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# The ambiguous loss of post-integration : a theoretical analysis of the effects of integration on clients with dissociative identity disorder

Elise A. Manning

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Elise Manning  
The Ambiguous Loss of Post-  
Integration: A Theoretical Analysis of  
the Effects of Integration on Clients  
with Dissociative Identity Disorder

## ABSTRACT

Although undergoing integration treatment and achieving intrapsychic integration is widely considered an unmitigated positive outcome for individuals diagnosed with dissociative identity disorder, the literature suggests that integration, which may include experiences or perceptions of loss, may be an outcome of far more complicated and varied resonance than is generally acknowledged. This theoretical study examines this little-examined element of the treatment outcome—the phenomenon of an individual’s experience or perception of loss following integration treatment. The phenomenon is analyzed through two theoretical frames: (1) ambiguous loss theory, a conceptual framework developed by Pauline Boss to explain the experiences of arrested grief and unclear loss that often arise in conditions wherein a loved one is physically absent but psychologically present *or* physically present but psychologically absent (Boss, 1999); (2) a Foucauldian discursive analytic (2006 [1961]), through which the shifting discourse of DID classification and treatment are traced in order to de-center the predominant taken-for-granted discourse of DID and highlight the varied subjective experiences of post-integration. In so doing, this analysis aims to widen the discourse of DID such that it becomes more inclusive and reflective of a multiplicity of perceptions, experiences and conceptualizations of DID and integration treatment, thereby shifting the discourse away from the prevailing understanding of the phenomenology and treatment of DID, in which intrapsychic integration is widely considered to be a preferred treatment outcome with wholly positive effects.

**THE AMBIGUOUS LOSS OF POST-INTEGRATION:  
A THEORETICAL ANALYSIS OF THE EFFECTS OF INTEGRATION ON CLIENTS  
WITH DISSOCIATIVE IDENTITY DISORDER**

A project based upon an independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

Elise Manning

Smith College School for Social Work  
Northampton, Massachusetts 01063

2011

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## **CHAPTER I**

### **Introduction**

Dissociative identity disorder has been a hotly contested issue within the psychiatric community since the complex symptomatology of the disorder first began to gain recognition as a psychological condition in the mid-1800's (Ellenberger, 1970; Kluft, 1995; Putnam, 1989). Originally introduced to the *Diagnostic and Statistical Manual of Mental Disorders-III* as a discrete diagnostic category in 1980 as multiple personality (MP; American Psychological Association [APA], 1980) and renamed multiple personality disorder in the *DSM-III-R* (MPD; APA, 1987), the diagnosis has garnered the attention of the media and the public and remains one of the most contentiously debated psychological diagnoses (Lilienfeld & Lynn, 2003; Lynn, Fassler, Knox & Lilienfeld, 2006; Traub, 2009). Despite its place in the crux of controversy, the diagnosis now known as dissociative identity disorder (DID) is estimated to affect between 1-3% of the overall population, far more than previously thought (International Society for the Study of Dissociation [ISSD], 2005).

Interest in dissociative identity disorder rose dramatically in the 1970's, due in large part to the broadening field of traumatology following the Vietnam War, an increased awareness of the widespread prevalence of domestic violence and child abuse (Krakauer, 2001), as well as Schreiber's (1973) book and subsequent film entitled *Sybil*, which greatly expanded the American public's familiarity with the disorder (Traub, 2009). This interest was followed by a

swell in empirical and theoretical research conducted on the history, etiology, legitimacy and treatment of DID (Foote, Smolin, Kaplan, Legatt & Lipschitz, 2006; Kluft, 1988b, 1991; Putnam, 1989). Critics of the diagnosis have sought to debunk the validity of DID as a mental disorder on grounds of malingering, due to increased media saturation on the subject (Freeland, Manchanda, Chiu & Sharma, 1993), and iatrogenic inception, due to suggestive or coercive therapeutic interventions and the use of clinical hypnosis (Coons, 1991; Coons & Milstein, 1994; Piper & Merskey, 2004; Traub, 2009). On another front, critics have pointed to findings in neurobiological research in an effort to challenge the physiological existence of the disorder (Traub, 2009; See also Cocores, Bender & McBride, 1984; Coons, Milstein & Marley, 1982; Mathew, Jack & West, 1985). Meanwhile, proponents of the legitimacy of DID have responded in similar fashion and have sought to corroborate the physiological existence of the disorder through neurobiological research of their own (Birnbaum & Thomann, 1996; Hughes, Kuhlman, Fichtner & Gruenfeld, 1990; Miller, 1989; Miller, Blackburn, Scholes & White, 1991; Putnam, Zahn & Post, 1990; Reinders, Nijenhuis, Quak, Korf, Haaksma, Paans, Willemsen & den Boer, 2006). Furthermore, they have contributed to an extensive body of literature regarding the history, prevalence, symptomatology and treatment of the disorder (Ellerman, 1998; Kluft, 1988b, 1991, 1993a; Pais, 2009; Putnam, 1989).

Pais (2009) has identified a wide range of treatment modalities for working with individuals diagnosed with DID, including clinical hypnosis, EMDR, creative art therapy, pharmacotherapy, group therapy, internal family systems therapy and individual psychotherapy. In practice, many of these modalities are often used concurrently in a therapeutic treatment plan, as clients may experience symptom relief through expressive art therapies or pharmacotherapy while engaging in individual psychotherapy with a clinician (ISSD, 2005). However, individual

psychotherapy has long dominated the field as the primary treatment modality for clients with DID (Kluft, 1993a; Putnam, 1989).

Within psychotherapy, Kluft (1993a) has identified four therapeutic approaches that are frequently employed in treatment: (1) reparenting, wherein the therapist aims to provide symptomatic relief to the client by conferring the multiple internal “self-states” with the status of real people and serves as a “curative agent” (p. 22); (2) adaptationalism, wherein symptomatic management or relief is the therapeutic goal; (3) personality-focused treatment, wherein internal collaboration between “self-states” is the goal of treatment; and (4) integrationalism, wherein the aim of therapy is for the client to achieve an integrated sense of self by fusing separate “self-states” into one cohesive self (Kluft, 1993a, 1993b). Of these approaches, this process of “integration”—wherein the perceived multiple internal selves or “alters” work toward “fusing” into one psychological entity—has received the most attention, as it has been widely regarded by clinicians as the preferred treatment of choice for many individuals with DID (Kluft, 1988b, 1993a; Putnam, 1989). Commenting on his previous research findings, Kluft (1993a) wrote, “There is a considerable body of experience and some uncontrolled research findings that indicate that [integrationalism] is the most desirable stance for the therapist to adopt” (Kluft, 1993a, p. 22; See also Kluft 1984b, 1994). Furthermore, the treatment outcome of total personality fusion or identity cohesion that can result from an integrationist treatment approach is highly favored among clinicians, as research demonstrates that clients are far less likely to decompensate into symptoms of DID when faced with new disturbing or overwhelming experiences (ISSD, 2005). However, after an individual “integrates” or fuses into a cohesive self, what is the result? What is the experience of *post*-integration? Critical exploration and analysis on the experiences of individuals who have undergone the integration process and are



now in a state of *post*-integration or *post*-fusion is relatively limited and begs further inquiry (Bristol, 1997; Coons & Bowman, 2001; Kluft, 1988b; Putnam, 1989).

The literature is relatively quiet on this question, save for the rare research endeavor (Bristol, 1997; Kluft, 1988b) or personal account of the process and experience of integration (Oxnam, 2005; Saraf & Light, 1993). What the existing research does suggest, however, is that the experience of post-integration causes significant changes that are often perceived as a combination of gains and losses (Bristol, 1997; Oxnam, 2005; Saraf & Light, 1993). Therefore, although undergoing integration treatment and achieving intrapsychic integration is widely conceived of as a nearly unmitigated positive outcome for individuals diagnosed with DID, these findings suggest that treatment outcomes are far more complicated and varied, as they may include experiences or perceptions of loss. As such, this study examines this particular treatment outcome—an individual's experience or perception of loss following integration treatment—using ambiguous loss theory, a conceptual framework developed by Pauline Boss to explain the experiences of arrested grief and unclear loss that often arise in conditions wherein a loved one is physically absent but psychologically present *or* physically present but psychologically absent (Boss, 1999). Then, this paper employs an analytic framework developed and utilized by Michel Foucault (2006 [1961]), in order to trace the shifting discourse of DID classification and treatment, thereby furthering an understanding of the myriad experiences of post-integration and problematizing the dominant discourse of DID.

This paper explores the phenomenon of dissociative identity disorder (DID) and subjective responses to and perceptions of integration treatment through two theoretical frameworks: (1) Pauline Boss's (1999) theory of ambiguous loss; and (2) Michel Foucault's analytic framework regarding the shifting discourse of madness and mental illness. The

conclusions drawn from this theoretical undertaking may have significant implications for the field of clinical social work on a number of fronts. First, this analysis of post-integration may provide more “experience-near” language, which is a concept originally developed and articulated by social worker and therapist Michael White describing the collaborative process of using and working with whatever language an individual uses to describe their own subjective perceptions of themselves and their experiences, thereby empowering the individual and validating their subjective experiences of reality (White, 1995). As such, exploring the phenomenon of post-integration through the lens of ambiguous loss theory may illuminate and articulate conceptual categories or possibilities of experience that have not yet been spoken/written into the dominant discourse of DID (e.g. “intrapsychic ambiguous loss”), thereby disrupting the prevailing discourse and providing new language to describe the experience of post-integration that is more reflective of a client’s subjective reality. Doing so may enable clinicians working in the field with post-integration clients to have a more nuanced understanding of the realities their clients face. Furthermore, having greater access to experience-near language may serve the clients tremendously, as they continue to interpret and make meaning out of their experiences with DID and integration (Brown & Augusta-Scott, 2007).

On another front, this research aims to expand the scope of ambiguous loss theory to describe the subjective perceptions of intrapsychic phenomena, as the theory has thus far been limited to descriptions of perceptions of interpersonal phenomena. Doing so may serve to alter the definition of ambiguous loss, thereby broadening the applicability of the concept. This research may also provide the impetus for more empirical research to be conducted on the post-integration phase of DID, as in-depth, qualitative empirical research in this field is limited.

Finally, and perhaps most significantly, this research aims to alter the discursive landscape regarding the phenomenon of DID, such that the subjective experiences of individuals living and coping with DID (either pre- or post-integration treatment) might gain greater inclusion into the prevailing discourse. As such, this paper may serve to slightly shift the locus of power within the discourse away from the previously established, authoritative voices of the professional psychiatric community and toward the disparate voices of those who have experienced DID and integration treatment. In so doing, this paper endeavors to more thoroughly and inclusively acknowledge the variable, multidimensional and subjectively perceptual experiences of this immeasurably complex phenomenon.

## **CHAPTER II**

### **Conceptualization and Methodology**

This paper examines the phenomenon of dissociative identity disorder (DID) and subjective responses to and perceptions of integration treatment through two theoretical frameworks: (1) Pauline Boss's ambiguous loss theory and (2) Michel Foucault's analytic framework regarding the discourse of madness and mental illness. Employing Foucault's analytic constructs to examine the shifting discourse of DID and integration treatment, this paper then applies the features and assumptions of Boss's ambiguous loss theory to the phenomenon in order to explore the possibility of an alternative discourse about the subjective experiences of DID and the post-integration phase of treatment that has thus far been excluded from the dominant discourse of DID.

#### **Plan of Analysis**

In Chapter III, the phenomenon—an individual's subjective experience or perception of loss following integration treatment—is explored in depth. In order to understand the historical and etiological contexts of this phenomenon, this chapter includes the following: (1) a brief history of the classification and epidemiology of DID; (2) an overview of the phenomenology and etiology of DID; (3) an explication of the process of integration treatment; and (4) a summary of the literature regarding the post-integration phase of treatment.

In Chapter IV, ambiguous loss theory is presented and examined. Ambiguous loss theory is predicated on the assumption that perceived experiences of loss can be unnervingly complex and bewildering, as when someone experiences a significant other as being simultaneously present and absent, both here and not-here in some profound and, perhaps, unsettling way (Boss, 2006). However, the theory has thus far been limited to examining and describing interpersonal experiences or perceptions of ambiguous loss; never before has it been applied to an intrapsychic phenomenon. As such, exploring the subjectively perceptual experiences of DID and integration treatment through ambiguous loss theory may shed light on the complex, ambiguous and perplexing perceptions of loss that may occur intrapsychically as a result of the changes that occur through the integration treatment process. Toward this end, this chapter outlines the definitions, assumptions and features of ambiguous loss, as delineated by Boss (1999, 2007, 2010). It then provides a brief overview of the empirical and theoretical research that has used ambiguous loss theory as a framework for analysis.

Following an exploration of ambiguous loss theory, Chapter V presents the Foucauldian analytic to be utilized in this paper. While many authors have written historical accounts of DID and the various changes that have taken place with regard to the phenomenon's conceptualization, classification and treatment over time (Ellenberger, 1970; Kluft, 1995; Krakauer, 2001; Putnam, 1989; Traub, 2009), this researcher has not yet found a published historical analysis of the shifting discourse of DID and integration treatment in the vein of the Foucauldian analytic. As such, this chapter begins with a brief overview of poststructuralist thought and is followed by a more focused examination of Michel Foucault's analytic framework, including an explication of Foucault's central theoretical constructs. Subsequently, this paper reviews Foucault's historical analysis of the discourse of mental illness, entitled

*History of Madness* (2006 [1961]), and conducts a similar analysis of the historically-bound and continually shifting discourse of dissociative identity disorder and integration treatment using four of the key theoretical concepts developed and employed by Foucault: (1) discourse, (2) power, (3) the subject and (4) modes of objectification. The three modes of objectification that are examined and applied to the phenomenon include: (1) objectification through classification; (2) objectification through dividing practices; and (3) subjectification.

Finally, Chapter IV provides an analysis of the phenomenon using ambiguous loss theory and explores the possible implications that this analysis may have for the prevailing discourse of DID and integration treatment. To begin this analysis, the two types of ambiguous loss delineated by Boss—physical presence with psychological absence or physical absence with psychological presence—are applied to the phenomenon of integration and the post-integration phase of treatment. Additionally, the foundational assumptions and key features of ambiguous loss are explored and applied to the phenomenon of integration. The assumptions of ambiguous loss include: (1) the change or condition that is experienced as an ambiguous loss is value-neutral (neither objectively positive nor negative); (2) the change or condition is subjectively interpreted by members of the relational system; (3) these subjective interpretations will be informed by cultural beliefs and values; and (4) the change or condition happens within the context of a relationship that is experienced as significant or meaningful (Boss, 2007). The features of ambiguous loss include: (1) ambiguous loss is unclear loss; (2) ambiguous loss is traumatic loss; (3) ambiguous loss is a relational disorder; (4) ambiguous loss is externally caused (e.g., illness, war), not by individual pathology; and (5) ambiguous loss is an uncanny loss – confusing and incomprehensible (Boss, 2010).

Following this analysis, this chapter examines the ways in which the dominant discourse of DID and integration treatment may be interrupted or altered by the preceding exploration of intrapsychic ambiguous loss, as the analysis introduces a heretofore unexplored narrative of experience of the post-integration phase of treatment that has been and continues to be excluded from the prevailing discourse. In so doing, this paper intends to contribute new thought to the discourse of DID and to the theory of ambiguous loss, a theoretical framework that has as of yet had limited applications in the clinical literature beyond the research and writing of Pauline Boss. Moreover, the synthesis of this analysis—examining the shifting discourse of DID and integration treatment by way of exploring the possible ambiguous losses of integration treatment—is uncharted theoretical territory at this time, thereby amplifying the possible contribution that this research may make to the field of mental health theory, research and practice. Therefore, to begin this proposed theoretical analysis, the phenomena of dissociative identity disorder, integration treatment and the post-integration phase of treatment will now be explored in detail.

## **CHAPTER III**

### **The Subjective Experience of Post-Integration**

In order to understand the post-integration phase of DID treatment, this paper will examine the phenomenon of dissociative identity disorder and the central tenets of an integrationalist treatment plan. While it is outside the scope of this paper to provide an in-depth history of DID, current understandings of the phenomenology and psychiatric treatment of DID are imbedded in both historical and contemporary controversies regarding the prevalence, etiology, symptomatology and legitimacy of the disorder. Therefore, a brief history of DID will be presented, followed by an exploration of the phenomenology and treatment of the disorder.

#### **History and Epidemiology of the Disorder**

Dissociative identity disorder has long been considered one of the most controversial diagnoses within the psychiatric community (Kluft, 1995; Lilienfeld & Lynn, 2003; Lynn et al., 2006; Traub, 2009). Interest and belief in the existence of the disorder has taken dramatic turns since the concept of multiple personalities or “double consciousness” rose to prominence in France during the mid to late 19<sup>th</sup> century. Putnam (1989) and Ellenberger (1970) have provided extensive historical accounts of the rise and fall of interest and belief in DID as a discrete diagnostic category. Between 1880 and 1920, scientists, doctors and the burgeoning world of psychology became deeply invested in exploring and understanding the psychological



phenomenon through scientific inquiry. This effort was spearheaded by Pierre Janet, a French philosopher and doctor who worked closely with Jean-Martin Charcot and presented some of the first case studies of patients exhibiting dual consciousnesses, “successive existences” or separate internal selves (Putnam, 1989, p. 2).

Interest and belief in the disorder then declined precipitously between 1920 and 1970, possibly due to several coincident trends in the psychiatric community: (1) the rise of psychoanalysis, wherein the notion of repression replaced the concept of dual consciousness; (2) the rapid increase in prevalence and popularity of schizophrenia as a diagnosis, which included aspects of multiple personality disorder as a sub-category; (3) mounting concerns that patients developed the conception of themselves as having multiple personalities by engaging in therapy and hypnosis; and (4) the psychopharmacological revolution, which ushered in widespread use of Thorazine and the medical model of treatment, which often decreased patient-clinician contact and therefore minimized therapeutic means of treatment (Putnam, 1989; Ellenberger, 1970).

Despite these factors, interest in the DID diagnosis re-emerged in the 1970’s, owing in part to the media attention garnered by the case of “Sybil” and the subsequent book and film made about her case (Schreiber, 1973), which resulted in increased public awareness of the disorder (Traub, 2009). On another front, reports of child abuse increased 800% during the 1970’s and 1980’s as the public began to acknowledge this societal ill as a widespread and insidious epidemic (Ellerman, 1998). Simultaneously, reports of DID rose during the 1970’s and 1980’s as well (Putnam, 1989), leading to increased acceptance of the legitimacy of the diagnosis within the psychiatric community and, ultimately, inclusion of the disorder in the DSM-III (APA, 1980).

Despite the stamp of approval by the APA, concerns about the validity of the disorder continue today (Traub, 2009). While some authors contend that DID is exceptionally rare (Rifkin, Ghisalbert, Dimatou, Jin & Sethi, 1998), other researchers and theorists aver that DID is a condition that manifests iatrogenically as a result of psychotherapeutic treatment and therefore should not be considered a valid psychological condition (Piper & Merskey, 2004). However, another faction of the psychiatric community maintains that DID is not only a valid diagnosis, but also far more prevalent than previously thought. Recent studies support this assertion, suggesting that DID accounts for between 5-29% of inpatient psychiatric patients and approximately 1-3% of the overall population, placing its prevalence on par with that of schizophrenia (Brand, Classen, Lanins, Loewenstein, McNary, Pain & Putnam, 2009; Foote et al., 2006; ISSD, 2005; Lynn et al., 2006). Most DID patients are women and reside in western, industrialized nations (Lynn et al., 2006). Though many have speculated as to the causes of this skewed distribution of the disorder, none have presented conclusive evidence to support their conjectures.

While estimates of the prevalence of DID vary, the effects of the disorder on the many individuals who are diagnosed can be gravely serious and it can take years if not a lifetime of treatment in order to effectively manage the symptoms. Notwithstanding DID's inclusion in the *DSM-IV-TR* (APA, 2000), seeking treatment can be fraught with its own challenges and obstacles, as the psychiatric community continues to hold forcefully disparate views on the legitimacy of dissociative identity disorder. Among those who do support the legitimacy of DID, however, there is a strong consensus regarding the phenomenology and etiology of the disorder, which will now be examined in greater detail.

## **Dissociative Identity Disorder: Phenomenology, Definitions and Etiology**

The *DSM-IV-TR* (APA, 2000) defines dissociative identity disorder (DID) as, “The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and the self)” (APA, 2000, p. 529). Additionally, these identities or personality states will at different times have executive control over the person’s behavior (APA, 2000), resulting in changes in speech, movement, mood, affect and memory, to name a few (Putnam, 1989). The *DSM-IV-TR* also states that the individual with DID will have significant memory loss that cannot “be explained by ordinary forgetfulness,” and that no marker or characteristic of the disorder can be attributed to the physiological effects of a substance or a general medical condition (APA, 2000, p. 529). Many theorists and practitioners have, however, written extensively on the likely precipitants and origins of the disorder, as well as further manifestations and symptoms of DID that are not fully captured by the *DSM-IV-TR*.

It is widely believed within the psychiatric community that DID develops during childhood as an individual’s psychological response to extreme trauma (ISSD, 2005; Coons, 1994; Foote et al., 2006; Kluft, 1991; Krakauer, 2001; Lilienfeld, Lynn, Kirsch, Chaves, Sarbin, Ganaway & Powell, 1999; Oxnam, 2005; Putnam, 1989; Schäfer, Ross & Read, 2008). In the face of torture, extreme neglect or severe and chronic physical or sexual abuse, a child may enter into a dissociative state in order to cope with the traumatic event. According to Krakauer (2001), “Traumatized individuals may utilize whatever dissociative ability they possess to defend against otherwise unbearable experiences” (p. 2). However, not all individuals exposed to trauma of this nature develop DID. Instead, Kluft (1984b) and others have posited that DID may develop as a complex defensive structure depending on the degree to which the following four factors are

present: (1) an individual's capacity for dissociation; (2) experiences that overwhelm the child, rendering other adaptive coping mechanisms insufficient for dealing with the traumatic events; (3) a combination of inherent mechanisms or potentials (such as a propensity for imaginary companionship or an inherent capacity for dissociation) and extrinsic factors (such as parent-child relationships, media influences and role-playing) that shape the child's ability to structure internal alternate identities and imbue them with individualized characteristics; and (4) a lack of restorative or soothing experiences following the traumatic event, such that the child must create alternative and private ways of soothing her/himself (Kluft, 1984b; See also ISSD, 2005; Krakauer, 2001). When these four factors are present, therefore, it is possible that a child will respond to their overwhelming experiences through dissociation and the development of DID.

Dissociation is described in the *DSM-IV-TR* (2000) as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception" (APA, 2000, p. 519). Putnam (1989) has elaborated on the adaptive function and principal features of dissociation, stating:

Dissociative states of consciousness have long been recognized as adaptive responses to acute trauma because they provide (1) escape from the constraints of reality; (2) containment of traumatic memories and affects outside of normal conscious awareness; (3) alteration or detachment of sense of self (so that the trauma happens to someone else or to a depersonalized self); and (4) analgesia. (p. 53)

Thus, a child experiencing an acutely traumatic event may dissociate in an unconscious effort to protect their ego and sense of self, especially when defense against or escape from their abuser is not possible. This is especially true of childhood physical or sexual abuse that is perpetrated by

parents or caretakers of the child, from which escape or defense is especially difficult if not impossible (Putnam, 1989).

As this dissociation is repeated and continued, the child's body and consciousness that are "present" to and conscious of the abuse and the child's dissociated psychological self that is unaware of the abuse become increasingly distinct psychological states, which are referred to as "self-states," "personality states," "alter personalities," or more simply, "alters" (APA, 2000; Lynn et al., 2006; Putnam, 1989). As the child continues to re-enter the dissociative state, the "self-state" begins to amass state-specific memories, behaviors and affects that are henceforth exclusively associated with and bound to that particular state. This "self-state" or "alter" now has its own identity and history; its gender, race, sexual orientation, (Krakauer, 2001) as well as its age, memory, personality style, cognitive ability, language, artistic or physical ability, movements and sense of self become differentiated within the child's unconscious psyche as a separate self (Krakauer, 2001; Putnam, 1989). Summarizing Kluft's (1988a) and Putnam's (1989) delineations of the central features of alternative identities, the ISSD (2005) has asserted:

In short, the alternate identities are intrapsychic entities that have a sense of self, have an emotional repertoire, and can process information. They have both the potential for "being-in-the-world" behavioral enactments as well as subjective symbolic and metaphorical characteristics. They have aspects of both structure and process. (p. 75)

For the purposes of this paper, the terms "self-state," "alter-state," "alter" and "personality state" will be used interchangeably and will be defined as: a psychological identity or personality within an individual person that (1) intermittently and recurrently has executive control of the behavior of the disordered individual; (2) develops state-specific behaviors, affects and other characteristics of personality and identity that are different from that of the disordered

individual's "host personality"; and (3) has memories that are kept out of consciousness from the disordered individual's "host personality," an entity that will now be described in greater detail.

As the dissociating child experiences more abuse or different forms of abuse over time, more alters may emerge within their psychological structure in an ongoing unconscious effort to protect the self from knowledge of harm. Some research claims that individuals can have up to hundreds or thousands of different alters (Acocella, 1999; as cited in Lynn et al., 2006), though most of the literature suggests that between 2-30 alters are typical of diagnosed individuals (Ellerman, 1998). Memories of the abuse or trauma remain known only to certain alters; alters that are then kept out of the child's conscious awareness through the development of what is often referred to in the literature as "amnesic barriers" or "amnestic barriers" (Ellerman, 1998; Krakauer, 2001; Putnam, 1989). Spiegel (1993) described this process as follows:

...[A] gap in the traumatic memories is accomplished at the expense of (or perhaps for the purpose of) warding off feelings or memories associated with the trauma.... Material that should be conscious is no longer conscious, and an amnesic barrier is constructed, interfering with the normal continuity between memory and present experience. (p. 94)

Due to these amnesic barriers, the child that presents herself to the external world (the personality predominantly known to outsiders) has no knowledge or memory of the abuse. This predominant self is referred to in the literature as the "dominant" or "host personality" (Kluft, 1984a; Putnam, 1989; Oxnam, 2005). According to Kluft (1984a), the host personality "has executive control of the body the greatest percentage of time during a given time" (p. 23).

Putnam (1989) added that the host "often has the least access to early historical information and experiences frequent gaps in the continuity of his or her experience" (p. 72). Furthermore, according to Putnam, the host personality is most likely to be the alter that either initiates or

presents herself for treatment (Putnam, 1989). For the purposes of this paper, the terms “dominant personality,” “host personality” and “host” will be used interchangeably to refer to the disordered individual’s sense of self and identity that (1) most frequently has executive control over the individual’s affect, memory and behavior, (2) often has little or no memory of the abuse, and (3) experiences frequent lapses in memory of current lived experiences, due to switching between alters.

According to Putnam (1989), most individuals who develop DID in early to middle childhood continue to contend with the disorder for much if not all of their lives. While it may be developed as an adaptive response to trauma, it serves the individual maladaptively when they enter adulthood and are expected to have a coherent and integrated sense of self, without significant lapses in memory or seemingly erratic behaviors or mood-states. Furthermore, the existence of DID is often not detected when the individual is still young, as many of their self-states will identify with the age and developmental stage during which they first were “conceived,” and thus, their various self-states may appear to outsiders as being age-appropriate or congruent with the dominant personality. Therefore, it is only when the individual matures into adulthood that the persistent presence of these child-like mood-states and affects become more incongruent with their dominant personality, resulting in more outwardly discernable changes in their presentation of self.

As a result of the oft-delayed awareness of the presence of alternate self-states, many individuals do not receive a diagnosis of DID until well into adulthood, often in their late-20’s or even as late as their mid-50’s (Putnam, 1989). Furthermore, because the existence of different alters is often unknown to the host personality, individuals frequently start therapy or treatment at the behest of their loved ones or associates who are privy to the multiplicity of the individual’s

behavior, affect and abilities (Oxnam, 2005). Of those who do receive treatment, many undergo a process referred to as “integration,” which will now be explored in greater detail.

### **The Process of Integration**

Integration is a process through which an individual becomes conscious of the existence of their alter personalities, amnesic barriers begin to fade or break down and, finally, the different alters may merge into one undivided personality, such that the individual experiences and perceives her/himself as a unified self (Putnam, 1989). In order to make important conceptual distinctions between the integration process and the possible outcomes of an integrationist treatment plan, the following definitions are provided as a basis for the ensuing discussion on the experience of integration and post-integration:

- *Integration* refers to a therapeutic process that may include multiple fusions and which continues after all personalities have merged into one. Kluft (1993b) defined integration as “an ongoing process of undoing all aspects of dissociative dividedness that begins long before there is any reduction in the number or distinctness of the personalities, persists through their fusion, and continues at a deeper level even after the personalities have blended into one” (p. 109).
- *Fusion* refers to the moment when a self-state ceases to exist or is merged with other self-states; when they have “ceded their separateness” (Kluft, 1993b, p. 109; See also ISSD, 2005).
- *Final fusion* is the point in time when a client experiences themselves as having a singular and unified sense of identity, memory and consciousness, instead of experiencing themselves as a composite of multiple selves (ISSD, 2005).



- *Unification* is a more general term that often encompasses both the completed process of integration and final fusion; may refer to those who have undergone an integration process yet have not or choose not to fuse all of their self-states into one unified self (Kluft, 1993b).
- *Partial integration* is a treatment outcome wherein a client may undergo multiple fusions of alters, yet choose to maintain several alter personalities within their personality system. This outcome likely includes total co-consciousness among the remaining alters and the complete dissolution of amnesic barriers, such that memory and consciousness become shared, while elements of identity may remain separate. As a result, each alter will at times continue to assume executive control over the behavior, affect and identity of the individual while the other alters are consciously “present” yet inactive.
- *Resolution* is a treatment outcome wherein the client experiences symptomatic relief or achieves increased symptom stabilization and management. This may include a greater degree of co-consciousness among alters and internal collaboration, but does not include fusions of self-states.

The process of combining or fusing many alters into one is often long and arduous and is not a necessary part of an integrationalist treatment plan, as resolution and partial integration are also acceptable treatment outcomes. However, many within the psychiatric community see final fusion as one of the most important outcomes for those suffering with the disorder, as total integration or unification of self-states can replace internal division with unity and promote a more coherent and whole sense of self (Putnam, 1989; Ellerman, 1998). Furthermore, as noted previously, research has shown that clients who achieve final fusion and a fully integrated sense

of self and identity fare better in the long term and are less likely to relapse into symptoms of DID when faced with new overwhelming experiences (ISSD, 2005). In order to examine the possible effects of final fusion or total integration, however, one must first understand the phases of the integration process that lead up to final fusion as well as analyze the existing outcome data on the phenomenon of DID integration.

The phases of the integration process have been enumerated by many within the dissociative disorders field (Greaves, 1989; Kluft, 1993b; Putnam, 1989). Putnam (1989) has identified eight stages of treatment for the individual diagnosed with DID, who is often referred to in the literature and within the DID community as a “multiple.” Greaves (1989), on the other hand, has identified 13 “markers” of evidence that a successful integration process is underway. However, ISSD (2005) has listed three broad phases of treatment that encapsulate what is widely-recognized to be the essential stages of integration:

- (1) safety, stabilization and symptom reduction,
- (2) working directly and in-depth with traumatic memories, and
- (3) identity integration and rehabilitation. (p. 89)

Within each of these phases, the scope, pace and content of the treatment will vary substantially, as the specific circumstances and psychological conditions of the client, the practices and preferences of the clinician and the therapeutic alliance forged between them will ultimately define the therapeutic process. Furthermore, the phases may not progress in a strictly linear fashion, as issues regarding safety and symptom stabilization may resurface at various points throughout the process (Kluft, 1993a). Instead, these phases represent different moments on the continuum of the integration process that may be revisited in a circular fashion as treatment progresses in greater depth. However, there are some common features of treatment that

frequently accompany each of the aforementioned phases of integration, which include: (1) safety, stabilization and symptom reduction; (2) working directly and in-depth with traumatic memories; and (3) identity integration and rehabilitation.

### **Safety, stabilization and symptom reduction**

When a client first presents for therapy, it is of utmost importance that the clinician work with the client to secure their physical safety and stabilize or reduce their symptoms. Given their history of abuse, many individuals with DID reenact behaviors that can pose dangers for themselves and others. Research suggests that clients with DID are at high risk for suicide and self-harming behaviors, as many with DID have a history of eating disorders, suicidal ideation and have made previous suicide attempts (ISSD, 2005). While a clinician may be able to develop a safety contract with the client in the initial sessions, safety issues may continue to arise throughout the integration process, especially when working with traumatic material. As such, this stage should not be thought of as occurring exclusively separate from subsequent stages but, rather, as co-occurring with other stages in the treatment process.

After the client has stabilized and some measure of safety has been established, a clinician often endeavors to next make contact with the alter personalities and begin to collect more information about the multiple's history. Putnam (1989) has referred to this as the "initial intervention stage," the goals of which are for the clinician to attain greater understanding of the client's personality system and to form a therapeutic alliance with the client. By forming an alliance with the client and making contact with some of their alters, the clinician and client can make agreements about the scope and goals of the treatment plan.

When treatment goals have been established, the next step is to establish greater internal communication and cooperation. This stage is essentially ongoing throughout the integration process, as multiples are constantly working to negotiate better communication and cooperation between and among alters. Furthermore, it is during this stage that the host personality often makes contact with their alter personalities for the first time, which is both an effect of and a contributor to the dissolution of amnesic barriers. Multiples in this stage also begin to develop an internal decision-making process, which forwards the goal of internal cohesion (Putnam, 1989).

The process of opening lines of communication between alters and fostering cooperation often involves the clinician making contracts with each alter regarding expected behavior. This not only supports the goal of cohesion and the breakdown of amnesic barriers, but protects a multiple from any alters that are prone to self-harm or harm to others. Furthermore, it prepares the client for the subsequent phase of working with traumatic memory. In working with a client named John, Ellerman (1998) has described this contracting process, writing:

I initiated verbal and written communication between John and the alters as we proceeded in treatment, and formal contracts were made about behavior and expectations. For example, Smokey agreed to abstain from alcohol and to stop cutting John, if John would respect Smokey and allow him to have a voice in the system. Additionally, JP was the guardian of memory who feared that John would kill himself if he became privy to memories of depravity; however, I convinced JP of John's ability to hold memory without decompensating and JP opened the gate slowly, allowing John to be visited by painful remembrances of things allegedly past. (p. 77)

As the multiple becomes conscious of memories of earlier trauma, the host personality has to contend with the painful reality of their past, often for the first time.

### **Working directly and in-depth with traumatic memories**

The goal of this stage is for traumatic memories to become shared among all alters, including the host personality, such that amnesic barriers begin to break down and the client can begin to confront the distressing reality of their past. In some cases, a particular alter or alters will hold all of the traumatic memory, thereby protecting the host personality and, perhaps, other alters as well from knowledge of painful past events. In other instances, memories will be fragmented among many alters, such that the therapist and client must work to recover and piece together different facets of the memory to construct a whole memory of an event. For example, one alter may hold the multiple's affective memory, while another holds the sensory memory and yet a third holds the narrative memory of the event. In combining these facets together and bringing them into the awareness of the host personality, the internal dividedness that has characterized the multiple for so long begins to fade (Putnam, 1989).

This stage of what Putnam (1989) has referred to as “metabolizing the trauma” must be done with great care, as the recovery of traumatic memories can trigger further dissociation if earlier stages of stabilization and internal cooperation have not been adequately achieved (1989, p. 140). Mairi McFall, a woman who discussed her experiences living with DID in Saraf and Light's documentary *Dialogues with Madwomen* (1993), recalled the terror that she experienced when undergoing integration:

When I was going through my recovery process, all of the fear that I didn't allow myself to feel as a child came roaring to the surface and I was terribly afraid, all the time. I was

sure that my father and all the other men who abused me were going to come get me. I was positive. (Saraf & Light, 1993)

Due to the difficult nature of this work, many clients choose to terminate the integration process at this point, as the recovery and processing of painful memories can be experienced as too difficult to bear. For those who continue with therapy at this juncture, however, the recovery of traumatic material can set the stage for the process of resolution, partial integration or final fusion to take shape (ISSD, 2005; Putnam, 1989).

### **Identity integration and rehabilitation**

As noted earlier, resolution is a treatment outcome wherein multiples who have achieved symptomatic reduction and stabilization may choose not to integrate but to instead remain multiples, especially after acquiring fuller memory of the past and achieving internal communication and cooperation. This option is often more appealing to multiples who fear that integration will cause them to lose or “kill” certain alters or to those who fear that they will not retain the same skills, abilities, creativity and interests when their separate alters merge into one (Putnam, 1989). In *Dialogues with Madwomen* (1993), Mairi McFall disclosed her fear of integrating, declaring,

I didn't want to integrate. Integrate meant that somebody was gonna to die. I didn't want to integrate. I did *not* want to integrate. I couldn't imagine – they were all separate people. How could we be one person? (Saraf & Light, 1993)

This fear was also well articulated by one multiple who calls herself Keepers and refers to herself in the plural. She wrote:

For us, there have been many points where keepers have thought about integration. We have had the usual fears of becoming integrated feeling like death to our alters. We have worried about losing abilities when this keeper or that one no longer exists as a separate entity. But, I think our greatest fear was that keepers would integrate and begin living a more singular life when some sort of trauma or tragedy might hit which would cause the resurfacing of our alters in order to cope. (Keepers, 01/04/08, para. 3)

In addition to existing anxieties about what may be perceived as the “death” of an alter or the loss of abilities associated with those alters, clients like Keepers fear that after achieving what appears to be final fusion, new traumatic experiences might trigger dissociation and internal dividedness to recur.

In the autobiographical work *A Fractured Mind: My Life with Multiple Personality Disorder* (2005), Robert Oxnam wrote about his life with DID and his choice to achieve and maintain partial integration, another outcome of treatment that exists on the continuum between resolution and total integration. After years of intensive treatment with a psychiatrist, Robert had achieved several fusions of alters, such that his eleven alters had been reduced to three. However, his remaining three personality-states (Wanda, Robert and Bobby) resisted integrating fully into one personality, writing:

Surprising as it may seem to normal, integrated people, each of us had reasons to resist full integration. Bobby, of course, was deeply determined to keep his youth, his energy, and his personal freedom. Wanda worried that total integration might undercut her internal incisiveness and outer perceptiveness.... In short, each of us feared losing that creative spark that had defined us as separate personalities. (Oxnam, 2005, p. 231)

Despite fear of and resistance to integration, many multiples do choose to go down the path of integration, merging their many selves into one coherent whole.

When final fusion takes place and total internal unification has been achieved, memory that was formerly separated by amnesic barriers becomes shared such that the individual no longer has blank spots or lapses in memory. Additionally, the characteristics of each self-state – language, ability, movement, affect – are often combined and integrated into the dominant personality (Putnam, 1989; Ellerman, 1998). These fusions are often accomplished through what is referred to in the literature as “fusion rituals” (Kluft, 1986a, 1986b, 1993b), which have been defined by Kluft (1986b) as “ceremonies at a discrete point in time which are perceived by some [DID] patients as crucial rites of passage from the subjective sense of dividedness to the subjective sense of unity” (Kluft, 1986b, p. 4). These ceremonies vary widely depending on the needs and wishes of the client, and in some cases, are not used at all to achieve fusion. Through whatever means clients come to perceive themselves as fully integrated, however, the internal process they undergo remains somewhat of a mystery to the witnessing clinician. In reflecting upon several clients who reported a complex process of negotiation between alters in the final steps before fusion, Kluft (1993b) commented:

It is difficult to know what to make of such reified internal myths; but it is a clinical fact that many MPD patients report such inner experiences, and the alters involved in the arrangement thereafter comport themselves as if these events [fusions] in fact have come to pass. (p. 21)

However, in the wake of the process of achieving final fusion, it is possible for the integrated self to experience losses as a result of integration treatment (Bristol, 1997), as feared by many multiples who resist integration (Keepers, 2008; Oxnam, 2005). It is these changes in certain



aspects of the self that this paper will explore in greater depth in order to better conceptualize what the experience of post-integration is for those who endeavor to live as an integrated whole.

### **Post-Integration**

After final fusion has been achieved, individuals who formerly experienced themselves as multiples now subjectively experience themselves as a singular self with undivided memory, consciousness and identity. This stage is often referred to as “post-integration,” “post-unification” or “post-fusion” (Kluft, 1993b; Putnam, 1989), terms that will be used interchangeably for the purposes of this paper. However, the final fusion of self-states does not necessarily signal the end to or completion of integration treatment. To the contrary, this stage often presents clients with new and unforeseen challenges that can be mitigated and managed through ongoing integration therapy. Kluft (1988b) has addressed this dilemma, asserting:

[T]he majority must now contend with important issues that could not become the focus of therapeutic exploration in the face of the chaos of the lives they led while suffering [DID]. Many find that the treatment required after unification proves more extensive than the work that preceded it. (p. 216)

Putnam (1989) has identified three broad areas of work to which newly integrated clients must often attend: (1) readjustments in important relationships, (2) facing problems previously evaded through dissociation, and (3) grief work (1989, pp. 317-319).

#### **Readjustments in important relationships**

As integration progresses and total integration is achieved, clients often become aware of significant shifts in their interpersonal relationships. While a multiple, they may have related to

their boss, spouse, children or friends in markedly different ways, depending on which alter or alters were primarily responsible for interacting with a particular person. For instance, a certain alter may have been utilized most frequently at work, when attention to detail and mathematical skills were required, or an alter may have emerged during marital disputes, such that conflicts were resolved when the host personality was not consciously present to the moment. As an integrated person, however, the individual will now face responsibilities at work or conflicts at home that were heretofore unknown to them. While they may have retained the mathematical skills and conflict-resolution techniques utilized by their alters, putting them into practice is a wholly new activity to which the integrated individual must now adjust.

On another front, individuals in the post-integration phase often realize that some of the important people in their lives would prefer them to remain a multiple (Putnam, 1989). While one may speculate about the specific reasons that a person might prefer their loved one to remain a multiple, one fact seems to be beyond speculation: an integrated person will appear and behave differently than they previously did as a multiple and, as a result, both the integrated individual and those with whom they have close relationships will face an adjustment period to these changes.

### **Facing problems previously evaded through dissociation**

As a multiple, the individual had an elaborate defensive structure that enabled them to survive trauma. As a result, clients emerging from their dissociative multiplicity have to face the memories of the trauma and the lasting implications of that trauma for the first time. Putnam (1989) has suggested, “As the dissociative fog lifts following [final] fusion, and the patient views his or her past and present life as a continuous whole for the first time, it is usually readily

apparent that this life is a mess” (p. 318). In addition to reckoning with past experiences of abuse, the client must now also take responsibility for actions and behaviors that they may have been previously unaware of, as alters had assumed executive control of the individual unbeknownst to the host personality. Due to their trauma history, many clients discover that they have become abusers themselves, as they have reenacted abusive behaviors they experienced as a child (Putnam, 1989). Facing this reality can be extremely difficult for clients in treatment, as they must take responsibility for themselves while finally holding their abusers responsible for their actions and behaviors as well.

### **Grief work**

In many ways, this area of work in the post-integration phase encompasses the former two, as clients must grieve any undesirable changes that take effect in their significant relationships and must grieve for both the distant and more recent past, both of which have now come into sharper focus. Putnam (1989) has elaborated upon this idea, suggesting:

Patients must grieve for the past, for the loss of an idealized view of their parents/abusers, and for the loss of what they could have been and done if they had not been dissociatively fragmented. [They] must also grieve for the loss of their alters. (p. 319)

Understanding the full scope of a client’s grief—what they are grieving for and why—is intimately related to the question at hand: how are clients experiencing the changes resulting from integration? What are their perceptions of these changes and how do these perceptions lead them to embark on a process of grieving? In order to attend to these questions, however, it is also essential to know what changes are taking place – are they characterological, physiological,

psychological or relational? Are these changes observable and identifiable or are they perceptual?

These and related questions regarding the subjective experiences of clients in the post-integration or post-unification phase have received little attention from practitioners in the field (Coons & Bowman, 2001; Putnam, 1989; Kluft, 1986a, 1988b). Kluft (1988b) and Putnam (1989) both noted the conspicuous lack of attention to this phenomenon over twenty years ago, with Kluft lamenting, “The problems and treatment needs of unified MPD patients have received relatively little discussion in the literature” (1988b, p. 214). Nearly a decade later, Bristol (1997) noted that the literature remained relatively scarce with regard to the experience of post-integration for individuals with DID, stating, “Many questions remain unanswered regarding clients’ perceptions, feelings about, and understandings of fusion” (1997, p. 24).

To contribute to the body of knowledge on the aforementioned questions, Bristol (1997) conducted a qualitative exploratory study with 12 DID clients that had completed final fusion and achieved unification. Her findings suggested that after achieving unification, participants experienced significant changes in physiology (i.e. eyesight, hearing, asthma), intellect and ability (i.e. fluency in a second language), temperament, attitude and preferences (i.e. favorite activities or foods). These changes were in some cases experienced as extremely positive, as in the newfound ability to speak Spanish, while other changes were experienced as negative, such as increased hearing impairment and a loss of interest in and ability to accomplish certain activities (Bristol, 1997). Bristol (1997) summarized her findings, writing,

Clients report varying degrees of difficulty with accepting their “new [selves].” ...  
[T]hose who lost talents or developed physical disabilities during integration experience greater difficulty in accepting these traits as ego syntonic. (pp. 58-59)

Furthermore, Bristol contended, "...[I]t seems that even clients in the stable-integration phase of treatment, despite the numerous years since their final fusion, are still struggling to accept their unified status into their self-concept" (1997, p. 59). In these instances, according to Bristol (1997), it is a loss of self-perception with which the newly integrated individual must contend, as their sense of themselves as a multiple—and all that that may entail—is fundamentally altered. While other qualitative and quantitative studies on the subjective experiences of post-integration individuals may exist, they have not yet been located for the purposes of this paper.

Bristol's (1997) findings suggest that unified DID clients experience both physiological (intellect, disability/ability) and characterological (temperament, attitude, preferences) changes. Her findings further suggest that such changes can be interpreted as positive gains or as negative losses. The unified client, Putnam (1989) has suggested, must then grieve for those changes that are perceived as losses. In order to further understand these perceptual losses, Pauline Boss's (1999) theory of ambiguous loss will now be examined as a possible framework for explaining or interpreting the subjective experience of post-integration.

## CHAPTER IV

### Ambiguous Loss Theory

Ambiguous loss theory explains the experiences of irresolvable grief and unclear loss that often arise in conditions wherein a loved one is experienced as physically absent but psychologically present *or* physically present but psychologically absent (Boss, 1999, 2010). Developed by Pauline Boss (1999) and subsequently used as a theoretical framework by a number of researchers in the field of social science research (DeYoung & Buzzi, 2003; Dupuis, 2002; Frank, 2008; Kean, 2010; Landau & Hissett, 2008), the theory speaks specifically to the experience of loss resulting from variable and indefinite traumatic stressors, such as the abduction of a loved one, as opposed to acute or distinct stressors, as in the death of a family member (Boss, 1999, 2006, 2007, 2010). Boss (2006) has elaborated on the ambiguity of such indefinite stressors:

Even without death, the people we care about disappear physically or fade away psychologically. The Alzheimer's patient, the brain injured, and the stroke victim, as well as the kidnapped or imprisoned, are out of reach. This ambiguity between presence and absence creates a unique kind of loss that has both psychological and physical qualities. (p. 1)

Experiencing such unclear and traumatic stressors, according to Boss (2010), can result in an inability to achieve emotional and psychological resolution leading to a "freezing" of the

grieving process, in which "...there is no verification, no closure, no rituals for support, and thus no resolution of grief" (p. 144). Suspended in a state of irresolvable grief, and without the support of cultural ritual and community recognition of the loss, the individual may struggle to feel that their grief or sense of loss is valid and justifiable.

### **Ambiguous Loss: Definitions and Assumptions**

Stemming in large part from her extensive work as a family therapist, Boss developed and defined the concept of ambiguous loss as a "stress- and resiliency-focused theory" for the study of how a shift in family membership effects the functioning of the family system (Boss, 2007). Within this conceptual framework, Boss (1999, 2010) has identified two types of ambiguous loss: (1) physical presence with psychological absence, and (2) psychological presence with physical absence.

#### **Physical presence with psychological absence**

This first type of ambiguous loss refers to circumstances wherein an individual experiences someone in close relationship to them as physically present but psychologically absent in some significant way. Boss (2010) has identified numerous examples, including serious and chronic conditions (e.g., Alzheimer's disease, traumatic brain injury and autism) as well as more common or intermittent conditions (e.g., an extreme preoccupation with work or a neurotic obsession with another person). While the individual is still physically present, their medical condition or mental state has resulted in psychological or characterological changes that have rendered them a fundamentally different person in the eyes of those in relationship to them. They may look or talk in the same manner or perhaps occupy the same house, but their

relationships have shifted dramatically as a result of these psychological changes. Consequently, they are experienced as simultaneously present and absent, as Boss (2010) has written, “Part is gone, part remains” (2010, p. 140). Mourning or feeling a sense of resolution about these changes or conditions, therefore, can be challenging given the indefinite and, in some cases, vacillating status of their loved one’s psychological “presence.”

### **Psychological presence with physical absence**

This second type of ambiguous loss, according to Boss (2010), pertains to circumstances wherein “a loved one is missing physically—lost, kidnapped, disappeared, but kept present psychologically because they might reappear [sic]” (2010, p. 138). Examples range from the more exceptional (e.g., an abducted child, a soldier who has been declared missing in action for 20 years) to the more commonplace (e.g., foster care, imprisonment, immigration). Given the uncertainty of whether or not the physically absent person may one day become present again, their absence may be experienced by those who have been close to them as confusing and indefinite, which therefore complicates the ability to grieve or find resolution about their absent or missing status.

For the purposes of this paper, “ambiguous loss” will be defined as: a change or a condition within a system of relationships that is interpreted by an individual as a loss, wherein another individual in the relational system is perceived as being either (a) physically present but psychologically absent, or (b) psychologically present but physically absent. To fully unpack this definition, however, this paper must define what constitutes loss and change, as well as establish who comprises the relational system in which the condition or change of ambiguous loss occurs.



### **Assumptions of ambiguous loss**

*Oxford Dictionaries Online* has defined loss as being either (1) “the fact or process of losing something or someone,” or (2) “the state or feeling of grief when deprived of someone or something of value” (Oxford University Press, 2010). Based on this definition, therefore, loss can refer to either an objective, empirical fact of something or someone being or becoming lost or absent, or to a subjective feeling state resulting from either the perception or fact of losing something. In other words, it is either the fact of a change having occurred—the present becoming absent—or the feeling response to that change. Within the context of ambiguous loss theory, it appears that both definitions are concurrently at play.

On the one hand, the former definition—the fact of a change having occurred—seems applicable to Boss’s definition of ambiguous loss, as the ambiguity of the loss refers not only to the feeling state associated with the change in the relationship, but to the situation of change itself. It is the fact of someone who was at one time present becoming absent that is confusing and unclear, as their absence is not total or definite but remains suspended in a mixed state of simultaneous presence and absence. When interpreted in this way, therefore, “ambiguous loss” refers to the uncertain status of a person’s physical or psychological presence and could synonymously be termed “ambiguous presence” or “incomplete absence.”

While most of Boss’s examples (1999, 2010) of ambiguous loss center on situations wherein a change has occurred that effects a relationship (e.g. divorce, immigration, an adult who sustains a traumatic brain injury later in life), several instances of ambiguous loss that have been examined in the literature suggest that ambiguous loss can occur when no change or shift has taken place. For example, parents of children born with autism (O’Brien, 2007) or with

profound developmental disabilities (Roper & Jackson, 2007) may identify with the experience of ambiguous loss, as they may perceive their children as being both physically present but psychologically absent to varying degrees. In these instances, it is an ever-present, unchanging condition that is experienced as ambiguous loss, as there is no previous state to which those experiencing ambiguous loss wish to return. It is not, as *Oxford* (2010) suggests, “the fact or process of losing something or someone,” but rather the loss of a projected hope, as the preconceived fantasy of having a child live into and fulfill normative expectations is thwarted and all that is perceived or experienced as less than normative is then conceived of as lost. As such, it may be that the condition—the unchanging fact of their child’s mental and physical state—is experienced as confounding and, to some extent, as a loss of “what-should-have-been,” rather than a loss of “what was.”

Examples of this type of ambiguous loss may also include a woman who gives a child up for an adoption and then feels compelled to grieve for the unknown potential of what could have been a relationship in her life. Similarly, a man who has no memory of his biological father, a man who has never been a presence in his life, may find himself unable to fully grieve the absence of his father as he simultaneously hopes this man may one day emerge as a presence in his life. In these instances, there is no previous state of relationship to which the mourner wishes to return. Rather, it may be the imagined possibility of a relationship—based on conceptions of what might constitute a “normal” relationship or mode of relating—that was never realized that the individual is now struggling to grieve, process or resolve. Therefore, ambiguous loss may be experienced in response both to a change that has occurred as well as to an unchanging external condition.

On the other hand, the latter definition—loss as a feeling response to a condition or to a change that has occurred—applies equally to the concept of ambiguous loss, as Boss’s theory was designed to capture the highly ambivalent feelings that often accompany situations wherein a loved one’s presence is tenuous and uncertain. Understood in this way, “ambiguous loss” refers not only to the ambiguity of the situation but also to the ambiguous feelings resulting from the situation. An individual wants to mourn the loss of their partner who has been declared missing in combat, but also remains hopeful for her return. This may place them in an emotional state of heightened ambivalence, wherein there is no clear, singular feeling-state that seems appropriate to the situation. Rather, the landscape of feeling is defined by conflict and uncertainty, as seemingly opposing feeling-states vie for prominence in their emotional template.

Based on this discussion of loss, then, ambiguous loss seems to refer to both (a) the *ambiguous fact of a change or a condition* in a relational system resulting in uncertainty about the status of an individual’s physical or psychological presence, and (b) the *ambiguous feeling-state* of loss in response to such a change or condition. Perceiving a change or a condition as a loss, however, is a subjective perception, not an objective reality. Therefore, ambiguous loss theory assumes the following about the conditions or changes that occur within a relational system: (1) the change or condition is value-neutral (neither objectively positive nor negative); (2) the change or condition is subjectively interpreted by members of the relational system; (3) these subjective interpretations will be informed by cultural beliefs and values; and (4) the change or condition happens within the context of a relationship that is experienced as significant or meaningful.

***The condition or change is value-neutral***

According to Boss (2007), “ambiguous loss as an external situation is assumed to be neutral. How it is perceived, however, has valence” (p. 106). Indeed, the examples of ambiguous loss to which the literature refers—dementia, adoption, autism, divorce or immigration—need not necessarily be perceived as losses. To the contrary, these very same phenomena may likewise be interpreted as wholly positive within a relational system. Therefore, ambiguous loss theory assumes that the condition or change within the relational system is value-neutral, neither objectively positive nor negative, while the feeling state of loss that may be aroused by the condition or change, as well as the perceptions or interpretations of the condition or change, are subjective and will vary in degree and severity depending on the circumstances and particularities of the individuals involved.

***Interpretations of the condition or change are subjective to the individual***

Boss (2007) has suggested that conditions or changes may be experienced or perceived very differently among those within the system of relationships under discussion, as ambiguous loss theory assumes that the truth about the loss is relative to the perception of the individual. For example, if a man is diagnosed with Alzheimer’s disease and his wife perceives the changes that he undergoes as an ambiguous loss, this does not mean that the man will necessarily share her perception—he may, in fact, be totally unaware that a change has taken place and may be fully content in his current circumstances.

*Interpretations are informed by cultural beliefs and values*

These interpretations and perceptions are not only subjective to the individual but are also shaped by cultural beliefs and values (Boss, 2007). When studying the effects of dementia on caregivers in family systems, Boss discovered a markedly different response to dementia than she had previously encountered among the Anishinabe women of northern Minnesota who served as caregivers for their elder family members with dementia. Recounting her experience, she wrote:

As we sat in a circle with the sweet smell of burning sage, I listened to their stories. I learned that these Native American women cope with the psychological absence of a demented parent by combining mastery of the situation with a spiritual acceptance of the illness. . . . They saw an elderly person's illness as part of nature's cycle from birth to death. (Boss, 1999, p. 17)

By accepting dementia as a natural part of the aging process, these women were able to find positive meaning in their elders' conditions. Since their community and culture shared their perspective, they had the benefit of ritual and community support for their feeling responses to the onset of dementia. As a result, the onset of dementia did not signify an ambiguous loss for these women, while it did for many other families of different cultures with whom Boss met (1999). These differences in perception and meaning-making illustrate the ways in which an individual's interpretation of a condition or change is informed by their intersecting social locations and identities—their culture, ethnicity, race, gender, sexuality, age and historical era all play a role in influencing their experience of ambiguous loss.

*The change takes place or condition exists within the context of a relationship that is subjectively experienced as significant or meaningful*

Given Boss's work with and clinical focus on couples and families, her descriptions of ambiguous loss often include mention of "family members" and "loved ones" (Boss, 1999, 2007, 2010). While these terms may be appropriate within the context of a family and couples therapeutic practice, the experience of ambiguous loss is not limited to the official members of a family (Boss, 2006, 2007). Instead, Boss (2007) has forwarded a more expansive definition of what constitutes a family system, writing, "...[A]mbiguous loss theory assumes that a psychological family exists and that this perceived construction of one's family may differ from the physical or legal family structure" (p. 106). Further developing this concept, she has written:

Cut off from loved ones physically or psychologically, people cope by holding on to some private perception of home and family. This psychological construction of family may coincide or conflict with official records and the physical family one lives with, but who is viewed as being in the family is of therapeutic importance. (Boss, 2006, p. 26)

Therefore, the notion of the family is not limited to a legal configuration but may include perceptual constructions as well. Hence, the psychological family refers to whatever grouping of people is perceived to be psychologically and emotionally significant to the individual.

Boss's definition of family within the context of ambiguous loss theory appears to have broadened to include whatever grouping of people or system of relationships is felt by the individual to be significant—be it a child, partner, close friend, colleague, neighbor or member of the clergy. It follows, then, that ambiguous loss can be experienced in a wide range of relationships and relational systems, depending on the subjective significance or meaning ascribed to the relationship by the members therein. Consequently, it seems inaccurate to limit a

discussion of ambiguous loss with the terms “family members” and “loved ones.” For the purposes of this paper, therefore, it is assumed that the change or condition that is experienced as an ambiguous loss occurs within a relationship that is subjectively experienced as meaningful and significant.

### **Features of Ambiguous Loss**

According to Boss (2010), an ambiguous loss caused by either the physical or psychological absence of a loved one is defined by several key features:

- Ambiguous loss is unclear loss
- Ambiguous loss is traumatic loss
- Ambiguous loss is a relational disorder
- Ambiguous loss is externally caused (e.g., illness, war), not by individual pathology
- Ambiguous loss is an uncanny loss – confusing and incomprehensible

(Boss, 2010, p. 138)

Exploring these features in detail illuminates the possible connections between the experience of ambiguous loss and the subjective experience of DID integration, which will be examined in the discussion chapter of this paper.

### ***Ambiguous loss is unclear loss***

Ambiguous loss is necessarily unclear, as experiencing a significant other as being simultaneously present and absent defies the finality and certainty of an unambiguous situation, such as death. Ascertaining what is gone and what remains can often be confusing, as the degree to which a significant other is experienced as physically or psychologically present may fluctuate

over time. Furthermore, a change or condition in a relationship experienced as an ambiguous loss may be either objectively definable and observable (e.g., divorce, immigration, abduction) or may be perceptual (“My husband just isn’t *there* any more. He’s no longer the man I married.”). As a result, perceiving such an experience to be a “loss” may be contentious, as different members within the relational system may hold conflicting perceptions of and responses to the ambiguous situation, thereby resulting in increased emotional ambivalence and confusion. Boss (1999) has observed:

Whatever the cause of the unresolved loss—immigration, war, divorce, remarriage, or adoption—its symptoms can be distressing. Anxiety, depression, somatic illnesses, and family conflict often afflict those who do not adapt and move on with their lives.

Without some kind of closure, the absent stay present. (p. 44)

The ambiguity of presence and absence, therefore, perpetuates uncertainty, as it remains unclear to what extent it is possible or culturally acceptable to resolve or mourn the “loss” of a relationship with another individual who is partially here and partially gone.

### ***Ambiguous loss is traumatic loss***

Similar to the precipitant traumatic stressors of posttraumatic stress disorder (PTSD), Boss (1999) has contended,

Ambiguous loss is also a psychologically distressing event that is outside the realm of ordinary human experience; like the events triggering PTSD, it lacks resolution and traumatizes. But with ambiguous loss, the trauma (the ambiguity) continues to exist in the present. It is not *post* anything. Ambiguous loss is typically a long-term situation



that traumatizes and immobilizes, not a single event that later has flashback effects.

(Boss, 1999, p. 24)

While some conditions of ambiguous loss are not “*post anything*,” as Boss has suggested, other situations experienced as ambiguous loss are indeed the result of a single event or change in a relationship that persists indefinitely. When a family member develops dementia or a child is declared MIA, for example, there is a discrete moment in time when their status—from present to absent—shifts, thus leading to the experience of ambiguous loss. Therefore, the ambiguous loss does in some instances occur after the fact of a change or a newly developed condition that affects a relational system.

However, there is a valid and important distinction that Boss appears to be making between the traumata that lead to the development of PTSD and the traumata of ambiguous loss. PTSD often develops in response to experiencing or witnessing acutely distressing life-threatening events, whereas ambiguous loss is often the result of witnessing another in a dubious situation that may or may not contain the immediacy, gravity or clarity of the trauma resulting in PTSD. Boss’s more commonplace examples of ambiguous loss exemplify this distinction, as a severe preoccupation with work hardly constitutes a traumatizing situation. In reviewing the various applications of ambiguous loss in Boss’s writing and in the empirical literature, therefore, it may be more accurate to suggest that ambiguous loss *can* be traumatizing, though may not be in all instances.

### ***Ambiguous loss is a relational disorder***

Boss (2007) has suggested that, “Ambiguous loss is inherently a relational phenomenon and thus cannot be an individual condition” (pp. 106-107). She elaborates on this point, writing:

When relationships are unclear and closure is impossible, the human need for finality can distress or traumatize families. . . . Bereft of rituals to support them (because the loss is unverified), families are left on their own. Because of the ambiguity, relationships dissipate as friends and neighbors do not know what to do or say to families with unclear losses. *For all of these reasons, ambiguous loss is a relational disorder and not psychic dysfunction* [italics added]. (Boss, 2007, p. 106)

While Boss has persuasively asserted that ambiguous loss affects relationships and causes distress between people, she has not fully clarified how or why ambiguous loss applies exclusively to the interpersonal realm of human relationships. Furthermore, her acknowledgment of the clinical significance of the “psychological family” suggests that individuals may determine for themselves what relationships of import—either *interpersonal* or *intrapersonal*—are composed therein.

***Ambiguous loss is externally caused (e.g., illness, war), not by individual pathology***

Boss (2007) has suggested that the causes of ambiguous loss are external to the relational system in which it is experienced:

The symptoms [of ambiguous loss] may be individual, resembling those of complicated grief, or depression, anxiety, and ambivalence, *but the culprit lies in the context outside the individual and their couple or family relationships* [italics added]. Because of the external context, the family’s ability to find coherence and meaning in the ambiguity surrounding the absence and presence of a loved one is impaired. (Boss, 2007, p. 107)

The precipitants of ambiguous loss, then, are not subjective to the individual. Rather, the cause itself is an objective event or situation that comes from outside of the individual, while the

emotional, intellectual or psychological response to or interpretation of the cause is subjective to the experience of the individual and to each of the members of the relational system.

***Ambiguous loss is an uncanny loss – confusing and incomprehensible***

Boss (2010) has maintained, "...[W]ith ambiguous loss, closure is a myth. Instead of a clear ending, there is a gradual slipping away that is full of confusion" (p. 141). In this instance, Boss seems to be referring to the progressive deterioration that takes place with dementia, for example. However, this characterization of the "gradual slipping away" of the other does not seem applicable to other conditions of ambiguous loss (e.g., imprisonment, abduction). While the notion of gradually "slipping away" may not be relevant in many other instances of ambiguous loss, the experience of the uncanny—the unsettling mystery and strangeness of ambiguous presence and absence—can indeed be profoundly perplexing and disorganizing.

Carolyn Feigelson (1993) expounded upon the experience of the uncanny after her husband sustained a traumatic brain injury in which he suffered "an irretrievable loss of responsive capacities that stops short of physical death," a phenomenon she called "*personality death*" (p. 332). Feigelson described the experience of being close to someone who has suffered personality death, remarking, "The anxiety of the uncanny involves something on the border of what we both know and don't know, both cognitively murky and affectively alarming" (1993, p. 331). Boss (2006) has elaborated on the inexplicability of such experiences, writing:

From a psychoanalytic perspective, ambiguous loss is indeed an uncanny situation of traumatic anxiety produced by a combination of the known and the unknown (physically present but psychologically absent, or vice versa). The intellectual and relational

uncertainty of living with someone both here and not here produces a terrible anxiety of bizarre human experience. (p. 5)

Situated between the known and the unknown, the observer must relate to a paradoxically present-yet-absent other, resulting in anxiety, ambivalence and uncertainty.

### **Empirical and Theoretical Research**

In order to further develop and clarify her theory, Boss and her colleagues have conducted qualitative research and clinical interventions to explore the implications of ambiguous loss (Boss, 1977, 1980, 2004, 2005; Boss, Beaulieu, Wieling, Turner & LaCruz, 2003; Boss & Couden, 2002). Other researchers have endeavored to conduct studies based on the conceptual framework of one of the two types of ambiguous loss identified by Boss: (1) physical presence with psychological absence, and (2) psychological presence with physical absence. The first type of ambiguous loss—physical presence and psychological absence—has been explored in studies conducted on the experiences of ambiguous loss in families of patients with traumatic brain injuries (Kean, 2010; Landau & Hissett, 2008) or cognitive impairment (Blieszner, Roberto, Wilcox, Barham & Winston, 2007), families with children with autism spectrum disorders (O'Brien, 2007) or with profound developmental disabilities (Roper & Jackson, 2007), and caregivers of family members with dementia and Alzheimer's disease (Dupuis, 2002; Frank, 2008).

The second type of ambiguous loss—psychological presence with physical absence—has received equal attention in the literature, with studies ranging from the effects of wartime conflict on displaced or disappeared persons (Luster, Qin, Bates, Johnson & Rana, 2008, 2009; Robins, 2010), the effects of servicemen declared missing-in-action (MIA) on their families

(Boss, 1977, 1980), the effects of foster care and adoption on children (Powell & Afifi, 2005; Lee & Whiting, 2007; Samuels, 2009), the effects of same-gender divorce on children (Allen, 2007), the effects of still-birth and prematurely born infants on parents (Cacciatore, DeFrain & Jones, 2008; Golish & Powell, 2003), the responses of families of abducted or missing children (DeYoung & Buzzi, 2003) to the reactions of military families in wartime (Faber, Willerton, Clymer, MacDermid & Weiss, 2008; Huebner, Mancini, Wilcox, Grass & Grass, 2007).

Adding to this body of literature are two studies conducted by Roer-Strier and Sands (2001) and Roer-Strier, Sands and Bourjolly (2009), both of which examined family members' reactions to their adult daughter's religious conversion or religious "intensification" (Roer-Strier & Sands, 2001, p. 868). Based on their research, Roer-Strier et al. (2009) have suggested a third type of ambiguous loss, wherein a family member is "*psychologically and physically present but symbolically absent*" (p. 225), which they have defined as follows:

The symbolic absence is the result of a change in a characteristic that identified a person as one who shared the family's identity (e.g., religion, ideology). The family's loss becomes ambiguous when the change threatens core cultural and religious norms, values, and/or beliefs and when the family's culture does not recognize the new change as legitimate. (p. 225)

Although this alternative conceptualization of ambiguous loss due to symbolic absence may have clinical or theoretical significance in a variety of circumstances, the scope of the discussion in this paper will henceforth remain limited to the two types of ambiguous loss enumerated by Boss (1999).

While the scope of empirical research related to ambiguous loss is rather broad, it is also confined exclusively to interpersonal loss, wherein an experience of ambiguous loss occurs

between two or more people. While this is in keeping with Boss's (1999, 2007) original conceptualization of the theory, it seems plausible to extend the application of ambiguous loss theory to *intrapersonal* or intrapsychic phenomena, such as the perception or experience of intrapsychic loss that may accompany DID integration. Indeed, doing so may provide important insights for clinicians into the experiences of multiples who have undergone the unification process. Furthermore, it may also provide researchers with greater grounds and impetus to conduct empirical research on the post-unification experience of those diagnosed with DID. The benefits of increased clinical insight and more expansive research will undoubtedly extend to those who have integrated as well, as they may be met with more acceptance and understanding by psychiatric and social work practitioners after their previously under-documented experiences of post-integration have been more widely heard, explored and disseminated.

In order to underscore the potential significance of conducting the forthcoming analysis regarding the possible ambiguous losses of achieving intrapsychic integration, this paper will now (1) explore poststructuralist thought and the work of Michel Foucault and (2) employ a Foucauldian discursive analytic (2006 [1961]) in an examination of the dominant discourse of DID and integration treatment.

## CHAPTER V

### Poststructuralism and a Foucauldian Analysis of Discourse

Poststructuralism emerged in the late 1960's and early 1970's in French philosophical and intellectual discourse as a set of responses to and critiques of the universalizing ontologies and epistemologies that are and have been foundational to the long-established Western intellectual tradition. Poststructuralist thought has been populated and influenced by a number of notable figures, including Gilles Deleuze, Jacques Derrida, Michel Foucault, Félix Guattari, Jacques Lacan and Jean-François Lyotard (Bogue, 2002; Borchert, 2006; Bunnin & Yu, 2004). While they and others are widely credited for developing and shaping much of poststructuralist thought, many do not identify themselves as being "poststructuralist" or "postmodernist" (Poster, 1989; Racevskis, 2002). Their resistance might be interpreted as characteristic of a poststructuralist perspective, in which the very notion of a singular or unified philosophical position is a target of criticism. Furthermore, such resistance is on some level warranted, as each of the aforementioned thinkers (and others who conduct analyses using a poststructuralist framework) have differing analytic approaches.

Despite their reluctance for such identification and cutting across deep divergences in methods and targets of analyses, however, is the shared aim of dismantling and problematizing the comprehensive and totalizing claims to truth, knowledge, objectivity and rationality that represent the central concern of much of modernist philosophical thought (Bunnin & Yu, 2004;

Poster, 1989). Poster (1989) has commented on this shared aim, writing, “Poststructuralists criticize the assumption of much of modern thought that theoretical discourse is a direct expression of a truth in the theorist’s mind, that this truth in some way captures historical reality...” (p. 4).

Much of early poststructuralist thought was directed toward a critical analysis of structuralist discourses, which maintain that language is comprised of opposing elements that serve as signifiers, each representing some essential underlying meaning or absolute truth (Bunnin & Yu, 2004; Oxford, Poststructuralism, 2011). Poststructuralists challenged this central assumption of structuralism, contending that the elements comprising a language system do not signify any stable meaning or absolute truth, as meaning is not fixed but is instead constructed through discourse. Indeed, poststructuralists “departed from the claims to objectivity and comprehensiveness made by structuralism and emphasized instead plurality and deferral of meaning, rejecting the fixed binary oppositions of structuralism and the validity of authorial authority” (Oxford, Poststructuralism, 2011).

While many poststructuralists preliminarily focused their analyses on structuralism (thereby earning them the designation of “*post-structuralist*”), poststructuralism was and continues to be fundamentally concerned with analyzing and deconstructing any and all totalizing and authoritative worldviews and systems of thought, of which structuralism is just one example. It takes aim not only at structuralism, therefore, but at numerous ontological and epistemological perspectives—some of which have been broadly conceptualized as modernism, positivism and empiricism—that forward essentialist, universalist or absolutist truth-claims regarding the nature of being and the nature of knowledge. Poststructuralists, in other words, contest the notion of pre-existing underlying truths about metaphysical or temporal reality.



Instead, poststructuralists view truth and knowledge as shifting and unstable ideas that emerge out of and are shaped by historical discourses; truth and knowledge are claimed rather than discovered (Borchert, 2006; Bunnin & Yu, 2004).

While the *targets* of poststructuralist analyses and critiques may be identifiable (by enumerating the dominant philosophical approaches they aim to disrupt or repudiate), identifying or characterizing any *claims* of poststructuralism poses a far greater challenge, as it represents not a unified body of philosophical thought, but a wide array of analytic approaches and positions. However, the interrelated concepts of the subject, discourse, and power emerge throughout much of what is considered to be poststructuralist thought. The re-writing of these three concepts is central to this project and will now be explored through Michel Foucault's examination and critique of the dynamics of power at play in the historical, contemporary and ever-evolving discourses of madness, unreason and mental illness.

### **Michel Foucault**

According to Foucault (1983), the objective of his work "has been to create a history of the different modes by which, in our culture, human beings are made subjects" (p. 208). Throughout his work, the examination and explication of the history of the human-being-made-subject has been inextricably tied to the discourses and modes of power that are implicated in the construction of the human subject. However, Foucault's usage of the terms "subject," "discourse" and "power" has differed from traditionally or widely-held definitions of these concepts, as he has complicated the meaning of each term and has underscored the complexity of their relationships to one another. For the purposes of this paper, Foucault's conceptions of these terms will now be explored and elaborated upon in greater detail.

## **Discourse**

At a basic level, discourse is defined as being comprised of written or spoken language or communication that is in use by a particular group of people at a particular time and place in history (Jolliffe, 2001; Oxford, Discourse, 2011). However, Foucault rejects the modernist assertion that such signs and utterances represent the real or correspond to essences. Instead, he views discourse as reflective of group practices, as it “reflects the social, epistemological, and rhetorical practices of a specific group” (Jolliffe, p. 102). Based on this analysis, then, Foucault views “truth” and “knowledge” as claimed and constructed through discourse, rather than discovered through inquiry, as the modernist contends (Borchert, 2006; Bunnin & Yu, 2004; Foucault, 2002 [1972]).

Foucault (2002 [1972]) has further suggested that discourses should not be treated simply “as groups of signs (signifying elements referring to contents or representations) but as practices that systemically form the objects of which they speak” (p. 54). Norman Fairclough (1992) has derived the following description of discourse from Foucault’s work:

Discourse contributes to the constitution of all those dimensions of social structure which directly or indirectly shape and constrain it: its own norms and conventions, as well as the relations, identities and institutions which lie behind them. *Discourse is a practice not just of representing the world, but of signifying the world, constituting and constructing the world in meaning.* (p. 64; italics added)

Therefore, discourse reflects the widely held truth- and knowledge-claims, beliefs, norms, mores and practices of a culture at a particular time while at the same time contributing to the formation

and reification of those very same truth- and knowledge-claims, beliefs, norms, mores and practices.

Discourse serves this constitutive function by delimiting what should be included in and excluded from a discourse (Canning, 2001). For example, in contemporary American culture, notions of “*whiteness*” and “*slender bodies*” for women are both reflected in and promoted by the dominant discourse of beauty, while “*women of color*” or notions of “*obesity*” are often excluded from the reigning discourse. In this way, discourse simultaneously reveals and reinforces the preoccupations, norms, values and customs of a society through practices of inclusion and exclusion. Discursive practices of inclusion serve to construct and support whatever becomes the dominant, prevailing discourse, while exclusionary discursive practices both reflect and reinforce the marginalization of any deviant discourses.

Dreyfus and Rabinow (1983) have described these power matrices as “normalizing technologies” (p. 198). They have suggested, “These exemplars [of normalizing technologies] immediately define what is normal; at the same time, they define practices which fall outside their system as deviant behavior in need of normalization” (Dreyfus & Rabinow, 1983, p. 198). Therefore, conceptions of normality and deviance—like “*white women*” and “*women of color*,” “*slender bodies*” and “*obesity*”—are only made possible through their relationship to one another, as they each define the space of possibility for the other’s existence. They require an opposite, an ultimate Other, against which they can be simultaneously defined; an Other which is constructed and reified through modes of power and the processes of objectification.

## Power

From multiple positions of analysis, poststructuralism seeks to unveil the power-laden processes and relations through which certain discourses become privileged while others become marginalized. Foucault's analysis of power differs radically from the modernist or traditional conceptions of power that are far more ubiquitous in the discourse of power. The modernist views power as a *thing*—an object, feature or dimension—that is possessed by or located within people, structures or institutions and that is largely wielded hierarchically, as people or institutions “*with power*” dominate or control those “*without power*.” In this view, power is viewed as a characteristic or capability belonging to an individual (as in physical strength or cognitive prowess) or as a structure or mechanism of authority (as in a governmental institution or a weapon). For Foucault, however, power is not an inherent quality of an individual (he would call these “capacities”), nor is it a structure, institution or a mechanism (1983, p. 219). He has maintained:

[L]et us not deceive ourselves; if we speak of the structures or the mechanisms of power, it is only insofar as we suppose that certain persons exercise power over others. The term “power” designates relationships between partners. (Foucault, 1983, p. 217)

But, Foucault has cautioned, “The exercise of power is not simply a relationship between partners, individual or collective; it is a way in which *certain actions modify others*” (1983, p. 219; italics added).

Foucault's analysis of power, then, relates less to the “what” of power but to the “how” of power. He has aimed “to move less toward a theory of power than toward an analytics of power” (Foucault, 1980, p. 82). Rather than viewing power as being possessed (as a capacity) or occupied (as a position), Foucault views power as relational and operative, as an action or a

series of actions, and as *exercised* from one subject (or subjects) upon another subject (or subjects) (Foucault, 1983). Borchert (2006) has observed:

On this conception of power there are no agents in whom power is concentrated, but only techniques, regimens, regulations, and measures that divide the normal or average from the pathological or criminal. ... This power is not in the service or control of a dominant interest, class or group, but dispersed throughout the social body.... (pp. 700-701)

Therefore, power is not *unidirectional*, operating hierarchically from the top down or from the bottom up, but *multidirectional*, as everyone participates in power relations, thereby forming a complex matrix of power relationships (Foucault, 1980; Dreyfus & Rabinow, 1983). Foucault (1983) has insisted:

In itself the exercise of power is not violence; nor is it a consent which, implicitly, is renewable. It is a total structure of actions brought to bear upon possible actions; it incites, it seduces, it makes easier or more difficult; in the extreme it constrains or forbids absolutely; it is nevertheless always a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of action. A set of actions upon other actions. (p. 220)

Foucault, then, seeks to analyze institutions and discourses through power relations or the “mode [s] of action upon actions” (Foucault, 1983, p. 222).

Foucault’s reconceptualization of the notion of power as a “mode of action upon actions” (Foucault, 1983, p. 222) gets underneath and upends the traditional discourse of power (in which one might ask “Who has power?”) as it sheds light on how and why power relations serve to create, support and perpetuate dominant discourses. According to Foucault, power relations are brought into being and exercised through a myriad of mechanisms and institutions, including but

not limited to systems of surveillance (e.g. medical establishment, penal system), economic disparities (e.g. maintained through the institutionalized classism, sexism and racism embedded in a capitalist system) and threats of violence or abuse (e.g. legal structures). Why would humans participate in power relations that reinforce reigning discourses and marginalize deviant discourses? According to Foucault (1983), human beings exercise and participate in power relations such as these for “the maintenance of privileges, the accumulation of profits,” and the maintenance of authority (p. 223).

Carrying out an analysis of power relations—instead of simply perpetuating and contributing to the aforementioned discourse on power—is a necessary political act according to Foucault (1983):

[T]he analysis of power relations in a given society, their historical formation, the source of their strength or fragility, the conditions which are necessary to transform some and abolish others... the analysis, elaboration, and bringing into question of power relations and the “agonism” between power relations and the intransitivity of freedom is a permanent political task inherent in all social existence. (p. 223)

Therefore, his objective is not to attack a particular institution of power (e.g. the government) or a particular group (e.g. an elite group or upper-income class), but rather the techniques or forms of power at play (Foucault, 1983). In so doing, according to Borchert (2006), Foucault “conceived of his work as tools for use in the strategic interruption of dominant discourses and practices” (p. 701).

Conducting such an analysis of power reveals how human actions reinforce what is perceived to be normative and deviant through practices of inclusion and exclusion. In so doing, we produce “truths” and “knowledge” about human beings and about ourselves, which serves to

gain or maintain privileges, security and authority for some through the disenfranchisement or domination of others. This domination is accomplished through what Foucault refers to as “modes of objectification,” which will be explored in detail in the following section.

### **The Subject**

Foucault focuses on the role of power in the construction and reification of dominant discourses as well as the role of power relations and discursive practices in the construction, objectification and subjugation of the individual subject (Bogue, 2002; Dreyfus & Rabinow, 1983; Racevskis, 2002). Whereas modernity touted the individual subject as being/having a singular, essential and autonomous identity, poststructuralism emphasizes the contingency of the subject whose identity is not fixed to any inherent or underlying essences, but is instead constructed through discourse. As such, the identity of the human subject is never wholly complete or static but is endlessly reconstituted, as the multiple discourses of which they are inescapably a part remain shifting and unstable, perpetually changing throughout time and place (Borchert, 2006; Bunnin & Yu, 2004; Pfohl, 1994; Poster, 1989). For Foucault, this reconceptualization of the human subject is significant because it underscores the ways in which discourses shape human beings through power relations by imposing and locating the subject within rigid and finite identity categories (e.g. race, gender, sexuality), thereby delimiting human being, experience and expression and undermining human dignity (a concept which is itself constructed and reconstructed through the dominant discourse). This delimiting or boundarying of the self happens through processes Foucault calls objectification and subjectification.

## **Objectification, Subjectification and Subjugation**

Foucault (1983) is interested in what he has called “three modes of objectification which transform human beings into subjects” (p. 208). The first mode of objectification, according to Foucault (1983), relates to the following:

...[M]odes of inquiry which try to give themselves the status of sciences: for example, the objectivizing of the speaking subject... [or] the objectivizing of the productive subject.... Or...the objectivizing of the sheer fact of being alive in natural history or biology. (p. 208)

Paul Rabinow (1984) has referred to this mode of objectification as “scientific classification” (p. 8), as human beings turn themselves and others into objects to be analyzed and scrutinized as though they can be definitively located within a discrete identity category, such as the allegedly mutually exclusive gender categories of “*male*” and “*female*.”

The second mode of objectification relates to what Foucault (1983) has referred to as “dividing practices,” in which “the subject is either divided inside himself or divided from others” through processes of exclusion, domination, differentiation and normalization (p. 208). Examples of the second mode of objectification include the exclusionary practices in which humans become differentiated and categorized as being either deviant or normal (e.g. “criminals,” the “insane,” “developmentally delayed” and their opposites) through discourse. Subsequently, those humans deemed deviant are excluded from the normal and relegated to prisons, “mental health” establishments and other institutions aimed at correcting or conquering deviance. Rabinow (1984) has noted that in these first two modes of objectification—classification and dividing practices—the human subject is in a “passive, constrained position,”



wherein identity categories and notions of deviance are imposed by others who have a vested interest in maintaining or gaining certain privileges (e.g. social, economic, religious, political) (p. 11). However, the third mode of objectification, referred to by Foucault as “subjectification,” is a process of “self-formation in which the person is active” (Rabinow, 1984, p. 11).

Subjectification refers to the ways in which human beings objectify themselves by “turn[ing] him- or herself into a subject” (Foucault, 1983, p. 208). By internalizing dominant discourses, human beings transform themselves into subjects by correcting their own deviance, conforming themselves to the dominant discourse of normality. For instance, a human might engage in techniques of self-discipline, self-monitoring and training in order to become an “*efficient worker*” or to attain a “*socially desirable body type*”; identities which reflect and reinforce the dominant discourses of *productivity* and *beauty*, respectively. Borchert (2006) has observed, “Modern power encourages one to correct one’s own deviance,” as power relations “operate inside and outside... disciplin[ing] subjects who show signs of disorder” (p. 700).

For Foucault, these three modes of objectification—*classification*, *dividing practices* and *subjectification*—are techniques of domination aimed at *subjugating* human beings, whereby they are controlled, subdued and conquered by dominant interests and discourses. As noted previously, it is not only members of an elite class or privileged group that aim to subjugate others and subjectify themselves, but all human beings who seek to either gain or maintain social privileges (Foucault, 1983). As Foucault notes, this domination leads to excesses of political power, which threaten human life and dignity. In extreme forms, he warns, such excesses can lead to the formation of concentration camps and the dehumanization and eradication of human beings (Foucault, 1983). Therefore, interrupting and challenging dominant discourses through Foucault’s analytic framework may serve to foster human life and dignity (elusive concepts

though they may be) by destabilizing or dismantling oppressive political regimes, truth-claims and discourses.

Foucault's analysis of discourse, power relations and the objectification of the human subject provides the scaffolding for this paper's examination of the post-integration phase of treatment for individuals diagnosed with dissociative identity disorder, as it begs for the exploration of a few critical underlying questions related to this discussion: How and why is it that this particular phenomena of being has come to be classified as a "mental illness" and defined as "DID"? How and why is it that the treatment of integration continues to reign the discourse of DID treatment? Whom or what do the classification of "DID" and the treatment modality of integration serve? To attend to these questions, we will turn to one of Foucault's seminal works on the history of madness or "unreason," in which he examines the modes of power at play in the objectification and subjugation of human beings through the discourse of madness, insanity, mental illness and their opposites (Park, 2003).

### **History of Madness**

One of Foucault's earliest and most well-known works delves into an analysis of discourse, power relations and the objectification of the subject by investigating and elucidating a history of madness (and its opposite, non-madness or "reason"). Originally published in 1961 as *Madness and Unreason: History of Madness in the Classical Age*, Foucault began the preface thusly:

We need a history of that other trick that madness plays – that other trick through which men, in the gesture of sovereign reason that locks up their neighbor, communicate and recognize each other in the merciless language of non-madness; we need to identify the

moment of that expulsion, before it was definitely established in the reign of truth, before it was brought back to life by the lyricism of protestation. To try to recapture, in history, this degree zero of the history of madness, when it was undifferentiated experience, the still undivided experience of the division itself. (Foucault, 2006 [1961], p. xxvii)

In other words, Foucault seeks to unravel and analyze the taken-for-granted “truths” about madness that have emerged and transformed throughout history in order to foreground an analysis of the dominant discourse on madness that reigns today.

Foucault winds his way through Western history (largely European and, by extension, North American) from the Middle Ages to the 19<sup>th</sup> and 20<sup>th</sup> centuries, all the while mapping the shifting terrain in which discourses of madness have been constructed and reconstructed through decisive discursive turns. At each turn, madness becomes reconceptualized—as poverty, immorality, illness and so on—yet remains situated both in the immutable position of the Other and in opposition to the ambiguously defined position of that-which-is-not-madness. What he presents, then, is a history of the objectification and subjugation of madness, unreason, mental illness and their opposites (Park, 2003) through persistent and ever-evolving practices of exclusion, oppression and normalization.

While discourses of the Other—of the excluded and marginalized—have no finite beginning or origin point, Foucault begins this history of the discourse of madness in the Middle Ages. In this era, the human being exhibiting deviant behaviors or thoughts was objectified as the “madman.” In the dominant discourse of madness at this time, the “madman” is conceived of as possessed by an evil spirit or by a transcendent, holy spirit; he is envisaged as holy or evil through his connection to an ineffable Other, God or Devil. The madman inhabits the world of the sacred or the profane, perhaps straddling two realities; the earthly and the Heavenly, the

material and the immaterial, the present world and the Otherworldly. Foucault then tracks a significant shift that takes place between the Middle Ages (wherein madness is conceived of as a sort of religious phenomenon) and the Classical Age (17<sup>th</sup> and 18<sup>th</sup> centuries), in which madness is reconceptualized as “unreason.”

The Classical Age, according to Foucault, is the age of reason and unreason, in which madness no longer signifies a connection to the transcendent but, rather, is defined by *what it does not signify*. Madness becomes an *absence*; specifically, the absence of reason:

A whole new ambiguous region was thus coming into being.... It was neither profanation nor pathology, but a region between their confines.... This region, halfway between the sacred and the morbid, was characterized above all by a fundamental ethical refusal, and formed the bedrock of what the classical age referred to as unreason.

(Foucault, 2006 [1961], p. 93)

This shift in the discourse of madness—from a religious phenomenon to a phenomenon of “unreason”—corresponded to and was born out of the shift that took place in intellectual, philosophical, scientific, political and cultural life, in which reason became heralded as the ultimate authority of truth-claims. Throughout this period, madness or “unreason” was objectified through divisionary practices, in which it became defined (and redefined) according to the constructed relationship to its supposed opposite, “non-madness” or “reason.” Foucault elaborates upon this definitional process, writing, “It was in relation to unreason alone that madness could be understood. Unreason lay beneath it, or rather defined the space of its possibility” (Foucault, 2006 [1961], p. 156). Therefore, as it now occupied the space of unreason, madness had to be quarantined and relegated to the margins of society in order to protect Reason from contamination by the Other, or that which is Unreason.

As capitalism began replacing the feudalism of the Middle Ages, new meanings were assigned to madness that correlated with the dominant sociopolitical and economic interests. The madman was now variably identified through language with poverty, moral degradation, crime, the inability to integrate into social group and, increasingly, the inability to work and produce profit for the reigning economic regimes. Therefore, in an effort to protect and perpetuate the interests of the dominant sociopolitical and economic order, as well as the prevailing moral, scientific and philosophical values, those with political power and religious authority partitioned off and locked up those who were considered mad or without reason with the other classes of social deviants: criminals, debauchees, the immoral and the poor. Thus, in the discourse of madness, the human subject perceived as the “madman” was objectified both through classification (identified as the poor, the criminal, the insane) and through dividing practices of exclusion and marginalization.

This partitioning, which Foucault refers to as “The Great Confinement”—was made possible by the prevailing beliefs and feelings about madness that were being reflected in and reinforced by the discourse of madness throughout all levels of society; most notably, the belief that madness posed a threat to social order. Therefore, it was not only the elite that had an interest in locking up the mad and the poor, but the working person, who in turn sought to gain some privilege by being differentiated from some “lesser” Other being. However, Foucault has suggested, this partitioning and confining of the mad was not initially aimed at reforming, curing or correcting madness, but at disciplining and confining madness.

Over time, however, as the discourse on madness shifted yet again, the treatment of madness and unreason shifted as well, as new conceptions of madness took shape. Toward the end of the 18<sup>th</sup> century, positivist science emerged as one of the dominant ontological discourses

that sought to uncover, differentiate and classify the allegedly essential, underlying truths about the “physical” world (Foucault would likely take issue with any such divisions between the “physical” and the “*meta*-physical,” or the “natural” and the “*super*-natural,” as such bifurcations are themselves constructed through discourse and power relations). Stephen Pfohl (1994) has commented on the positionality of positivism, writing, “...[T]he positivist appears to position himself *as if* outside nature and looking down upon it. ... [He] gazes upon the body of nature set apart from himself and laid bare by his supposedly “naturalistic” laws” (p. 133). It is from this allegedly assumable stance of detached objectivity that positivism endeavored to classify and demarcate phenomena such that the world would finally become known and finite in its dimensions.

Predicated on the epistemological assumption that all phenomena are knowable, definable and categorizable, positivist scientists of the reigning medical institutions strove to provide taxonomies of madness. Early attempts floundered, as they struggled to pin madness down, “as though madness were in flight from its own truth” (Foucault, 2006 [1961], p. 197). However, their struggles did not thwart the positivist classificatory project, as the epistemological premise that phenomena are knowable prevailed, thereby emboldening those who were intent on locating and organizing madness in all its various forms. Such intensity of purpose stemmed from the fact that conceptions of madness had shifted once again; madness was now defined as a sickness in need of a cure. Thus, there was a newly prescribed curative task with regard to madness, which sought to restore madmen to their “natural” state of “health” and wellness. This curative science relied on the persisting belief in essences, a belief in an absolute state of health or wellness or normalcy against which states of un-health or illness could be

defined. From this point in history onward, the conception of madness as sickness has endured, resulting in the contemporary reigning discourse of *madness as mental illness*.

### **Madness as Mental Illness**

The dominant discourse of madness as “mental illness” has not been static since the end of the 18<sup>th</sup> century, as new taxonomies of madness and the rise of psychology and psychiatry in the 19<sup>th</sup> and 20<sup>th</sup> centuries continue to alter the discursive landscape. While the definition of madness as mental illness has created space for the curative endeavor to emerge and flourish, it has neither replaced nor succeeded the divisionary practices of the Great Confinement; rather, it has renegotiated the terms of confinement, as exclusion and marginalization of the “mentally ill” continue to take on new forms.

As was the case during the Great Confinement and the Age of Unreason, Foucault’s first two modes of objectification—classification and dividing practices—operate in tandem in the contemporary discourse on madness, as typologies or classifications of madness are delineated, normalized and naturalized (e.g. *Diagnostic and Statistical Manual of Mental Disorders*), while new modes of division and exclusion are perpetuated (e.g. inpatient institutionalization and psychopharmacological treatment). In his introduction to *History of Madness*, Jean Khafla (2006) asserted,

...[T]he modern medical positivism which [developed from the end of the eighteenth century is based on an attempt at objectifying madness which, when looked at in detail, in particular in the institutions it accompanies, is a new mode of social control. (p. xvi)

So while the Classical Age attempted to master and control madness or “unreason” by locking it up at the margins of society, mental illness is now more furtively mastered and controlled

through increasingly medicalized modalities (Thornton, 2007; Pickering, 2006). As Canning (2001) has suggested, “[P]sychiatric discourse identifies different types of madmen, whose physiognomy changes as categories are displaced or reinvented,” but also produces discourse-objects such as the “madman,” the “criminal,” and the “mentally ill” as things that threaten the social order and require social intervention (p. 133-134).

For Foucault, then, the history of madness is not one of progression, of science and society marching steadily toward an ultimate, absolute knowledge and understanding of the essential “truths” about madness or mental illness. As Khafla (2006) writes of the varying constructions of madness through time, “[T]hese conceptions are not discoveries but historical constructions of meaning” (Khafla, 2006, p. xiv). As such, this discourse (like all discourses) never arrives at a final destination of its complete Truth, but is endlessly evolving through a matrix of power relations that serve to legitimize and privilege certain discourses as normative and delegitimize and marginalize others as deviant. Therefore, examining the ever-evolving discourse of DID classification and treatment sheds light on the power relations that continue to normalize and legitimize a particular discourse of DID through processes of objectification.

### **The Dominant Discourse of Dissociative Identity Disorder**

Similar to the discourse of madness and mental illness generally, the discourse of DID has shifted throughout history. Conceived of as a religious phenomenon of possession in the Middle Ages and classified as a psychological phenomenon of “successive existences” toward the end of the Classical Age, DID is now classified through processes of objectification as a “mental illness,” in keeping with the overarching discourse of madness and mental illness previously discussed (Ellenberger, 1970; Putnam, 1989). Today, the discourse of DID is yet



again in a state of flux, as many authoritative voices within the psychiatric community continue to legitimate DID as a neurological or psychological response to extreme trauma, while others contest its legitimacy as a classified mental illness (Kluft, 1995; Lilienfeld & Lynn, 2003; Lynn et al., 2006; Traub, 2009). While it is beyond the scope of this paper to examine this discursive split, future theoretical exploration of this topic would be beneficial to the field of mental health theory, research and practice, as it may further illuminate the historically-bound constructions of meaning that have and continue to undergird the discourses of mental illness and mental health.

Despite the aforementioned dispute within the mental health field, DID continues to be classified as a discrete diagnostic category in the American Psychiatric Association's (2000) *DSM-IV-TR*. As such, for the purposes of this paper, the prevailing "dominant discourse of DID" will be defined as a discourse in which DID is considered a valid psychological phenomena, the features of which are delineated in the APA's (2000) *DSM-IV-TR*. The following discussion will briefly explicate how and why the dominant discourse of DID has been constructed, maintained and perpetuated through the three modes of objectification described by Foucault: classification, dividing practices and subjectification.

### **Objectification of DID through classification: The DSM**

As noted previously, conceptualizations and classifications of DID have varied throughout history, as scholars and practitioners in the fields of philosophy, psychology and medicine have grappled with the task of understanding and defining the phenomenon that has now become known as dissociative identity disorder (Ellenberger, 1970; Putnam, 1989). While DID was classified as a spiritual or moral phenomenon in the Middle Ages, in which the individual was believed to be possessed by a supernatural spirit, it became classified as a

psychological phenomenon in the mid to late 19<sup>th</sup> century, as the rise of psychiatry gained momentum and the discourse of mental illness began to take shape (Putnam, 1989). At that time, the phenomenon was described as a disorder of “double consciousness” or “successive existences,” in which it was thought that the individual had separate internal selves or personalities. This conceptualization of the phenomenon persisted throughout much of the 20<sup>th</sup> century, as scholars and practitioners who affirmed the legitimacy of the disorder conceptualized it as a psychological disorder in which an individual has multiple personalities.

Initially categorized in the DSM-II in 1968 under the diagnostic classification of “Hysterical Neurosis, dissociative type” (APA, 1968, p. 40), the phenomenon was first awarded a discrete diagnostic classification in the DSM-III in 1980, at which point it became known as “multiple personality” (APA, 1980) and later “multiple personality disorder” (APA, 1987). In part, this semantic and conceptual shift from “hysteria” to “multiple personalities” was reflective of a broader shift in the discourse of mental illness, as the notion of hysteria, which had been prominent in the late 19<sup>th</sup> century, had since become a marginalized concept in the dominant discourse. However, this discursive shift also corresponded to an increased awareness throughout the U.S. of the prevalence of child abuse, as well as a dramatic increase in the number of patients exhibiting the psychological and behavioral characteristics that were consistent with the diagnosis (Ellerman, 1998; Putnam, 1989), thereby warranting greater attention in the DSM’s classification system.

The discourse of DID did not remain static, however, but continued to shift, as the APA reclassified the phenomenon yet again in the manual’s 4<sup>th</sup> addition, this time garnering it the designation of “dissociative identity disorder” (APA, 2000). This represented a significant conceptual shift in the discourse of DID, as the notion of *having* multiple personalities was

replaced with the notion of *perceiving* the self as being composed of dissociated fragments of identity. In this new conceptual framework, then, it was the individual's *deluded perception of self* that became the focus of classification and treatment, rather than the actual presence of multiple personalities.

Today, the phenomenon remains classified as dissociative identity disorder in the APA's (2000) *DSM-IV-TR*, which serves as "the standard classification of mental disorders used by mental health professionals in the United States" (APA, Diagnostic and Statistical Manual section, para. 1, n.d.). Due to the *DSM-IV-TR*'s status as the benchmark of mental disorder classification in the U.S., mental health scholars and practitioners, as well as medical providers, use the text to determine which diagnostic categories best account for or describe the psychological, emotional or behavioral phenomena that they perceive or witness in their clients or patients. In turn, health insurance companies, which are responsible for paying mental health practitioners and medical providers for their professional services, require a *DSM-IV-TR* diagnosis in order to remit payment. As such, practitioners are reinforced to use the diagnostic categories delineated in the *DSM-IV-TR* in order to receive reimbursement, which reinforces and perpetuates the *DSM*'s status as the standard system of classification. In turn, as practitioners and insurance companies continue to mutually reinforce the legitimacy of the *DSM-IV-TR*'s system of classification, clients are reinforced to accept the *DSM* diagnoses that are given to them, as doing so ensures that they will be eligible for particular treatments and services.

Therefore, the continued classification of a phenomenon in the *DSM-IV-TR* is reinforced and perpetuated through power relations, as the payee (insurance company), provider (mental health clinician) and classified or pathologized individual (client) each reinforce the power and status of the *DSM-IV-TR* in order to gain or maintain certain benefits (e.g. money, therapy). As

such, the classification of DID as a mental disorder within the APA's (2000) *DSM-IV-TR* is mutually maintained by payees, providers and clients who each have a vested interest in its continued status as a diagnostic category. This classification of DID is grounded in a set of implicit assumptions that are based on prevailing notions of normalcy and deviance, which are reinforced and perpetuated through the objectifying dividing practices of normalization.

### **Objectification of DID through dividing practices: Normalization and treatment**

As explicated in Chapter 3, the *DSM-IV-TR* (APA, 2000) classifies DID as a defined set of behaviors, thought processes, beliefs and capacities that are currently conceived of as “symptoms” of a “disorder” (APA, 2000), concepts that originated in the positivist perspective that has been endemic since the Classical Age (Foucault, 2006 [1961]). These symptoms include limited access to autobiographical memory, periods of dissociation, and the perception of the self as having multiple ego-states or the belief that the self is composed of separate internal selves that variably control behavior, affect, memory and thoughts (Kluft, 1984a; Krakauer, 1991; Putnam, 1989). Given its status as a *dis*-order, it is assumed by many scholars and practitioners within the mental health field that these “symptoms” of DID are abnormal, deviant and pathological. Since deviance and normalcy are mutually enforcing concepts (Foucault, 2006 [1961]), the assumption that these symptoms are deviant or pathological aspects of being correlates to the corresponding assumption that it is normal and non-pathological to experience full access to memory, to be free of the experience of dissociating, and to have or to perceive the self as having a singular ego-state, a cohesive and unified personality and an undivided sense of self. Moreover, it is widely assumed that this deviance or psychopathology should be altered or

corrected through psychiatric treatment in order for the disordered individual's beliefs, perceptions, behaviors and experiences to fall within the "normal" range of acceptability.

Unlike the more conspicuous and coercive dividing practices of the Great Confinement described by Foucault (2006 [1961]), psychological deviance is now marginalized, controlled and corrected through more diffuse means, as the management and treatment of DID may range from involuntary psychiatric hospitalization to voluntary psychopharmaceutical treatment or psychotherapy (ISSD, 2005; Pais, 2009). As such, the treatment of DID has become increasingly voluntary and collaborative, as individuals may elect whether or not to "cure" or "correct" their symptoms of DID and, furthermore, may have the authority to select a treatment modality with which they feel most comfortable. Nonetheless, the division between the mentally well and the mentally ill—between normalcy and deviance—persists and is maintained and perpetuated in large part through subjectification, as individuals diagnosed with DID seek to distance themselves from the pathological by conforming themselves to the normal through treatment.

### **Subjectification of the self: Reflecting and perpetuating the prevailing norms**

While making the choice to either remain a multiple or to embark on a treatment process of integration is value-neutral—there is no absolute, objective "rightness" or "wrongness" about either decision—either choice nevertheless reifies contemporary notions of what it means to be considered normal or deviant within the dominant discourse of mental illness and mental health. For those who do choose to integrate, their choice to integrate may reflect, construct and reinforce the reigning discourse of DID, as it carries with it the possible implication that perceiving oneself as a multiple is abnormal and deserving of corrective treatment. However, this discourse of DID is normalized and perpetuated not only by individuals diagnosed with DID,

but by all participants in the discourse—those considered “normal” and “healthy” or “deviant” and “disordered”—as each subject continually attempts to police and modify their thoughts, beliefs and behaviors that might be deemed deviant or abnormal in order to fit within the prevailing scope of normalcy.

Yet, it should be noted that subjectifying the self to better reflect and conform to the prevailing norms of a particular group or society often carries with it important social, economic and personal benefits that need not be overlooked or maligned. For example, many who choose to undergo integration treatment report that becoming completely psychologically integrated and perceiving themselves as having a singular ego-state enables them to view themselves and to be viewed by others as being “normal” and “healthy” (Bristol, 1997, p. 45), which in many instances provides them greater access to work opportunities, increased financial stability, improved continuity in interpersonal relationships and an increase in positive self-regard (Bristol, 1997). In one case, a male participant in Bristol’s (1997) study reported, “I don’t think I’m the sickest kid on the block anymore. I pass for normal all the time, healthy even” (p. 45). Similarly, a female participant in the 1997 study reported, “I feel ordinary; it’s a nice feeling after being crazy for most of your life” (p. 45). Thus, achieving final fusion and living as a psychologically integrated individual can enable post-integration individuals to experience themselves and be experienced by others as more aligned with the contemporary standards of normalcy and health, while simultaneously reinforcing those notions of normalcy and deviance, which continue to be constructed within and perpetuated by the dominant discourses of “mental illness” and “mental health.”

## Conclusion

According to Foucault, we cannot operate outside of discourses or practices of power, as we, as subjects, are already and forever participants in the matrices of power relations that operate in the objectification of others and of ourselves. Furthermore, a discourse on madness and mental illness cannot be extricated from power relations, thereby forgoing the possibility of achieving an idealized discourse wherein power relations are nullified or neutralized. However, by noticing the ways in which modes of objectification privilege and legitimate certain discourses while simultaneously delegitimizing others, Foucault has, according to Dreyfus and Rabinow (1983), “loosened the grip, the seeming naturalness and necessity these practices have” (p. 203). Furthermore, they argue, conducting such an interpretive analysis may serve to strengthen certain resistant practices, those practices that have, to some extent, resisted totalizing normalization.

In so doing, however, poststructuralism does not seek to privilege discourses or subjects that were previously marginalized or to marginalize those which were previously privileged. Nor is it the project of poststructuralists to totally democratize or neutralize power relations within discourses, such that none are privileged and none marginalized, as they assert that the inescapable historicity of the subject and the inevitability of power relations make such a project impossible. Instead, it is by examining and critiquing the construction, objectification and subjugation of the human subject that poststructuralists’ analyses seek to unmask and, therefore, alter dominant discourses and prevailing power relations (Foucault, 1974; Rabinow, 1984).

In light of the shifting discourse of the legitimacy of DID classification and treatment, the ensuing discussion of post-integration through the theoretical framework of ambiguous loss is aimed at reexamining and problematizing the dominant discourse of DID through the explication

of subjugated, deviant narratives. By examining integrated individuals' subjective perceptions of themselves, as well as their responses to and experiences of integration treatment, which do not conform to the dominant discourse of DID classification and treatment, it may be possible to widen this discourse, thereby creating more space for the innumerable possibilities of human experience to be included in the ever-evolving discourse of DID and mental illness.



## **CHAPTER VI**

### **Discussion**

Foucault's insistent analysis of discourse, power relations and the subject suggests that the shifting discourse of DID classification and treatment should not be taken for granted as declarative or representative of absolute or universal truths. Instead, as Foucault avers, this discourse is necessarily history-bound, perpetually reflecting and reconstituting the current beliefs held and truth-claims forwarded about the many manifestations of human experience (Foucault, 2002 [1972], 2006 [1961]). Foucault's analysis of the discourse of madness, then, serves as an impetus for the following discussion of dissociative identity disorder, as it sheds light on the power relations and modes of objectification at play in privileging a particular discourse of DID at the exclusion and marginalization of other discourses. As such, it is incumbent upon scholars and practitioners in the field of mental health research and practice to continually reexamine the prevailing discourses of mental illness and DID, lest they risk unwittingly perpetuating and reinforcing these discourses. Therefore, the ensuing analysis is aimed toward reexamining and problematizing the dominant discourse of DID classification and treatment through the consideration of an alternative and marginalized discourse, in which the experiences of change described by individuals in the post-integration phase of DID treatment are conceptualized as ambiguous losses.

While Boss's explication of ambiguous loss theory is limited to interpersonal relationships—wherein an individual experiences ambiguous loss due to the simultaneous presence and absence of a significant other—examining DID and the experience of post-integration through the lens of ambiguous loss theory may contribute new thought or illuminate possible areas for future research regarding this complex, controversial and under-studied phenomenon, such that new perspectives on the phenomenon might be explored that have not yet been included in the dominant discourse of DID. In order to conduct this analysis, the following section will apply the definition of ambiguous loss, including the features and assumptions of Boss's theoretical framework, to some of the experiences of integration treatment that have been detailed in the literature. For the purposes of this discussion, ambiguous loss will be defined as referring to both (a) the *ambiguous fact of a change or a condition* in a relational system resulting in uncertainty about the status of an individual's physical or psychological presence, and (b) the *ambiguous feeling-state* of loss in response to such a change or condition.

## **Analysis**

### **The Ambiguous Loss of DID Post-Integration: A Perceptual Loss of Self**

Prior to integration treatment, an individual diagnosed with dissociative identity disorder experiences themselves as a composite of separate and distinct psychological self-states, or “alters,” inhabiting one physical body. Undergoing a process of total integration, in which an individual perceives the final fusion of all alters, may result in significant changes within an individual's internalized relational system, as their subjective sense of self may be fundamentally reconfigured from being perceived as a composition of multiple ego-states to being perceived as a singular, unified ego-state. This process of internal reconfiguration and intrapsychic

reconceptualization, which typically takes place over a period of months or years, involves the perceived loss of certain alters through fusion ceremonies, in which two or more perceived alters lose their felt sense of distinctness. Through the process of undergoing multiple fusions, an individual's capabilities, memories, preferences, postures and affective states—which had been previously subjectively experienced as “belonging” to different, discrete alter personalities—coalesce into a unified whole. Upon achieving final fusion, then, all previously perceived distinct self-states are experienced as merging into one self-state such that no alters are perceived as existing apart from a person's singular sense of self and consciousness (ISSD, 2005; Kluft, 1986b, 1993a; Putnam, 1989).

As noted in the previous chapter, for some who undergo and complete integration treatment, achieving final fusion and being in a state of post-integration is experienced as largely beneficial, as it enables them to experience themselves as being “normal” and to experience their relationships and the world-at-large in a more unified way (Bristol, 1997; Putnam, 1989). However, while many individuals who choose to become completely integrated experience the psychological, interpersonal, economic and social benefits of integration, some simultaneously report experiences of complicated loss, as aspects of their formerly divided selves (e.g. skills, capabilities, physical attributes, alternate personality structures) become lost through the process of integration treatment (Bristol, 1997; Saraf & Light, 1993). In the following analysis, this paper will assert that such losses—wherein an integrated individual experiences a subjectively perceptual loss of self through the process of integration treatment—might be conceptualized as ambiguous losses. In order to conduct this analysis, both types of ambiguous loss will be applied to the experience of post-integration—*physical presence with psychological absence* and *psychological presence with physical absence*.

### **Physical presence with psychological absence**

It is a relatively undisputed belief within the mental health field and among individuals diagnosed with DID that an individual develops DID in childhood, through the psychological construction and reification of perceptually distinct alter personalities, in order to cope with unbearable trauma (Coons, 1994; Foote et al., 2006; Kluft, 1991; Oxnam, 2005; Putnam, 1989; Saraf & Light, 1993; Schäfer, Ross & Read, 2008). Many individuals with DID who achieve co-consciousness among their alters report that their alter personalities had previously developed relationships among themselves, often without the host personality having any knowledge of these relationships until co-consciousness is achieved (Oxnam, 2005; Saraf & Light, 1993). These internal intrapsychic relationships become vital to their psychological survival of trauma and, therefore, provide a great deal of security and comfort (Bristol, 1997). Following integration, however, these intrapsychic relationships are often experienced as lost, as the integrated individual's internal sense of self shifts from the relationality of multiplicity to the solitary mode of having a singular ego-state. Bristol (1997) found, "Soon after unification...[m]ost clients report feeling a profound sense of 'loss' and 'aloneness.' Clients mourn the loss of their alters and grieve the loss of their divided selves" (p. 57). Moreover, certain aspects or characteristics of the individual alters may also be lost through integration, as each alter's personality traits, gender identity and sexual orientation may no longer find full expression in what becomes the primary identity of the integrated individual (Bristol, 1997; Oxnam, 2005; Saraf & Light, 1993).

According to both Bristol (1997) and McFall (Saraf & Light, 1993), some integrated individuals report experiencing changes in their abilities or capacities, as well as in their sexual orientation, temperaments, attitudes, interests and preferences. According to Bristol's (1997)

findings, some of these changes are perceived positively as the benefits or gains of integration. She suggested, “Those individuals who acquired desirable traits from their alters, such as new talents or knowledge, easily incorporate these skills into their self-concept” (Bristol, 1997, p. 58). However, Bristol noted, other changes resulting from integration are met with grief, as they are perceived to be losses. One participant remarked:

For the first time in my life, I was truly alone. Not only weren't there any people around, there weren't any people in my head. I listened, listened hard, but didn't hear any talking, not even a whisper. Just silence. I felt so small and alone. It was terrifying!  
(Bristol, 1997, p. 48)

Experiencing such dramatic changes to an individual's sense of self, then—including psychological and characterological changes in their personality structure, internal self-identification, capacities and interests—requires the individual to modify their self-concept or internalized representation of self. In so doing, the individual may remain physically intact and be perceived by others as inhabiting the same physical being as they did prior to integration, while their internal representations of self are profoundly altered or lost through integration. Therefore, the resultant dissonance between their internal experiences of themselves and outsiders' perceptions of them may be interpreted as an ambiguous loss, as the integrated individual loses significant aspects of their internalized sense of self and psychological structure while being perceived as physically present and unchanged.

### **Psychological presence with physical absence**

Bristol's (1997) findings suggest that some individuals who undergo integration treatment perceive physiological changes as well, including changes in eyesight, hearing,

neurology (i.e. intellectual capabilities, the ability to speak a second language) and overall health. McFall (Saraf & Light, 1993) similarly recounted experiencing physiological changes following her final fusion:

Different personalities who were old enough would have different menstrual cycles; the little kids didn't have any at all. So when I integrated, you know, my menstrual cycle went haywire. Some of them didn't wear glasses and some of them did and once I integrated, my eye prescription changed. [She smiles.] For the better. (Saraf & Light, 1993)

In some instances, these perceived changes in physiology are experienced as positive, as in the case of Mairi McFall's delight in experiencing improved eyesight. However, Bristol's (1997) findings suggest that some of these changes may be experienced negatively as losses. She observed, "[T]hose who lost talents or developed physical disabilities during integration experience greater difficulty in accepting these traits as ego syntonic" (Bristol, 1997, p. 59). A female participant in her study reflected on the physiological changes she experienced following integration, saying:

Sally [alter] had always been hard of hearing. She was used to wearing a hearing aid.

The rest of us heard just fine. After we integrated I found I had trouble hearing... It was hard adjusting to being hard of hearing...and I had a lot of trouble learning how to put the hearing aid in. Sometimes I still forget to wear it. (Bristol, 1997, p. 42)

Thus, although the integrated individual in these instances may be able to maintain or develop a cohesive and comprehensive psychological sense of self, they experience or perceive a partial loss of their physical self. Furthermore, this perception of loss might remain ambiguous for an indeterminate amount of time, as some physical changes following integration are lasting while

others are temporary (Bristol, 1997). On another front, the ambiguity associated with these perceived physical losses is reinforced by the dominant discourse of DID, as scholars and practitioners continue to dispute the alleged legitimacy of such perceived physiological changes (Lilienfeld & Lynn, 2003; Traub, 2009), thereby undermining and delegitimizing an individual's subjective experience of self. Therefore, the newly-integrated individual perceiving a partial loss of their physical sense of self may experience two types of ambiguous loss: (1) ambiguity about the status of the physical attribute or capacity—its presence or absence—as they remain uncertain about whether or not they will regain this physical attribute or ability or become physically restored to their pre-integration state as time goes on; and (2) ambiguous feelings in response these perceived losses, as their subjective experiences of physical loss are dismissed and marginalized within the dominant discourse of DID.

### **Features of Ambiguous Loss**

As explicated in Chapter IV, each type of ambiguous loss—physical presence with psychological absence *or* psychological presence with physical absence—may refer to either or both (a) the *ambiguous fact of a change or a condition* in a relational system resulting in uncertainty about the status of an individual's physical or psychological presence, and (b) the *ambiguous feeling-state* of loss in response to such a change or condition. According to Boss (2010), such ambiguous losses are defined by several key features: ambiguous loss is (1) unclear loss; (2) traumatic loss; (3) a relational disorder; (4) externally caused (not caused by individual pathology); and (5) uncanny loss – confusing and incomprehensible. In order to elaborate upon the ways in which ambiguous loss might be experienced in the post-integration phase of treatment, these features will be applied to the experience of integration treatment.

***The ambiguous losses of integration may be subjectively experienced as unclear***

The losses of integration described by Bristol (1997) are not total or finite, as in death, nor are they necessarily perceptible to outsiders. Instead, they are losses of subjective perception, as an integrated individual perceives that a change has occurred in their psychological, characterological or physical sense of self. As their personality structure and internalized relational system is reconfigured through integration, an individual may experience uncertainty and ambiguity about what has been lost and what remains of the features or aspects of their former psychological selves. On a related front, the losses of integration are unknown, as an integrated individual does not know whether or not certain losses might be regained after an indefinite amount of time (e.g. the reemergence of intellectual capacity or a physical ability). As a result, due to the uncertainty about the possible reemergence of the lost part of the self—a part which is conceptualized as being either psychological or physical or both—the grief work required in the post-integration phase of treatment (Putnam, 1989) may be suspended, as the individual lacks clarity and certainty about the presence or absence of that which is perceived as having been lost. In these instances of loss, then, both types of ambiguous loss might occur: (1) there may be an *ambiguous fact of a change or a condition* within their internalized relational system, as they might be uncertain about what has been lost through integration and what remains, and (2) there may be *ambiguous feelings* in response to those perceived changes, as the individual may both celebrate what they experience as the positive gains of integration, while mourning that which they experience as a loss.



***The ambiguous losses of integration may be subjectively experienced as traumatic***

While Boss has contended that ambiguous loss is a traumatic loss (1999, 2010), the varied examples of ambiguous loss that she has provided—ranging from the abduction of a child to a severe preoccupation with work—suggest that the spectrum of what might be considered to be or experienced as traumatic is broad and subjectively interpreted by those persons implicated in the event or experience. In part, the apparent disconnect between Boss’s assertion that ambiguous loss is a traumatic loss and the varied examples she draws upon to illustrate the theory might point to a problem of definition, as Boss does not clearly define the concept of trauma or delimit what experiences she believes should be included in or excluded from the discourse of *the traumatic* (Boss, 1999, 2007, 2010). Nevertheless, this problem of definition is not Boss’s alone, but rather reflects the seeming impossibility of defining—in a comprehensive, exacting or exhaustive way—the limits or boundaries of what might be considered traumatic, which is a necessarily subjective state of being or response to phenomena. As such, based on Boss’s examples and other examples of ambiguous loss in the literature, this paper has previously asserted that it is perhaps more accurate to suggest that (1) the extent to which an ambiguous loss is experienced as traumatizing is subjective to the individual and that (2) although ambiguous losses *can* be traumatizing, they may not be in all instances.

Despite the ill-defined basis for her assertion, Boss (1999) does attempt to articulate how the trauma of ambiguous loss differs from other types of trauma, suggesting that, “Ambiguous loss is...a psychologically distressing event that is outside the realm of ordinary human experience...it lacks resolution and traumatizes...” (p. 24). Based on this description of the “psychological distress” of ambiguous loss, some experiences of integration might aptly be conceptualized as traumatic, as integrated individuals become conscious of and must work

through traumatic memories and affective-states that had previously been relegated to and contained by different alters. Moreover, although undergoing integration treatment and becoming an integrated individual can eventually lead to a sense of resolution and healing, some individuals report feeling extremely destabilized, uncertain and alone immediately following final fusion, as they struggle to contend with a new internal reality as well as new external demands and stressors in their newly-integrated state (Bristol, 1997). While none of Bristol's research participants described these unsettling post-integration experiences as being "traumatic," it may be that their level of distress and disorientation would fit within the broad scope of experiences that Boss has described as "traumatizing."

***The ambiguous losses of integration may be subjectively experienced as relational***

Boss has asserted that ambiguous loss is necessarily relational, by which she means that it is experienced within the context of an interpersonal relationship between two or more people. While she originally postulated that ambiguous loss pertained only to interpersonal familial relationships (Boss, 1999), Boss later expanded her working definition of what constituted a familial relationship to include any relationship—with someone alive or deceased, present or absent—that was experienced as significant or meaningful to one or more of the individuals within the relational system (Boss, 2006). She referred to this construction of family relationships as being an individual's "psychological family," about which she wrote:

The psychological family is intrinsic to the human psyche. It compensates for loss, a basic feature of human experience. More than simply a collection of remembered ties, the psychological family is an active and affective bond that helps people live with loss and trauma in the present. (Boss, 2006, p. 26)

The psychological family, then, serves as a balm and stronghold for individuals in psychological distress, as their relational ties—both alive and remembered—help them to better cope with trauma and hardship.

While Boss's concept of the psychological family is limited to interpersonal relationships, it seems conceptually akin to the psychological structure of the individual with DID, in which an internalized and intrapsychic relational system composed of different alter personalities helps the individual survive unspeakable trauma. At the onset of DID, the literature suggests that alter personalities are created within the psyche of an individual in order to cope with overwhelming experiences that are otherwise too psychologically distressing and emotionally painful for their ego to endure. Over time, as more alter personalities are developed to soothe and protect the individual's ego, each alter personality within the multiple's constructed psychological family becomes imbued with particular state-specific characteristics (e.g. gestures, affects, preferences, age, gender) and establishes its role within the intrapsychic relational system (e.g. the keeper of secrets, the school attendee, the protector). As such, relationships develop between alters, which contributes to the establishment of distinct relational roles, dynamics and functions within the individual's intrapsychic relational system. Moreover, this network of intrapsychic relationships—present or absent, real or imagined—may serve as the individual's primary resource as they attempt to self-soothe and cope with unbearable traumatic experiences (ISSD, 2005; Kluft, 1991; Krakauer, 2001; Oxnam, 2005).

Through the process of integration, however, these alter personalities are merged into one personality through fusion ceremonies, wherein alters cede their sense of distinctness and coalesce into a single ego-state and personality. As each alter within their internalized relational system merges with another alter—typically represented as the host personality—this merger

may be experienced as an ambiguous loss, as the psychological presence of an “other” is experienced as both present and absent, incorporated into the self yet lost as a distinct entity. No longer perceived as being composed of a network of intrapsychic relational ties, the integrated individual now experiences themselves and their internal representation of self in an entirely new way: as a singlet.

Boss has also suggested that interpretations of the condition or change are subjective to the individual, by which she means that each individual within a relational system may perceive or experience the phenomenon in question differently (Boss, 2007). For example, while one person may experience a change within their relational system as an ambiguous loss, another person in the relational system may express neutral feelings about the change or may not even be aware that a change has taken place at all. Similarly, different alters can have dissimilar experiences of the integration process. In one notable instance, Robert Oxnam reported that while a number of his alters were eager to integrate and merge with the host personality, other alters resisted integration, which ultimately led him to pursue partial integration as a treatment outcome, in order to maintain three of his alter personalities (Oxnam, 2005). As such, it appears that not only might an integrated individual experience ambiguous loss following integration, but their various alters may anticipate and experience the integration process differently from one another, thereby contributing to greater internal ambivalence and potentially undermining the integration process.

Determining whether or not this perceived intrapsychic relational system would be regarded by Boss as comparable to the relational system she describes poses some challenges, as the existence of such a “psychological family” is subjectively perceptual; it cannot be perceived empirically or verified irrefutably by an outsider to the system. However, Boss (2006) has also

written, “The myth of absolute presence or absence erodes when we ask, “Whom do you see as your family?” (p. 26). Implied in Boss’s question is the previously articulated assumption that ambiguous loss happens within the context of a relationship that is subjectively perceived or experienced as significant or meaningful (Boss, 2007). As such, the *perceived* intrapsychic relational system experienced by the multiple as well as the *perceived* relational losses resulting from integration have valence because they are *experienced* as meaningful to the integrated individual.

***The ambiguous losses of integration are externally caused, not by individual pathology***

Boss has contended that while “[t]he symptoms [of ambiguous loss] may be individual, resembling those of complicated grief, or depression, anxiety, and ambivalence,” the cause of or precipitant to ambiguous loss “lies in the context *outside* the individual and their couple or family relationships” (2007, p. 107; italics added). She went on to suggest that the individual’s struggle to find “coherence and meaning in the ambiguity surrounding the absence and presence of a loved one” is a result of the external context of the change or condition that contributed to the experience or feeling of ambiguous loss (Boss, 2007, p. 107). In applying this feature to the perceived psychological and physiological changes resulting from integration, one might make the argument that integration treatment is the external context through which perceived changes to an individual’s intrapsychic relational system take place.

***The ambiguous losses of integration are uncanny – confusing and incomprehensible***

The experience of the uncanny—the inexplicable ambiguity of simultaneous presence and absence—can be profoundly baffling and disquieting. Recall Carolyn Feigelson’s (1993)

depiction of “*personality death*” (p. 332), in which she described the uncanny experience of being close to someone whose altered personality structure makes them seem both present and absent to her, at once intimately known yet unrecognizable. She described the uncanny as producing an anxiety that lives at “the border of what we both know and don’t know, both cognitively murky and affectively alarming” (Feigelson, 1993, p. 331). Boss (2006) elaborated upon the inexplicability of such experiences, writing, “The intellectual and relational uncertainty of living with someone both here and not here produces a terrible anxiety of bizarre human experience” (p. 5).

For the integrated individual, the post-integration phase of treatment may indeed be uncanny, as they simultaneously experience a dramatic reconfiguration of their psychological structure and internalized sense of self, while perhaps successfully incorporating and maintaining all of the aspects of their formerly split-off selves. Living into their newly-integrated selves, questions of selfhood and identity may loom large, as their experience of themselves and of the world is fundamentally transformed. Perhaps even the pronouns used to speak of the self will feel foreign and surreal, as “we” and “us” are replaced with “I” and “me.”

*Who were “we”? Who am “I”?*

*What defined “us”? What now defines “me”?*

*Am “I” now defined by who “we” each were?*

Thus, they may feel as though they are living at the nexus of the known and the unknown—here and not-here—as they let go of their former selves and step into a newly-configured self that is both old and new, in which alters are both lost and merged, simultaneously absent and present.

To outsiders—those who have not had the internal experience of perceived multiplicity—there is a certain strangeness, a mysteriousness, an incomprehensibility about the phenomenon of

DID and, subsequently, the phenomenon of integration. The very notion of perceiving the self as a multiple may be thought of as not only abnormal but as unfathomable, as it deviates so far afield from the limited spectrum of that which is constructed as “normal” within the dominant discourse of mental health and wellness. In part, this unfathomability is related to the unreachability, untouchability and, ultimately, unknowability of psychological phenomena. DID and the experience of intrapsychic integration, like any psychological phenomena, is, to some extent, an ineffable human experience. Hence, it is this ineffability—the unknowability of the contours of the internal experience of DID and the process of integration—that defies definition. And perhaps it is the uncanny-ness of this phenomenon, which resists being pinned down definitively, exhaustively and comprehensibly, that continues to disrupt and destabilize the dominant discourse of DID.

### **Synthesis**

Applying the features and assumptions of ambiguous loss theory to the phenomenon of DID and the post-integration phase of treatment illuminates a range of possible experiences of DID and responses to integration treatment that have been and continue to be largely excluded from the dominant discourse of DID. In so doing, the alternative perceptions and interpretations of DID and integration treatment that are explored and articulated in this paper may interrupt and trouble the prevailing discourse, as previously unexamined possibilities of experience are considered. Examining the ways in which the preceding analysis both challenges and conforms to this discourse underscores the assumptions undergirding DID classification and integration treatment, as well as the power relations that serve to boundary and demarcate that which is to be included in and excluded from of the dominant discourse of DID.

## **Troubling the discourse of DID classification and treatment**

In the preceding exploration of the phenomenon of DID through the lens of ambiguous loss theory, this paper assumes that the features of DID that are described in the literature and, most notably, delineated as diagnostic criteria in the *DSM-IV-TR* (APA, 2000)—including the thoughts, beliefs, perceptions and behaviors associated with a DID classification—are relatively accurate approximations of internal experiences of multiplicity that have been described by individuals diagnosed with DID. As such, this analysis does not challenge and, therefore, reinforces the value-neutral descriptions of the features of DID that are currently forwarded in the dominant discourse of DID. However, this analysis does call into question the assumptions and interpretations of meaning that have become associated with and imposed upon these features; namely, that these features are considered deviant or abnormal and in need of correction.

In the prevailing discourse of DID today, the associated features or “symptoms” of DID are assumed to be deviant or abnormal, in keeping with the dominant discourse of mental illness. In contrast, Boss’s theory of ambiguous loss assumes that phenomena that are perceived or experienced as ambiguous losses are value-neutral, neither “good” nor “bad,” “right” nor “wrong” (Boss, 2007). In applying Boss’s theory to the experience of integration, then, this paper assumes that while an individual’s subjective perceptions of the process and outcome of integration treatment may be *value-laden*—interpreted as being “positive” or “negative,” “right” or “wrong”—the process of integration itself and the countless possible outcomes of integration treatment are *value-neutral*—neither objectively “right” nor “wrong,” “positive” nor “negative.” In so doing, this analysis problematizes the predominant assumption that integration treatment serves as a preferred corrective for a deviant psychological state of being, a process aimed at



repositioning an individual from a state of deviance to a state of normalcy. For, if transitioning from a state of perceived multiplicity to a state of perceived intrapsychic integration is a value-neutral event, then perhaps it follows that remaining in a state of perceived multiplicity is equally value-neutral, neither universally “right” nor “wrong,” “positive” nor “negative.” And if living in a state of perceived multiplicity is value-neutral, wherein lies its supposed deviance?

By maintaining Boss’s assumption of value-neutrality, this analysis calls into question the underlying assumption of deviance that serves to construct and perpetuate the classification of DID as a mental disorder. In so doing, the dominant discourse of DID classification and treatment shifts, as the phenomenon is no longer necessarily wed to notions of deviance and pathology. However, detaching an assumption of deviance from DID does not conversely attach it to an assumption of normalcy, thereby shifting from one pole of the discourse to the other. Rather, it frees the phenomenon from the mutually-enforcing binary of psychological deviance and normalcy—a binary that is both a function and a consequence of the discourse of mental illness—such that DID is no longer perceived or defined as either “normal” or “deviant,” “healthy” or “ill” but as a value-neutral phenomenon that is subjectively perceived and defined. While problematizing the assumption of deviance and troubling the dominant discourse of DID does not extricate the phenomenon from being imbedded in and constructed through discourse, it may serve to shift and disseminate the locus of power within the discourse to individuals experiencing the phenomenon of DID.

As universalist, essentialist truth-claims regarding the alleged deviance of DID and supposed preferability of integration treatment are dismantled, the individual, subjective perceptions of and beliefs about the internal, intrapsychic experience of DID may gain more prominence within the discourse. As such, perspectives on the experience of DID and of

integration treatment that had previously been marginalized and excluded from the dominant discourse may gain legitimacy and be invited into the discourse, thereby deepening an understanding of the phenomenon and contributing to a broader, more inclusive conceptualization of the phenomenon of DID and the experience of integration treatment. Moreover, achieving such a shift in power may allow new questions to surface and develop regarding the conceptualization (and continual *re*-conceptualization) and treatment of DID, thereby further troubling the dominant discourse and creating space for a multiplicity of truths to occupy an emerging discourse of DID.

### **Strengths and Weaknesses**

As noted previously, the subjective experiences of individuals in the post-integration phase of treatment has received very little attention in the clinical literature (Bristol, 1997; Kluft, 1986a, 1988b; Putnam, 1989). Similarly, the utilization of ambiguous loss theory has been relatively limited until now, as only a small number of researchers apart from Boss have employed the theory in their empirical research. Furthermore, the scope of ambiguous loss theory has remained more or less confined to Boss's original conceptualization of the theory (Boss, 1999, 2006, 2010), as this researcher has found no published literature that disputes, challenges, augments or expands upon the ideas that Boss has forwarded to this point. As such, the foregoing analysis of the subjective experiences of post-integration treatment through the theoretical framework of ambiguous loss introduces a new realm of thought to the prevailing discourse of DID and integration treatment, while also contributing to and, perhaps, broadening the field of ambiguous loss theory.

In part, the paucity of literature pertaining to both the phenomenon of post-integration and the theory of ambiguous loss made it possible to conduct a fairly thorough literature review, as this researcher was able to locate and examine nearly every available text that cited ambiguous loss theory or that explored the subjective experiences of post-integration treatment. Simultaneously, however, due to the lack of existing literature on the phenomenon of post-integration, the preceding analysis is based on very few empirical sources, none of which have been published in peer-reviewed scholarly journals, thus limiting the applicability of the conclusions drawn herein. On a similar front, this researcher found few peer-reviewed sources regarding the phenomenology, history and etiology of DID and integration treatment that have been published within the past ten years, thereby possibly excluding the most up-to-date research (if indeed more recent research exists) and further limiting the reach of this analysis. As such, there is a great need for more qualitative empirical research to be conducted regarding the phenomenon of DID and the subjective experiences of post-integration in order to contribute to an ever-deepening awareness of this complex and controversial phenomenon.

This study has been conducted from a perspective that is critical of universal or essentialist truth-claims regarding psychological phenomena, which contributed to the selection of poststructuralist thought and a Foucauldian analytic framework for this analysis. Given this perspective on psychological phenomena, this study holds that an individual's subjective perceptions of their inner world and experiences of the external world are valid and legitimate in their own right, regardless of how these experiences are interpreted or constructed by others. Therefore, the analysis of the phenomenon explored in this paper is biased toward a deconstructionist approach, as this study has sought to understand how and why it is that particular truth-claims regarding the etiology and phenomenology of DID have and continue to

wax and wane from their positions of dominance within the discourse of mental illness. It is from this standpoint that this researcher felt compelled to explore the perceived experiences of internal multiplicity and intrapsychic integration that have long been underrepresented in the literature. On another front, however, it should be noted that this researcher began this theoretical endeavor with limited knowledge about the phenomenon of DID and integration treatment and with no personal history with the diagnosis. As such, the lack of personal connection to anyone who has been diagnosed with DID may minimize the degree to which the outcomes of this research may be biased in any particular direction.

### **Implications for Social Work**

This paper has been written with the intent to examine the prevailing discourse of DID classification and treatment, and to contribute to the relatively limited bodies of literature pertaining to both the phenomenon of post-integration and the theory of ambiguous loss, such that the former is more deeply examined and the latter is more widely applied. In so doing, it may further develop the concept of ambiguous loss as Boss originally postulated it, such that the concept of “intrapsychic ambiguous loss,” as hypothesized about in this paper, may serve to augment and expand the borders of this compelling yet under-utilized theory. On another front, this theoretical analysis may persuade scholars in the field of mental health to conduct more qualitative empirical research on the subjective experiences of the post-fusion phase of integration treatment, as this topic has received little attention in the literature. Moreover, this paper may contribute to an ongoing analysis of the ever-evolving discourses of DID and mental illness, such that historically-bound constructions of meaning and knowledge regarding

psychological phenomena may continue to be unsettled, thereby dislodging such constructions from their purportedly ahistorical, objective and universal origins or positions.

In the realm of social work practice, this theoretical analysis may have important implications for clinicians working with clients who are currently undergoing integration treatment as well as those who have already completed integration. Raising awareness about the possibility that individuals may experience ambiguous loss following integration may help clinicians become more attuned to and affirming of their client's subjective experience of integration. Furthermore, doing so may increase clinicians' capacities to anticipate how wide and variable the range of responses to integration may be with an as of yet un-integrated client, thereby helping a client to better prepare themselves for the post-integration phase of treatment.

Lastly, this research may have importance for integrated individuals themselves, whose multidimensional experiences as post-multiples have evidently been largely unexamined by many of the practitioners and scholars in whose expertise and care they have entrusted themselves when pursuing or undergoing such treatment. By articulating previously unexplored possibilities of experience, this examination of the experience or perception of intrapsychic ambiguous loss in the post-integration phase of treatment may give clients greater access to "experience-near" language, wherein the language used to describe the experience of post-integration is more acutely reflective of a client's subjective reality (White, 1995). As such, clients may feel more emboldened to voice and defend their subjective interpretations of their experiences with DID and the process of integration. In doing so, their stories, their voices and the meanings that they make of their intrapsychic experiences may gain inclusion into the prevailing discourse of DID, thereby expanding the borders of this discourse.

## Conclusion

In keeping with the assumptions of ambiguous loss theory—which emphasize the value-neutrality of phenomena, as well as the subjectivity (not in the Foucauldian sense of the word) and historicity of responses to and perceptions of phenomena, this analysis assumes the following: (1) the immeasurably complex constellation of thoughts, behaviors and beliefs that have become classified as DID is a value-neutral phenomenon that has been constructed and continues to be reconstructed through a historically-bound discourse; (2) an individual's experience or perception of integration is subjective, informed by their time and place in history and the multiple discourses of which they are inevitably a part. Therefore, this analysis challenges the assumptions that underlie the dominant discourse of DID classification and treatment, as it calls into question the presumed deviance of DID, the supposed preferability of integration treatment and the alleged positivity of achieving intrapsychic integration. Furthermore, this analysis highlights the ultimate unknowability and ineffability of psychological phenomena, thereby underscoring the innumerable complexities of human experience. In so doing, it may serve to dislocate the objectified and subjugated subject—in this case, an individual diagnosed with DID—from their allegedly fixed position of social and psychological deviant, thereby disrupting and destabilizing the dominant discourse of mental illness.

While this paper does not suggest or assume that the experience or perception of ambiguous loss is an inevitable consequence of integration treatment, nor does it make any claims about the prevalence or likelihood of such an experience occurring, it does suggest that there is a great deal more to be learned about the subjective perceptions and experiences of the post-integration phase of treatment. Furthermore, by examining first-hand accounts of post-integration, this paper suggests that the loci of knowledges pertaining to this phenomenon lie

with the integrated individuals themselves. As such, this paper aims to slightly shift the locus of power regarding the discourse of DID away from the authoritative voices of scholars, mental health practitioners, insurance companies and the APA's (2000) *DSM*, and toward the disparate voices of those who have undergone integration treatment and who have learned to adjust and live into what they may perceive to be a newly-reconfigured sense of self and identity.

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