DISSOCIATIVE EXPERIENCES OF WOMEN CHILD ABUSE SURVIVORS
A Selective Constructivist Review

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A selective literature review of dissociation in women abuse survivors was undertaken from a feminist, constructivist perspective. Dissociation has been conceptualized many ways historically. Current understandings of dissociative phenomena are diverse, as reflected in the research and treatment literature. Dissociation has been linked to physical and psychological problems, including major mental illnesses, pelvic pain, somatization disorders, and eating disorders. There has been a preoccupation with rare but fascinating extremes of dissociation, such as multiple personality disorder, with less emphasis on more frequently seen types of dissociation, such as depersonalization and derealization. Views of dissociation as it occurs in women child abuse survivors affect their autonomy and perceived credibility and determine treatment trajectories. Questions remain as to what aspects and types of dissociation are “pathological.” There is evidence that dissociation may be a commonplace human experience in the general population. Implications for theory, research, and practice are included.

Key words: women’s health, somatization, dissociation, dissociative disorders, child abuse, sexual abuse, social constructivism, feminism

Our innate, malleable survival capacities adjust creatively to environmental impingements or prolonged periods of stress and deprivation by segregating, sequestering, reduplicating, distracting, and/or sacrificing parts to protect the whole, such that when physical or psychological survival is threatened, breakdowns occur. Disunity is almost always favored over unity.

Schwartz (2000, p. 8)

Many women have survived childhood abuse through the defenses that are collected under the term dissociation. How can we account for stony numbness, for a transparent but impenetrable shield between self and environment, and/or the lack of knowledge for events that happened early in life, followed by remembrance of them decades later? How can post-

AUTHOR’S NOTE: The author wishes to thank Jill Powell, Ph.D., APRN, BC, for clinical and conceptual consultation and dialogue about the content of this manuscript. The author especially acknowledges Debra Thomas, MSN, and Karen Phillips, MSN, for their assistance in managing and analyzing the volume of literature reviewed in order to complete this article.

TRAUMA, VIOLENCE, & ABUSE, Vol. 4, No. 4, October 2003 283-308
DOI: 10.1177/1524838003256559
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traumatic anxiety result in both difficulties in responding emotionally, and conversely, overreaction, to similar triggering stimuli in women survivors of childhood abuse? What can account for adult women survivors’ individual differences in “splitting of consciousness” in response to childhood abuse? Are abuse survivors so different from the general population in these responses?

We have only partial answers to these questions. Few phenomena have been conceptualized and defined in as many ways as have been dissociation and dissociative experiences. We have known for a century that dissociation occurs. Yet its basic processes remain mysterious, despite much study during the last two decades. The following are parameters and a focus for this review of literature on dissociation in women child abuse survivors, with the assumption that their social position and experience is different than that of male survivors of abuse. Some of the points made in this review, however, might also be applicable to male abuse survivors. This review will not be an attempt to settle diagnostic dilemmas and controversies about dissociation that have evolved in various versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The review is not focused on resolving the question of whether dissociation is a unitary or multidimensional phenomenon, although aspects of this debate are discussed. The term dissociation will be used as a general category, with definitional nuances implied according to the various references being discussed.

With the information explosion, it becomes impossible to chronicle all of the types of literature about dissociation as it may apply to recovery from trauma. Treatment of dissociation is not a primary focus of this review. Thus, this review will not be exhaustive but selectively representative of ideas about dissociation in the context of women surviving childhood abuse. These ideas are taken from selected books, print journals, and dissertations mostly appearing in the past three decades, with some reference to historically important earlier works.

DEFINITIONS, PURPOSES, AND FRAMEWORK

Braun (1988) defined dissociation as the “separation of a thought or idea from the mainstream of consciousness” (p. 87). He includes four types: the dissociation of behavior, affect, sensation, and/or knowledge. Diagnostic criteria from the DSM that describe dissociative disorders are limiting and do not account for the larger spectrum and variety of dissociative experiences (Waites, 1993). Steinberg (1995) categorized five types of dissociative experience: amnesia, depersonalization, derealization, identity confusion, and identity alteration.

For the purposes of this review, dissociation is broadly defined as significant discontinuity in awareness, perceptions, bodily sensations, and/or memory that is self-reported; meets psychiatric diagnostic criteria for a dissociative disorder (American Psychiatric Association, 2000); or is so delineated as a result of psychological measurements, such as the Dissociative Experiences Scale (DES) (Bernstein & Putnam, 1986).

In this review, the focus is on women’s dissociative experiences occurring in the aftermath of childhood abuse. The review begins with assumptions that dissociation is a real phenomenon, having multiple manifestations, but is also a social construct. Such constructs are often applied distinctly across gender. Many of the problems linked with dissociation, as well as
the history of how dissociation was studied, leave the impression that women abuse survivors dissociate more often than do others. Likewise, the problems linked to dissociation are often those seen more often in women, including pelvic pain, somatization, nonepileptic seizures, and borderline personality disorder, to name a few. What social consequences are faced by women abuse survivors when they are purported to have dissociative experiences, and how well do past and current treatments mediate these social consequences? These questions guided this review, covering an expanse of many descriptions of dissociation and problems linked with it, as they affect the credibility, autonomy, and interests of women child abuse survivors. This review is selective in that it focuses on dissociation as an issue in which women have a stake.

Much of the literature available on women survivors of childhood abuse focuses on sexual trauma, although the attempt will be made to be inclusive of multiple forms of abuse. The term abuse “survivor” will include all forms of child abuse, though sexual abuse is often the referent in much of the literature. The framework for this review is constructivist, highlighting a variety of discourses that can be inferred from conceptualizations of dissociation.

Human beings do not find or discover knowledge so much as we construct or make it. We invent concepts, models, and schemes to make sense of experience, and we continually test and modify these constructions in the light of new experience. Furthermore, there is an inevitable historical and sociocultural dimension to this construction. (Schwandt, 2000, p. 197)

The review is feminist in that it is focused on the ways that clinicians talk about dissociation and act on these ideas, such that they affect the day-to-day lives of women survivors of child abuse (Cameron, 1990). The adoption of dissociation as a diagnostic category is far superior to painting women survivors as “hysterical,” as was done in the past (Waites, 1993). Yet it is important to determine how women survivors are viewed when dissociation is conceptualized in various ways, what is at stake, and what the political and sociocultural implications are for these women in various conceptualizations (McAllister, 2000). The language used to explain phenomena in the arena of health (i.e., the body) constitute an “invisible” structural web of meanings that determine the nature of practices in relation to those phenomena (Bourdieu, 1977). Some alternative views of dissociation in women abuse survivors are suggested for further theory, practice, and research. The purpose of this review is to explore conceptualizations of dissociation, their effects on women who have dissociative problems and those who may be so labeled by clinicians and researchers, and the ways that discourses created by these conceptualizations serve, or do not serve, the interests of women child abuse survivors.

A BRIEF HISTORY

Hilgard (1977) outlined the early development of the concept of dissociation beginning with Janet’s 1889 book, L’automatisme Psychologique. According to Janet (1889/1973), ideas are associated with particular systems of thought into an integrated whole, held together by mental energy. Janet believed that dissociation did not occur in most people but was the result of earlier traumatic experiences. Those with insufficient mental energy could not hold the thought systems together, and separated ideas that then were unavailable relative to a system of thought were thus termed dissociated (Doan & Bryson, 1994). Janet used hypnosis with his patients to discover dissociated traumatic memories and images as well as to change these ideas to nontraumatic ideas. Janet believed those women he treated for hysteria were
easily hypnotizable and were thus dissociating or compartmentalizing certain ideas that then persisted only subconsciously, out of awareness. Hilgard himself continued working under the assumption that dissociation can be demonstrated through hypnosis, conceptually linking these phenomena. He did many experiments using hypnosis to better explicate dissociative experiences. Although some have seen dissociation as an example of hypnosis, in his theories Hilgard considered dissociation to be the larger phenomenon of which hypnosis was an example (Doan & Bryson, 1994).

Like Janet, Freud also worked with women who were “hysterical,” many with histories of incest. His emphasis on repression, reconceptualization of the unconscious, and especially the redaction of his seduction theory are now well known (Masson, 1984). It was politically and professionally expedient for Freud to deny that incest was generally the basis for hysteria, instead asserting that adulthood distress can be ascribed to children’s incestuous desires in early development. This has had devastating consequences through the 20th century for women survivors of actual childhood abuse. Nevertheless, Freud’s original contention, that childhood sexual abuse (CSA) in particular could result in a complex of ideas separated from one’s central personality, supported Janet’s tenet that dissociation resulted from trauma.

Another view, aside from Janet’s and Freud’s theories about dissociation, stems from consideration of evolution. Behaviorists have demonstrated that other species are capable of perception and response without consciousness. It is therefore not difficult to believe that human beings have this capacity as well and that awareness is selective and limited at times (Bowers, 1994). It should not be inferred from theories of evolution that dissociative experiences are of a “lower” biologic order. Rather, it should be expected that throughout history, human beings would continue to access/not access information through dissociative processes. It is widely accepted that dissociative symptoms are posttraumatic effects (Fine, 1990; Spiegel, 1991). But in Bowers’ view, trauma may or may not be the precursor of dissociation, which may occur in a variety of situations. Several theorists suggest that even “normal people” have many executive functions that act in network fashion, comprising multiple “minds.” Such multiplicity is likened to an orchestra, with diverse parts of the brain unified as in musical production (Beahrs, 1982; Gazzaniga, 1985).

Idea about dissociation have appeared on the scientific and clinical “stage” over the last century, and the amount of literature on the topic has burgeoned since the 1970s when posttraumatic syndromes were brought into focus. Yet it is not as if the ideas neatly replace one another in chronological fashion as new paradigms emerge. More accurately, the new and old conceptualizations seem to coexist and still compete. These constructions continue to act as foundations for current discourses and related practices. An example of this is the ongoing debate about the degree of volition employed, or not employed, in amnesic phenomena, reflecting use of the terms “repression” or “dissociation,” respectively (Tuch, 1999; Yarom, 1997). If dissociation is volitional, the implication is that one may not be honest about memories; if it is avolitional, the implication is that such information is not accessible and thus consciousness is not complete. Each of these implications bears on the credibility of the woman survivor of abuse when viewed from a feminist perspective.

With some exceptions, (e.g., Briere, 1992; Briere & Conte, 1993; Chu, 1998a; Irwin, 1996, 1999a, 2001; Kench & Irwin, 2000), most of the studies about dissociation in women abuse survivors focus only on sexual abuse, not the entire gamut of child maltreatment and neglect. Yet consistent subtle emotional trauma and neglect may also result in serious damage to abilities to self-regulate, to organize affects and perceptions, and to maintain continuity of experience (Emde, 1983; Toth, Cicchetti, Macfie, & Emde, 1997). This is significant. Feminism was helpful in illuminating gender and sexually based forms of violence, beginning with the legitimation of the rape-trauma syndrome in adults. Yet this trend, as well as the backlash against it, such as the false memory debate, turned focus and media sensationalism toward sexual abuse. This undoubtedly decreased the aura of silence and denial surrounding CSA but did not signifi-
cantly increase concern for other forms of child maltreatment.

MEASURING DISSOCIATION AND ITS INCIDENCE IN CHILDHOOD ABUSE CASES

A significant turn in conceptualizing dissociation was the development of scales to measure it (e.g., the DES). This scale does not place an individual on a continuum of dissociative capacities by type but rather provides a quantification of “amounts,” or levels of dissociation. This tool has been widely used in research and has also been applied clinically. It has been determined that scores on the DES are negatively correlated with age, which supports the notion that dissociation is more common in childhood. Thus, dissociation (along with denial and projection) is considered a “primitive” or immature method of coping. The DES selectively measures one coping strategy not in context with other coping strategies that the individual might use. A source of validity concern is the heterogeneity of items included in a scale purported to be measuring a single neuropsychiatric “construct” (Alper et al., 1997). It has been used as a means to link dissociation with psychiatric disorders other than the specific dissociative disorders. Importantly, positive effects of dissociation have not been studied through correlation with the DES and similar scales, which may foster more negative attitudes toward those women who dissociate as a result of trauma. The scales measuring dissociation have provided standardized measures for dissociative experiences in adults, thereby fostering research. Studies using scales usually correlate dissociation with (a) other psychological constructs, (b) experiences, and (c) physical and mental problems. Such research most often serves the interests of women by providing clarity but must be viewed critically so that the concept is not overextended as an explanation for these other phenomena.

Among large general population samples, the range of childhood abuse histories in women is 22% (McCauley et al., 1997) to 53% (Golding, 1994). There is ample evidence that women survivors of CSA have more dissociative experiences than do nonabused counterparts (e.g., Briere & Runtz, 1988; Chu & Dill, 1990; Spiegel, 1991). Studies have linked more frequent abuse, severe abuse, combined physical and sexual trauma, greater numbers of perpetrators, early age of onset, and other characteristics of the original maltreatment to greater levels of dissociation (Boudewyn & Liem, 1995; Briere & Conte, 1993; Irwin, 1994; Terr, 1991; Zlotnick et al., 1994). Some researchers have not found relationships between abuse severity/characteristics and dissociation in adulthood (O’Neil, 1997) but emphasize that the meanings ascribed to abuse events might mediate levels of dissociation (Johnson, Pike, & Chard, 2001). In some research, physical abuse was more highly correlated with high DES scores than was CSA (e.g., Mulder, Beattrais, Joyce, & Fergusson, 1998). That meanings of abuse might mediate dissociation suggests that women abuse survivors’ individual subjectivity concerning their trauma alters the symptomatology of dissociation and should receive more attention in treatment and research.

Some actually use the presence of high levels of dissociation as a basis for assuming that childhood trauma occurred, meaning that it is diagnostic in itself (e.g., Carlson, Armstrong, Loewenstein, & Roth, 1998). This is an unsupported assumption (Merckelbach & Muris, 2001), and it should likewise be noted that as many as half of women incest survivors, for instance, do not develop psychological symptoms (Herman, Russell, & Trocki, 1986). In contrast, in a nonclinical sample, there were no significant differences in levels of dissociation between women with and without CSA histories, and the coping mechanism projection, not dissociation, was more commonly seen (Romans, Martin,
Morris, & Herbison, 1999). Chu (2000) took issue with the study findings, arguing that because the participants were in the community, they must not have suffered as severe or early age onset sexual abuse, even though many women in this study had experienced penetration as children. He concluded that these women could compensate and not dissociate as much. It is curious to note that researchers are somewhat defensive when DES scores of abused women are found to be low, undermining the current paradigm. It is helpful to find the links between CSA and dissociation, but care should be taken not to establish theory that this is the sole pathway to dissociation, nor that such women always become dissociative as adults. To do so leads to potential misinterpretation of any behaviors or verbalizations that are similar to signs of dissociation, and other meanings and explanations are then missed and/or treated incorrectly.

The widely accepted explanation for dissociation as more frequent, pronounced, and even problematic in adult women survivors of abuse is that (a) children consciously avoid thoughts of abuse that they experience, (b) over time this becomes an “automatic” habit, and (c) eventually all or part of the traumatic material is compartmentalized out of awareness (Herman, 1992; Terr, 1991). Some also posit that double messages about reality cause children to become anxious and to exhibit trancelike behavior, altering perceptions (Beahrs, 1982; Waites, 1993). Those who dissociate in childhood tend to experience more severe dissociation in adulthood, and more dissociation is associated with greater childhood physical injury and the belief that one might be killed during the abuse (Johnson et al., 2001; Marmar, Weiss, & Metzler, 1998). In contrast, however, O’Neil (1997) found more dissociative experiences in those whose abuse occurred after age 14. Although dissociation is more often seen in children than adults, it is not clear that with earlier abuse, dissociation is increased. Women’s interests are not served when conclusions are drawn about actual abuse events, based on the exhibiting of dissociative symptom patterns. Many abused women do not have dissociative experiences.

Dissociation and Hypnotizability

Dissociation has been associated with hypnotizability. It is held that dissociative persons are highly hypnotizable, based on the fact that they score highly on scales developed to measure these constructs. Hypnotizability may even be inherited (Putnam, Helmers, Horowitz, & Trickett, 1995). If hypnotizability is inherited and accounts for dissociation, the link between child abuse and dissociation would not be clear. Of course, it may be that hypnotizability and dissociation “runs in families” just as patterns of child abuse occur intergenerationally. (Recall that Hilgard saw hypnosis as a case of dissociation). Conversely, there may be no relationship between childhood sexual abuse and hypnotizability (Nash, Hulrey, Sexton, Harralson, & Lambert, 1993). Yet it is still held that hypnosis can be used to treat women CSA survivors (Kluft, 1984, 1992; Maldonado & Spiegel, 1995). Maldonado and Spiegel (1998) stated that “hypnosis is controlled dissociation” (p. 95). They describe traumatized patients and therapy as follows:

On the one hand, they visualize the old self . . . and, on the other, they see themselves as soiled, defenseless, and helpless victims, incapable of doing much to alter their present or future. . . . Patients are encouraged to acknowledge the content of the traumatic memories rather than avoid (dissociate) or repress them. Acknowledgement is followed by therapy . . . that allows them to put into proper perspective the painful events . . . The same shift in concentration elicited at the time of trauma can now be controlled with the help of hypnosis . . . Once memories are recovered, patients must confess feelings and experiences of which they are profoundly ashamed. (Maldonado & Spiegel, 1998, pp. 95-96; parentheses in original)

In this recently written passage, we see not only the equation of dissociation with hypnosis and recommendation of hypnosis as treatment, but a very negative character portrait is painted of the survivor of abuse or trauma. Clearly, the therapist-hypnotist defines and evaluates the goals of this treatment process with little regard for the client’s desires and ways of framing her situation. She must “confess” experiences anticipated by the therapist. Women thus lose control of their own therapy process and are imputed
with disabilities and feelings of shame that they may or may not actually have. Without assuming that the above quote exemplifies all therapy toward women survivors of child abuse, it is disconcerting to see this approach described at all in the literature. Hypnosis has been used to “treat” dissociation even though it is in many circles actually equated with dissociation, as is shown above. Women abuse survivors’ dissociative experiences may be misinterpreted, and hypnosis as treatment may exacerbate problematic dissociative experiences by fostering confusion, pathologizing, and loss of autonomy.

TYPES OF DISSOCIATIVE EXPERIENCE AND CONSEQUENCES FOR WOMEN ABUSE SURVIVORS

Steinberg (1995) held that amnesia is the foundation for the other forms of dissociation. All the forms of dissociation are thus means to block awareness of the traumatic memory. She defines depersonalization as a feeling of being divorced from the body or feeling like one is moving through life like a robot or an automaton. For some women abuse survivors, this is akin to feeling that one is like a doll or a shell of a person (Waites, 1993). Derealization is defined as feeling alienated from the environment. People or things around the survivor seem unreal, as past experiences take the center focus in a flashback. These, as well as simple absorption, are frequent experiences of women abuse survivors. Less frequently, women survivors experience the last two types of dissociation described by Steinberg: identity confusion and identity alteration. Identity confusion is a sense of conflict, sexual ambiguity, or uncertainty about identity. Sexual confusion, including gender role interruption or constraint, may be seen in some women who were sexually abused. Abuse survivors experience dissociative fugue less frequently than the first two types. Fugue is defined as a period of time loss when one acts and perhaps even relocates for a time, shifting into a markedly new role or identity. The person later “awakens” to realize that this has occurred, and the familiar, consistent identity then resumes control. Identity alteration would include multiple personality disorder (MPD), now known as dissociative identity disorder (DID), which will be discussed separately (Steinberg, 1995). MPD/DID is more rare among women abuse survivors than the abundance of literature and research would indicate. In fact, three quarters of those experiencing dissociation do not exhibit signs of identity disorders (Chu, 1998b).

Many authors describe dissociation as a continuum of experiences from simple absorption and minor “time loss” to DID. Measurement demonstrates, however, that there tends to be a bimodal distribution—that is, low dissociators and high dissociators, the latter being more frequently diagnosed with dissociative disorders (Putnam et al., 1996). This indicates that there likely are women with abuse histories who might fall into the latter category, and who need treatment. Thus, it cannot be assumed that dissociation itself is merely a social construction.

Dissociation is the focal point for discussions of the veracity of delayed recall of childhood abuse memories. These two preoccupations have overshadowed many other, perhaps more pressing abuse and dissociation-related experiences of women abuse survivors from their view (Waites, 1993). These may include shame, guilt, depression, and a sense of helplessness (Waites, 1993). It may not be a necessary or desired clinical goal to corroborate abuse memories or the suspicion of them. It remains a question, especially in the cases of those who were multiply abused over long periods, how efficacious it is to expose and reconceptualize memories that will not likely take the forms of “events” but rather trajectories of experience, locations in the past (Hall, 1996a). Generally, the so-called less severe forms of dissociation are often quite problematic for women abuse survivors, although less attention is paid to these difficulties.

The relationship of childhood trauma to depersonalization is understudied, and although sexual abuse is often the preoccupation, as has been stated, emotional abuse is a strong predictor of depersonalization (Simeon, Guralnik, Schmeidler, Sirof, & Knutelska, 2001). Alexithymia, the inability to recognize or express feelings (Berenbaum & James, 1994; Rodin, de Groot, & Spivak, 1998; Stout, 2001) has been
Alexithymia and dissociation are linked to not having felt safe in the family of origin (Berenbaum & James, 1994). Similarly, if the family lacks emotional support, this seems to contribute to the development of dissociative symptoms (Irwin, 1996). Ignoring or downplaying these forms of dissociative experience deprives women survivors of treatment and the benefits of more in-depth research that could improve the quality of their lives.

MULTIPLE PERSONALITIES AND CHILDHOOD ABUSE

MPD was nominally changed in the fourth edition of the DSM to DID (American Psychiatric Association, 2000). This is of some interest linguistically and politically because the notion of personality is related to the word persona or “mask,” a social self presented to the world. Identity, on the other hand, implies a rigid aspect of self that is not drawn out in interaction but rather is constant. Identity is not malleable; it is only “discoverable.” The terminology change enabled clinicians to take the position that the several entities encountered in diagnosing DID were “already present when I got there,” so to speak. This makes it less likely that clinicians will be accused of “planting” personalities in their patients, an accusation made by the “false memory syndrome” movement. Moreover, an immutable quality is assigned to DID when an etiology is posited in which disruptions in parental caregiving to the child leads to changes in the developing orbitofrontal cortex (Forest, 2001). This might play out poorly for women diagnosed as having DID because it creates the impression that compartmentalized aspects of the self are unchangeable and disperses personal accountability for behavior. This is another way in which autonomy and responsibility are compromised for some women abuse survivors—on the basis of real or imputed dissociated identity.

Clients may be learning the terminology of DID from clinicians or from others with DID who learned it from clinicians. For example, words such as “switching” and “alters” are not in the common parlance. Once one begins to define oneself as having DID, most new behavior is easily parleyed out between several existing or emergent alters. This may lead to the “emergence” of new personalities to explain new behaviors. Although it is conceivable that one might have several developed personalities, reports of providers of having patients with perhaps 100 separate personalities do not seem credible from a common-sense viewpoint. Little research can confirm the exact number of personalities or identities one might have due to definitional ambiguities and lack of longitudinal designs. When institutional language of DID must be used by women to describe their experience in order to “fit in” to treatment paradigms, it decreases credibility, autonomy, and the right to name one’s own experiences.

Spanos (1996) pointed out that people behaving as though they had two or more selves, with separate memories and behaviors, is cross-cultural and that only in North American society is this labeled MPD. Women abuse survivors may thus be exhibiting behaviors considered socially acceptable in their own cultures, but often this is pathologized. Spanos emphasized that MPD is a response to the social expectations of others, noting that the dimensions of MPD have changed with historical context. Gleaves (1996) countered Spanos’s argument that the media has “created” MPD by insisting that it falsely interprets the characteristics and treat-
ment of MPD/DID and obscures its connection with childhood trauma. And the (probably small) number of women child abuse survivors who actually have DID experience an intense degree of suffering and often disabling disruption because of this condition (Levin, 1997). It is essential that women abuse survivors not be erroneously diagnosed as having DID, yet those who warrant such diagnosis deserve safe and non-pathologizing treatment for this as well as for other dissociative problems they may have.

Unfortunately, hypnosis is still advocated for diagnosis and treatment of DID in women abuse survivors, among others. Caution is warranted, following a study of 11 males and 18 females, wherein hypnosis was used successfully among the highly hypnotizable participants to suggest or “create memories” (Laurence, Nadon, Nograd, & Perry, 1986). Although Janet used hypnosis in traumatized women to “create” substitute positive memories to counter traumatic ones, the same mechanism could theoretically be used to foster the recall of nonexistent abuse “memories.” In one case, hypnosis was used to assist a woman incest survivor to recall the abuse incidents by allowing her to access “resources” held by disparate parts of herself (e.g., a younger self, etc.). The author concluded, however, that this compartmentalization did not constitute a case of DID (A. Miller, 1986).

Boyd (1997) emphasized the rapidity with which hypnosis could resolve DID, a point that might make it appear attractive as an intervention to behavioral health organizations that increasingly demand quick solutions to mental health problems. If DID is as “fragmenting” and as deeply rooted within the abuse survivor as has been historically maintained, it seems unreasonable to press for the use of hypnosis as a rapid intervention when it is now usually reserved as a short-term therapy in far less disabling conditions (e.g., for smoking cessation). And the most pressing problem posed by these studies and cases is that supposedly those most in need of hypnosis (dissociated, highly hypnotizable persons) are also most vulnerable to suggestion of “memories” during the process of hypnosis. In the case of DID, it seems that for women abuse survivors whose suffering is sometimes difficult to verify, hypnosis can cloud the picture considerably.

In at least one case, hypnosis (said to be incorrectly employed) was used by a police hypnotist to elicit a false confession by a woman to a shooting after the “appearance” of an alter personality. The woman was charged with a crime but not convicted due to the manner in which the evidence was extracted. She had no prior history of dissociative problems (Coons, 1988). This example points to the problems posed when abuse memories uncovered by hypnosis must be considered in the courts; the uncovered material is often dismissed as unverifiable by legal standards.

Perhaps the most bizarre claim about the relationship between MPD and women abuse survivors is that because of a proposed tendency for self-harm in such individuals, one alter might act sexually against another (the primary self), resulting in “self-rape” (Beer, Beer, & Beer, 1994). This “explanation” has the potential to discredit dissociative women abuse survivors who actually are raped as adults, creating a scenario wherein even physical evidence of rape could be dismissed as resulting from the actions of an alter self against the primary self. Because of the potential for hypnosis to discredit women with DID, as well as those with delayed recall of abuse, it does not seem to be in their interests to undergo hypnosis as a therapy nor as part of a criminal investigation.

FALSE MEMORIES, DISSOCIATION, AND CHILDHOOD ABUSE

A Medline search of the term “false memory syndrome” yields more than 1,400 hits beginning in 1965. Some of these results refer to brain injury, but more findings, beginning in the late 1980s, are sharply focused on questions about the veracity of delayed recall of abuse, especially sexual abuse. The False Memory Syndrome Foundation came to the defense of many accused perpetrators of sexual abuse of children, claiming that “pseudomemories” are often created or implanted by therapists and via clients’ participation in sexual abuse support groups. This was accompanied by a preoccupation of the topic in the psychology literature that
In a general population study, 42% to 60% of CSA survivors experienced at least some delayed recall of the abuse, and delayed memories were related to having been threatened by perpetrators (Briere & Conte, 1993). Thus, women who have dissociated memories of abuse not only have severe trauma histories, but there is a rationale for “forgetting.” Evidence was not convincing to the psychiatric community. Recent work also shows that adulthood abuse triggers existing trauma memory networks, supporting that earlier abuse would likely then be recalled after amnesia (Herman, 1992).

The focus on a potential false memory syndrome has been very discrediting and infantilizing of women abuse survivors. It implies a level of suggestibility and deficient reality testing far from the norm. There is also a suggestion that women would concoct stories of abuse to “get back at” those they accuse of being abusive over imagined wrongs or out of spite. These notions are indeed disparaging toward abuse survivors. Accusations of ritual or satanic abuse by children are often doubted as elaborations, fantasy, or stimulated through reinforcement or social contagion from one child to another in a group of survivors (e.g., Garven, Wood, & Malpass, 2000). A distinction has not been clearly drawn, however, between the apparent suggestibility of children and the mature memory capabilities of adult women, who may have indeed dissociated memory for early abuse. In support of this, Leavitt (1997) actually found lower suggestibility scores among persons with recovered memories as compared to nonabused counterparts.

In a general population study, 42% to 60% of CSA survivors experienced at least some delayed recall of the abuse, and delayed memories were related to having been threatened by perpetrators (Briere & Conte, 1993). Thus, women who have dissociated memories of abuse not only have severe trauma histories, but there is a rationale for “forgetting.” It is a fairly common, though not simply random, occurrence. “Falsely forgetting abuse” due to dissociative amnesia is often not a consideration in the debates about veracity of memories (Baars & McGovern, 1995). Subjectively, the most frequent pattern for a woman child abuse survivor is that abuse was known but kept in the back of her mind, and most survivors had continual knowledge of the abuse events, although problems associated with this knowledge might become more prominent or troublesome in adulthood (Dale & Allen, 1998). In a similar study, only 16% reported a period of amnesia followed by recovery of memories, whereas half said that they clearly had never forgotten abuse. Previous psychotherapy was reported as a factor in recall of abuse by about one fourth of those studied. Usually, individualized, trauma-like reminders and life crises stimulated the delayed recall of childhood trauma (Herman & M. R. Harvey, 1997). Most women in one study reported that their first recalled memories of abuse did not occur with therapists, that suggestion was an infrequent contributor to recall, and that levels of amnesia corresponded positively with earlier ages of abuse in childhood (Chu, Frey, Ganzel, & Matthews, 1999; Leavitt, 2000).

Most of this research focused on sexual abuse. The upshot is that there is great diversity in the ability to recall abuse. Furthermore, not remembering abuse that actually occurred at least for a period of time characterizes women abuse survivors’ experience far more often than does rare, if substantiated at all, cases of “false memories” of abuse that did not occur. Therapists’ fears of “planting memories” or the legal consequences of “uncovering” memories of abuse that never
occurred are probably unwarranted. Women abuse survivors usually need support in believing abuse happened to them, especially when it was accompanied by threats, cloaked in secrecy, and represents negation and violation of one’s autonomy and personal boundaries.

The Chu et al. study (1999), although having acceptable limitations involving self-report, supports the credibility of women CSA survivors and depathologizes dissociative memory disturbances. Yet this research touched off a barrage of challenges in the form of commentaries in the *American Journal of Psychiatry* in August 2000 (Vol. 157, No. 8). The eruption of this debate supports Faludi’s (1991) thesis that feminism struck too accurately at the status quo in terms of female marginalization and victimization, and therefore dominant majority backlash has been consistent and pervasive. The backlash has also affected those outside the circle of White middle-class women who spearheaded the movement but left other groups of women behind (Hooks, 1989). The minority groups who survive abuse and experience dissociation are discredited by attributions of false memory syndrome, and these women have even fewer advocates in the scientific debate and in the health care arena. To be fair, nearly every backlash occurs because there is a need for some correction to a sweeping generalization. It is likely that both recovered and false memories may occur, even in a single person’s experience (Baars & McGovern, 1995). Furthermore, it is not the case that gender inequity alone can explain child abuse or even child sexual abuse. In many cases, these are only to be explained as crimes, as evils against male and female children that have been part of many cultural milieus, past and present.

The veracity of memories is not the same as the existential authenticity of memories, and this aspect can best be understood phenomenologically (Casey, 1987; Hall & Kondora, 1997). Keep in mind that part of what may be dissociated in “forgetting” abuse are the meanings (Schwartz, 2000) communicated in the trauma: shame, terror, betrayal, sadism, torture, negation of self-worth, and/or sexualization of nearly all interactions. One may also be socially coerced into forgetting and not speaking about abuse in an atmosphere of secrecy, denial, and lying about it in families in which it occurs as well as in some (substandard) psychotherapy (Frawley-O’Dea, 1997; Hall, 1996a).

**DISSOCIATION AND RELIGIOUS/RITUAL ABUSE**

There is debate about the prevalence of ritual abuse, though it is reasonable to assume that there are some cult-related forms of abuse as well as cases of abuse by mainstream priests and ministers, much of which has been purposefully concealed. In the case of Catholic priests, many cases of abuse of children and adolescents have been documented. Furthermore, it has come to light that the Catholic institutional hierarchy usually settled out of court with victims, sealed the records, and merely relocated the perpetrating priests (Berry & Greeley, 2000). On the other hand, Jenkins (1996) argued that such abuse is not widespread but has been constructed as a crisis by media and public fascination in the past decade. This author further reframed the situation as part of a longstanding anti-Catholic tradition. Thus, the allegation of religiously related sexual abuse is politically charged. Religious abuse is now an undeniable reality, and many survivors of such abuse recall subtle coercive elements to the abuse that rested on the trust they had in perpetrators as community and spiritual leaders.

Although a frequent assumption is that sexual abuse targets of clerics are male, a significant number are female. The stories of many of these survivors are obscured by the agreements of nondisclosure that accompanied many legal settlements of claims against religious perpetrators. Likewise, as the statutes of limitation expire for many survivors of this kind of abuse, justice is not obtainable by adult survivors at this point. These factors affect women survivors’ sense of integrity about their experiences, as the community cannot hear about and believe what has happened in the context of religion.

Spanos, Burgess, and Burgess (1994) equated reports of ritual abuse with UFO sightings and alien contact, and past-life experiences. They termed these collectively as fantasy events that then are “constructed” as memories under the
pressures of hypnosis and interviewing techniques, which create social expectations for such reports. There have been legal landmarks about ritual abuse, such as the well-publicized McMartin case, in which there were strong allegations of organized and long-term ritualized abuse of a group of children. After revelations about coaching of the involved child witnesses by interviewers in the investigation, however, only one conviction resulted, that of a past sex offender. Prosecutors developed more careful and objective methods of investigation in subsequent cases.

Legal outcomes and the generally unusual reports of strange events occurring in ritual abuse, such as satanic cult behavior, have precipitated doubts about women who claim to have been ritually abused as children. This is a source of delegitimization of individual victims and the aggregate of ritual abuse survivors. Without speculating about the incidence of a highly secretive and potentially threatening form of abuse, it is safe to say from clinical experience with survivors that it occurs but is difficult to verify. Adult female ritual abuse survivors have been found to report much more severe forms of sexual and physical abuse than did a second group of women abused without ritualism. In this study, however, the ritual abuse group showed no greater levels of dissociation or PTSD, suggesting that assumptions of dissociative interference with memory is not particularly affecting this group (Lawrence, Cozolino, & Foy, 1995).

Somatic links to dissociation have consequences for the acceptance and credibility of women abuse survivors, because somaticized psychic pain is not well understood and can lead to diminishment of the suffering of the affected woman client. Somatization disorders are chronic, often painful conditions that may affect many body systems over years and that occur in the general population but are highly associated with trauma histories (Rodin et al., 1998). Saxe et al. (1994) found that 64% of patients with dissociative disorders also met criteria for somatization disorder, although none of those without dissociative disorders met somatization criteria. Women with physical and sexual abuse have more hospitalizations and lower estimations of their overall health (Moeller, Bachmann, & Moeller, 1993). Sexually abused women report more health risk behaviors and more medical problems, and they scored greater on somatization scales (Springs & Friedrich, 1992). They commonly have gastrointestinal disorders, more surgeries, and multiple somatic symptoms (Drossman et al., 1990). Golding (1994) found that sexually abused women reported poorer health, more diagnosed chronic health problems, and also had more...
medically unexplained symptoms. Those with severe childhood sexual trauma have significantly more medically unexplained symptoms and more harm avoidance and dissociation than do less severely traumatized or nonabused women (Walker, Gelfand, Gelfand, Koss, & Katon, 1995). It has been concluded from these studies that somatization is either a form of dissociation or that there is a high concurrent incidence of the two. In contrast, McCauley et al. (1997) found that women with child abuse histories were more likely to have physical symptoms, somatization, psychiatric illnesses, and substance misuse but that these difficulties were just as prominent among women abused as adults.

Chronic pelvic pain in adult women is significantly related to histories of sexual abuse, physical violence, and emotional trauma (Lampe et al., 2000; Walker et al., 1997). More somatization, dissociation, sense of disability, and current psychological distress characterizes women with sexual abuse histories with chronic pelvic pain (Walker, Katon, Neraas, Jemelka, & Massoth, 1993). In one study, as many as 39% of women reporting pelvic pain had histories of childhood physical abuse, but there was no increased incidence of CSA in this group (Rapkin, Kames, Darke, Stampler, & Naliboff, 1990). Fry, Crisp, and Beard (1997) reviewed the literature on chronic pelvic pain and found mixed results, suggesting that more attention needs to be paid to the specific subgroups and symptom patterns among those thought to have "psychogenic" pain. Although this pain may be medically “unexplained,” some research shows biochemical pathways revealing physiological stress states in women abuse survivors with chronic pelvic pain (Heim, Ehlert, Hanker, & Hellhammer, 1998). One study showed that abused and nonabused groups did not score differently on pain description but that the abused persons experienced less sense of self-efficacy, greater Global Severity Index scores, and had more pain-related emergency room visits (Toomey, Seville, Mann, Abashian, & Grant, 1995).

Thus, whether medically explainable or not, the pain syndromes of women survivors of childhood abuse appear to be more distressing when compared to these syndromes in the general population. They more often have surgery and use emergency rooms and hospitals. The research does not tell us whether this is due to increased psychic stress, past injuries and posttraumatic physiologic syndromes, lower pain thresholds, lack of help seeking in earlier stages of illness, and/or nonresponse or inappropriate referrals on the part of providers who first encounter these women survivors. In any case, there is cause for clinicians to respond more accurately in terms of physical pathology, to meet psychosocial needs and not dismiss symptoms as "only psychiatric"—that is, as a dissociative response to trauma about which little can be done.

Exploration has been based on the question of whether physical and psychiatric problems co-occurring with dissociation, particularly in CSA survivors, might have common underlying factors. In a multivariate study of gastrointestinal patients, history of severe CSA, perceived physical disability, lifelong dysthymia, alcohol problems, and anxiety comprised the model best predicting high levels of dissociation (Engel, Walker, & Katon, 1996). The investigators concluded that when dissociation is seen, providers need to look for these potentially co-occurring factors and treat them. This does not often occur in today’s segmented health services in the United States, and women abuse survivors are among those who receive inadequate and inappropriate care as a result.

Pseudoseizures are another historically discrediting diagnostic category that has been linked to dissociation in women child abuse survivors. Pseudoseizures are associated with high DES scores and diagnostic criteria for dissociation. However, pseudoseizures are also associated with affective, somatic, anxiety, and personality disorders, all of which have some symptom convergence (Bowman & Markand, 1996; Engel et al., 1996). Alper et al. (1997) referred to these events as “conversion nonepileptic seizures,” a term that accords more legitimacy to the seizure experiences of women abuse survivors. High dissociators with conversion nonepileptic seizures especially exhibit the depersonalization/derealization dimension of dissociation.
If pseudoseizures are a form or result of dissociative experience following childhood abuse, they certainly seem to be an expression of acute psychic suffering. Health care providers do not see them as life threatening but rather breathe a sigh of relief that there is no documentable, “real” neurological disturbance involved. Currently, the specific physiologic processes that constitute pseudoseizures are not known. Similarly, little is known about the subjective, lived experiences of those who have these nonepileptic seizures. More practically, what is the treatment standard for pseudoseizures? They appear to present a definite safety concern and indicate the need for urgent mental health care. More research is needed on adequate and effective interventions for pseudoseizures; this would be in the interests of women abuse survivors who have them.

Eating disorders such as anorexia and bulimia have been correlated with sexual and physical abuse (Demitrack, Putnam, Brewerton, Brandt, & Gold, 1990; Torem, 1986), although the link is not clearly explained and is nonspecific in some research (Welch & Fairburn, 1996). It is hypothesized that one might binge or exercise while in a trancelike dissociated state. Swirsky and Mitchell (1996) found that the binge-purge cycle in bulimia produces a subsequent dissociative numbing of affect. Thus, it is paradoxically hypothesized that dissociation is both a potential antecedent and a consequence of eating disorder behaviors. The link between bingeing and dissociation is questionable, and dissociation does not explain many other aspects of eating disorders, such as laxative abuse, fasting, and obsession with weight and calories consumed. Core cognitive beliefs may play a central role in the development of eating disorders in women who are abuse survivors (Waller et al., 2001). There are undoubtedly many women with eating disorders who do demonstrate high levels of dissociation. This seems to be another case in which dissociation is reached for as a “mechanism” through which a clearly pathologic disorder is fostered. It is convenient to insert dissociation as an explanation for problems that are difficult to understand and treat. Yet this may lead to hyperpathologizing of dissociation and overestimation of its involvement in such problems.

There is no evidence to link dissociation or trauma to factitious disorder (intentionally feigning signs or symptoms of medical or psychiatric illness). Nevertheless, the suggestion has been made that through yet a third element, disturbances in sense of self and reality, such as borderline personality disorder, there is a link to dissociation (Spivak, Rodin, & Sutherland, 1994). Some go so far as to suggest that factitious disorder itself should be categorized as a dissociative disorder (Cocores, Santa, & Patel, 1984). Black persons and younger White women are more likely to be diagnosed with factitious disorders, even when not referred for medically unexplainable symptoms (Slavney & Teitelbaum, 1985). Thus, another potential source of delegitimization has been suggested for women abuse survivors. Dissociation is conceptually converted into negatively viewed syndromes that frustrate providers, and these diagnoses are applied in a stereotypic fashion toward women and minority groups. It is logical to assume that this would affect access to and quality of care.

There are diverse results in studies about dissociation, abuse history, and somatic problems. A clear linkage between dissociation and medically unexplained symptoms is not established. Yet this has been an empirical focus, and dissociation would potentially provide the “mechanism” by which abuse distress is expressed in somatic complaints. The danger to women abuse survivors of accepting this conceptualization of dissociation is that serious medical illness might be misdiagnosed or not even considered when chronic pain is the presenting symptom in a woman who has dissociative experiences, for example.
ered when chronic pain is the presenting symptom in a woman who has dissociative experiences, for example. Medical treatment might be withheld in favor of referral to psychiatric services or perhaps the prescription of anxiolytic drugs. There is also the possibility that chronic pain may lead one to self-distract, become absorbed, in other words, to use dissociation as a means of coping with pain. Research has not been done from this perspective. Which comes first, the pain or the dissociation? What would serve the interests of women in general with chronic pain, pelvic pain, and risky health behaviors is investigation of the possibility of past and current violence in their lives that compounds physical distress and that both physical and mental symptoms be addressed (Koss & Heslet, 1992).

PHYSIOLOGY OF DISSOCIATION AND TRAUMA

Another consideration about physical changes and dissociation is currently emerging evidence that there are apparently related physiologic changes in neurotransmitters and memory pathways. These changes occur after trauma, interfere with the usual processing of abuse memories, and may be related to anxiety states (Bremner, Krystal, Charney, & Southwick, 1996; Tryon, 1998; van der Kolk, 1996; van der Kolk, van der Hart, & Marmor, 1996; Zola, 1998). This means that dissociation likely has a psychobiologic basis. Presently, it is poorly understood by psychiatry; that is, it is not as “explainable” as are depression, schizophrenia, and bipolar disorder.

What cannot be explained becomes difficult to treat. Yet at the same time, dissociation is the most dramatic of the cluster of symptoms of posttraumatic stress. This creates a paradox: A kind of clinical fascination may be accompanied by inaction and a feeling of helplessness and even voyeurism on the part of the provider (Chu, 1998b). This is consistent with a focus on memory retrieval as treatment because it is aimed at what has been the past, psychologically based, though not adequately neurophysiologically founded, explanation of the cause of dissociation. Clinicians have been unable in many cases to control the symptom and therefore aim at its theoretically presumed cause. Note that when medications became available to treat the neurobiologic brain disorders, causes became less focal. The effectiveness of the drugs allowed inferences to be made about physiologic mechanisms underlying behavioral and subjective symptoms.

SELF-HARM, ABUSE, AND DISSOCIATION

Self-harm, such as cutting oneself, and dissociation have been hypothesized to occur together. Suicidal intentions may or may not be associated with self-harm behaviors in survivors (Green, 1978). There is a strong correlation between physical and sexual abuse history and self-harm, thought by some to be linked through dissociative processes (Fava & Conterio, 1989; Herman, 1992; van der Kolk, Perry, & Herman, 1991). Assuming that borderline personality disorder is a form of PTSD (Herman & van der Kolk, 1987), self-cutting mediated by dissociation then completes the link to childhood trauma. This chain of concepts depends on a number of logical but hard to verify assumptions. For example, in a study of female borderline patients, no significant relationship was found between childhood sexual abuse and dissociation (Zweig-Frank & Paris, 1997). Nevertheless, dissociation is commonly posited as a mechanism to explain relationships among variables that lack known pathophysiologic causal pathways. Can we presume that if one stopped the processes involved in dissociation, the linkage with other problems would fall away and that these problems would then be solved or eliminated? Borderline personality disorder is a stigmatizing, marginalizing label that has drastic life and health care consequences. This diagnosis is more frequently applied to women. Providers who see clients diagnosed as borderline often avoid contact with clients or become frustrated in their attempts to impose structure and prevent self-harm behaviors. The patient is a sort of persona non grata in the treatment milieu. It is not in one’s interests to be labeled borderline, even if one fits the DSM criteria for this diagnosis. It seems especially
important not to infer that a woman abuse survivor has any personality disorder simply because she has dissociative experiences.

A social problem in underscoring a link between self-harm and dissociation in abuse survivors is the history of how self-cutting or “mutilation” has been viewed in the past by some scientists and clinicians. It has been equated with neurosis, poor impulse control, masochism, aggression, wishes for sexual penetration, and has been described as a substitute for masturbation (Crabtree, 1967; Novotny, 1972; Siomopoulos, 1974). These are quite stigmatizing perspectives on self-cutting, which may be viewed by some women survivors as a coping strategy that prevents even worse outcomes than physical wounds.

Self-harm has been viewed as trauma reenactment in which there is indirect communication of emotions related to abuse, including a sense of victimization, and reaction to the mental presence of the perpetrator and those who failed to protect against trauma (D. Miller, 1994). In a narrative study (Scheel, 1999) of girls and women, self-cutting was related to affect regulation and dissociation. It served to tell the story of trauma and to express internal pain. However, the behavior was seen to be used for stimulating dissociation in some and for stopping dissociation in others. In one woman’s words, cutting made her feel “like I was watching myself . . . just sort of an altered state . . . not real” (Scheel, 1999, p. 107) or as if it was not really herself that she was cutting. One woman said cutting helped her “keep parts of her self separated” (Scheel, 1999, p. 105). On the other hand, cutting could be used to feel “real”, ground the self bodily, relieve flashbacks, alleviate “numbness,” and/or stop a sense of “speeding” (Scheel, 1999, p. 105). Overall, great diversity was seen in the reasons given for cutting, including comfort and preventing suicide (Scheel, 1999). Thus, for some women abuse survivors, self-harm may not always be accurately explained as “harm” when they consider alternatives that could occur. Because the link with dissociation is explained in the literature as both “cause” and “effect” of such behavior as cutting, the link is apparently poorly understood and may be spurious.

THE LANGUAGE AND PRACTICES OF TREATMENT

Therapeutic goals of abreacting and discussing abuse memories might be questioned because such work often exacerbates posttraumatic symptoms, including dissociation, depression, and the like. This is risky business in some cases. The byword is that “you will get worse before you get better.” In what other realms of health care is this acceptable clinical philosophy? Surgery and cancer chemotherapy come to mind. Yet the provider cannot remove the memories of abuse and instead settles for re-integrating “fragmented” memories or parts of the self. There is evidence that the language of fragmentation is clinical in origin and is not common to some survivors when they describe dissociation in their own words (Hacking, 1995; Hall & Powell, 2000). Survival and quality of life issues seem to take a back seat to the issues of re-integration of the fragmented self. Yet the former may be more important to women clients. Becoming financially stable, getting education and work, recovering from substance misuse, and resolving core issues of self-image are often pressing for women child abuse survivors (Hall, 1996a, 1996b, 2000a, 2000b).

Ironically, the risks of recovering memories most often addressed in the literature, for both client and provider, are legal rather than mental health-related (e.g., Cannell, 2001). Chu (1998b) insists that there is a rational and humane way to pace psychotherapy with dissociative clients. He stresses early psychoeducational interventions to control PTSD and dissociative symptoms should be done before any abreactive work is begun and that this may take a long time in some cases. This is good news for women survivors, and indeed psychotherapy remains the mainstream treatment for posttraumatic problems, including dissociation. One somewhat disturbing recommendation in Chu’s (1998b) directives for therapists is as follows: “As can often be said to patients, ‘It isn’t a question of doing it my way or your way. These are the ways that have been shown to help persons like yourself overcome the difficulties that you experience’” (p. 109; italics in original). Although this sounds egalitarian, it is not, because the client is left
with a “one-size-fits-all approach” that is based on the provider’s assumptions of what her problems are and how they should be prioritized. An obvious drawback to long-term psychotherapy is that HMOs and other gatekeepers are increasingly tending to deny medical need for this form of treatment, beyond a few sessions. Until there are verifiably effective short-term interventions, caregivers, survivors, and the public will need to advocate for long-term psychotherapy based on a relationship of safety, constancy, and trust. Accessibility of therapy as well as control over treatment priorities remain salient issues in considering autonomy of women abuse survivors.

DISSOCIATION AND REVICTIMIZATION

There is a hypothesized link between dissociation and the known tendency for abuse survivors to experience revictimization, including being murdered, raped, beaten, or psychologically dominated in adulthood. Freud and recent theorists (e.g., Schwartz, 2000) have held that women abuse survivors who dissociate also engage in behaviors that “reenact” the interpersonal dynamics of the abuse situation in an attempt to master or gain control over the traumatic material. This has also been referred to as a “repetition compulsion” (Irwin, 1999a). This may be an explanation of how some women are revictimized, although the reenactment theory places accountability for the dynamics with the survivor, who is seen as acting in isolation. This interpretation is also used by therapists to describe frustrating exchanges they have with survivors who become angry, vulnerable, or “seductive.” Any client can exhibit these behaviors, but note that in the case of an abuse survivor, the “motive” of reenactment is already constructed and one need not look further for “the problem.” This therapy scenario has been emotionally damaging to the woman survivor of child abuse with rage, a legitimate complaint, or a profound need, or for one who is being sexualized by the provider.

Previous victimization is the strongest (by 4 times) predictor of later victimization, but women with high DES scores were no more likely than low- to midrange DES scorers to experience revictimization. In this study, however, other PTSD symptoms were associated with heightened vulnerability (Sandberg, 1995). Becker-Lausen, Sanders, and Chinsky (1992) hypothesized that persons who dissociate lack awareness or block information about potentially painful interpersonal relationships. They found a strong relationship between high DES scores and revictimization, but this was a cross-sectional design, therefore the direction of the relationship could not be ascertained, which is a typical problem with research on this topic.

Kluft (1990) held that those who have been abused lack the capacity to respond to danger signals and that they do not integrate information that would foster self-protection. However, the referent sample included only persons who had been sexually abused by therapists, a special case of vulnerability. Clients should be safe to invest their trust in the therapeutic relationship. Most of the search for why women are revictimized focuses on them, rather than on dynamics within the perpetrator and interaction between individuals at the time of the adult abuse. This points to a false “culpability” imputed to women abuse survivors who are revictimized in adulthood, which diminishes their right to be equally protected by law and cultural practices from violent crimes.

PATHOLOGY AND/OR PROTECTION

Although dissociation may be found to be significantly related to mental health symptoms as well as having a history of childhood trauma, dissociation does not appear to mediate these symptoms (Banyard, Williams, & Siegel, 2001). Several recent studies have found that those
CSA survivors with more severe presentations of dissociation are sometimes mistakenly diagnosed as having schizophrenia when the Minnesota Multiphasic Personality Inventory--Version 2 (MMPI-2) is used (Armstrong, 1995; Briere, 1997). Elhai, Gold, Mateus, and Astaphan (2001) also found that women CSA survivors who scored high on the DES reflect a similar MMPI profile in terms of appearing “psychotic,” although depression accounted for more of the variance in scores. These studies demonstrate current ideas about dissociation as falsely “pathologized” when the MMPI-2 is used. A nonpsychotic perceptual phenomenon has been termed “pseudohallucinations,” and this appears to occur with dissociation. It may also be viewed as within the bounds of normal memory and perception (van der Zwaard & Polak, 2001). Irwin (2001) also linked dissociative tendencies in abuse survivors with schizotypal symptoms, maintaining that the dissociation, and not the abuse itself, appears more directly involved. The result is that labels may be applied to both the depressive and dissociative aftereffects of trauma, resulting in stigma, lowered social and self-expectations, and incorrect and often ineffective treatment.

Some investigators have suggested that there is a relationship between having been abused in childhood and later becoming abusive as parents toward their children. Obviously, this may sometimes occur, though it is widely known that the majority of women abuse survivors are not abusive or violent toward others and are often quite vigilant about protecting their children. One study revealed that dissociation accounted for about one half of the relation between being physically abused and having potential to become abusive (Narang & Contreras, 2000). Limitations of the study include that only college students (male and female) were sampled and only the potential to abuse was ascertained. Yet a relationship of this kind, though not common, is worth further exploration, because it is in women survivors’ interests to stop the apparent intergenerational cycle of physical violence. Whether dissociation or a third covariant accounts for this cycle has not been determined. From a feminist perspective, careful analysis is in order because there is a persistent essentialist view of mothers as incapable of the horrific violence that their grown daughters sometimes report. All mothers are not benign, and it is not clear that all of those who abuse their daughters were themselves abused. We must consider that dissociation might be offered as a “reason” why the essentialist view of women as “benign by nature” occasionally does not hold true. We would be wise to take into account the heterogeneity among women in terms of their capacity for violence.

Clinical diagnostic criteria emphasize that dissociation is disordered cognition, identity, and/or memory. What is not included is the notion that dissociation may be an attempt to “control overwhelming emotional experience” and that dissociation represents a “failure in the development of the capacity for affect integration” (Rodin et al., 1998, p. 161). Irwin (1999b) found that pathological (more severe or pervasive) dissociation was correlated with childhood trauma, whereas milder, nonpathological dissociation (defined as “psychological absorption”) was not. Nonpathological dissociation is thought to be a developmental extension of infant distraction and soothing that is fostered by parents. Pathological dissociation may be conceptualized as having begun as a disruption in self-regulation occurring when abusive parents distort soothing of the child by accompanying it with anxiety or threat (Waites, 1993).

Farber and Sacco (1999) viewed repression as similar to dissociation but also as a phenomenon in which the “disconnected” awareness is still part of the integral “self.” They found that, in contrast to previous studies and theory, those who use repression were not more likely than others to have been abused in childhood. Furthermore, they did not find that repression was significantly deleterious to functioning. They were surprised at their findings.

Repression, after all, must have deleterious psychological consequences. On the other hand, this finding may be considered yet another indication that repression, under certain circumstances, is highly adaptive. Not only does it apparently function as a means of keeping traumatic material out of conscious awareness but it does so without any signifi-
cant loss of reality testing. It is anxiety that is associated with higher levels of reality testing problems. . . . Thus, clinicians working with abused individuals have a particular obligation to respect the use of repression and other defense mechanisms. (p. 217)

It would be in the interests of women survivors if degrees of dissociation were taken into account. Many survivors of child abuse seem to use lesser degrees of dissociation without compromising their quality of life. These women may be “low dissociators,” as discussed by Putnam et al. (1996). Ross, Anderson, Heber, and Norton (1990) found increased levels of dissociation and sexual abuse histories among prostitutes and exotic dancers, suggesting that these adult populations may be similar to runaway adolescents who were abused. Perhaps dissociation aids in the ability to carry through in high-risk, sexually charged activities, such as working in the sex trade. Ideally, women should not have to engage in these activities to survive. Nevertheless, for those who have no other economic options, dissociation is perhaps adaptive and psychologically protective in the short run. This does not minimize the actual risk of violence, legal, and/or long-term psychological harm that may accompany these activities.

Dissociation may be compared to the multiplicity of roles or “selves” that one develops in order to function in a postindustrial era, when continuities in the environment are the exception rather than the rule. Lifton (1993) described a number of diverse cases wherein fairly pronounced discontinuities in cognition, behavior, and life trajectories were considered to be signs of resilience as long as the individual remained basically functional and nondistressed. Lifton observed an adaptive use of personal change and compartmentalization of experiences. Dissociation is obviously protective in its basic processes. It can foster creativity and spiritual/religious experiences. These “uses” of dissociation are culturally sanctioned (Waites, 1993). Those dissociative experiences not culturally sanctioned in a given society are pathologized, and attempts are made to prevent or counter these forms of dissociation therapeutically. White (1997) referred to dissociation as simply an anomalous—that is, exceptional—human experience that may be expressed in either negative or positive narratives. Negative accounts can be opportunities for growth and can be transformed to positive ones, increasing resilience and creativity.

CONCLUSIONS

Researchers and theorists commonly define dissociation in women child abuse survivors as a continuum, much of which constitutes problematic phenomena in the wake of trauma. To a lesser degree, the literature emphasizes that, short of DID, dissociation is basically a normal function and that it may be adaptive for women abuse survivors. To the extent that it is seen as problematic, the implication is that treatment is needed in the form of psychotherapy or, in fewer cases, hypnosis. There are no clear developments in terms of efficacious psychopharmacological interventions, presumably because physiologic mechanisms that may be associated with dissociation are only minimally understood.

From the feminist and constructivist perspective, there are problems in how women abuse survivors are portrayed in some characterizations of dissociation and related behaviors. Abuse and dissociation have been linked in ways that not only suggest that affected women need assistance but that they are also potentially dishonest, spiteful, highly suggestible, desirous of reenacting trauma, helpless, feigning illness, frustrating to providers, abusive, fragmented, and prone to severe mental disorders. Those with somatic problems and eating disorders are often dismissed, in that dissociation is used to “explain” their symptoms, perhaps closing off avenues of help to actually relieve their distress.

Abuse and dissociation have been linked in ways that not only suggest that affected women need assistance but that they are also potentially dishonest, spiteful, highly suggestible, desirous of reenacting trauma, helpless, feigning illness, frustrating to providers, abusive, fragmented, and prone to severe mental disorders.
This review points toward four key realizations about women child abuse survivors. When women volitionally do not pay attention to traumatic material, this is not dissociation. When dissociation is not problematic, it can be normalized. When problems related to but not caused by dissociation occur, both components need attention. When dissociation itself is interfering with life’s purposes and pleasures, women need to receive treatment that preserves their autonomy, credibility, and interests.

QUESTIONS AND IMPLICATIONS

This review analyzes possible effects of various constructions of dissociative experiences of women child abuse survivors. It raises additional questions and points to some implications for practice and research. The following are questions and suggestions for future theory, practice, and research raised by this review.

What is the complete developmental profile of dissociation in the general population? Although we know that dissociative responses to trauma occur in children, it is not clear whether or how dissociation occurs and problems it may cause in the elderly, for example. It is not known whether problematic dissociation spontaneously resolves, because many people who cope in this fashion do not seek therapy. Longitudinal research is needed to establish patterns of dissociation across the life span.

Gender differences need to be clarified. Conditions commonly attributed to women, such as eating disorders, borderline personality disorder, and pelvic pain, have been linked to dissociation. Although it is known that the DES does not discriminate between genders in terms of overall scores, the experiences of dissociation might be diverse according to gender as socially defined and as genetically and biochemically determined. Both qualitative and quantitative research is needed to clarify these issues.

We need to know whether and which “non-pathological” helpful strategies and conditions are linked to dissociation. For example, is dissociation related to increases in hope, optimism, functionality, specific learning abilities, and/or self-preservation? Might it decrease other traumagenic symptoms, such as compulsiveness, anxiety, and depression? Clinically, these present implications in terms of whether it is best to try to “eliminate” what may be non-pathological dissociation, or dissociation that is problematic, but still protective against even worse outcomes.

More information is needed about why dissociation and abuse might be related, beyond the level of correlation. It is possible that there are elements common to both that account for the links seen in much of the research. In addition, we must explain the relationships between childhood abuse events, dissociation, chronic illness, somaticized stress, and perceived disability/poor health, not merely establish correlations among these variables. Then interventions need to address the dissociative component if that will ease the somatic problem.

What are common and diverse features of the subjective experiences of various types of dissociation? Dissociative experiences have been oversimplified through the use of scales that do not reflect the context of real life for survivors of childhood abuse. We have too often relied on therapist/scientist/physician interpretations of dissociative experiences and not enough on first-person descriptions.

The links between dissociation and not remembering abuse are not clear. In one sense, dissociation may be thought of as on a continuum of decreased awareness or forgetting of traumatic events. We need to know more about motives and actual social expectations about remembering abuse. What is the role of overwhelming fear on not remembering? It is possible that, in many cases, abuse is not recalled because there is no social context for dealing with it. Not only the abused girl, but also often her family and certainly the perpetrator, have motives for not wanting to “know” the ugly truth.

It has been suggested that clinically we might establish a broader category of “trauma-related syndrome” (Chu, 1998b; Zlotnick et al., 1996), given the overlap in the phenomena of PTSD, dissociative disorders, anxiety, and depression (Ferguson & Dacey, 1997). This would shift the focus from specific “diagnoses” to symptom-targeted treatment and may be a more flexible
way of approaching the diverse problems of women abuse survivors.

Language establishes the limits of our understanding and often clinically defines experiences, perhaps incorrectly when the subjective is not considered. Alternative ways of speaking about dissociative experiences are needed for research and practice purposes. The language of “splitting,” “switching,” “alters,” and “fragmentation” may falsely homogenize actual subjective experiences and force clients to speak in clinical jargon that does not reflect their own discourse about dissociation.

A CAUTIONARY NOTE

Although Hacking (1995) was speaking about comments on the frequent application of DID to the cases of women abuse survivors as perhaps not a benevolent alliance between caregivers and women clients, his words are also significant when regarding the treatment of dissociation in general in this population.

The alliance is intended to be supportive of women, but in fact it continues the old system of disempowerment. Leys offers a genuinely radical critique of current theories and practices . . . It does not dispute the prevalence of family violence or question its societal foundations. It does not deny that past abuse can, in a cultural and clinical milieu, lead to symptomatology of a florid sort. It does question the complacency of a theory that purports to take the part of the patient. It conjectures that the theory, practice, and underlying assumptions reinforce the patient’s self-image as a passive victim. Taken to one possible conclusion . . . current theories of abuse, trauma, and dissociation are part of another cycle of the oppression of women, all the more dangerous because the theorists and clinicians represent themselves as being so entirely on the side of the “victim”—whom they thereby construct as helpless, rather than as an autonomous human being. (Hacking, 1995, p. 76)

In closing, this review was based on the theory that the avoidance of painful material is at the base of dissociative experiences. Yet if not for the ability to compartmentalize overwhelming stress, such as childhood abuse, the woman survivor could not psychologically carry the realities of the trauma with her until such time as these “demons” can be released and tamed. In other words, dissociation may more generally be understood as a way to remember versus a way to forget. Whether problematic or not, it seems that at times some women abuse survivors need to use their talent for dissociation. This must not be forgotten in the enterprises of research and treatment.

REFERENCES


**SUGGESTED FUTURE READINGS**


Joanne M. Hall is a registered nurse who has practiced in the areas of substance misuse treatment and mental health. She earned an M.A. in nursing from the University of Iowa in 1986. She earned a Ph.D. in nursing at University of California, San Francisco (UCSF) in 1992. She also completed a postdoctoral fellowship at UCSF, sponsored by Dr. Afaf Meleis and funded by the National Institute of Nursing Research, in 1994. Areas of research include collaboration and principal investigator roles on many women’s health projects. She has been engaged in research on lesbian health, recovery from substance misuse, persons living with HIV, and mothers and children’s understanding of research and informed consent. Her most recent research includes four studies of women survivors of childhood abuse and neglect. She has presented findings at regional, national, and international meetings and has written extensively in nursing as well as interdisciplinary journals. Hall is a fellow in the American Academy of Nursing and a member of Phi Kappa Phi. She held a position in the School of Nursing at the University of Wisconsin–Milwaukee from 1994 to 1998 and is currently a professor at the College of Nursing, University of Tennessee. Her current study is an NIH-funded, large-scale qualitative investigation entitled “Thriving in Women Child Abuse Survivors.” Hall has developed theory about marginalized populations, including national and international vulnerable groups, with a focus on their mental health and access to care.