MANIFESTATIONS OF POST-TRAUMATIC STRESS DISORDER

IN

MULTLIPLE PERSONALITY PATIENTS

JOEL OSLER BRENDE, M.D.

Staff Psychiatrist
Director of PTSD Education
Bay Pines V.A. Medical Center
Bay Pines, Florida

Assistant Professor of Psychiatry
College of Medicine
University of South Florida
Tampa, Florida

ABSTRACT

The author has reviewed the symptoms of Multiple Personality Disorder (MPD) and found that many of them fit diagnostic criteria for Post-Traumatic Stress Disorder (PTSD), including the presence of a recognizable stressor (traumatic event), numbing of responsiveness, intrusive traumatic re-experiences, aggressive outbursts, and feelings of guilt (survival guilt). MPD is unique however in that these symptoms are personified by alternate personalities serving protector, victim, and aggressor functions.

MPD patients are similar in several ways to Vietnam veterans with chronic PTSD including the fact that their traumatic experiences have been associated with feelings of abandonment and betrayal, their personality traits often fit the criteria of Borderline Personality Disorder, and they have similar identity fragmentation patterns including a triad of "victim-self," "protector-self," and "aggressor-self."

The diagnosis of Multiple Personality Disorder (MPD) has been described in the Diagnostic and Statistical Manual (DSM-III) (1980) with a focus on the existential characteristics, behaviors, varying appearances of the different alternate personalities, their relationships and modes of communication with each other, but with little mention of psychodynamic or etiological factors. We can, however, learn from other DSM-III diagnoses such as Borderline Personality Disorder (MPD) (Horevitz & Braun, 1984; Clary, et al, 1984) and Post-traumatic Stress Disorder (PTSD) which describe symptoms and characteristics similar to those found in MPD.

Therapists have long recognized that nearly all of their MPD patients have been victims of traumatic experiences during childhood (Kluft, 1984; 1985a,b; Braun & Sachs, 1985; Goodwin, 1985a,b; Wilbur, 1984, 1985); patient reports have been confirmed by research--for instance, that 97 of 100 MPD patients had suffered some kind of trauma (Putnam, et al, 1983). Because of this, it seemed logical to investigate if Post-Traumatic Stress Disorder (PTSD) symptoms described in the DSM-III might also apply to patients with MPD. Diagnosis of PTSD includes these symptomatic criteria: 1) the presence of a recognizable stressor (traumatic event), 2) numbing of responsiveness, 3) intrusive traumatic re-experiences, 4) aggressive outbursts, and 5) "survival" guilt.

Recognizable Stressor:

The first criterion of the DSM-III diagnosis is the existence of

a recognizable stressor that would evoke symptoms of distress in almost anyone. In normal adults, this includes war, natural disasters, physical abuse, rape, and severe accidents.

Putnam, et al (1983) surveyed therapists of 100 MPD patients; they revealed that only three percent of their patients had no evidence of childhood trauma. Likewise, Goodwin (1985a) has stated that Mary Reynolds, the first documented patient with MPD, was probably a victim of village riots.

Braun (1981) found that there were at least four different categories of traumatic experiences occurring in childhood which predisposed the development of MPD:

1. He found numerous examples of violent physical abuse. These included beating a child often with an object, cutting, burning, hanging, tying up, holding a child's head upside down in a toilet and flushing it, dangling out a window and other diabolical tortures.

2. In Braun's experience, sexual abuse had occured in every case. Examples included rape by parent/sibling/relative or an early traumatic first sexual experience. Coons and Milstein (1985) found a lower incidence of sexual abuse, however, and reported that 75% of a group of 15 patients with MPD suffered childhood sexual abuse, 11 (55%) suffered childhood physical abuse, and 30% of this group had been raped as adolescents or adults.

3. Braun also reported a high incidence of emotional abuse within the family such as severe criticism, scapegoating, use of

isolation as punishment, inappropriate performance expectations, inconsistency, lack of protection, abandonment and betrayal. An example of devastating emotional abuse was reported by Bliss (1984): "She never touched me. Never gave me a hug - just gave me the silent treatment. She threatened always to leave. No matter what you did was bad... whatever I was, wasn't good enough... I would have preferred to have the hell beat out of me. Emotional abuse can be worse." (p.142)

4. Finally, Braun (1979) found that MPD patients often suffered the effects of "visual abuse such as being made to watch a rape of a sibling or violence toward a parent or even witnessing of a murder of family members, pets or strangers ..." (p. 9). Similarly, other authors reported traumatic effects caused by hearing about or observing the abuses toward or deaths of other persons. Ludwig and his colleagues (1972) described a man with MPD whose symptoms of dissociation followed hearing about his friend's death in Vietnam, although there were other predisposing traumas. In I'm Eve (1977), Chris Sizemore saw, as a young girl, a macabre event of a man being cut in half by a saw in an accident at a sawmill. Braun and Sachs (1985) described: "...[a patient who had been]... continually forced to accompany her homicidal brother, and actually witnessed several bizarre ritualistic murders. This patient reported many details about these crimes during treatment both to her therapist and then to the police...." (p.56). Kluft (1984) reported that some of his patients were traumatized by seeing people murdered or being forced to touch or even kiss dead bodies.

In most cases there is a variety of traumatic events. Putnam (1985) has described: "At the present time all cases of MPD diagnosed in children [in a current NIMH study] have had a verifiable history of either child abuse or massive psychic trauma, such as, witnessing the massacre of family members. In most cases, the trauma took the form of sexual abuse, usually incest. In addition, several children had histories of physical abuse and/or confinement abuses, such as being locked in closets, cellars, or trunks, being buried alive, or being repeatedly bound and gagged." (p.77).

The response to these traumas is compounded by the absence of protective persons or even outright betrayal by parents or relatives who should have protected the victim. Thus, the betrayal is a second and perhaps more significant traumatic experience.

Stern (1984) studied eight MPD patients, all of whom had at least one abusive parent. All eight experienced their first "split" because of trauma involving an interpersonal relationship, usually with a parent.

Wilbur (1984) reported that "most sexual abuse...occurs within the family or the neighborhood. Both male and female infants and youngsters may be sexually abused by both parents and other relatives of both sexes. Female children have been subject both to rape and to other forms of abuse as sexual objects by their fathers, brothers, male neighbors, or the paramours of mothers, sisters, or other [protectors]." (p. 24).

Wilbur (1984) has cited parents' emotional neglect, sexual abuse, misuse of medicines and drugs, and demeaning psychological abuse: "...The child is not bathed, kept warm, diapered, or fed adequately; [it suffers] sexual abuses, occuring in infancy and childhood....The female infant is raped and may subsequently be used by male members of the family including father, brothers, stepfathers, and neighbors as a sexual object....The male infant or child is sodomized by male members of the family...[and suffers] chronic exposure to sexual displays and sexual acts...." (p. 3) "A 9-year old boy was buried in the ground by his stepfather. The stepfather had put a stove pipe over his face [and urinated into it] ...then threatened to leave the child and tell everyone that he had run away". (p. 4)

Sybil (Schreiber, 1973) was severely abused by her mother: "A favorite ritual...was to separate Sybil's legs with a long wooden spoon, tie her feet to the spoon with dish towels, and then string her to the end of a light bulb cord, suspended from the ceiling. The child was left to swing in space while the mother proceeded to the water faucet to wait for the water to get cold....She would fill the adult size enema bag to capacity and return it to her daughter. As the child swung in space, the mother would insert the enema tip in the child's urethra and fill the bladder with cold water...." (p. 209).

It is significant that there is often a transgenerational impact; abused children become abusing parents (Braun, 1985). Coons (1985) found that children who become MPD patients often have

mothers who suffered a high incidence of sexual abuse as children themselves. Kluft (1984) has described "the creation of multiple personality [patients] by abuse performed by an assaultive personality of the mother who was known to have MPD." (p.126)

The severity of abuse has often been disbelieved or ignored by parents, officials, and members of the "helping profession" (Braun & Sachs, 1985; Goodwin, 1985b; Wilbur, 1985). Even therapists are often disbelievers. Freud came to doubt and eventually disbelieved the accuracy of his patients' histories of having been abused by parents (Masson, 1984). It is indeed unfortunate that examining physicians often are coerced by abusing parents into disbelieving the truth. There are of course reasons that responsible persons disbelieve including the fact that MPD patients may appear anti-social or emotionally indifferent. Abuse victims' stories often horrify the listeners who are likely to suppress their alarm by disbelieving. In some cases, abused children may become liars, in order to protect themselves from unsupportive and disbelieving people in their environment. In some cases, the extent of the trauma may be beyond belief (Goodwin, 1985): "Stories that will be disbelieved include those involving genital mutilation, the placing of objects into the vaginal, anal, or urethral openings, incest with multiple family members, incest pregnancies, and the protracted tying down or locking up of children." (p.8)

In most cases, reports of traumatic events came from the patients themselves and have often been verified by objective

investigators. Bliss (1984) investigated reports of traumatic experiences in his MPD patients and found 9 of them to be true: "In one case a father was questioned and he verified early incest. In two other cases the patient had been told by sisters that they had also been raped by the father. In another case, the patient consciously remembered fragments of the trauma at age seven: her pain, bruises, bleeding, and vaginal infection. Unrecalled, but resurrected in therapy, was the actual rape by a vagrant. In another case, a mother confirmed her daughter's molestation." (p. 141).

There are other conditions which also predispose to identity fragmentation. Braun & Sachs (1985) have stated that the formation of alternate personalities is caused not only by trauma but also from a number of factors such as the biological capacity to dissociate which "...interact[s] with inconsistent love/abuse or other traumatic stimuli until a particular precipitating event causes an initial split..." (p. 54).

Furthermore, the impact of repetitive traumas leads to more dissociation, splitting and the formation of additional alternate personalities which have particular adaptive functions (Braun & Sachs, 1985).

Parental instability and an atmosphere of extreme ambivalence are also important predisposing factors (Greaves, 1980). Allison (1974) has described families where polarization of strong feelings is encouraged. Braun and Sachs (1985) have described extreme parental responses to their children: "... A child may be

told by his mother, 'I love you,' and then burned with a cigarette." (p.47)

A vulnerability to developing MPD is enhanced at certain ages: "In the vast majority of recorded cases, the first splitting off of an alternate personality appears to occur within a window of vulnerability extending from age six months to approximately 12 years ... A few cases are reported in which the appearance of an alternate personality is said to have occurred in late adolescence or early adulthood." (Putnam, 1985, p.77)

At such vulnerable ages, victims of abuse "lack sufficient positive introjects...[having not internalized loving and supportive family members into their self-experience] and may suffer ego and identity damage when the trauma occurs early in life...during the period of ego and identity formation." (Greaves, 1980, p.587).

The significance of age vulnerability in trauma victims has also been recognized in Vietnam veterans with chronic symptoms of PTSD. They developed a high incidence of personality disorders and episodes of dissociation follwing exposure to the trauma of war associated with experiences of abandonment and betrayal - at the vulnerable age of 19 - during the developmental phase of identity consolidation (Erikson, 1968; Wilson, 1980; Brende, 1982; Brende and Parson, 1985).

Numbing of Responsiveness

As would be expected in patients with MPD, one or more victim

personalities harbor all feelings of fear, guilt, and grief associated with traumatic memories. In contrast, one or more alternate personalities express attitudes of denial, detachment and invulnerability--a description of certain post-traumatic symptoms. The DSM-III lists emotional detachment, estrangement from others, constricted emotional response and diminished interest in significant activities as primary symptoms of PTSD. Horowitz (1976) described denial and numbing as primary defenses against the emotional impact of the trauma along with amnesia, detachment and cognitive constriction which he categorized as post-traumatic symptoms of "relative over-control."

The PTSD symptoms of denial-numbing appear to go hand-in-hand with dissociation and "splitting." Spiegel (1984), one of the first to link the two diagnoses (MPD & PTSD), described dissociation in MPD as a post-traumatic symptom. "It is not uncommon for individuals undergoing severe stress, such as an assault or rape, to have at the time a spontaneous dissociative experience, often referred to as an 'out of body' dissociative experience, in which they seem to be floating above their own bodies." He cited the case of a girl traumatized by her parents: the cruel mother's blows to the girl's face, then scalding her with boiling water; the father's beating her with a board studded with nails. The dissociation eventually resulted in formation of protector personalities, "split-off" from the "victim" personality.

The principal function of alternate personalities which form in

response to trauma is to defend and protect the traumatized personality against the fear of helplessness and future traumatic events. Stern (1984) has described the prurpose of protective alternate personalities as counterphobically defending against outside dangers and the threat of death at all costs (even if it means suicide). This is accomplishsed by maintaining complete control over the feelings and behaviors of the vulnerable personalities.

Victims of child abuse who respond to repeated trauma with dissociation lack the support of protective persons and, since they have no source of external support, must create internal support by forming alternate personalities. As Braun (1979) stated: "We believe the multiple instinctively recognizes the need for protection, support, and a sense of belonging and creates other selves who internally provide a support system."

The qualities of protective personalities may vary, not only in relationship to the severity of the trauma but also to the nature of the environment and the traumatizing person(s) (Greaves, 1980). MPD patients form alternate personalities who "identify with aggressors" (who are like the abusers). Protective alternate personalities may also have aggressive or antisocial qualities which protect against the experience of fear, guilt or shame of the victim personalities by their antisocial or promiscuous behavior. Bliss (1984) described a protector's reports of her duties: "I came to help when she was raped. She needed someone to take over. I don't like sex but I can manage it. I'm a whore and a prostitute, but she [the

patient] is very moral and proper. I'm a tramp, just dirt and filth, but I take over the sexual part of life which she can't tolerate." (p.138)

Protective personalities which present themselves to therapists during early treatment are generally undifferentiated host personalities who are attempting to cope with active symptoms (Braun, 1983) and are unaware of the presence of hidden victim personalities. But, during the course of successful treatment, at least one (and sometimes more) "protector" becomes aware, helpful, and differentiated into a more interesting and emotionally responsive personality (Allison, 1977).

Ralph Allison (1978) has described the qualities of a protective alternate personality which he has named the Inner Self Helper (ISH) and became as helpful as a co-therapist during the process of psychotherapy in one of his MPD patients. This alternate described herself as follows: "I have many functions. I am the conscience. I am the punisher if need be. I am the teacher, the answerer of questions....I will always be here and I will always be separate, but [will also have]...a oneness with a fine line of distinction. An emergency backup perhaps. I must have the ability to know. If I am gone, she is just a body. She can send part of me off and leave a small portion. But if all is taken, she is a shell....My function is overseer of the dump. I am kept busy sorting out the different messes created by and the problems created between the alternate personalities."

According to Allison, the Inner Self Helper is likely to emerge

during the course of therapy in all patients and manifests the following traits: (1) moral guide; (2) protector of the body during times of stress; (3) management of the alternate personalities; (4) predictability; (5) timelessness; (6) detachment from emotional and physiological distress; (7) intuitive communication; and (8) teacher, thinker, and wise person.

Re-experiences, intrusions, re-enactments and physical symptoms:

In Vietnam veterans, "flashback" phenomena, whereby veterans relive traumatic war experiences, are characteristic symptoms. Intrusive and repetitive dreams, images, emotions, physical symptoms and re-enactments of survival behavior are sometimes triggered by events which are reminders of the original traumatic experiences. Horowitz (1976) categorized these symptoms as manifestations of "relative under-control" of sensations, moods and images which intrude upon cognitive functioning, and represent attempts to redo, undo, or gain mastery of the frightening events.

MPD patients' traumatic dreams, intrusive traumatic imagery, and recurring traumatic physical symptoms are not intrusive in the same sense. These traumatic memories and emotions are completely split-off from awareness of the host personality and are embodied by victim personalities and re-experienced in the form of repetitive and self-destructive symptoms.

Brende & Parson (1985) reported recurring physical symptoms in

Vietnam veterans with PTSD who began to recall traumatic memories. This same phenomenon has been described in patients with MPD where physical symptoms often obscure more severe pathology: "...we discover that behind their well described hysterical conditions--the paralysis, the pain, the factitious fevers--there lie real conditions desperately camouflaged and cryptically expressed by the somatoform symptoms." (Goodwin, 1985, p.14).

Braun (1983) found that his MPD patients developed physiological symptoms associated with reliving or recollections of traumatic life events. "A female multiple personality patient suffered many tortures from both her mother and her brother.... During a [therapy] session in which the personality [victim] who received the burns had control of the body I noticed the outcropping of several red dots on her skin. They were approximately the size of the end of a cigarette and varied in shape from circular to triangular....Each time that personality returned, the spots returned...[which] were due to the burns....Another personality developed stripe marks across the lateral aspects of both arms...shoulders...and back of the neck...reported to be the results of a whipping (with a bullwhip) administered by the mother...." (p. 4-5)

A male MPD patient (Brende & Rinsley, 1981) was sexually traumatized during an incestuous experience when a boy and later raped as an adult. Whenever exposed to situations and sensory stimuli reminding him of these sexually traumatic events, the

primary victim personality James suffered frightening auditory and visual hallucinations--exaggerated forms of traumatic memories and emotions--during rainy weather and exposure to the color red, both reminders of having been traumatized.

When James relived traumatic experiences during treatment, therapeutic interventions effectively led to positive changes, not only in James but also in all of his alternate personalities. Reliving experiences of original traumatic events predictably occurs during the course of treatment in all patients who have been traumatized and suffer the symptoms of PTSD, particularly during guided hypnotic regressions (Allison 1974a; Braun, 1981; Kluft, 1982; Brende, 1980; 1985).

Aggressive Outbursts and Borderline Traits:

Aggressive outbursts are not unusual PTSD symptoms and have been defined in the DSM-III as resulting from abnormally elevated, autonomic arousal responses to triggering events. In MPD, aggression is usually personified by alternate personalities who defend vulnerable personalities against further abuse as in the following examples: "...[she] developed a violent personality when, at the age of 4 1/2 she discovered that she could make her abusive stepfather, who was coming after her, back away when she had a large carving knife in her hand. The hostile alternate carried a weapon with her from then on, always on guard against an overwhelming attack by her stepfather whom she feared would kill her...." (Wilbur, 1985, p.28). "One male patient developed an extremely aggressive, sometimes violent, personality

when at the age of 7 he was set upon by three boys larger than himself and was afraid he was going to be killed. At this time the violent alternate took over and managed to resolve the situation as he was unencumbered by any feelings other than rage." (Wilbur, 1984, p. 5).

Aggressive alternates are derived from pathological identifications with abusers such as the patient who developed an alternate violent personality that embodied the rage he felt when his stepfather abused him sexually. (Braun & Sachs, 1985)

The presence of violent alternates may be aggravated by MPD patients' inability at expressing anger in normal ways: "...female multiple personality disorder patients...[were often] punished severely [as children] when they became angry, and were informed that their expression of anger proved that they were sinful, and would go to hell." (Wilbur, 1984, p.4)

Aggression is particularly likely to be present in PTSD patients suffering from the trauma of war. Soldiers were conditioned to fight instinctively, to protect themselves from being victims. Those suffering from PTSD continue to have hypervigilance, startle reactions and frequent loss of control over aggression when feeling vulnerable. Their "killer" instincts have given them bad reputations in society, causing them to have enormous problems within the legal system (Brende & Parson, 1985).

A Vietnam veteran with aggressive outbursts is frightened that he might lose control and kill again because he harbors a

"split-off," "killer" combat identity (Brende, 1983; Brende & Parson, 1985). Typically, a Vietnam veteran will describe the following: "I don't react like normal people. I'm always waiting for something to happen...if I get into a fight, I can't stop. It's like I've been programmed to complete a task and something inside of me says don't stop until the task has been completed even if it means killing.'" (Brende & Parson, 1985) (p.83)

Unfortunately Vietnam veterans are, too often, victims of their and repeatedly destructive and self-destructive symptoms. A Vietnam veteran often describes himself as if he had become sub-human (Brende & McCann, 1984), possessed by a demon or evil power. One such patient recalled fragmented memories of being in a bar fight during which time he lost control of his rage and felt another power came over him that wanted to kill." MPD patients may often describe similar experiences of "being possessed."

Typically Vietnam veterans with chronic symptoms of PTSD suffer from loss of identity, unstable emotions, unpredictable behaviors and are often diagnosed as having Borderline Personality Disorder (Brende, 1982; 1983). MPD patients also frequently meet the criteria for Borderline Personality Disorder (Clary, et al, 1984; Horevitz & Braun, 1984).

Survival Guilt:

Survival guilt, initially considered an important part of the PTSD diagnostic criteria in the DSM-III, has been deleted from

the revised DSM-III. Yet most therapists find that their patients with post-traumatic symptoms often feel guilty, particularly if others were killed at the time of the traumatic event. Historically, those who suffered from the psychiatric malady called Hysteria, a century ago, often harbored guilty secrets related to childhood sexual abuse (Benedikt, 1894).

It has been the experience of many therapists treating patients with MPD, as well as those with chronic PTSD symptoms, to find that they suffer from profound guilt originating from a number of sources, all of which deeply affect self-esteem. Lifton (1973) found that the guilt of survivors was related to feelings of having transgressed normal boundaries of conscience related to witnessing and inflicting death, leading to indelible changes in their identities.

Guilt and shame in MPD patients is not experienced by host personalities through "splitting" and dissociation. Instead, it is only experienced by victim alternates who feel that they deserve punishment and do not perceive themselves as having been mistreated." (Wilbur, 1984). Braun (1979) found his patients suffered "emotional abuse such as degradation, pejorative language, and severe personal criticism....[Others said] 'You are no good, stupid, ugly, and clumsy. Why were you born? I never wanted you.'...and predictions [were often made such as] 'You will grow up to be a worthless, a whore, a criminal, a liar. You will go to hell...'" (p. 9)

Resolving the guilt and shame - often related to shame-ridden

"pathogenic secrets" (Benedikt, 1894) - is an important part of treatment of all MPD patients (Allison, 1974b) and other traumatized patients who have felt abandoned and betrayed.

The Aggressor, Protector, and Victim Triads::

In MPD patients, alternate personalities have specific functions, primarily the following: to serve, hold or buffer traumatic experiences; to identity with aggressors and become persecutor personalities inflicting pain and punishment on the victim personality through suicide attempts or self-mutilation; to help, advise, protect, or perform functions that the central personality cannot perform; and to provide a sense of continuity of memory (Putnam, 1985).

Another way to view functions of the various alternate personalities is as a triad of PTSD symptoms - victimization, protector, and aggressor symptoms: 1) Victimization is experienced only by a victim personality, for example: "One woman had been raped by her father when she was 4 1/2 years of age, and subsequently was used as a sexual object not only by her father, but also by some of his friends...that if she dared to resist, she suffered severe physical abuse, as well as sexual violation." (Wilbur, 1985) (p.29). 2) Protective functions (amnesia/denial/numbing) are manifested by a host or protector personality, described within the section on 'Numbing and Responsiveness.' 3) Aggressive behavior (startle reactions, aggressive outbursts and over-arousal) is expressed by an aggressive alternate personality also described previously. This

triad of symptoms has also been described as personality fragments - "victim-self", "killer-self" and "protector-self" - in Vietnam veterans with PTSD (Brende, 1983; Brende & Parson, 1985).

MPD patients' triad of common PTSD symptoms are expressed as victim, protector, and aggressor alternate personalities. In such patients, symptoms shift as personality switching takes place - from victimization to protector or aggressor behavior and finally back again to victimization symptoms or behaviors.

The victim, protector, aggressor triad may be more readily observed in male MPD patients. Caul (1986), has described therapeutic interviews with 12 male multiple personality patients, including Billy Milligan, and has found the triad of protective, aggressive, and victim personality in all 12. In a previously published case (Brende & Rinsley, 1981) an MPD patient was described with five alternate personalities. The symptoms and behaviors of all five could have been organized into the triad: 1) James, the original person, became a victim when he was raped on several occasions. He suffered from nightmares, intrusive images, recurrent traumatic memories, startle reactions, physical symptoms of pain, autonomic disturbances, and feelings of abandonment, fear, guilt, and shame. Two other of James' sub-personalities, Jim and Jimmy, shared some of the victim-related symptoms. 2) The host personality, Jay, had protective characteristics which included amnesia, denial/numbing, sleeplessness, control over physical functioning, and verbal

skills. 3) Shay, a homosexual alternate personality, pathologically identified with those who had been sexually abusive and was an aggressively acting-out and amoral individual.

This triad has also been observed in the MPD patient, Billy Milligan (Keyes, 1981). Between the ages of 8 and 9, his stepfather beat, sodomized, tied him up, threatened to kill and bury him in the barn, and then said he would tell his mother that he had run away from home. Billy was indeed a victim who "split-off" two protective personalities, Arthur and Regan. Billy grew into adult years, with an aggressive alternate personality who committed crimes of robbery and rape. After being arrested for rape and subjected to an extensive psychiatric evaluation, he was discovered to have ten alternate personalities which included a number which divided up defensive tasks and sought human contact only through selected and sometimes anti-social ways, including and rape. They were fused into three basic ones after six months of treatment: 1) Billy was the victim who suffered repeated symptoms of fear, guilt and grief associated with re-enactments of victimization and abandonment. 2) Arthur, the primary protector, was intellectually superior, narcissistic, omnipotent, and protected Billy from experiencing fear and self-destructive behavior by keeping him asleep. 3) Regan was the aggressor/protector who was skilled with a weapon and the "keeper of rage" who neutralized the fear, shame, and guilt experienced by Billy and another victim alternate, David.

Summary:

MPD patients have suffered a variety of traumatic experiences - primarily severe physical and sexual abuse at vulnerable ages, frequently at the hands of family members. Those who have been traumatized develop all of the symptoms fitting diagnostic criteria for Post-Traumatic Stress Disorder: 1) the presence of a recognizable stressor (traumatic event), 2) numbing of responsiveness, 3) intrusive traumatic re-experiences, 4) startle reactions and aggressive outbursts, and 5) "survival" guilt. Uniquely in MPD patients, perhaps because they have felt abandoned by those who should have protected them, these symptoms are personified by dissociated alternate personalities which are identifications with those people who hurt them. These alternate personalities often embody a triad of symptoms: 1) traumatic intrusive images, emotions, and "nightmares" - experienced only by victim personalities 2) denial/numbing - experienced by protector personalities and 3) aggressive outbursts - acted on by aggressor personalities.

MPD patients are similar in several ways to Vietnam veterans with chronic PTSD. Both groups of patients have been described as frequently fitting the criteria of Borderline Personality Disorder; they both suffer similar identity fragmentation patterns into the triad of victimization, protector behavior and aggressive symptoms.

Applying the knowledge of PTSD symptoms particularly as manifested in severely traumatized individuals who had also felt abandoned and betrayed, can better help therapists understand and treat patients with MPD.

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* In a personal communication with Billy Milligan's first therapist, Dr. David Caul, he stated that there are no scientific articles published about the Milligan case. Dr. Caul states further that Keyes, the author of the popular book, The Minds of Billy Milligan, did a remarkable and accurate job of investigative reporting and describing the personality characteristics of each alternate personality.

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