociative symptoms, signs, or experiences to a pathological degree: depersonalization, derealization, time loss/amnesia<sup>1</sup>, identity confusion, identity alteration. Signs, symptoms, and experiences were considered

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<sup>1</sup> Exclusive of amnesia for the current offense.

pathological when their frequency or severity posed a strong threat to the subject's ability to function normally or caused him to feel a significant degree of pain, fear, anger, sadness, or confusion. An additional seven subjects scored in the midrange for dissociation, having experienced at least three of the above dissociative symptoms, signs, or events to at least a moderately disabling degree; i.e., the subject, or those coming in contact with the subject, had expressed concern about dissociative phenomena.

While this study produced dissociation figures somewhat higher than those noted by Snow, Beckman, & Brack in their 1996 study of jail inmates, I concur with those authors that dissociative experiences are much more common in an inmate population than in the general population (Ross, Joshi & Currie, 1990). Snow and her colleagues found that 24.1% of general population male inmates had elevated dissociation scores, with 15% meeting the criteria for severe dissociation. In this study, 33% of inmates were found to have elevated dissociation scores, while 22% were severely dissociative. Differences between the findings in the two studies are potentially attributable to two factors.

First, Snow and her colleagues relied on the Dissociative Experiences Scale II (Carlson & Putnam, 1993) alone to determine levels of dissociation. The DES II is a self-administered questionnaire which may not elicit the kind of in-depth information that can be gleaned in interviews performed by experienced researchers. My own experience with administering the original version of the DES to members of my sample (n=27) showed results that were more problematic than enlightening. The DES differentially classified four moderately dissociative and four severely dissociative subjects as falling within the normal range. The DES also differentially classified two subjects as severely dissociative and another two as moderately dissociative that I categorized as only mildly dissociative. Further analysis of DES forms filled out by inmates raise suspicions about inmates' ability and motivation to fill out self-administered questionnaires. Many subjects appeared to mark forms (either haphazardly or in some rote way) without really reading the questions, as indicated by a lack of internal constancy on the forms themselves, and scant reliability when the forms were compared with inmates' responses during interviews.

Second, former psychiatric patients appeared in greater numbers in my sample than in the likely population of inmates tested by Snow and her colleagues. Forty inmates in our sample (the thirty nine psychiatrically hospitalized subjects plus one medical admittee who had a previous psychiatric diagnosis), or 62.5% of the sample, had been previously recognized as psychiatrically impaired. Estimates of the proportion of psychiatrically ill inmates in the general jail population from which Snow and her colleagues drew their sample have been put at 16% (Department of Justice, 1996), although this figure likely minimizes the true prevalence of mentally disordered offenders. Thus, the overrepresentation of psychiatrically ill subjects in my sample may explain the percentage differences for dissociative signs, symptoms, and events. As can be seen below, psychiatric status emerged as the single most important brushstroke in the portraiture of dissociation among the incarcerated.

TABLE III.

## DISTRIBUTION OF DISSOCIATIVE SYMPTOMS BY ADMISSION STATUS (n=64)

NUMBER OF SYMPTOMS	PSYCHIATRIC SUBJECTS	MEDICAL SUBJECTS
0	6	17
1	11	5
2	3	1
3	6	1
4	4	1
5	8	1

## Psychiatric Status of Pathologically

## Dissociative Inmates

Thirteen of the fourteen subjects experiencing severe dissociation (92.8%) had previously been recognized as suffering from a psychiatric disorder. Thus, the often-ventured hypothesis that a hidden subset of dissociative offenders lurks undetected in our jails and prisons can be thrown into serious doubt. Although almost always differentially diagnosed, these offenders appear to come to the attention of mental health personnel at some point in their lives.

In line with the current research on the diagnostic profiles of dissociative individuals in the general population (Kluft, 1985; Putnam, 1985), most severely dissociative inmates had a laundry list of previous psychiatric diagnoses. Of the fourteen severely

dissociative subjects, eight (57%) had received at least three previous diagnoses. *Fully half (50%) of severely dissociative subjects had received four or more previous (and divergent) psychiatric diagnoses.* In a more predictive vein, over a third (36.8%) of those receiving four or more diagnoses were classified as severely dissociative. Thus, the number of previous diagnoses that an inmate has received is itself a red flag signaling the importance of screening for a dissociative identity disorder. In the general population, adults with DID may wait as long as 6.8 years for an accurate diagnosis of their condition (Putnam, 1985). Given the lack of psychiatric services for the jail population, the wait for appropriate diagnosis may be infinite.

#### The Diagnostic Profile

##### ***Adjustment Disorder***

In the severely dissociative group, 42.9% were diagnosed with adjustment disorder. Adjustment disorder is characterized by marked distress or a significant impairment in functioning following exposure to an identifiable stressor, within three months of the onset of the stressor, but not persisting for more than six months from the onset of symptoms (American Psychiatric

Association, 1994). Of interest to forensic clinicians is that, at least in this sample, the adjustment disorder diagnosis seems to have far eclipsed diagnoses of antisocial personality disorder among the incarcerated. Only 6.3% of the total sample, and only one of the severely dissociative subjects, received a diagnosis of antisocial personality disorder. Of those who were diagnosed with adjustment disorder, 46.2% were severely dissociative.

### ***Borderline Personality Disorder***

If severely dissociative, you are more likely to have received a diagnosis of borderline personality disorder than if you are not severely dissociative. Three of fourteen severely dissociative patients, or 21%, were classified as borderline compared to only 8% (4 of 50) of those who were not severely dissociative.

This finding was not surprising, given the many similarities between borderline and dissociative patients. Borderline patients suffer a noticeable identity disturbance. Their sense of self seems unstable and their self-image is poor. Under stressful conditions, borderlines are given to narcissistic panic (Kohut, 1971), identity diffusion (Erikson, 1956), affective instability, inappropriate anger, and transient paranoia (American

Psychiatric Association, 1994). Thus, it is quite easy to see how the identity fluctuations in DID might be mistaken for borderline symptoms by the naïve diagnostician who has not before encountered cases of severe dissociation, or by the forensic evaluator who has neither the time nor the resources to employ more sensitive instrumentation.

The most striking difference between the borderline's identity fluctuations and those of the patient with DID lies in the discreteness of the dissociator's alternate identities. While borderline patients may have marked changes in outlook, and may even adamantly deny that they were ever in a different frame of mind, they are not *amnesiac* for their own actions. A borderline's identity is fragile and his mood may rapidly shift, but the borderline patient remains cognizant of his activities while the DID patient does not.

The borderline patient relies on the primitive defensive strategy of *splitting* to deny contradictory images of himself or others. Meissner (1984, p.172) cites Kernberg on the nature of splitting in borderline ego operations:

"splitting" refer[s] only to the active process of keeping apart introjections and identifications of opposite quality...Splitting, then, is a fundamental

cause of ego weakness...a weak ego falls back easily on splitting, and a vicious circle is created by which ego weakness and splitting reinforce each other.

In other words, the borderline personality splits representations of the self and others by engaging in a rapidly shifting series of idealizations and devaluations that forestall the ambivalence that borderlines find intolerable. Like the dissociator, the borderline seems incapable of true autonomy and so is continually engaging in projective and introjective identifications with other people. However, while the borderline is "caught between conflicting identifications" (Meissner, 1984) and so suffers a diminished identity buttressed by artifice, severely dissociative individuals actually reconstitute their partial selves with magically animated false personas who face the world where the lone self cannot<sup>2</sup>.

According to DSM IV, the criteria for a borderline diagnosis may include dissociative symptoms, although these are not the primary diagnostic focus. Dissociation, in borderline diagnoses, is secondary to an array of other symptoms<sup>3</sup> (i.e., terror of abandonment, unstable and intense

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<sup>2</sup>This research suggests that the large number of offenders with elevated dissociation scores who do not fulfill the criteria for DID may indeed be exhibiting a borderline level of dissociative defense.

relationships, unstable self-image, impulsivity, self-harm, reactivity of mood, feelings of emptiness, inappropriate anger, and paranoid ideation). On the other hand, dissociation is the defining feature of DID. The clinical checklist for a diagnosis of Dissociative Identity Disorder includes depersonalizations, derealizations, amnesias, and the presence of at least two distinct identities that recurrently take control of the person's behavior—all dissociative events. Hence, though the misdiagnosis of dissociative identity disorder as borderline personality disorder is understandable, it is by no means unpreventable, as sensitive diagnostic work will ultimately distinguish one from the other.

### ***Epilepsy***

Those patients who were severely dissociative were more likely to have received a previous diagnosis of epilepsy. Two of fourteen, or 14.3%, of severely

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<sup>3</sup>Some researchers have insisted that the DID diagnosis is inclusive of borderline symptoms and that borderline symptoms will disappear when dissociative symptoms are addressed (Ross, 1989). Others have suggested an integrative approach to treatment that recognizes the similarities between the two disorders and simultaneously treats both the underlying trauma that engenders dissociation and the borderline character pathology (Berzoff & Darwin, 1995).

dissociative individuals were diagnosed with epilepsy, versus only one in fifty, or 2%, of those who were not severely dissociative.

The connections between epilepsy and dissociation have been recognized but are not well analyzed. A history of psychogenic seizures, with or without EEG changes, has been noted in individuals with DID (Braun, 1987) but the meaning of this finding remains open to question. Further complicating the picture, dissociative trances may be mistaken for petit mal seizures, thus increasing the likelihood of misdiagnosis (Lewis, 1991).

The number of similarities between epilepsy and DID are striking. Both epilepsy and DID are characterized by deliberate behaviors performed while the actor is apparently not conscious of his deeds. Both neurogenic seizures and personality alterations in DID can be triggered by emotional stress (Williams, 1982, Williams et al, 1987). Temporal lobe epilepsy patients, like DID patients, are often diagnosed with incapacitating psychiatric illnesses and can be prone to aggression and violence (Baer et al, 1984; Lewis et al, 1982; Lewis, 1983).

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Whether the two disorders are concomitant or just mutually obfuscating is yet to be determined. Epilepsy may be a contributing factor in the susceptibility to dissociative states, or the reverse may be true: dissociative states may somehow stimulate seizure activity. Or, perhaps, the inclination to dissociate and the tendency to seize hail from a common neurological ground. Both may involve the overexcitation of brain cells, the warping or cancellation of memories, and the perceptual instability that such neurological activity promotes.

### ***Schizophrenia***

Slightly more than one third (35.7%) of severely dissociative subjects had previously been diagnosed as schizophrenic.

DID and schizophrenia have many features in common. Both the schizophrenic and the dissociator experience a feeling of being controlled by outside forces.

Hallucinations<sup>4</sup> are common to both disorders. Erratic,

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<sup>4</sup> Dissociators experience both auditory and visual hallucinations, whose suggested purpose is to "creat[e] a distance between the self and the source of conflict (Kessler, 1972)." During these hallucinatory experiences, unconscious material may become conscious during an altered state of awareness (Asaad, 1990, pp.35) Rothstein (in Asaad, p.96) speculates that these hallucinations belong to a primitive stage of ego development when "thoughts are equivalent to actual images." People suffering from DID

sometimes violent, behaviors in the dissociator may seem psychotic. Thus, a number of researchers have noted that DID is often misdiagnosed as schizophrenia (Lewis, 1991; Rosenbaum, 1980).

On the other hand, there are a number of characteristics that distinguish schizophrenia from DID. Schizophrenia usually has a prodromal, an active, and a residual phase. The sufferer will generally experience a significant decline in functioning with each cycle. No such decline has been noted in DID patients over the course of their illnesses. Second, affect is skewed in schizophrenia—it may be flattened or inappropriate—while DID patients can be incredibly engaging. Finally, schizophrenic symptoms—especially the “positive” symptoms such as hallucinations

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report hearing the voices of their alternate personalities conversing and see themselves in the mirror with the physical attributes of these alters.

Schizophrenic hallucinations are predominantly auditory, although they may sometimes be visual. Their content is often relevant to a psychodynamic conflict with which the patient struggles. Voices may be perceived as coming from inside or outside the head. They may be quite specific (e.g., the Devil's voice commanding one to do something) or they may be simple and unformed (e.g., hearing snickering or parts of words). The content of schizophrenic hallucinations may be quite bizarre and congruent with delusional materials (e.g., receiving personal messages through the television set).

and delusions—are often responsive to psychotropic medications, whereas no drug has thus far been found to diminish hallucinations and delusions in DID.

Because our severely dissociative subjects could not be followed over a long period of time, it was not possible to conclude with certainty that they were *not* schizophrenic. However, a qualitative analysis of the interviews of severely dissociative inmates suggests that in only three of five cases were certain elements of the psychiatric presentation even somewhat consistent with diagnoses of schizophrenia. In two cases, delusional and hallucinatory experiences seemed more bizarre than the usual form taken in DID, although the subjects did clearly meet the criteria for Dissociative Identity Disorder. In the other case, antipsychotic medication appeared to have had a positive effect on command hallucinations and delusional experiences. Such psychotropic intervention is generally thought to be ineffective in DID, although no truly empirical work had been done in this area. Thus, it appears that while severe dissociative symptoms can and do occur within the context of schizophrenic breaks, it is less clear, given the confines of our study whether (a) the

disorders can coexist or (b) dissociative symptoms are being misdiagnosed as schizophrenic ones.

### ***Depression***

Roughly a fifth (21.4%) of highly dissociative subjects had been considered clinically depressed at some time prior to their current incarceration.

Of note, among the fourteen subjects considered severely dissociative, there had been a total of twenty-three suicide attempts lifetime. Therapists specializing in the treatment of individuals with full blown dissociative disorders have noted that the high suicidality in this group accrues as much from homicide attempts made by certain "personalities" upon other, weaker personalities in the dissociative constellation as it does from periodic episodes of crippling depression (Braun, 1986). Depressive symptoms, both overt and masked, may be understood (Lifton, 1996, p. 181) as a way of structuring traumatic stimuli to diminish their power.

### ***Malingering***

Severely dissociative subjects were more likely to receive a diagnosis of malingering than were subjects in

the mild or moderately dissociative group. Half (50%) of the severely dissociative subjects received this diagnosis, versus only 8% of those who fell on the mild/moderate end of the dissociative continuum.

This finding is not surprising, given the theatrical nature of dissociative symptoms. Claims of amnesia by individuals charged with crimes appear to have an ulterior motive, stories of horrific childhood abuse may seem likewise manufactured, the appearance of alter personalities can strain credulity. At this point, no instrument exists that screens for dissociation and has a malingering detection subscale that can adequately negotiate the murky terrain of fragmented consciousness.

### ***Other Diagnoses***

The single subject carrying a previous diagnosis of Generalized Anxiety Disorder was highly dissociative, as was the one subject who had been diagnosed as having a Narcissistic Personality Disorder.

Two of fourteen severely dissociative subjects had been labeled as suffering from Bipolar Disorder.

Only one of fourteen severely dissociative subjects carried a diagnosis of Antisocial Personality Disorder.

**None** of the severely dissociative subjects had ever received a diagnosis of Dissociative Identity Disorder, Dissociative Fugue, or Dissociative Disorder Not Otherwise Specified.

## CHAPTER 17

### DISSOCIATION AND ABUSE

- Does child abuse engender or exacerbate dissociative symptoms?
- Is the experience of sexual trauma during one's childhood either a sufficient or a necessary condition for the presence of dissociative symptoms?

Of the fourteen severely dissociative subjects in our study, half were both physically and sexually abused. Of these, five were severely physically abused and sexually abused. Two were moderately physically abused and sexually abused. Four were severely physically abused without sexual abuse. One was moderately physically abused without sexual abuse. One subject denied that any type of abuse had taken place, and one subject refused to discuss his childhood.

It is clear that one can endure horrific maltreatment during childhood and still not dissociate to a pathological degree. After all, almost half (48.4%) of the total sample (n=64) reported a history of severe abuse, while fewer than half of these became markedly dissociative. On the other hand, it seems equally clear that severe abuse, especially-

but not exclusively—accompanied by sexual abuse, is a common childhood antecedent of dissociation.

Of equal interest, an additional eighteen abused subjects who did not meet the criteria for severe dissociation reported relying on a variety of dissociative mechanisms during or following episodes of abuse. Although they could not be considered pathologically dissociative, these subjects seemed characteristically prone to continuing to use dissociative strategies as their primary defense against stress in adulthood.

This brings the total number of previously abused subjects employing dissociative defenses on a regular basis to thirty, which constitutes 58.8% of the abused population. It can be inferred from this finding that, even when it does not contribute to DID, child abuse is often the prelude to the adaptive use of dissociation to avoid threats to the self.

## CHAPTER 18

### DISSOCIATION AND AMNESIA FOR CURRENT OFFENSE

- How are claims of amnesia for criminal activity related to dissociative disorders?

Of the total sample of sixty-four offenders, seven subjects claimed amnesia for their current offense and six subjects completely denied having committed the offense with which they were charged.

Of the seven subjects who insisted that they did not remember committing the crime with which they were currently charged, five had a long history of severe dissociation, evidencing at least four of the following symptoms to a pathological degree: depersonalization, derealization, trances/time loss, identity confusion or identity alteration. In other words, *71.4% of offenders claiming amnesia for the current crime were found to be pathological on other measures of dissociation.* Four subjects, or 57.1% of those claiming amnesia for their

current crime, met the criteria for Dissociative Identity Disorder.

Conversely, none of the subjects who claimed outright to be innocent of committing the crime for which they were currently charged had dissociative histories, suggesting that the nature of an inmate's denial should be qualified in order to ascertain its potential relevance to mental disorder.

CHAPTER 19  
DISSOCIATION AND VIOLENCE

- Are there links between severe dissociation in an individual and his level of violence?

There was no indication that being dissociative leads subjects to greater levels of violence than their nondissociative peers ( $X^2(4) = 6.61$ , n.s.). There were violent, and even extremely violent, subjects among those with only mild or moderate symptoms of dissociation.

However, the most severely dissociative subjects usually had a history of violent activity. Only three of the fourteen extremely dissociative subjects had committed nonviolent crimes exclusively. The table on the following page shows the self-reported offense histories of the severely dissociative subjects.

**TABLE IV.**  
**Offense Histories of Severely Dissociative Subjects (n=14)**

Subject 1	Petty Larceny, Burglary, Weapons Possession
Subject 2	Arson, Murder, Aggravated Assault, Prostitution
Subject 3	Drug Possession, Rape, Robbery, Cruelty to animals, Firesetting
Subject 4	Drug Possession, Stolen Property, Assault
Subject 5	Armed Robbery, Kidnapping, Assault, Robbery, Drug Possession, Criminal Trespass
Subject 6	Attempted Matricide, Threatening, Aggravated Assault, Computer Tampering
Subject 7	Drug Possession
Subject 8	Aggravated Assault, Weapons Possession, Cruelty to Animals
Subject 9	Drug Sales, Petty theft
Subject 10	Burglary, Weapons Possession, Disorderly Conduct
Subject 11	Armed Robbery, Robbery, Domestic Assault
Subject 12	Armed Assault, Weapons Possession
Subject 13	Attempted Murder, Aggravated Assault, Armed Robbery, Robbery, Weapons Possession, Drug Possession, Domestic Violence
Subject 14	Assault, Fraud, Grand Larceny,

## CHAPTER 20

### SUMMARY OF QUANTITATIVE FINDINGS

This study both reinforces and magnifies the findings of Marilyn Snow and her colleagues (1997) in suggesting that dissociation is the defense mechanism of choice for a large segment of jail inmates.

#### **Prevalence of Pathological Dissociation**

Twenty subjects (31.2% of the total sample, n=64) employed dissociation as part of their defensive repertoire, at least occasionally. This is not out of line with estimates regarding the use of a benign spectrum of dissociative defenses in the general population (Ross, Joshi and Currie, 1990). As this relatively mild degree of dissociation does not appear to inhibit function in any significant way, it was not considered pathological.

Roughly one third (33%) of subjects had elevated dissociation scores (i.e., chronically used at least three of five dissociative strategies to deflect anxiety). Of

these, seven subjects were considered moderately dissociative. Rephrased with McWilliam's (1994) theoretical construct in mind, these subjects exhibited a *borderline* level of dissociative functioning.

**For a full 22% of the sample (14 subjects) dissociation was clearly the primary coping strategy.** For this group of subjects, dissociation either dominated the psychic terrain or was an exclusive resort. These pathologically dissociative individuals relied regularly on at least four of the five dissociative maneuvers investigated (derealization, depersonalization, time loss, identity confusion or identity alteration). **Eleven subjects (14% of the sample) met the criteria for Dissociative Identity Disorder as defined in DSM IV.**

#### **Dissociation and Psychiatric Status**

Eighty-two percent of psychiatric subjects (n=39) had dissociated at one time or another, as had 36% of those in the medical group (n=25). It is not surprising that mentally ill inmates felt a greater need to rely on myriad psychological tactics, including dissociation, than did their counterparts in the medical group. Although all inmates encounter specific, legitimate threats from without

and endure great stress, the mentally ill inmate is also plagued by a significant degree of internal threat that must be addressed defensively. However, as stated above, this mild degree of dissociation is not, in and of itself, considered pathological.

**The overwhelming majority (92.8%) of severely dissociative subjects had previously been diagnosed as mentally ill.** Eighty-six percent of those with elevated scores (three persistently dissociative adaptations) carried a previous psychiatric diagnosis. Thus, the idea that there lurks a *hidden* group of dissociators among jail inmates, a thesis often floated in the literature (Carlson, 1993), is thrown into serious doubt. These patients are highly visible. In fact, in a stepwise regression, a history of previous psychiatric diagnoses was the only variable significantly associated with the severity of dissociative symptoms ( $R = .36$ ,  $F(1,57) = 8.35$ ,  $p = .005$ ). **However, sadly, these men are not recognized as dissociators, but are instead chronically misdiagnosed.**

These dissociative inmates, like their counterparts in the outside world, display such a confusing concurrence of symptoms that each intervening diagnostician interprets their presentation differently. Thus, 57% of severely

dissociative patients had at least three previous, divergent diagnoses. **Half of severely dissociative subjects had at least four previous divergent diagnoses.**

**No subjects in this study had previously been diagnosed as suffering from a dissociative illness.** Highly dissociative subjects were likely to be labeled borderline, schizophrenic, and malingerer. Severe dissociators were more likely to carry a concurrent diagnosis of epilepsy than were their nondissociating counterparts on the psychiatric ward. Dissociative individuals were often depressed and suicidal. (See Chapter 16 for a detailed discussion of alternate diagnoses.) As the study did not track inmates over a long period of time, it is difficult to say with certainty whether the diagnosis of dissociative illness would, over the long run, have proven to be the dominant diagnostic label; merely a concurrent diagnosis; or may itself have been ill-conceived.

### **Dissociation and Child Abuse**

Eighty percent of the men in this sample were physically abused during childhood, almost half (48.4%) severely so. A fifth of the sample (21.8%) witnessed significant family violence. Over a third (34.3%) of the

men were sexually abused. Well over half (58%) of the abused group relied at least moderately on dissociation to distance themselves from perceived threat. **The frequency of resort to the dissociative defenses in this group suggests that dissociation is a common defense mechanism among abuse survivors, even when not used exclusively or pathologically.**

Severe abuse, even when coupled with sexual abuse, did not always presage a dissociative outcome. However, inmates with elevated dissociation scores were much more likely to have endured both physical and sexual abuse during childhood than were those who were only mildly dissociative or not dissociative at all. Of those with elevated dissociation scores—chronic use of three or more dissociative symptoms—47.6% had been physically and sexually abused, while among those without elevated scores only 23.2% had endured both physical and sexual assault). Exactly half of the severely dissociative subjects had been both physically and sexually abused.

### **Dissociation and Violence**

Dissociators were no more likely to be violent than their nondissociative counterparts. However, the majority of the

severely dissociative subjects had long histories of violent activity, often committed in dissociative states.

#### **Dissociation and Amnesia for Current Offense**

Many subjects in this dissociative group were amnesiac for the crime with which they were currently charged. **Seventy-one percent of offenders claiming amnesia for their current crime were found to be pathological on other measures of dissociation.** Four subjects claiming amnesia for the current crime met the criteria for Dissociative Identity Disorder.

Conversely, none of the subjects who claimed outright to be innocent of committing the crime for which they were currently charged had dissociative histories, suggesting that the nature of an inmate's denial of criminal activity should be qualified in order to ascertain its potential relevance to mental disorder.

#### **Statistical Regression**

A statistical regression, using the backward removal method, was performed in order to find the most parsimonious model to explain the severity of dissociation. The following variables explained 46% of the variance ( $r = .459$ ) in dissociative severity: claiming amnesia for the

current crime, number of previous psychiatric diagnoses, presence of hallucinations, severity of abuse, and not having been diagnosed with borderline personality disorder (BPD).<sup>1</sup> These factors were significantly associated with dissociative severity ( $R^2 = .68$ ,  $F(5,53) = 9.00$ ,  $p. < .001$ ).

This model suggests that **offenders presenting with a complex of factors that include claims of amnesia, a long list of previous differential diagnoses that may include a diagnosis of BPD, the presence of hallucinations, and a history of severe abuse during childhood—especially when coupled with sexual abuse—should be screened for the possible presence of a dissociative disorder.**

Unfortunately, the data were not sufficient to draw a conclusive picture of the relative contributions of

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<sup>1</sup>The fact that a diagnosis of Borderline Personality Disorder (BPD) correlates *negatively* with the severity of dissociation should not be interpreted as implying that such a diagnosis (or misdiagnosis) is has no theoretical significance. BPD was much more often diagnosed in severely dissociative subjects than in their less dissociative counterparts (21% of highly dissociative subjects versus 8% of not severely dissociative subjects). However, since nearly 80% of severely dissociative subjects had not received BPD as a previous diagnosis, the statistical association occurred in a negative direction. (See Chapter 15 for a full review of this issue.) Of note, this research suggests that it is likely that *both* DID and a borderline (i.e., nonpsychotic) variant of dissociative disorder are underdiagnosed in the offender population.

neuropathology, drug use, and other types of trauma to dissociative outcome. In this population, factors such as perinatal trauma, early head injury, addiction, and youthful encounters with death, disease, and separation were so common that it was impossible to distinguish the possible influences of each on present day psychopathology.

PART IV  
DISCUSSION AND CONCLUSION

## CHAPTER 21

### SUMMARY AND DISCUSSION

Pierre Janet offered dissociation theory as an explication of the apparent glitches in memory that occurred in the aftermath of trauma. The theory suggests that trauma, because it poses such an overpowering threat to the ego, cannot be assimilated in a normal fashion. Threatening material is instead walled off, encapsulated in a different part of consciousness, so that its awesome power is diminished. Dissociation, then, is the mind's way of organizing and disarming information that does not fit into existing cognitive schemas. Janet believed that the products of this secondary consciousness constituted a "successive existence" for the dissociator—a separate personality who operated outside the volitional control of the traumatized individual.

Over the last decade, as research into the consequences of child maltreatment has increased, Janet's model has been resurrected to explain some of the transmogrifying effects of abuse. This dissertation applies an updated version of Janet's theory

to a group of men known both for their traumatic histories and their apparent lack of behavioral control. The men were inmates at two New York City jails in the early 1990s. They were interviewed at Bellevue Hospital, where they had been transferred for medical or psychiatric evaluation.

The findings of this study suggest that, indeed, brutal, chronic physical abuse—especially when accompanied by sexual molestation—often presages a dissociative retreat for those who are victimized. Well over half (58.8%) of the men who were abused in childhood employed dissociative strategies to cope with their trauma. These men distanced themselves from abuse by depersonalizing or derealizing the experiences, or by simply forgetting key components of early traumatizing events.

In addition, a significant portion (22%) of formerly abused inmates relied on dissociative defenses to a pathological degree. These men dissociated not only perverse episodes from childhood but also onerous events in their ongoing lives. Often, the memories of these incidents could only be accessed through the voices of subnarrators—deadened, split off parts of the self that the psyche had magically reanimated to deal with threatening material. Most important, nearly three-quarters of the men (71.4%)

who were classified as severely dissociative had no memory of the crimes for which they were incarcerated. While not every violent inmate was pathologically dissociative, the majority of dissociative subjects had long histories of violent offending, often committed in dissociative states.

Inmates hospitalized for psychiatric evaluation or intervention were far more likely to have dissociative histories than were those being evaluated for medical conditions. Almost all of the severely dissociative subjects (92.8%) had come to the hospital because of florid signs of mental illness. They were not "hidden" from the view of criminal justice personnel in the sense that Ralph Allison and others had assumed. As this study predicted, their psychological maladies were quite visible.

However, as this study hypothesized, dissociative symptoms in this group were often overlooked, misconstrued, or disbelieved. Dissociative inmates fit the usual diagnostic profile accorded dissociative individuals in clinical settings—numerous, conflicting diagnoses over the course of a lengthy history of psychiatric evaluation. None of the severely dissociative inmates in this sample had ever been diagnosed with a dissociative disorder.

It was beyond the scope of this investigation to conclusively determine whether, in individual instances, dissociative diagnoses should be considered superordinate to other diagnostic categories. I inferred, on the basis of available information, that in several instances it seemed highly likely that further evaluation would produce a primary diagnosis of dissociative disorder while in other cases it appeared that dissociative events were secondary to schizophrenic process. In addition, the differential diagnosis of borderline syndrome proved a close call and, absent the opportunity to follow subjects over a long period of time, could not be appropriately evaluated<sup>1</sup>.

Finally, there is a strong possibility that, at least in some cases, dissociative disorders are comorbid with other disorders. This is especially important to bear in mind when confronted with the controversy that often surrounds dissociative diagnoses. Psychiatrist Maeve

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<sup>1</sup>The two diagnoses, Dissociative Identity Disorder and Borderline personality Disorder, are often so similar in presentation that Judith Herman has proposed both as variants of hysteria. Because hysteria likely has traumatic origins, Herman suggests subsuming both DID and BPD under a new diagnostic entity: Complex Posttraumatic Stress Disorder.

Lawler-Fahy (1992) writes in the British Journal of Psychiatry:

Why can psychiatrists not recognize that just because somebody has a certain diagnosis, this does not preclude that the patient cannot have other illnesses concurrent with their primary diagnosis. Instead of arguing over the existence of multiple personality disorder or dissociation, we should recognize that dissociation exists in different degrees and continue to treat the victim, who is traumatized, rather than leave him or her without treatment while we argue over the validity of the diagnosis.

Clearly, there is no reason not to treat schizophrenic, bipolar, or depressive symptoms appropriately, even when dissociative symptoms overshadow them<sup>2</sup>. Moreover, it makes good sense to pay particular attention to dissociative co-morbidity when hallucinations, delusions, mood swings and suicidality seem intractable, as the dynamic treatment of underlying trauma may facilitate psychopharmacological interventions.

I had hoped to present a statistically robust

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<sup>2</sup>Several antidepressants, most notably Zoloft, have already been shown to be effective in the treatment of Posttraumatic Stress Disorder. If DID and PTSD have common physiological—as well as psychological—profiles, we may find that both can be treated effectively with serotonin reuptake inhibitors.

etiological model for the development of dissociative pathology. Unfortunately, the data gathered by this study were not sufficient to draw a conclusive picture of the relative contributions of neuropathology, drug use, and other types of trauma and mental illness to dissociative outcome. In this population, factors like perinatal trauma, early head injury, social instability, addiction, and youthful encounters with death, disease, and separation were so common that it was impossible to distinguish the relative influences of each on present day psychopathology. This is a potent area for further investigation.

### **Practical Implications**

The etiology and diagnosis of dissociation have been discussed at length here because of the tremendous bearing they may have on offender disposition. While the courts have largely dismissed the idea that dissociative disorders so violate the necessary conditions for consciousness and volition that mens ra cannot exist, forensic clinicians and researchers should continue to investigate the extent to which dissociation might bear on issues of competency or provide mitigation of criminal responsibility. In the current climate of skepticism that surrounds the diagnosis

of dissociative disorders, and the child abuse that apparently antedates them, it is perhaps difficult to make accurate assessments of offenders who present with dissociative signs and symptoms. Clinicians must try to make their evaluations independent of the fear of potential controversies. Dissociative disorders ideally should not be held to a different standard of credibility than other mental illnesses. Forensic researchers and clinicians should work toward the refinement of evaluative instruments that can detect dissociative symptoms, differentiate dissociative disorders from other mental illnesses, and screen for malingered symptoms. Clearer diagnostic guidelines will hopefully temper the controversies that dissociative diagnoses currently invite.

Dissociative symptoms occur on a continuum, much like paranoia or depression. Dissociation, as a character pathology, can constitute a mildly neurotic adaptation or a borderline level dysfunction. Dissociative patients may have psychotic features. In some cases, dissociative episodes may give rise to criminal or violent behavior. When they do, dissociation should be considered potentially mitigating, as any other episode of mental illness would be.

At the present time, there is no reason to doubt that the courts have evaluated individual dissociative claims on their merits. The problem occurs somewhat earlier in the process, when forensic clinicians miss or disbelieve dissociative signs and symptoms, and thus never provide defense attorneys with evaluations that suggest the salience of dissociation to the commission of the offenses charged. A reliable interview protocol, like the SCID-D (Steinberg, 1993) or the dissociative schedule of the JJAI (Lewis, 1992) should be added to the battery of regularly administered psychiatric screening instruments used by forensic clinicians.

This research also suggests that dissociative symptoms are evident at a very young age. Pathologically dissociative men in this study usually pinpointed nascent dissociation between the ages of seven and ten years. Since many of these men had peculiar difficulties in school (e.g., being accused of spacing out, forgetting material that they had previously mastered, being blamed for conduct that they didn't remember performing) it is likely that they were exhibiting signs of, as well as experiencing symptoms of dissociation early in life. If this is the case, early screening for dissociative disorders would be a

useful tool for school psychologists, and other clinicians working with troubled youngsters, particularly in cases where histories of abuse have been documented.

Finally, this study offered some interesting insights into the way in which incarcerated men perceive and process the abuse that they have endured, regardless of their dissociative status. In the course of our interviews, many inmates were reluctant to discuss even horrifying episodes of abuse in pejorative terms. Male inmates in this sample largely communicated that childhood beatings were both necessary and just. Similarly, inmates' experiences of sexual molestation, particularly when the perpetrator was female, were likely to be displayed as badges of manhood rather than be articulated as traumatizing encounters. This denial in the service of protecting the ego only encourages the further derealization of abusive encounters and potentially fuels unconscious acts of retribution toward innocent surrogates. Although the experience of child maltreatment was common among inmates (80% of the men had been abused and 48.4% had endured severe abuse), most men said that they had never been questioned at length about abuse and related traumas prior to this study. Hence, an important intervention may be in the area of offering

support—perhaps even support groups—for inmates, to help them both reconstruct and appropriately process their childhood experiences.

### Theoretical Implications

Many theorists, Pierre Janet foremost amongst them, have attempted to cogently explicate the divided self. Elaborating Freudian paradigms, early ego and object relations theorists (A. Freud, 1936; Hartmann, 1939; Klein 1952; Sullivan, 1956; Laing, 1959, M. Balint, 1968; E. Balint, 1963) concentrated on the notion of defensive splitting. Robert Jay Lifton (1996, p.420) deviated more radically from Freud, rejecting the idea of a split and polarized self. Instead, Lifton's theory of doubling has called attention to opposing or shadow selves that may become dangerously unrestrained. Most recently, neo-dissociationists (Kluft, 1985; Putnam, 1985; Herman, 1992; Gelinas, 1995) have embraced a trauma model, not unlike Janet's, to explain the alterations in consciousness that plague dissociative patients. Others, like Cornelia Wilbur, Sybil's<sup>3</sup> psychiatrist; and Leonard Shengold (1989) have

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<sup>3</sup>"Sybil" is the pseudonym of perhaps the world's most famous case of multiple personality. The book about her analysis (Screiber, 1974) has been both hailed and decried

combined traditional psychoanalytic theory and newer trauma models to explain their patients' dissociative symptoms.

The data from this study both confirm and expand existing theory. The findings suggest that the wall separating traumatic memory from consciousness, although more porous than Janet assumed, does exist for people who have been brutally and chronically abused. Since the majority of dissociative subjects in this study had additional psychiatric symptoms, I speculate that the presence of a mental illness—or the early predisposition toward one—may make one more likely to dissociate when confronting trauma. The findings also support the idea that dissociative splitting can engender discrete self-representations, or embodied narratives, that act with varying degrees of volitional control. These narratives, as has been observed by others (Barrett, 1994; Dell and Eisenhower, 1990) fall into stereotypical—or even archetypal—categories: babies; deities; protectors; avengers; sleepers. In this study, narratives took three main forms: they told the story of the person whose soul

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for triggering the steep rise in diagnoses of dissociative disorders over the last twenty-five years.

was lost to abuse (petrification), the story of the person whose job it was to avenge abuse (putrefaction), and the story of the person who needed to make amends for having been victimized or having retaliated for victimization (purification).

Theoretically, inadequate attention has been paid to the dissociative pathway from abuse to violence. Those who have written about dissociation and aggression have relied primarily on themes of identification with, or introjection of, the abuser. These explanations seem inadequate to explain the centrality and pervasiveness of violent themes in the lives of the men I interviewed. I believe that theory in this area could be expanded in two directions: (1) to encompass a greater understanding of the pivotal role of guilt, both as a response to being abused, and as an accelerant for violent behavior and (2) to reconceptualize aggression as a life force gone awry in the service of reanimating a deadened self.

Most traumatic experiences provoke both shame and guilt in the victim. The dynamics of guilt and shame have been discussed extensively in relationship to combat veterans, concentration camp prisoners, and those who live through natural and man-made disasters (Lindemann, 1944;

Kardiner, 1947; Lifton, 1968; Van der Kolk, et al, 1996). More recently, the twin concepts of guilt and shame have been used to explain the defensive adaptations of incest survivors (Grand, 1997; Shengold, 1989; 1999). But guilt and shame may belong as much to those who are beaten as to those who are raped. The men in this study endured both types of assault.

Responses to physical and sexual abuse may be more alike than we realize. Not only are both situations profoundly frightening and disempowering for the victim, they are both intensely stimulating<sup>4</sup>. So stimulating, as we have seen, that the child must dissociate his core self from what is happening to the body. The men who described "disappearing" during abuse were probably articulating a two-pronged response to trauma. First, they were expressing their feeling of invisibility when caretakers refused to "see" the real them and, instead, saw only a body to hurt.

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<sup>4</sup>Freud discussed the intimacy of physical battery and the sexualization of remembered beatings in his 1919 paper on the genesis of sadomasochism, *A child is being beaten*.

Second, they were verbalizing the safety inherent in having your essence, or real self, retreat. If you disappear, only your body can be robbed and maimed.<sup>5</sup>

In this splitting, the body is objectified and despised for being party to the abuse. The core self feels shame for allowing the violation, and guilt for the murderous rage he feels toward the abusive caretaker.

The abusive interaction provokes intense anxiety: anxiety over one's own sadism and the imagined retaliation of the object of one's sadism. As Melanie Klein has noted, in this malevolent interaction, violence is the only cathartic; "violence liberates anxiety" (Klein, 1952, p. 260). Moreover, since murdering the other and killing the self are synonymous, the killing takes care of guilt. Klein writes:

Love is not absent in the criminal, but it is hidden and buried ... the criminal is now in the position of hating and persecuting his own loved object; as this is an intolerable position, all memory and consciousness of any love for any object must be suppressed. If there is nothing in the world but enemies, and that is how the criminal feels, his hate and destructiveness are, in his view, to a great

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<sup>5</sup>See also Balint, 1963 and Laing, 1959 on distortion of body image as a defense against disordered or incomplete parenting.

extent justified—an attitude which relieves some of his unconscious feelings of guilt. Hate is often used as the most effective cover for love; but one must not forget that to the person who is under the continuous stress of persecution, the safety of his ego is the first and only consideration.

The men in this study seemingly protected their egos with preemptive strikes against parental surrogates. Their violence, often without apparent motive, forgotten even as it was committed, seems to me evidence of the kind of primitive, dissociated sadism that Klein so well describes.

Lifton (1996) tells of a patient who fantasized murdering her parents because "they are creating all the evil in the world". The patient, in a classic double bind, felt that, if she didn't murder her parents she would bear the guilt for the world's suffering but if she did kill them, well, she would be guilty of murder. She felt guilty just thinking of this because she still loved them. Lifton (p. 152) writes:

[...]her false mission had to do with overcoming what is perceived as deadly evil, an effort at purification that would help to overcome one's own evil or guilt.

Lifton's patient developed a delusion of Godliness, much as so many of the subjects in this study created

reparative narratives to negate their own guilt over having been victims and victimizers. They created healers where none had been; they attempted to resurrect their own souls, murdered during abusive experiences. They acted violently to end the abuse against them and the guilt it engendered; they undid violence with deft deifications of the self. In both regards, they revitalized the murdered part of the self; they strained toward life, connection, and movement—albeit in a perverse—and sometimes even deadly—way.

## CHAPTER 22

### CONCLUSION: WEATHERING CONTROVERSY

It has become de rigueur in clinical and legal circles to question the "reality" of dissociative disorders (Mersky, 1995). It is a strange fence to perch upon: many who long ago gave up questioning the validity of that anchor of psychological constructs, the unconscious, feel obliged to debunk theoretical proposals regarding the fragmenting effect of trauma on the psyche. Yet, the evidence for such effects is plentiful.

It is not surprising that denial seems to follow most investigations of early trauma and their sequelae. Kempe (1962), Gelinias (1995), and Masson (1984;1986) have documented the long history of motivated ignorance of child maltreatment in order to preserve the psychological comfort, and the legal power, of adults. In the courtroom, the current zero tolerance attitude toward criminals encourages the notion that assertions of past abuse are merely excuses for volitional behaviors. In the examining room, there is often a jaundiced eye cast upon

the claims of mental illness proffered by offenders. When these dual suspicions are wed, dissociative defendants may receive a less than fair hearing at the bar of justice.

While reviewing the interviews of the severely dissociative men who participated in this study, I was struck not by the supposedly theatrical nature of Dissociative Identity Disorder (in fact, I found dissociation no more or less dramatic than other florid signs of mental disorder) but by the men's bewildered resignation regarding their own criminal activities. It was as if the central lesson of their early abuse was that things happen to people for no discernable reason. Put up. Shut up. The violence done to you is the evidence of your own guilt.

An accumulation of emotionally wrenching data over the past decade suggests that the physical and sexual abuse of children is widespread. Many of these abused children end up wreaking havoc on society, often in the form of law violation. My own research suggests that criminal acts are often performed in dissociated states. Why, then, is criminality the final frontier of the trauma/dissociation paradigm? Criminals who dissociate, because of their direct effect upon us, should be studied, understood, and treated.

Simply choosing not to believe in their past trauma or their dissociation won't make either go away. In the words of Charcot: La Theorie c'est bon, mais ca n'empeche pas d'exister. Theory is fine, but it doesn't stop facts from existing.

I trust that this work has added in some small way to the understanding of abuse, mental illness, and violence. I hope that it kindles the interest of other researchers, with greater resources and expertise, to commence a similar study of dissociation and crime, on a much grander scale.

## APPENDIX A

### JUVENILE JUSTICE ASSESSMENT INSTRUMENT (J.J.A.I.)

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New York, N.Y. 10016

Bellevue Prison Ward Study 1992-1993

#### RECORDING RESPONSES TO THE J.J.A.I.

**Each question must be followed by at least one written sentence. Responses should also be coded in the box to the right of the questions. Writing responses verbatim is very important. First, what is written verbatim should justify your coding. Second, verbatim responses allow others to code the responses independently. Third, and most important, others assessing the subject will be able to make use of the subject's verbatim responses in order to understand him/her better.**

#### CODING RESPONSES TO THE J.J.A.I.

The coding scheme used to code responses can be found to the right of questions. The most common scheme used is 0 = no, 1 = yes. However, other schemes are occasionally used and are clearly marked. For any question, if the subject does not know the answer, code '' (this means missing data); if the question does not apply to the subject, code '9' (this means not applicable).

#### NOTING OBSERVATIONS

Use the left margin to make notes about the subject's behavior during the interview. It is important to note whether the subject seems to be behaving out of the ordinary, e.g. s/he seems unduly uncomfortable answering a question, seems to be lying, acting inappropriately, etc. so that others reading through the interview will be able to better understand the subject's responses.

**DEMOGRAPHIC INFORMATION**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_ Age \_\_\_\_\_  
Sex \_\_\_\_\_  
Race \_\_\_\_\_

Mother's Name \_\_\_\_\_ Mother's Age \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

Fathers Name \_\_\_\_\_ Father's Age \_\_\_\_\_  
Step Mother's Name \_\_\_\_\_ Step Mother's Age \_\_\_\_\_  
Step Father's Name \_\_\_\_\_ Step Father's Age \_\_\_\_\_

Siblings (Sex/Age/Name) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Marital Status \_\_\_\_\_  
Spouse/companion (Sex/Age/Name) \_\_\_\_\_

Interviewer's Name \_\_\_\_\_ Date of Interview \_\_\_\_\_  
Discipline \_\_\_\_\_ Interviewed at \_\_\_\_\_

**GENERAL QUESTIONS REGARDING OFFENSES**

The interviewer should ask any questions he/she feels are relevant regarding the subject's history of criminality. These questions should include the following topics:

1. What happened that brought you to Bellevue?  
(Describe)

suicide attempt |  
psychotic episode |  
med. stabilization |  
psych. evaluation |

a. To Riker's/jail?

Nature of current offense:  
robbery |  
burglary/larceny |  
murder |  
sex offense |  
kidnapping |  
weapons possession |  
drug possession/  
dealing |  
other |  
0 = no  
1 = yes

b. Do you remember everything that happened?  
(Describe)

c. Were drugs or alcohol involved?  
(What kind? How did it effect the subject?)

d. When else has something like that happened?  
(Describe)

e. What do you think caused you to get in trouble?

**QUESTIONS REGARDING A VIOLENT ACT**

If an offense was violent or potentially dangerous (for example, if someone was shot, knifed, or badly injured), in addition to asking general questions regarding the offense, the following questions should be asked:

2. Before it happened, could you tell it was going to happen? How could you tell?  
(Describe)

Subject could tell \_\_\_\_\_  
in advance  
Subject felt queasy, \_\_\_\_\_  
headachy, sweaty, etc.  
Subject felt threatened \_\_\_\_\_  
(e.g. "He looked at me  
funny.")  
0 = no  
1 = yes

a. While it was happening, could you have stopped on your own or would someone have had to stop you?  
(Describe)

Subject needed to be stopped/pulled off \_\_\_\_\_

0 = no  
1 = yes

b. How about afterwards? How did you feel?  
(Was subject remorseful...justified...bland/uncaring?)  
  
How about sleepy or dizzy?

Subject felt: \_\_\_\_\_

0 = unclear  
1 = remorseful  
2 = unfeeling  
3 = justified  
4 = other

LIVING ARRANGEMENTS

3. Who do you live with now (on the outside)?

4. When you were growing up, did you ever lived outside your home?  
(Probe for why the subject lived away from home, the age at time of placement, duration of placement, and why s/he left. Specifically ask:)

a. A foster home?

Number of placements in foster care \_\_\_\_\_

b. With relatives or friends of the family?

Number of placements with relatives/friends \_\_\_\_\_

c. A group home?

Number of placements  
in group homes —

d. Residential treatment center or hospital?

Number of placements in  
residential treatment —

e. Detention or correctional facility?

Number of incarcerations —

**WORK HISTORY**

**SAY: I'd like to ask you some questions about your work history.**

**5. What kinds of jobs have you had?**

a. **What is the longest job you held and how long did it last?**

b. **Were you ever fired from a job?**

6. **Have your bosses or coworkers ever complained that you were told to do something and you didn't do it? (Describe)**

7. Were you ever blamed for things and you could swear you hadn't done them?  
(Describe)

8. Have your bosses or coworkers ever said that you seemed like 2 different people?  
(Describe)

**SCHOOL HISTORY**

**SAY:** Now I'd like to talk with you about your school history.

9. How far did you go in school?

Last grade completed \_\_\_\_\_

10. What sorts of problems did you have in school?

Subject had:  
academic difficulties \_\_\_\_\_  
behavior problems \_\_\_\_\_

a. Were you ever in special ed or homebound instruction?  
(Describe)

b. Did you ever have to repeat a grade?  
(Describe)

Number grades repeated \_\_\_\_\_

11. Were you ever called hyperactive?  
(Describe)
12. Did you ever take medication to help you concentrate or sit still?  
(Describe)
13. Did you ever have trouble daydreaming or spacing out in school?  
(Describe)
14. Did you ever seem to miss what a teacher was saying?  
(Describe)
15. Have you ever come to class or taken a test you knew you had studied for, but it seemed as if you had never seen the material before?
16. Have you ever had the experience of suddenly being unable to do something that you could always do?
17. Is your handwriting always the same?  
(Describe)

- a. How do you sign your name?
  - b. Do you ever sign it differently?
  - c. Do you ever use a different name?
  - d. Do you have any tags or aliases or nicknames?  
(Have person write all names)
  - e. Have people ever called you by names that you did not recognize?
18. Has anyone ever said you seemed like a different person?  
(Describe...more sexy?...more aggressive?...more like a baby?)
19. Have you ever been told that your voice sometimes sounds different?  
(Describe)
20. Has anyone ever said that you seemed possessed?  
(Describe)

a. Have you ever felt that way?

21. Have you ever felt like 2 different people?  
(Describe)

TEMPER AND HISTORY OF FIGHTS

22. Tell me about your temper.

a. When you get mad, do you ever break things  
or punch walls?  
(Describe)

b. How do fights start? ...Do you ever start them?

c. Whose fault it is usually?

d. Are they shouting fights or fist fights?

Frequently loses temper —  
Verbal aggression —  
Physical aggression against objects —  
Physical aggression against people —  
0 = no  
1 = yes

Subject usually starts —  
1 = yes  
0 = no  
Others usually start —  
0 = no  
1 = yes

Subject usually gets into fist fights —  
0 = no  
1 = yes

23. What's the worst that's ever happened to you in a fight?  
(Describe)

a. Have you ever been knocked out or knocked dizzy? (When else?)  
(Determine when and for how long. Also ask whether subject received treatment)

Number of times subject has lost consciousness

—

Number of times subject has been knocked dizzy

—

24. What's the worst you've ever done to someone else?  
(Describe)

Subject has seriously injured person in fight  
0 = no  
1 = yes

—

25. When you and your spouse/companion get into an argument, what happens?

a. Have you ever lost your control and gone further than you meant to?  
(Describe)

b. How about \_\_\_\_\_? Has s/he ever lost his/her cool and gone further than s/he meant to?  
(Describe)

c. Has your spouse/companion ever accused you of saying or doing something and you could swear you hadn't said/done it?  
(Describe)

26. Can you tell in advance when you're going to get into a fight?  
(Describe)

Subject can tell in advance \_\_\_\_\_  
Subject feels threatened \_\_\_\_\_  
0 = no  
1 = yes

27. When you get into a fight, can you always stop if you want or do you need to be pulled away?  
(Describe)

Subject needs to be stopped/pulled off \_\_\_\_\_  
0 = no  
1 = yes

28. After a fight, how do you feel?

Subject feels: \_\_\_\_\_  
0 = unclear  
1 = remorseful  
2 = unfeeling  
3 = justified/victim deserved it  
4 = other

a. Do you ever feel sleepy or sick or  
dissy or shaky? How about sleepy?  
(Describe)

Subject has physical —  
symptoms  
0 = no  
1 = yes

29. After a fight, do you always remember  
everything that happened?  
(If the subject has no memory, or an impaired  
memory for the act: When else has that happened?)

Impaired memory for —  
fights  
0 = no  
1 = maybe  
2 = yes

30. Have you ever gone further than you meant to or  
found out you hurt someone more than you thought you had?  
(Describe)

31. Have you ever set a fire to anything?  
(Describe...When else?)

32. A lot of kids think it's fun to tease animals.  
As you were growing up, did you or your friends  
ever tease or hurt an animal?  
(Describe)

**WEAPONS USE**

33. When you feel that you need to protect yourself, what do you carry?

a. Have you ever carried a knife? A gun? Anything else?  
 (Determine when and why weapons are carried, and how often. Also, get a description of the knife, gun, or other weapon)

Has carried gun  
 Has carried knife  
 Has carried other weapon  
 0 - no  
 1 - yes

—  
 —  
 —

b. Have you ever felt that you had to use the \_\_\_\_\_ (gun/knife/other)?  
 (Get circumstances under which all weapons mentioned have been used)

Has used gun to threaten  
 Has used knife to threaten  
 Has used other weapon to threaten  
 Has shot gun  
 Has cut person  
 Has hurt person with other weapon  
 0 - no  
 1 - yes

—  
 —  
 —  
 —  
 —  
 —

**OVERSUSPICIOUSNESS**

**34. Can you tell how people feel about you? How can you tell?  
(If the subject tells of knowing when people don't like him/her, try to get several examples of when this happens)**

Subject knows when \_\_\_\_\_  
others don't like  
him/her  
Others look at subject \_\_\_\_\_  
in a funny way, or  
stand in a funny way  
0 = no  
1 = yes

**a. Do people talk about you behind your back?**

Subject feels others \_\_\_\_\_  
talk about him/her  
0 = no  
1 = yes

**How can you tell?**

**b. Have you ever had the experience of thinking that people called you a bad name behind your back or said something bad about your mother, and you turned around angry, but they said they didn't say anything?  
(Obtain examples of when this has happened)**

Subject has \_\_\_\_\_  
misperceived or imagined  
threats  
0 = no  
1 = maybe  
2 = yes

These misperceptions  
have caused fights  
0 = no  
1 = yes

c. Have you ever gotten into a fight because of it?  
(Describe)

**MEMORY**

35. How is your memory?

a. How far back can you remember things in your life?

b. What is your earliest memory from childhood?

Impaired memory for  
nonviolent acts without  
alcohol or drugs  
0 = no  
1 = yes

36. Have you ever been told that you said or did something and you could swear that you hadn't done it?  
(Obtain examples of when these types of incidents have occurred. Clarify whether these memory problems were a result of alcohol and/or drugs use, or whether they happened when the subject was "straight")

Impaired memory for  
aggressive acts without  
alcohol or drugs  
0 = no  
1 = yes

a. Have you ever cursed at someone or thrown something or hit someone and you could swear you hadn't done it?  
(Describe)

37. Have you ever lost track of hours or even days and you don't know what happened?

a. Have there been important events in your life that you just cannot remember?

38. Have you ever found yourself someplace and you don't know how you got there?

39. Have you ever been blamed for something or called a liar or a thief and you were sure you didn't say or do what you were accused of?

40. Have you ever had the experience of not being sure if something you remembered really happened or if it was just a dream?
41. Have you ever found yourself wearing something you don't remember putting on?
- a. How about finding things in your room or in your closet that you don't remember buying?
- b. Have you ever found drawings, writings, or notes among your belongings that you must have done but don't remember doing them?

**ALCOHOL AND DRUG USE**

42. How does beer or wine or liquor affect you?  
(If subject claims that he/she does not drink, ask: Why not?)

**Effects of alcohol:**

- 0 - doesn't drink  
1 - no effect  
2 - happy  
3 - sad  
4 - rowdy/wild  
5 - violent  
6 - suspicious/paranoid

a. Does beer or wine or liquor ever make you angry or violent?  
(Describe and obtain several examples if possible)

b. Has anyone ever thought drinking was a problem for you?

c. How often do you drink?

Frequency of alcohol use —  
0 = not at all/holidays only  
1 = occasionally  
2 = once a week  
3 = more than once a week

d. How much?

Average quantity consumed —  
0 = doesn't drink  
1 = 1 drink  
2 = 2 - 3 drinks  
3 = 4 or more

43. Have you ever blacked out from drinking?  
(Describe)

Blackouts from alcohol —  
0 = no  
1 = yes

44. How about drugs? What have you tried?  
(For each drug mentioned, determine at  
its what age the subject started, the  
drug's effects, and frequency of use)

a. Do any drugs ever make you angry or  
violent?  
(Describe)

Subject has become \_\_\_\_\_  
violent when on drugs  
0 = no  
1 = yes

45. Have you ever received help for alcohol or drug  
problems?  
(Ask when, duration of treatment, and  
whether it helped)

Received outpatient alc/ \_\_\_\_\_  
drug treatment  
Received inpatient alc/ \_\_\_\_\_  
drug treatment  
0 = no  
1 = yes

46. Have drugs or alcohol ever made you think  
that you heard or saw something and you  
know your eyes or ears were playing tricks on  
you?  
(Determine what happened and ask for other  
examples)

Auditory hallucinations \_\_\_\_\_  
with drugs/alcohol  
Visual hallucinations \_\_\_\_\_  
with drugs/alcohol  
0 = no  
1 = yes

- a. Has that ever happened without alcohol or drugs?  
 (Ask for details of incident and ask how subject reacted to hallucination (i.e. did it scare him/her? Also try to obtain examples of other times this has happened)

Auditory hallucinations  
 without drugs/alcohol  
 visual hallucinations  
 without drugs/alcohol  
 0 - no  
 1 - yes

**FAMILY HISTORY**

47. How is your mother's health? Has she ever had a serious illness or been in the hospital?

Mother has had serious  
 medical illness  
 0 - no  
 1 - yes

48. Has she ever had emotional or psychological problems?  
 (Describe. Prompt by asking:)

Mother has had  
 emotional problems  
 0 - no  
 1 - yes

- a. How could you tell she had problems?

Subject described  
 mother's problem as:  
 depression  
 anxiety/nervousness  
 strange behaviors  
 violent outbursts  
 substance abuse  
 other  
 0 - no  
 1 - yes

- b. Did she ever take medication for her nerves?  
 (Ask why medicine was taken and whether it seemed to help)

Mother has taken  
 medication for  
 emotional problems  
 0 - no  
 1 - yes

<p>c. Has she ever seen a psychiatrist, psychologist, or social worker? (Describe nature of problem)</p>	<p>Mother has seen therapist as outpatient 0 - no 1 - yes</p>
<p>d. Has she ever had a nervous breakdown, or been in a psychiatric hospital? (Determine why, when, how long she stayed, and whether there were other times)</p>	<p>Number of times mother was psychiatrically hospitalized</p>
<p>e. Has she ever received treatment for drugs or alcohol? (Determine when, how long she stayed, and whether there were other times)</p>	<p>Mother was treated for drug abuse Mother was treated for alcohol abuse 0 - no 1 - yes</p>
<p>49. How about your dad, how is his health? Has he ever had a serious illness or been in the hospital? (Describe)</p>	<p>Father has had serious medical illness 0 - no 1 - yes</p>
<p>50. Has he ever had emotional or psychological problems? (Describe. Prompt by asking:)</p>	<p>Father has had emotional problems 0 - no 1 - yes</p>

<p>a. How could you tell he had problems?</p>	<p>Subject described father's problem as:  depression  anxiety  strange behaviors  violent outbursts  substance abuse  0 = no  1 = yes</p>
<p>b. Did he ever take medication for his nerves?  (Ask why medicine was taken and whether it seemed to help)</p>	<p>Father has taken medication for emotional problems  0 = no  1 = yes</p>
<p>c. Has he ever seen a psychiatrist, psychologist, or social worker?  (Describe nature of problem)</p>	<p>Father has seen therapist as outpatient  0 = no  1 = yes</p>
<p>d. Has he ever had a nervous breakdown, or been in a psychiatric hospital?  (Determine why, when, how long she stayed, and whether there were other times)</p>	<p>Number of times father was psychiatrically hospitalized</p>
<p>e. Has he ever received treatment for drugs or alcohol?  (Determine when, how long she stayed, and whether there were other times)</p>	<p>Father was treated for drug abuse  Father was treated for alcohol abuse  0 = no  1 = yes</p>

Sibling psychiatrically treated or hospitalized  
 Grandparent psychiatrically treated/hospitalized  
 Other relative psychiatrically treated or hospitalized  
 0 = no  
 1 = yes

51. Have any other relatives--sisters, brothers, grandparents, aunts, uncles, cousins--had emotional problems or been treated in a psychiatric hospital? (Describe)

Mother depressed  
 Father depressed  
 Sibling depressed  
 Other relative depressed  
 Mother suicide attempt  
 Father suicide attempt  
 Sibling suicide attempt  
 Other relative suicide attempt  
 0 = no  
 1 = yes

a. Has anyone been very depressed or tried to kill himself/herself? (Ask who and what the person did. Also ask 'Who else')

Mother seizure  
 Father seizure  
 Sibling seizure  
 Other relative seizure  
 0 = no  
 1 = yes

b. Has anyone in your family ever had a seizure, or a fit, or epilepsy? (Describe)

c. Does anyone in the family have a drinking problem or a drug problem? (Determine nature, severity, duration of problem, and whether person received treatment)

Mother alcohol problem —  
Father alcohol problem —  
Sibling alcohol problem —  
Other relative alcohol problem —

Mother drug problem —  
Father drug problem —  
Sibling drug problem —  
Other relative drug problem —  
0 = no  
1 = yes

PHYSICAL ABUSE AND FAMILY VIOLENCE

52. As you were growing up, who in the family had a temper? (Describe how it showed. Make sure to ask who else has a temper)

Mother has temper —  
Father has temper —  
Sibling has temper —  
Other relative/care-giver has temper —  
0 = no  
1 = yes

53. Who did the punishing at home? (Ask... who else?)

Mother disciplines —  
Father disciplines —  
Sibling disciplines —  
Other relative/care-giver disciplines —  
0 = no  
1 = yes

a. What happened when you did something wrong or something that \_\_\_\_\_ didn't like? (Describe)

b. Have you ever made him/her loose his/her cool and go further than she/he meant to? (Determine what happened, who did it, the age of the subject, and make sure to ask: When else has that happened?)

Parent/Caregiver has lost control disciplining  
0 = no  
1 = yes

54. What's the worst physical punishment that's ever happened to you? (Determine who did it, when, why, whether there were injuries and if so whether they were treated)

TO INTERVIEWER: For each of the following questions regarding abuse, it is very important to ask: What happened...Who did it...At what age did it occur...How long did it go on...Were there injuries... How were they treated...When else did something like that happened...When was the first time?

55. Have you ever been hit with a:  
leather belt or belt buckle?

Subject has been:

Hit with leather strap  
Hit with buckle  
0 = no  
1 = yes

How about an extension cord?

Hit with extension cord  
0 = no  
1 = yes

**A board or a stick?**

Hit with board/stick \_\_\_\_\_

0 = no

1 = yes

0 = no

1 = yes

Hit in face/head with  
any of above objects \_\_\_\_\_

Hit on parts of body  
other than on buttocks \_\_\_\_\_

0 = no

1 = yes

**Anything else?**

(Give examples: shoe, hanger, etc.)

**a. Were you ever punched or thrown around?  
(Describe)**

Subject was punched \_\_\_\_\_

Subject was thrown \_\_\_\_\_

0 = no

1 = yes

**b. Were you ever bruised or cut or burned?  
(Describe)**

Subject was cut/  
stabbed \_\_\_\_\_

Subject was bruised \_\_\_\_\_

Subject was burned \_\_\_\_\_

0 = no

1 = yes

**c. Were any of your bones ever broken?**

Subject had broken  
bones from punishment \_\_\_\_\_

0 = no

1 = yes

**d. Were you ever knocked unconscious or  
knocked dissy?  
(Determine who did it, when, duration of  
loss of consciousness)**

Subject was knocked  
out \_\_\_\_\_

Subject was knocked  
dizzy \_\_\_\_\_

0 = no

1 = yes

56. Some people can block out pain so they can't feel it. Can you do that?  
(Describe... ask "When was the first time?")

57. Who else has hurt you physically?  
(Describe what happened and why)

a. How about your brothers/sisters or other relatives?

**TO INTERVIEWER:** Observe any scars on child's face, arms, neck, wrists, hands, etc. Ask about each scar and how it was received. If the subject tells of scars on the back, legs, etc., ask to examine them and ask how they were acquired. Mark all scars on the diagrams below. Then ask:

58. Are there any other scars I can't see?

BASED ON QUESTIONS

47a TO 50a, DECIDE:

Mother was abusive

Father was abusive

Sibling was abusive

Other relative/care-

giver was abusive

Other adult was abusive

0 = no

1 = yes

Age in years when first abused

Ever treated medically for abuse

0 = no

1 = yes

Subject has scars

from:

Physical abuse

Self-mutilation

Fights

Accidents

0 = no

1 = yes

59. Do you have any scars or injuries and you don't know how you got them?  
 (Describe... Ask, "When did you notice it for the first time?")

60. Did you ever hurt yourself on purpose?

61. What would happen when your folks got angry with each other?

a. Have they ever hurt each other or threaten with weapons?  
 (Determine the nature and extent of violence in the family. Ask for several examples. Also find out how it affected subject)

Parents have assaulted each other  
 Other people in household have assaulted each other  
 0 = no  
 1 = yes

62. Do you know if, as your folks were growing up, anyone ever hurt them or beat up on them?  
 (Describe)

Mother physically abused  
 Father physically abused  
 0 = no  
 1 = yes

- a. Do you know if anyone ever bothered them sexually?  
(Describe)

Mother sexually abused    —  
Father sexually abused    —  
0 = no  
1 = yes

FRIENDSHIPS AND LEISURE ACTIVITIES

SAY: Now I'm going to ask you some questions about your childhood.

63. What were your favorite TV shows and movies?
64. Could you ever get so caught up in a TV show or movie that you lost track of time?
- Would people have to shake you to get your attention?
65. Sometimes when things get too rough, some kids can kind of switch channels, like on a TV set. They can suddenly get bigger or stronger, or maybe smaller - like a baby. Could you ever do that?
66. When you were little, did you have any very special toys, like a stuffed animal or a doll?

- a. Did it ever seem very real to you?  
(Explore)
- b. Did a toy or doll ever frighten you?
- c. When you were a child, did you ever find that a toy was broken and you didn't know how it happened?
67. Have you ever had a make-believe or imaginary friend? Brother or sister?  
(Explore)
68. Some people have a special place they can go to in their head when they need to get away from everything - like a beach or the moon. Can you do that?  
(Explore)

69. When you were lonely, or when things got rough, were you ever able to talk with someone in your head?  
(Explore)

**SEXUAL ABUSE**

70. As you were growing up, who taught you about sex? How were you taught?

Subject was taught about sex by:  
1 = parent  
2 = school  
3 = by peers  
4 = no one/experimented

a. How old were you when you first had sex?

b. Have you ever had sex with someone who was much older or much younger than you? (Describe what happened and determine age of the subject as well as age of the partner)

Subject had sexual experience with much older person  
This experience should be considered sexual abuse  
Subject had sexual experience with much younger person  
This experience should be considered sexually abusive behavior by subject  
0 = no  
1 = yes

c. When you were little, did anyone ever try to have

71. There's been a lot on TV about people in the family bothering kids sexually. What experiences can you remember?  
Did you have?  
(Ask who was involved, how long relationship lasted, how far it went, whether the subject ever told anyone and, if so, what happened. Also, don't forget to ask: Who else bothered you?)

How about outside the family?

72. Have you ever had sexual experiences with your own sex?

**MEDICAL HISTORY**

SAY: Now I'd like to ask you some questions about your health.

73. When you were born, do you know if your mother had any trouble giving birth, or if you were too early or had any problems?  
(Describe)

Mother was sexually abusive —  
Father was sexually abusive —  
Sibling was sexually abusive —  
Other relative was sexually abusive —  
Other adult was sexually abusive —  
0 = no  
1 = yes

Age in years when first sexually abused —

Duration in months of longest sexually abusive experience —

Number of sexually relationships where —

subject was victim

Mother had problems with pregnancy or delivery —  
Subject was premature —  
0 = no  
1 = yes

74. Have you ever seen a counselor or social worker or psychiatrist because of behavior problems or emotional problems? (Determine type of problem, age, duration, treatment, and whether treatment helped)

Subject was treated \_\_\_ for behavior/emotional problems  
0 = no  
1 = yes

Age in years when first treated \_\_\_\_\_

a. Have you ever been hospitalized because of emotional or behavior problems? (Determine what happened, when, duration of stay, whether there were other times)

Number of psychiatric hospitalizations \_\_\_\_\_

Age when first psychiatrically hospitalized \_\_\_\_\_

Duration in months of longest psychiatric hospitalization \_\_\_\_\_

**SERIOUS ACCIDENTS AND INJURIES**

TO INTERVIEWER: Serious accidents include those requiring medical care, stitches, dizziness and those causing loss of consciousness.

75. Tell me about some of the worst accidents you've ever had. (Describe the nature of accident; age; duration of loss of consciousness; whether there was dizziness, nausea, or headaches; whether treatment was obtained; and whether there were behavior changes or learning problems after the accident. Prompt for car, bike, falls, etc.)

FOR QUESTIONS 68 TO 68g, TALLY:

Total number of serious accidents/injuries w/out head injury: \_\_\_\_\_

Number of accidents or injuries with head injury, but no loss of consciousness \_\_\_\_\_

Number of accidents or \_\_\_\_\_

a. Have you ever had any broken bones?  
(Describe)

b. Have you ever been hit with something like a stick or a bat, or knocked out or knocked dizzy?  
(Determine how long subject was unconscious, and whether s/he was hospitalized. Also ask: When else has that happened?)

76. Have you ever been in the hospital or the Emergency Room?  
(Describe... Ask, "When else?")

77. Have you ever had a seizure? Convulsions? Epilepsy?  
(Describe and determine when it first happened)

Subject has had seizure(s)  
0 = no  
1 = yes

Age in years when seizure occurred

78. Do you get headaches?  
(Ask subject to describe where the headaches are located, when they first occurred, the severity and frequency of headaches, and how they were treated)

Subject has had frequent severe headaches —  
0 = no  
1 = yes

Age in years when headaches first occurred —

79. Have you ever had stomach trouble?

a. Do you ever feel nauseous or have pains in your abdomen for no reason?

80. Have you ever had pain or bleeding when moving your bowels?  
(Describe...Inquire about treatment.)

81. Have you ever had pain or bleeding when urinating?  
(Describe...Inquire about treatment.)

82. When you were a child, did you ever have problems soiling or wetting your pants?  
(Describe... Ask, "When did it start; how long did it last?" Inquire about treatment.)

**83. How are your eyes? Do you wear glasses?**

**a. Have your eyes ever played tricks on you? For instance, have you ever had the experience of having things seem to get big and up close or small and far away while you're looking at them? (Describe and try to obtain several examples)**

Objects have seemed to get bigger —

Objects have seemed to get smaller —

0 = no  
1 = yes

**b. Have you ever had the experience of seeing something or someone and it seemed real but you knew it wasn't real? (Obtain a detailed account of these experiences. Try to determine the time of day and circumstances surrounding the experience, and whether drugs/alcohol were involved. Also ask what subject did in response to the hallucination. VERY IMPORTANT TO ASK: When else has that happened? When was the first time?)**

Subject has had visual hallucinations w/out drugs or alcohol —  
Subject has had visual hallucinations w/out drugs or alcohol —

Hallucinations have occurred only on awakening or on falling asleep —

Subject has experienced only illusions (i.e. something only looked like something else) —  
0 = no  
1 = maybe  
2 = yes

Age when visual hallucinations first occurred —

**c. Have you ever had the experience of feeling as though you were outside your own body and you were watching yourself do something? (Describe)**

d. Have you ever felt as though you could make things disappear?  
(Describe)

84. How are your ears? Have you ever had earaches or hearing problems?  
(Ask when, severity, and how the ears were treated)

Has had severe ear ache or ear infection  
Subject has trouble hearing  
0 = no  
1 = yes

e. Have your ears ever played tricks on you? Have you ever had the experience of thinking someone said something to you or told you to do something?  
(Obtain a detailed account of these experiences (e.g. was it a man's or woman's voice? what did it sound like?) Try to determine the time of day and circumstances surrounding the experience. Also ask what subject did in response to the hallucination. VERY IMPORTANT TO ASK: When else has that happened? When was the first time?)

Subject has had auditory hallucinations  
0 = no  
1 = maybe  
2 = yes  
Age in years when auditory hallucinations first occurred

b. Have you ever heard someone inside your head telling you to hurt yourself, or hurt someone else? (Describe the experience and the subject's reaction. VERY IMPORTANT TO ASK: When else that has happened? When was the first time)

Voice has told child to hurt/kill self  
 Voice has told child to hurt/kill other  
 Subject acted in response to command  
 0 = no  
 1 = maybe  
 2 = yes

c. Have you ever heard two people talking or arguing with each other in your head? (Describe)

Age in years when command hallucination first occurred

d. Have you ever had the experience of someone inside your head commenting on something you did or telling you to do something?

Has heard voices talking to each other  
 0 = no  
 1 = maybe  
 2 = yes

85. Have you ever had the experience of hearing a baby cry and there was no baby around? (Describe)

86. Have you ever had the experience of hearing your mother or father inside your head? (Describe)

87. Did you ever feel that things around you were not real or as if you were in a dream?
88. Do you daydream much - or just sit and stare off into space without noticing what is happening around you?  
(Describe)
- a. Do you have a special place you can go to in your head during these times?  
(Describe)
89. Have you ever been told that you were 'out of it' or in a trance?  
(Describe)

**MOODS**

SAY: No I'm going to ask you about your moods.

- a. Have there ever been times in your life when you felt very sad and depressed?  
(Ask how it shows)

Subject has felt  
depressed/very sad  
0 - no  
1 - yes

b. When else have you felt depressed?  
How long do these depressions tend to last?

Depression last:  
0 = hours  
1 = days  
2 = weeks

90. Have you ever had trouble sleeping?  
(Determine how long it takes to fall asleep, whether s/he awakens during the night, and/or awakens too early)

Number of depressed periods

Subject has had trouble falling asleep  
Subject has had trouble staying asleep  
Subject has had trouble with awakening too early  
0 = no  
1 = maybe  
2 = yes

91. Have you ever had terrible nightmares that seemed very real to you?  
(Describe)

a. How about flashbacks - where you remember something so strongly that it feels as though it is happening all over again?  
(Describe)

b. Have you ever woken up with marks or scratches on your body and you don't know how they got there?  
(Describe)

92. Were there ever times when you just didn't feel like eating and you lost a lot of weight?  
 (Ask when, what caused the lack of appetite, and how much weight was lost)
- Subject has had times w/ very poor appetite  
 0 = no  
 1 = maybe  
 2 = yes
- Most weight lost (in pounds)
- a. How about times when you ate and ate and you gained a lot of weight?  
 (Ask when, what caused the increase in appetite, and how much weight was gained)
- Subject has had times with excessive eating  
 0 = no  
 1 = maybe  
 2 = yes
- Most weight gained: (in pounds)
93. Have you ever felt so sad that you wanted to hurt or kill yourself?  
 (Determine age, circumstances under which subject felt suicidal, and what s/he thought of doing. Also ask when else this has happened)
- Subject has had times of wanting to kill/hurt self  
 0 = no  
 1 = maybe  
 2 = yes
- Age at first occurrence
- a. Did you ever try to hurt yourself, or kill yourself?
- Number of suicide attempts
- Age at first attempt

b. **What did you do?**  
(Also ask when it happened, what lead up to the attempt, and VERY IMPORTANT: When else did you try to hurt yourself?)

Nature of attempt(s):

- Pills
  - Hanging
  - Weapon
  - Jumping
  - Other
- 0 = no  
1 = yes

—  
—  
—  
—  
—

94. **Are there times when you really feel terrific for no good reason, or full of energy and can do a lot?**  
(Determine when these episodes have occurred and how long they have lasted. It is important to determine that the subject was not on drugs when feeling this way).

Subject has had days when s/he felt unusually full of energy

- 0 = no
- 1 = maybe
- 2 = yes

a. **Do you ever feel more special than other people or as if you were chosen to do something great in the world?**

Subject has felt grandiose

- 0 = no
- 1 = maybe
- 2 = yes

—

b. **Are there ever times you think more rapidly or your mind races?**  
(Describe)

Subject has had racing thoughts

- 0 = no
- 1 = maybe
- 2 = yes

—

c. Have you ever stayed up all night or for days at a time because you were feeling really full of energy or couldn't stop thinking? (Determine when these episodes have occurred, how long they have lasted, and what the subject did. Also, it is important to determine that the child was not on drugs at the time)

Subject has had  
of too when s/he stays  
up all night because  
of too much energy  
0 - no  
1 - maybe  
2 - yes

d. Are there weeks or months when you really feel high or full of energy and maybe spend too much money or do silly or dangerous things? (Describe. It is important to determine that the subject was not on drugs when feeling this way)

Subject has had times  
when s/he felt so good  
that s/he did foolish or  
dangerous things  
0 - no  
1 - maybe  
2 - yes

e. Has anyone ever told you that you seemed very changeable?

f. Have you ever felt very changeable?

**THE FUTURE**

**SAY:** I've asked you a lot of questions about your past and about how things are now. Let's talk a bit about your future.

**95.** What do you picture yourself doing 10 years from now?

Signature of Interviewer \_\_\_\_\_

Date \_\_\_\_\_

## SCORING INSTRUCTIONS FOR THE DISSOCIATIVE EXPERIENCES SCALE (DES)

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- The Dissociative Experiences Scale (DES) is a 28-item, self-administered questionnaire that screens for dissociative disorders. The subject completes the questionnaire by marking the 100 mm analog lines with a slash indicating where he or she falls along a continuum of frequency for each experience.
- The scale is scored by measuring the intersection of the slash and analog line in millimeters from the 0% (left hand) line. Individual item scores can range from 0 to 100. The DES score is the average of the individual item scores (i.e.  $DES\ Score = \frac{Item1 + Item2 + Item3 + \dots}{28}$ ). DES scores of 30 or greater are highly suggestive of a dissociative disorder or posttraumatic stress disorder. If the subject fails to complete 3 or more items, the DES is invalid.

Date \_\_\_\_\_ Age \_\_\_\_\_ Sex: M F \_\_\_\_\_

1. Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

8. Some people are told that they sometimes do not recognize friends or family members. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Mark the line to show what percentage of the important events in your life you have no memory for.

0% |-----| 100%

10. Some people have the experience of being accused of lying when they do not think that they have lied. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

11. Some people have the experience of looking in a mirror and not recognizing themselves. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

13. Some people have the experience of feeling that their body does not seem to belong to them. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

19. Some people find that they sometimes are able to ignore pain. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

20. Some people find that that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

21. Some people sometimes find that when they are alone they talk out loud to themselves. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that this (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

25. Some people find evidence that they have done things that they do not remember doing. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Mark the line to show what percentage of the time this happens to you.

0% |-----| 100%

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