Volume 3

Frontiers in the Psychotherapy of Trauma & Dissociation

*The Official Clinical Journal of
the International Society for the
Study of Trauma and Dissociation*

**The First Individual with
Dissociative Identity
Disorder (DID) That One
Knowingly Diagnoses and
Treats**

*Warwick Middleton, MB BS,
FRANZCP, MD*

Frontiers in the Psychotherapy of Trauma & Dissociation

The Official Clinical Journal of the ISSTD

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ARTICLE

THE FIRST INDIVIDUAL WITH DISSOCIATIVE IDENTITY DISORDER (DID) THAT ONE KNOWINGLY DIAGNOSES AND TREATS

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This paper represents additional background to a recently published commentary in Frontiers in the Psychotherapy of Trauma and Dissociation concerning alleged satanic ritual abuse, maladaptive daydreaming, false memories and organized abuse. Such issues are referenced here to the first individual the author knowingly diagnosed as having Dissociative Identity Disorder (DID). The complexities of even this first such case made it desirable to assemble a conceptual framework for accurate and inaccurate memories of reported trauma. This lead naturally to an inventory of personal self-directed advice, assembled in order to try and enjoy a reasonably safe and harmonious career working in the trauma and dissociation field.

KEYWORDS *maladaptive daydreaming, dissociative identity disorder, satanic ritual abuse, false memories, organized abuse*

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INTRODUCTION

As was the case with all my peers, my training as a psychiatrist in Australia, which commenced in 1980, included essentially nothing on dissociative disorders. Incest was barely mentioned. Multiple Personality Disorder (MPD), if it existed at all, was in that pantheon of rare/culturally-bound syndromes (e.g., Wendigo, Koro, Amok, Capgra's syndrome, Cotard's syndrome) that the average psychiatrist was unlikely to encounter in a lifetime of practice. In March 1991, I was to publish a paper in an obscure journal stating, "Open discussion of sexual trauma has for a long time been a particularly taboo subject" (Middleton, 1991, p. 12), and, "The syndrome of multiple personality disorder, for many years a curiosity or the demarcation point for fantastic fiction is representative of a response syndrome to overwhelming trauma occurring in particular circumstances" (Middleton, 1991, p. 13).

Locked within the experience of my first informed encounter with an individual with Dissociative Identity Disorder (DID) was an engagement with virtually all of the many issues that have played out for the modern dissociative disorders field and an attempt to address the many challenges that required a proactive stance. This paper is not meant to be an exhaustive review of the evolution of theory and practice in the assessment and treatment of individuals with DID. It arose out of the consideration of recent papers by Ross (2018, 2019), Miller (2019) and Somer (2019) on the issues of maladaptive daydreaming (MD) and alleged Satanic Ritual Abuse (SRA), and it is a personal extension of the comments I offered then in respect to the issue of alleged SRA and the broader nature of organized abuse (Middleton, 2019).

I reflected that engagement with the issues of ongoing incestuous abuse during adulthood, and its incorporation of various forms of organized abuse, had been issues I had been encountering since I first knowingly engaged in the treatment of individuals with DID. In case this personal journey may be instructive and stimulate other colleagues to reflect further on the issues canvassed, I have offered this account in the form of a narrative, followed by something of an overview of the psychological explanations I assembled at the time concerning the challenging issues of trauma and memory that I was encountering. This precedes the personal self-directed advice I assembled in respect to not only surviving in the field, but in making one's involvement as professionally as safe as possible and hopefully career-enhancing.

Back in my early days of having ongoing direct involvement with DID patients, I encountered a patient (whose DID I had not yet diagnosed), who I had been treating, after alarm had been raised that she was turning up to work with obvious fresh bruising, seemingly associated with visits to her mother's house. Whilst her parents were separated, her father continued to visit her mother's house.

My patient rang me in a highly distressed state, after I had known her for a period of weeks, to say that she had just been assaulted by her abusive father in the student nursing accommodation she lived in. This accommodation was in the grounds of a large teaching hospital. I decided to ring the police and I met them at the scene. Despite the fact that the student nursing facility accommodated a considerable number of other student nurses, no one had seen a man in the vicinity or had heard anything suspicious. Yet my patient was covered in fresh injuries, was bleeding, and appeared authentically acutely traumatized. Her account was that her father had come to her room, violently assaulted her and then left. The distribution of the injuries, including those to her back, were such that the police and I were genuinely perplexed as to how they could have been inflicted, if not by someone else. Yet it seemed highly unlikely that an intruder could have entered the student nursing accommodation, got into my patient's room, carried out what, on the evidence of the injuries, might normally be expected to be a violent (and noisy) assault and then exit the building without the many people present seeing or hearing anything untoward. Additionally, why would someone intent on carrying out such an assault risk so much by carrying it out in circumstances where common sense would indicate that there was a high risk of detection?

In my conversation with one of the police officers who attended, I casually enquired as to what had been the most extreme example of self-inflicted injury he had witnessed in his police work. He replied that he had once been called to a house where a man had cut off his own head with a circular saw. I had no idea at the time that the officer just happened by remote chance to be describing one of my patient's principal abusers, a man who as a church youth group leader sexually abused a number of young girls associated with a suburban Christian church and who, when belatedly detected, gave an obliquely-worded apology to the church congregation and then a few days later dropped the activated circular saw on his own throat. It was the same circular saw that I was to subsequently learn had been held at the face and genitals of my patient during her sexual torture. Subsequent to learning of the activities of this man, I was to view, in a police journal, a picture of his severed head. I still have the picture. I was also, over time, to meet two more of his victims, one of whom remains my patient to this day. This victim was not only abused by him, but on occasion by his extended pedophile ring which included, it seems, two nationally-reported and convicted pedophile abusers. The mother of yet another victim of this church youth group leader wrote a book concerning his abuses, though with all names changed (Wanmer, 2012).

One of this youth group leader's alleged co-abusers was jailed essentially for life in 2003. The number of his verified child victims exceeded 300. The second pedophile co-abuser was in more recent years a focus of international news when convicted of multiple child sexual exploitation

offenses in another country. My current patient has always been adamant that she was sexually abused by him in 1988, and the details she gave of the rape contained information about his particular *modus operandi*, that only became generally known at the time of his trial for sexually abusing other children, adding to the veracity of her long-held account.

At the time that I first met my original patient, she was a 17-year-old student nurse who had only recently moved out of her mother's house (which her father was still visiting). Both parents had extreme fundamentalist religious beliefs and prior to their breakup had been involved in trying to establish a "spiritual warfare school" in a rented house. The landlord had become so keen on moving them on that reportedly he ultimately resorted to cutting off the power and water supply in order to force them out. When I first met my patient, her father had progressed to being employed in an administrative role in a Protestant church while her mother was heavily involved in a cult-like religious splinter group that believed her daughter was demon possessed, a belief that was reinforced by her abrupt switching between dissociative identity states.

What was reported from early on in my contact with my patient was that she had suffered long-term sexual and physical abuse at the hands of her father, which had only been brought to cessation at the time she moved out of her mother's home to take up nursing. (Despite the separation of her parents, her father continued to visit her mother's home.) Her early nursing career was punctuated by occasions when she would come to work with possible recent self-mutilation evident, or when she made statements claiming she had recently been attacked by her father. Predictably, in the lead-up to the time that I first saw her someone had presumptively mentioned that she must have "schizophrenia," an explanation that was seized on by her father as an explanation for the "delusional" beliefs she had regarding being abused by him.

Due to concern about her ongoing safety, my patient was moved out of the nursing student accommodation, which set in motion a mounting sense of alarm in her mother. This reached fruition when her mother and a group of her religious fellow travelers literally kidnapped her in broad daylight in front of astounded passersby, dragging her into a van, all the while chanting, "We take you in the name of the Lord!" My patient resisted and in the ensuing struggle one of her knees was dislocated. The stated plan was to drive her over the state border to some enclave the group had in a forested area, where she would again be exorcized of the demons that were obviously behind her resistive behavior. She refused to go willingly, and half an hour into the journey her abductors had a change of mind. Perhaps it dawned on them that kidnapping associated with inflicting grievous bodily harm usually is associated with a lengthy jail sentence. Losing their nerve, they released her, and she rang me. My patient did not press charges, but I did speak to her mother. Her mother's explanation of the injuries inflicted

in the kidnapping of her daughter was, "Oh, she dislocates easily!" (This was said in a similar manner to someone deemphasizing a bruise by saying, "Oh, she bruises easily!")

As has been the described experience of many, particularly in the early years of the modern dissociative disorders field, there is nothing quite so reorienting of one's world view of DID than discovering it for the first time for one's self. My perplexing patient repeatedly showed evidence of apparent assaults. For much of the time she was dysphoric and distressed by her inability to understand fully what was happening with her life. Yet there were periods where she was actively social. Periods in hospital did not resolve anything, and she showed no particular responses to antidepressants. Opinions on her management were sought from colleagues. On occasions she would suddenly run from my consulting room, yet would make no mention of such actions when seen subsequently. On one occasion I was rung from another hospital to say that she had turned up there using a different name.

It was puzzling. One day, after she had spent quite some time in hospital, I was seeing her in my office. She was depleted. Nothing was improving. She did not understand what was going on, and I was unable to enlighten her. Fate intervened. My phone rang. I turned away to answer it. I spoke briefly to the caller and when I turned back to my patient, it was apparent that the depleted and dysphoric individual had been transformed into a vivacious party girl. It reveals a lot about my unconscious processes, that the very first thing I said was, "And who are you?" She replied, "Oh, I'm Katie!" My second question followed immediately. "And who are all the others?" Much that had been so puzzling became suddenly much clearer.

In time the full extent of my student nurse patient's identity states was able to be accessed. There was much about her case that is of direct relevance to the issues concerning alleged SRA that is a focus of Ross' recent paper (2018) and the associated commentaries (Middleton 2019; Miller, 2019; Salter 2019; Somer, 2019).

It also became instantly apparent that another perplexing patient I had on the same ward also had DID. Within a year I had diagnosed 15 patients with DID in addition to my first patient. One of these I still have regular contact with to this day. In terms of the number of alters and the complexity of how they were layered, she is perhaps the most dissociative individual I have ever encountered. She was my particular introduction to the hidden world of ongoing incest during adulthood (see Middleton, 2013a and 2013b).

I had the opportunity, during a time that my initial DID patient was in hospital, with her permission, to speak to her father for at least an hour on one occasion. He was impeccably groomed, articulate and superficially charming. He went on about how much he cared for his daughter and then spoke at some length about her "schizophrenia" and her "delusional"

beliefs. Aware that he had not convinced me that she was psychotic, he then tackled the issue of MPD and quoted the fact that no published series had a finding that 100% of patients with MPD gave a history of childhood sexual abuse and proffered the opinion that his daughter must be one of the small percentage of patients with MPD who had not been sexually abused. I deliberately let him go on, appearing seemingly convinced by his declarations of love and concern, and his line of argument. His confidence grew. After an hour his guard dropped, his eyes flashed, and the suppressed anger suddenly erupted with the statement, "And if she doesn't retract I'll crucify her!" When I later recounted to my patient the threat that he had made, she visibly shuddered.

Amazingly, I was rung at one point by an individual who said that he was then working as a social worker on a mental health team in rural New South Wales. He rang about my patient and further enquiry elicited that he had been involved with my patient's parents in the "spiritual warfare" venture and that he was one of my patient's past exorcists. In hushed tones he told me that she was now a "high priestess of the devil," that she had been inducted into a coven at the age of four and that subsequently for all her life had been involved with all the trappings of Satanism. How at the age of four she supposedly made her way to regular meetings of her coven over a thousand kilometers distant was never explained. (It is I think, the only time in my career where I have been rung by a qualified health professional who claimed to be my patient's exorcist.) (The parents were both at that earlier time involved in a religious cult that actively practiced exorcism.) It is interesting to reflect that the earliest detailed case thus far discovered that conforms with a diagnosis of DID was the sixteenth-century case of presumed demonic possession involving a 25-year old Dominican nun, Jeanne Fery (van der Hart, Lierens, & Goodwin, 1996).

My patient described a childhood that incorporated ongoing sadistic sexual abuse at the hands of her father. She had tried to tell her mother about the abuse, but her mother's paradigm focused on demons. She was aware that her mother had herself been sexually abused as a child. As my patient dissociated in response to the incestuous abuse, her dissociative switching was taken to be evidence of demonic possession, and she would be repeatedly subjected to exorcisms. Not infrequently, as she later explained, she would be sexually abused in the course of these exorcism rituals, with her abusers then declaring that it was the Devil in her that was causing them to act that way, i.e., it was her fault. The exorcisms contributed to her dissociating, and her florid dissociation was interpreted, in turn, as evidence of the need for more exorcisms. Even when she attended the youth group of a seemingly more mainstream church, she ran straight into the clutches of the pedophile youth group leader with the circular saw. One slightly paradoxical aspect of this case was the fact that one of the few church-affiliated individuals who treated her respectfully, was helpful, did

not exorcise her, torture her, kidnap her or sexually abuse her was a televangelist who had had a previous career as an armed bank robber before conversion to Christianity.

Of course, my patient survived the madness of her highly-dysfunctional and grossly-abusive family by dissociating, and elements of her trauma were compartmentalized via various alters. Teachers recorded in school reports of earlier years, mention of perplexing behaviors, e.g., apparent switching, or sudden outbursts. Her 19 alters ran the familiar gamut from seductive to self-mutilating/self-hating entities, and one incorporated the identity of her father. What became apparent was that an alter had been created in response to the trauma of the cessation of her father's sexual abuse associated with her moving out of her mother's home. What the patient in her host state had experienced as an assault by her father in the student nurse's quarters was in effect an assault on her own body carried out by the alter that incorporated the personification of the father.

Paradoxically, the internal void created by the cessation of the regular sadistic abuse at the hands of my patient's father was filled by the creation of an alter that was experienced by other alters as being the father that parts of her were trying to separate from and that other parts of her were missing. Her "memory" of her father coming to the nursing student quarters and assaulting her was simultaneously "true" and "false." I have little doubt that she was not trying to lie or deceive, nor does the descriptor of "fantasy" seem adequate. She experienced real "assaults" that parts of her believed were perpetrated by her father. Furthermore, there was obvious physical evidence of such "assaults." At the time, no accessible internal window had been opened that could reveal to me, and to her, the turmoil associated with her attempt to separate from her father. Yet obviously what she reported to me at the time was not historically accurate—her father had not assaulted her in the student nursing quarters, even though her initial emotional reaction seemed indistinguishable from someone who had been assaulted in the way she initially described. Over subsequent years, and over very many patients, I have been impressed time and again by the tenacity of the attachment that severely traumatized women (and on occasions men) have to fathers whose abuses would be equivalent to those of Josef Fritzl.

My patient was highly intelligent and had an extraordinary eidetic imagery (photographic memory) capacity. Her photographic memory became apparent to me, via her again being in my office when my phone rang. On this occasion someone needed my 16-digit credit card number. I quickly read out the number and thought no more of it—until a week later my patient casually recited back to me without error, the entire 16 digits. There are simple visual tests for eidetic imagery such as one that uses two apparently random patterns, each made up of 10,000 dots. Eidetics can mentally superimpose the image of one onto the other, to form a simple picture,

a task my patient could perform in seconds (Middleton, 2004; Time Life, 1991). My patient was eerily able to give verbatim accounts of conversations associated with her abuse, dating back to the middle of her childhood.

When, ultimately, I gave my patient the Dissociative Experiences Scale (Bernstein & Putnam, 1986), she scored 82. My patient worked very hard to integrate her life and communicated a need to safely process elements of her compartmentalized trauma. Perhaps predictably, she married young and moved interstate. Her wedding occurred in a mainstream church. It must be one of the few church weddings where bouncers were employed and placed strategically around the church in case her father, who was not invited, arrived and created a scene. He duly turned up, but there was no violence or verbal outbursts, and he left without drama.

Thus, the very first patient I knowingly diagnosed with DID incorporated memories of mainstream trauma, e.g., some assaults by her father, that turned out to be historically inaccurate, and memories of extreme trauma, e.g., her contact with the serial abuser with the circular saw, that turned out to be accurate. She had been brought up in an abusive and extreme fundamentalist environment where its inhabitants were immersed in combating the work of Satan and his demons, and they had formed the belief that she was a “high priestess of the devil” which, in turn, led to her being repeatedly subjected to traumatic exorcisms.

Clearly, at that time, in choosing to engage with the challenges of working in the embryonic dissociative disorders field, it was self-evident that it brought with it numerous complexities and that societal belief systems (including those concerning SRA) could become incorporated in the clinical material in ways that made the need for caution paramount, particularly, as it was apparent, that individuals with DID were far from uncommon. It seemed that essential steps in assisting the development of the field in Australia at that time lay with publishing a baseline representative series that detailed the abuse histories and clinical phenomenology of a representative series of individuals with DID (Middleton & Butler, 1998), in addressing the issues of trauma and memory in a widely-accessible publication (Middleton, De Marni Cromer, & Freyd, 2005), in supporting colleagues who had been drawn to the emerging field, in establishing a dedicated inpatient unit for such individuals, and in supporting conferences and seminars that were geared to the needs of health professionals grappling with such patients (see Middleton, 2017).

Ross’ recent paper and Miller’s commentary (Miller, 2019; Ross, 2019) stimulated me to drag out an unpublished paper that represented something of a longer and earlier version of a paper that I was ultimately involved in writing with my colleague Jeremy Butler, and which ultimately described the abuse histories and phenomenology of 62 individuals diagnosed with DID, with the formal collection of data occurring over the years 1992–1997. I sent a copy of this earlier paper to Frank Putnam around 1993–1994. A

component of the paper that particularly resonated with Dr. Putnam was my attempt to identify for my own orientation what seemed to be the many factors that to some degree contributed to the genesis of false memories in dissociative patients. I have reproduced here the summary, dating back a quarter of a century, regarding my take then on the genesis of false memories. The perspective was a mix of what I gleaned from publications relating to the earlier years of the modern dissociative disorders field combined with my own clinical observations. Given that it is something of a representative historical document that incorporated a personalized synthesis of such elements, and given that, in its original form, there was no attempt at a scholarly rendering of the multiple references that could be linked to some of the factors, I am hoping that for the purposes of the exercise, that the reader will accept the listing as a representative personal working document associated with the epoch, rather than an attempted scholarly review. (Arising out of the elaboration of some of the listed memory issues a paper was published in 2005 [Middleton, De Marni Cromer & Freyd]).

FACTORS THAT MAY PLAY A ROLE IN THE GENESIS OF FALSE MEMORIES IN DISSOCIATIVE PATIENTS

The listing that I titled back then, along with its content is reproduced below.

1. Continuation of Childhood Fantasy Proneness

Severe dissociative disorders have their genesis in early childhood and are erected with children's age-related capacity to dissociate. Children of this age naturally have a capacity to create internal worlds, alternative realities and imaginary companions. Due to the need to maintain dissociative defenses, such elements that usually would dissipate are maintained and may, indeed, be elaborated.

2. Links Between Creativity and Dissociation

Creativity, and by extension the use of metaphor, simile, symbolism, personification or dreamlike thought are central to the dissociative process. Symbols are frequently central to the content of dreams or hallucinations, and given the propensity to experience multiple realities demonstrated by some patients, leakage or incorporation of creatively configured images or events becomes possible, leaving the patient at times uncertain about the source of authenticity of an apparent memory.

3. Repetition-Compulsion

The severely traumatized are destined to repeat aspects of their trauma, and in some untreated dissociative patients the process can become like an endless feedback loop; trauma creates dissociatively-based alter states, some of whom repeat aspects of the trauma invoking further dissociative defenses, and so on it goes. The repetition-compulsion can involve actual or symbolic ways of repeating the trauma, with, at times, traumas being repeated in intra-psychic ways associated with apparent memory.

4. Alters Reenacting Past Traumas

Here an alter based on an abuser, and for which there is little or no co-consciousness, reenacts in contemporary time by way of self-harm, aspects of abuse previously experienced, while other alters perceive and remember this as a continuation of abuse by a particular abuser. (On occasions, the repetition-compulsion can involve an adult in flashback mode revisiting traumas by inflicting on others, traumas first experienced as a child victim, themselves.)

5. Lack of Tethering Points/Source Attribution Errors

Severely dissociative patients lack autobiographical memory and thus frequently cannot place an apparent memory in the context of defined tethering points or clearly-defined chronological memory of events in the relevant time period. Such defined tethering points make it easier for non-amnesic patients to place an apparent memory of an event in the context of things that were happening before, at the same time, and after, and which allow for a quick internal corroboration process to operate to, for example, separate an internal image that first occurred in a dream, from one that was part of a remembered sequence of events.

6. Merged Memories

Because with highly-dissociative individuals memories are prone to be untethered, fragmentary or uni-dimensional (e.g., visual without narrative, affect without visual, etc.), it is particularly likely that as with uncombined DNA such “pieces” of memory may recombine in a manner that is not autobiographical and that such combinations may involve fragments derived from fantasy or dream life that, in turn, are spliced together such that they, with a greater or lesser degree of metaphor, portray central issues of trauma and abandonment.

7. Exaggeration as a Defense

Many patients with DID have experienced severe traumas without any opportunity to tell anyone who would either validate or protect them. Given the magnitude of their childhood abandonment, later in a safer therapeutic setting, for some patients it is as if they operate on the premise that no one will pay heed to any account unless it is embellished with gruesomeness, threat or a sense of immediate crisis.

8. Focusing on the Fascinoma and Not the Person

Here the therapeutic alliance is weak, though the therapist may not have realized it in his/her quest to meet more and unusual alters. The patient recognizes the therapist's interest in them as a phenomenon, and for a time tries to maintain the therapist's interest by giving them what they seem to want. The misuse of treatment in this way perpetuates splitting and multiplicity along with distorting apparent memory.

9. Memory as the "Currency" of Therapy

Where a therapist makes a major focus of therapy the "recovery" of all memories, to the exclusion of other issues, and where the patient is particularly dependent or prone to adopt the recovery of "memories" as the currency of relatedness, a symbiotic dyad can be created where memories are inexhaustible and where there is no sense of a therapeutic management plan. The therapist endlessly pursues "memories," and the patient endlessly produces them to the exclusion of dealing with anything else.

10. Transference Memory

Here the patient recasts contemporary paradigms of evil, danger, etc., in a way that replays issues in a "therapy" setting that were never addressed originally by those who could have but did not provide protection in the face of severe and continued childhood abuse.

11. Lack of Impartiality by Therapists

At times patients with severe dissociative disorders are uncertain about the authenticity of what may be fragmentary memories. If their therapist enthusiastically endorses what has been uttered and anoints it with the imprimatur of absolute historical truth, and strongly suggests that the patient will find a lot more where that came from, a powerful and disturbing message has been sent, particularly, as is common with the victims of trauma, there is likely to be in existence a significant propensity for dependency. The lack of impartiality frequently extends to notions of the patient being "special" with the therapist seeing their own role as heroic or unique.

12. Suggestion or Active Shaping on the Part of Therapists

If a therapist is, for whatever reason, convinced that what in reality are a fairly non-specific group of posttraumatic symptoms, e.g., sleep disturbance, amnesia, aggression, anxiety, sexualized behaviors, etc., constitute confirmatory evidence of an as yet unacknowledged syndrome, e.g., SRA, then we have a traumatized patient and a therapist who not only shows interest and an overt willingness to step into the role of protector, but as well provides the explanation for behaviors and feelings with an implicit message that such interest and protection is conditional on the patient accepting the framework of the role unconsciously offered to them and reinforced by leading questions and unjustified assumptions.

13. Transgenerational Imprinting

A patient who as a child witnessed the spontaneous and frightening abreactions of a parent may so identify with what the parent was reacting to, that they will remember the content of the abreaction as if it happened to them.

14. Multiple Realities

Patients with dissociative disorders, as much as they may manifest differing ego states, may experience life as multiple different realities.

15. Source Attribution Errors

In non-dissociative individuals source attribution errors are common, e.g., an individual may recognize a face in a crowd but despite the familiarity of the face may have marked difficulty placing the context from which the individual is known. In the dissociative individual where there are repeated gaps in memory associated with episodes of partial or complete amnesia and where frequently the individual is being triggered into flashback states, the standard difficulty that exists in being able to correctly source a memory is compounded such that events, stories, films seen, the distant past, and, flashback experiences may exist as fragmentary memories that are difficult to accurately source.

In looking back over this listing of factors that I put together a quarter of a century ago I have reflected on how my perspective might have changed since. There are things that now I would give more emphasis to, but the basic outline I would still pretty much agree with. I may, on reflection, have made a more specific reference to screen memory, given its historical significance. Some updated pertinent reflections include the following:

- (a) With very traumatized patients with DID, I do not think it is well appreciated just how much of their waking hours is spent in states experienced as existing outside of present time. One encounters individuals whose subjective experience is that the majority of their conscious life is spent in such states. Living like this can only mean that life is experienced as having only limited chronological order, and the past is readily incorporated or relived in what is an unending series of discontinuities. When encountering a seemingly new scenario involving claims of current threat/abuse, I am very mindful of the importance of clarifying with the patient which parts are involved and what their understanding is as to the current date.
- (b) With some very traumatized patients with DID, life is lived in a state akin to a permanent state of flashback. The past intrudes massively into the present, yet it may be largely experienced in quite unformed ways, e.g., hearing fleeting fragments of voices, seeing visual flashes of scenes or places that may seem difficult or impossible to identify, experiencing feelings of being touched, experiencing sudden smells, tastes, etc. With so much arising from within that is so incapacitating, there can be genuine confusion as to whether what is being remembered actually happened or whether what is being experienced belongs in the past or the present. A sense of present danger may be conveyed, but also a frustrating lack of the detail necessary to nail down unequivocally whether such a threat is indeed a current reality.

In the early stages of my involvement in the dissociative disorders field in the early to mid-90s, I was reading with some apprehension about the experiences of my U.S. and European colleagues as controversies regarding SRA, DID and “recovered memories” became a particular focus for the newly-formed False Memory Syndrome Foundation. This was associated with a backlash regarding how alleged abuse was being generally reported in the press. At the time I was working towards establishing an inpatient trauma and dissociation unit here in Australia. It was self-apparent that one needed to develop a number of guiding principles and a schedule of self-survival advice if one was to achieve something approaching a relatively harmonious professional life. While none of these guiding principles are of themselves likely to be particularly original, collectively they are probably worth repeating here, as they are perhaps a reference point for how our field engages with the many forms of proven or alleged extreme abuse that inhabit a world in which “fake news” and “alternative truths” have become daily staples of the news cycle.

For what they are worth, I have included below a short summary of these pieces of self-advice:

1. In writing or in making public statements about aspects of abuse, never go beyond the limits of the actual verifiable data.
2. Be friendly and respectful. Remain receptive to dialogue with colleagues about dissociative patients and endeavor to be helpful.
3. Do not publicly attack colleagues. The natural response of an individual who is attacked is to find supporters and to counter-attack.
4. There will be a few occasions where public attacks may be so inaccurate or egregious that a sober, dignified, measured and well-referenced factual public statement is required.
5. Engage with doing sound clinical work and relevant research—with publications appearing in mainstream mental health peer-reviewed journals as well as in dedicated trauma journals.
6. For both personal and professional reasons, it is useful to also have prominent career interests that are not particularly aligned with complex trauma.
7. Within reason, be as qualified and well-credentialed as possible. The more qualified and the better credentialed one is, the harder it is to easily dismiss one's work.
8. Be collaborative. Be a credible contributor and play a constructive role in those organizations dedicated to advancing knowledge and understanding in this field of endeavor. Support and collaborate with one's credible fellow travelers—both individuals and organizations.
9. Make involvement in this field enjoyable and as professionally safe and interesting as possible for those junior colleagues who show an interest in engagement.
10. Proactively support credible political initiatives that increase society's recognition of severe childhood abuse and which respect and validate survivors.
11. Involve oneself in the organization of relevant conferences and seminars.
12. Exercise caution in dealing with the lay press, and be mindful that anything you have written or publicly stated can, and not infrequently will be, quoted out of context. Not all journalists are focused on accurate and balanced reporting. It was Oscar Wilde (1891) who observed, "In the old days men had the rack. Now they have the Press."
13. Take a long-term view and be patient.

14. Be strategically proactive in publishing authoritatively on topics that will resonate with interested professionals and which are hard for detractors to nullify.

CONCLUSIONS

As *Frontiers in the Psychotherapy of Trauma and Dissociation* has been established as a clinically-oriented journal, incorporating a range of functions originally associated with the pioneering journal, *Dissociation*, it is healthy that opinions over clinical matters are respectfully aired, as has occurred with recent debates concerning allegations of SRA, MD and organized abuse. I wonder if there can be ongoing occasions where we grapple with and try to make meaning of what was deposited when other individuals discovered, tripped over, or otherwise for the first time recognized someone as having DID. I suspect that such accounts will have a particular resonance for those colleagues who have recently engaged with their first patient with DID.

A Comment from the Editor

As Editor for *Frontiers*, I will take the opportunity to add to the author's concluding remarks about the merit of publishing a thread of articles on the same topic, e.g., sharing details of instructive clinical experiences or respectfully debating theories and practices. On this occasion, I welcome readers' personal accounts of how they discovered or tripped over a patient with DID for the first time, along with an engaging and informative discussion of relevant clinical and theoretical lessons associated with that experience.

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