Pergamon

Clinical Psychology Review, Vol. 21, No. 2, pp. 301–320, 2001

0272-7358/01/$–see front matter

PII S0272-7358(99)00049-5

THE RELATIONAL TREATMENT OF DISSOCIATIVE IDENTITY DISORDER

Noelle Burton and Robert C. Lane

Nova Southeastern University

ABSTRACT. *The intent of this paper is to review the literature pertaining to the transference and countertransference components in the treatment of dissociative identity disorder. Aspects of transference and countertransference are presented and discussed within the relational psychoanalytic model. The functions of empathy, enactment, projective identification, and transitional objects are reviewed. Specific attitudes in the transference and countertransference are illuminated and major transference themes are discussed. Finally, a case vignette illustrates some of the central issues involved in the treatment of dissociative identity disorder. © 2001 Elsevier Science Ltd.*

KEY WORDS. Dissociation, Multiple personality, Professional standards.

CONTEMPORARY RELATIONAL PSYCHOANALYTIC approaches have brought a focus to the complex mix of reactions occurring between therapist and client, known as the transference-countertransference matrix. Within recent years there has been an increasing interest shown by relational psychoanalysts in applying these principles to treating dissociation and dissociative identity disorder (DID) (Bromberg, 1991, 1994, 1995; Davies & Frawley, 1992, 1994; Schwartz, 1994). The relational perspective offers certain advantages over more traditional perspectives with regard to the conceptualization of dissociation, and the specific treatment interventions utilized. Treating DID presents the therapist with an array of treatment options as well as a virtual minefield of potential countertransference errors, some of which will be elaborated upon. This article concludes with a clinical vignette to illustrate these errors and how they affect treatment. Interventions based upon relational psychoanalytic principles will also be discussed.

Correspondence should be addressed to Robert C. Lane, Ph.D., Nova Southeastern University, Intensive Psychodynamic Psychotherapy Clinic, Maltz Psychology Building, 3301 College Ave., Ft. Lauderdale, FL 33314-7796.

DISSOCIATIVE IDENTITY DISORDER DEFINED

Putnam (1985) points out that certain thoughts, feelings, and experiences in the dissociated patient are not integrated normally into consciousness and memory. Research suggests that infants have a physiological defense mechanism that allows them, when exposed to painful stimuli, to raise sensory thresholds by shifting into a different state of consciousness (Emde, Gaensbauer, & Harmon, 1976; Young, 1988). The current conceptualization of DID is that it is a complex, chronic form of posttraumatic stress disorder (Kluft, 1984) resulting from severe, repetitive childhood abuse or trauma, usually beginning before the age of 5. Putnam and others (Putnam, Guroff, Silberman, Barban, & Post, 1986) found that 97% of 100 DID patients reported a history of child abuse: 83% sexual abuse, 75% physical abuse, and 68% both sexual and physical abuse. The child dissociates in order to cope with the trauma, and the patterns of dissociation increasingly assume a more systematized and organized structure in order to deal with subsequent trauma. Distinct identities or personality states recurrently take control of the individual's behavior accompanied by an inability to recall important personal information (American Psychiatric Association, 1994).

THE RELATIONAL MODEL OF PSYCHOANALYSIS

The relational model of psychoanalytic thought consists of a group of theories which have been drawn from the schools of American Interpersonalism, British Object Relations, Self Psychology, and Intersubjectivity. These schools hold in common a focus on self-other relations, a less rigid authoritarian stance on the part of the analyst, primacy of affects over drives, and greater mutuality between analyst and patient. It is within this context of mutuality where relationship themes are played out between analyst and patient and become the focus of therapy (Aron, 1996). Overall, there is a simultaneous focus on both transference and countertransference, rather than transference being primary.

Relational analysts view the issue of neutrality somewhat differently from more traditional analysts. There is an expectation that the therapist will engage, unwittingly, in enactments of the patient's earlier object relationships. These enactments are viewed, not as technical errors, but as conduits to the exploration and analysis of the patient's core issues. In this model, therapeutic neutrality is defined as the therapist's ability to engage flexibly in all possible enactments of the patient's internal object world (as opposed to being limited to engaging in some object relationship enactments but excluding others). Preserving neutrality also means treating all of the aspects of the patient fairly as opposed to favoring or aligning oneself with one dissociated aspect, that is, alter, over another.

TRANSFERENCE AND COUNTERTRANSFERENCE DEFINED

The relational definition of transference (Davies & Frawley, 1994) includes all aspects of the analytic work which have previously been defined as the working alliance, the "real" relationship between patient and analyst, and the patient's internalized, dynamically based system of relational paradigms. In addition, transference includes the patient's conscious and unconscious processing of the therapist's characteristics and dy-

namics (Greenberg, 1991). Transference also includes the patient's expectations of and fantasies about the therapist's view or perspective (Aron, 1991). Relational psychoanalysts refer to one's perspective as one's "subjectivity." Countertransference is defined as the moment-to-moment therapist counterparts to the transference (Racker, 1968). Relational psychoanalysts also include the real feelings the therapist has toward the patient and responses that emerge in reaction to the patient's conscious and unconscious, verbal and nonverbal communications. Finally, countertransference encompasses the responses in the therapist arising from her dynamically based conflicts (Davies & Frawley, 1994).

Classical definitions of transference and countertransference have been narrower. Generally speaking, classical analysts were primarily focused on the "maladaptive" and "distorted" perceptions of the patient, that is, transference. Countertransference was viewed similarly in that it was viewed as neurotically based (within the analyst's character) and believed to be an obstacle to the therapist's understanding of the patient. Relational psychoanalysis views these narrow definitions as unnecessarily limiting and artificial in their attempts to distinguish between what is neurotic or distorted, and what is not. Relational psychoanalysis seeks to avoid placing the therapist in the position of arbiter of reality. Instead, the therapist aspires to open up all the responses of both therapist and patient to inquiry and exploration. For most of the time the therapist will explore her own responses privately.

DISSOCIATION AND THE FUNCTIONS OF EMPATHY, ENACTMENT, AND PROJECTIVE IDENTIFICATION

Dissociation may be understood from the developmental perspective offered by Bromberg (1993):

> There is now abundant evidence that the psyche does not start as an integrated whole, but is nonunitary in origin—a mental structure that begins and continues as a multiplicity of self-states that maturationally attain a feeling of coherence which overrides the awareness of discontinuity. This leads to the experience of a cohesive sense of personal identity and the necessary illusion of being "one self" (p. 162).

This maturational process is traumatically disrupted for individuals with DID. Trauma and abuse may interfere with the development of basic trust and a cohesive sense of self, and in turn promote the maintenance of dissociated self-states. The relationists do not believe that the individual with DID can experience conflict, because by definition, conflict involves two opposing ideas or feelings. Contradictory feelings or perceptions are not typically contained within a single alter. Each alter represents a particular feeling or perspective. Opposing realities and their interpretations are not available to the individual for negotiation or, as in the writings of Donald Winnicott (1971), "to play with." For example, the child who is sexually abused by caretakers experiences intense feelings of fear and rage, yet is unable to give expression to these feelings due to complete and utter dependence on caretakers. To experience such fear and rage towards one's caretakers interferes with the child's ability to trust. Affects and experiences associated with the abuse are dissociated so that loving ties may be maintained with caretakers (Davies & Frawley, 1992).

Dissociation differs from both repression and splitting. It results from an overwhelming of the ego and a subsequent disintegration process, and leads to a severing

of connections between one set of mental contents and another. It differs from repression and splitting in that an opposing set of mental contents can always be accessed if one can make contact with the altered state in which those mental contents reside. For example, a DID patient may love and hate the therapist, with the loving aspect contained in one alter and the hating aspect contained in another. In the borderline patient who utilizes splitting, hatred or love may be repressed, or may be split between two individuals.

The psychotherapeutic treatment of DID may be viewed as a developmental process (Schwartz, 1994). Children learn how to empathize through the experience of having their caretakers understand and empathize with their own feelings. Since the capacity to trust, attach, and self-regulate have been significantly disrupted, the role of empathy in the treatment becomes central. Empathy is understood here as the consistent "vicarious introspection" (Kohut, 1971) of the analyst, which is communicated to the patient. Kohut (1984) defined empathy as "the capacity to think and feel one's self into the inner life of another person" (p. 78). Schwartz (1994) discusses the importance of an empathic environment which will allow for the unfolding of the patient's multiplicity. In fact, he asserts that hypnosis is not necessary in the treatment of DID and that empathic resonance may be as effective in increasing the permeability between dissociative barriers.

The relational treatment of dissociation and DID requires objective observation as well as the consistent empathic participation on the analyst's part (Bromberg, 1994, 1995, 1996; Davies, 1996; Davies & Frawley, 1992, 1994; Schwartz, 1994). It is through this back and forth movement, between objectively and subjectively experiencing the patient, that the therapist can come to a fuller understanding of the patient, on both an intellectual and a visceral level. This work is carried out through the therapist's participation in and analysis of enactments that occur within the therapeutic relationship. Enactment is defined as the externalization of the patient's internal experience of the therapist, that is, the patient engages in a replay, with the therapist, of the original context that produced the dissociation.

It is through the process of understanding the meanings of various and multiple enactments within the transference-countertransference matrix that significant healing takes place. Ferenczi (1932) was well aware of this phenomenon, stating:

> I have finally come to realize that it is an unavoidable task for the analyst: although he may behave as he will, he may take kindness and relaxation as far as he possibly can, the time will come when he will have to repeat with his own hands the act of murder previously perpetrated against the patient. (Dupont, 1988, p. 52)

Enactment is a form of communication to the therapist in what may be the only way possible for the patients to make themselves known (Bromberg, 1993). Davies (1996) states:

> Although the patient cannot speak of what happened, she can show us, through the specific nature of her involvements with others, including most especially the analyst, how her early object world was constructed. (p. 203)

Bromberg (1995) asserts, "The 'truth' that is held by a dissociated state is not accessible to interpretative intervention because it exists as an experiential memory without an accurate perceptual or cognitive memory linked to the self" (p. 144). Bollas (1987) refers to this experiential memory of the trauma as "the unthought known." For ex-

ample, a patient with dissociated rage is aware of a rageful part but cannot make sense of this feeling state. There seems to be no rational basis for this feeling. Connections to genetic material cannot be made real to the patient without first experiencing the "here-and-now intersubjective context" (Bromberg, 1996) being enacted in the analytic relationship. This context is a replay of the original early relationship that caused the trauma. It is necessary for the therapist and patient to articulate or narrate the current enactment between them so that the patient's experiential memories or multiple realities (i.e., incompatible feelings arising from dissociated self-states) can be linked and encoded. Talking about and exploring what is happening in these replays between patient and analyst creates a much needed basis for understanding and linking feelings to memories.

Memories, including associated thoughts and feelings, are state-dependent; for example, rage states that are felt to be alien. These dissociated or "not me" states of mind, when in the patient's awareness, can then be contained and understood through articulation and inquiry. Without this cognitive symbolization, the patient experiences the past trauma as a present danger (Bromberg, 1994).

The patient will enact roles from the past and unconsciously pressure the therapist to participate in the enactment. It is therefore essential for the therapist to engage in the enactment with the patient, and to be able to offer the patient new relational possibilities. Interpretation and analysis of these transference-countertransference paradigms are also in order. The patient-therapist enactment allows for the emergence of state-dependent memories associated with unintegrated and unarticulated real and fantasied relations to others (abusive relational paradigms). These enactments provide access to traumatic memories (Davies & Frawley, 1994). Davies and Frawley (1992) stress the necessity for the analyst to refrain from immediately interpreting an enactment and state:

> Only by entering rather than interpreting, the dissociated world of the abused child, can the analyst "know" through his own countertransferences, the overwhelming episodes of betrayal and distortion that first led to the fragmentation of experience. (p. 19)

It is the style of the transference, or the nature of the enactments, which graphically illustrates the experience and accompanying affect of the patient's relationships with early caregivers. Bromberg (1994) has stressed that dissociated aspects of the self become symbolized through enactments within a relational context.

When the patient unconsciously pressures the therapist to engage in a particular role, this is referred to as projective identification. It is regarded that there are two steps in projective identification. First, the patient projects a split-off, internalized, self-representation onto the therapist, to control good or bad aspects of the internal world. Second, the therapist identifies with the patient's projection, despite the fact that it may feel ego-dystonic or alien, although consistent with the projection from the patient (Ogden, 1982). The therapist participates in a way that allows for the construction of new possibilities of relating not previously available to the patient.

The following illustrates this idea of projective identification and a helpful therapeutic intervention. The week before the therapist was to go on vacation, a patient's dissociated child self-state complained to the therapist that she felt unloved and abandoned. "Katie" stated that she secretly feared that the therapist hated Katie's dependency cravings and that the therapist only pretended to accept and care for her (the projection of Katie's hatred of her own dependency needs). The therapist, upon re-

flection, became aware of some feelings of wanting space and time away from this aspect of the patient (the therapist's identification with the patient's projection). However, the therapist did not believe that she was only pretending to care and in fact felt a deep caring and concern for Katie. The therapist responded, "I'm aware of having many feelings about your dependency on me and I'm quite interested in understanding your feelings better." The therapist then asked the patient what it was like to feel hated for her dependency needs and to be subjected to "pretend caring." In addition, the therapist told the patient that she felt a deep concern and caring for her. The patient was then able to explore these issues further and moved into feelings of intense sadness associated with earlier experiences with her parents.

Building upon positive experiences, the patient's trust in the therapist increases, thereby permitting the patient to take more risks in exploring feelings towards the therapist. In this way the patient is able to relinquish the world of hidden feelings and secrecy and to relate in a more spontaneous and authentic manner. The patient can explore, experientially as well as verbally, these new possibilities and to compare these positive experiences with the abusive relational experiences of the past.

THE DID PATIENT'S AVOIDANCE OF INTERNAL CONFLICT

The patient utilizes dissociation and enactment in the service of avoiding the experience of internal tension and conflict. The internal conflict resulting from the nature of the abuse would have been intolerable for the child to bear. The nature of this internal conflict reflects the child's inability to understand why caretakers abuse rather than keep their promise to protect and nurture. Internal conflict is defined here as a conflict which is experienced within a single self-state. In the DID patient, the conflict may manifest itself in an overt form between two or more alters. For example, the patient may have overwhelming dependency needs which are expressed through a needy child alter. Representing the other side of this conflict may be an angry, rebellious teenage alter who claims to have no needs. These alters may dislike or even claim to hate each other and may be constantly arguing with one another. The patient may report hearing voices arguing or fighting in her head. For any of the alter personalities, including the host, this inability to tolerate internal conflict may lead to a propensity for concretizing experience, that is, the patient having great difficulty tolerating any ambivalence. Situations are viewed in terms of splits between incompatible and irreconcilable personality aspects with a tendency towards polarization. There is no expectation on the patient's part to engage in a dialogue concerning feelings of anger or rage.

A primary goal of the therapeutic endeavor is to assist the patient in developing a capacity to sustain the experience of internal conflict. The therapist attempts to release polarities and establish a dialectical relationship so as to restore the tension between opposites. The patient's early caretakers were unable to tolerate the expression of a normal spectrum of emotions. For example, physical beatings may have elicited rage in the child. However, expression of this rage would come at a high price for the child and, in the interest of preserving a loving relationship, these rageful feelings become dissociated. It is a therapeutic and developmental achievement when the patient is able to hold these conflicts in consciousness, and then learn to "play" with their opposites (Winnicott, 1969). For example, when a patient can entertain and empathize with two contradictory self-states, the patient is on her way towards integration. Winnicott asserts that paradox heals when it can be accepted, tolerated, and respected even without being re-

solved. Patients often do not expect the therapist to be able to tolerate feelings of bitterness and rage towards them. Early caretakers did not tolerate these bad feelings and the child was usually severely punished for expressing them. The therapist introduces a new reality by accepting and caring about rageful feelings as well as loving feelings.

TRANSITIONAL OBJECTS AND SYMBOLIZATION

In normal development, the presymbolic or preverbal child exists within an intermediate area between reality and fantasy which Winnicott (1971) called the "potential space." In DID, the interplay between reality and fantasy within the potential space is disrupted, resulting in a dissociation of each pole from the other and subsequently a loss of meaning (Ogden, 1989). In other words, there is no longer a dialectical tension between these poles, and so meaning has collapsed to one pole or the other. Dissociation has interfered with the symbolization, with the encoding, of experiences (Van der Kolk & Van der Hart, 1989). In normal development a child converts external reality to internal reality through fantasy or transitional objects (e.g., the mother's presence is preserved and internalized through a teddy bear) (Winnicott, 1953). Smith (1989) asserts that patients with DID have not reached this developmental level of achievement. It is through use of fantasy and transitional objects that dialectical relationships can be created between polarities. It is a function of the therapist to teach the patient how to play with polarities and their potential meanings, and how to utilize transitional objects in order to reawaken their capacity for fantasy.

This task is a challenging one because the patient continuously attempts to foreclose the exploration of possible realities. Instead, the patient will act out feelings, that is, make them concrete, rather than talk about them, in order to keep them within the realm of abstraction. For example, rather than verbalizing disappointment in an empathic failure by the therapist, the patient will instead act out via self-mutilation or a threat of suicide. The therapist, in turn, may respond to the patient's concretization of reality with counterconcretization. This may occur through restraint, hypnosis, or hospitalization. Schwartz (1994) warns that this countertransferential response of the therapist serves to fuel the paradigm of multiplicity, which revolves around themes of domination, polarization, and the continual replaying of early abusive dramas. Schwartz offers that the therapist at times may need to introduce concretization in order to contain the patient, but that such concretization always carries with it inherent dangers. For example, there may be times when simply talking about and exploring suicidal feelings may not be enough to contain these feelings for the patient, and hospitalization may be necessary. The danger of hospitalization is that the patient may feel unable to explore these feelings in a more symbolic way because the therapist's own anxiety cannot be contained. There is a need for the therapist to become the "guardian of the realm of the symbolic," thereby allowing and encouraging the patient to move back and forth between reality and fantasy. In this way, the patient can learn to tolerate, experience, and integrate feelings of pain, grief, and rage. The patient's propensity to concretize experience can be transformed into a tolerance for ambivalence and ambiguity.

How does the therapist preserve this potential space for exploration for the patient? One way is to ask the patient directly about her fantasy, as illustrated in this exchange:

P: I want to kill myself.
T: What are you feeling?

P: Like I want to kill myself.
T: I wonder if there are feelings that are connected with the impulse to kill yourself that we can understand better?
P: I don't know. I just want to die. (Notice how the patient's response remains concrete and resistant to exploring affects).
T: What if you went ahead and did it? What would that be like?
P: It would be a relief. I wouldn't have to feel this anymore.
T: Describe what you feel.
P: Unbearable pain. It feels too hard—I can't take it.
T: We need to try to put words to this pain in order to better understand it. Right now there are no words and no understanding, just a strong impulse to kill yourself. Every time you think of killing yourself, we have to figure out what you're feeling underneath. So let's try that now, okay?

It is important to mention here that the occurrence of self-mutilation and suicidal threats are ongoing phenomena in this work. Davies and Frawley (1994) discuss how to understand and treat these in more detail.

Another important developmental step in the treatment of the DID patient is to move from object relating to object use (Schwartz, 1994). Object relating is when the patient believes that others can be omnipotently controlled; there is not, in this case, a clear distinction or boundary between the patient and the other. Object usage involves relating to the other as real and independent of the patient's control, and it is this more mature level of relating which allows the patient to utilize the therapist for growth and maturation (Winnicott, 1969). In this manner, an auxiliary ego is made available to the patient through the therapist, who encourages the emergence of frustrated developmental needs via an empathic bond with the patient. The therapist becomes a bridge that connects alters for the patient by empathically resonating with all ego states of the patient, and by recognizing both the developmental and defensive needs of the patient.

In terms of specific interventions, the therapist needs to explore, with punitive alters, their enjoyment of sadistically punishing other alters. Rather than concretizing the experience by setting limits and contracting with patients, exploration is recommended as an initial step (Schwartz, 1994). To introduce reality too quickly by discussing limits and contracts might foreclose the exploration of fantasy material. Intrapunitive alters are dissociated self-states which are identified with the aggressor, and Schwartz (1994) advocates confronting the punitive alters with the intrapsychically damaging outcome of their hostile manner. The patient needs to understand that doing harm to other self-parts may in fact be a way to dominate the therapist much in the same manner that the patient was once dominated by important objects. Davies and Frawley (1994) emphasize that any form of acting out by alters (e.g., self-mutilation, suicide attempts, binge-eating, purging, etc.) always has some transferential component and must be addressed by the therapist. Although it may be addressed genetically or within the patient's current extratherapeutic life, if this acting out is not addressed transferentially, the patient is likely to escalate.

In the course of symbolizing the unspeakable and unformulated experiences (Stern 1997) of the patient, the issue of the veracity of specific memories arises. Enactments cannot be taken as literal truth but instead can be viewed as the patient's subjective experiencing of past events and relationships. There are some things that the patient and therapist may never know. The therapist is not an investigator seeking to establish historical fact, nor does she seek to encourage the patient to assume that her memo-

ries are objective reality. Rather, the therapist is primarily interested in assisting the patient to reconstruct her experiences and to understand the various and multiple meanings of these.

ATTITUDES IN THE TRANSFERENCE AND COUNTERTRANSFERENCE RESPONSE

The transference which unfolds in the course of treatment is intense and ever-changing. This intensity results from affects that may have been locked up in dormant alters for many years; affects that resulted from horrendous abuse at the hands of caretakers. The inconsistency and changeability of the transference mirrors the fluctuating attitudes and child-rearing practices of the parent towards the child. Alter personalities will likewise take on different attitudes and postures in relating to the therapist. These multiple transferences are based on the multiple self- and object-representations contained in the dissociated parts of the self (Putnam & Loewenstein, 1993). Transference themes include domination, aggression, and coercion, as well as passivity, victimization, and masochism. The patient may be overly compliant at one moment and actively defiant at another. Defiance may become manifest in the patient's unwillingness to give up control to the therapist regarding the direction of treatment. These patients have difficulty tolerating ambivalence, as they literally cannot simultaneously hold opposing emotions. Schwartz (1994) explains that this difficulty may become manifest in the patient's accusations of the therapist's betrayal when the therapist attempts to encourage the patient to hold and experience inner conflict.

Davies and Frawley (1994) discuss such vacillation in the client's transference between increased need and dependency on the therapist along with increased mistrust and a desire to detach. In order to continue to provide containment for the patient, additional sessions or telephone contact may be necessary. Davies and Frawley stress the importance of maintaining a balance between being dependably available and yet not becoming involved too quickly. They warn that these patients may easily become overwhelmed.

Davies and Frawley (1994) outline several transference-countertransference paradigms which are inevitably enacted between therapist and dissociative patient, the exploration and symbolization of which form the core of this analytic work. Davies and Frawley have presented four relational matrices: (1) the unseeing, uninvolved parent and the unseen, neglected child; (2) the sadistic abuser and the helpless, impotently enraged victim; (3) the idealized, omnipotent rescuer and the entitled child; and (4) the seducer and the seduced. They contend that all of these paradigms will be enacted during the course of therapy, with the therapist and patient each enacting all of the roles.

In order for the therapeutic work to be successful, the therapist needs to assist the patient in symbolizing these patterns and their associated affects. This work is carried out through the provision of a holding environment, via empathic understanding, and use of interpretation. If a specific alter emerges and discusses how she felt hurt by the therapist due to a perceived abandonment, the therapist may then empathize with this alter and help link this experience with earlier experiences of abandonment. The difference between this kind of analytic work and more classical work is that in the relational model, the patient is allowed to dissociate and enact roles with the therapist, who works to maintain a holding environment. Dissociation is not viewed merely as a defense to be interpreted, but as a valuable conduit to affects and unsymbolized memories, which can be reexperienced, symbolized, and integrated (Davies & Frawley, 1992).

What does the therapist do to give words to the unspeakable? And how do patients move beyond enactment? DID patients frequently refer to words as being meaningless, and there is a climate of futility surrounding the task of putting experiences into words. The patient has the need for the therapist to "personally know" (Bromberg, 1994) the unspeakable in a way that cannot be communicated through the patient's words alone. The therapist working with a DID patient does not have a choice as to whether or not she will experience the disorienting, unpleasant affective states corresponding to the patient's own trauma. These states in the therapist will be brought about when the patient cycles through different alters, taking on the perspectives of aspects of her sadistic abusers. For example, the patient may become cruelly critical of the therapist, perhaps leaving the therapist feeling stripped, bare, and bruised. It is these experiences that help the therapist to know the patient and know her experience in a visceral way. The therapist will inevitably feel as if she has lost her bearings to some degree in the face of the patient's sadism. After regaining her bearings the therapist may interpret and articulate to the patient these experiences from the patient's perspective vis-à-vis her abusers. The key here is that the therapist must necessarily lose her bearings and regain them again and again to truly know her patient. The therapist must survive these disorienting and unpleasant experiences and tell the story that they symbolize.

AGGRESSIVE ALTERS AND THE IMPORTANCE OF EMPATHY

Aggressive alters defend against the experience of hope, guilt, vulnerability, and disappointment via their hostility towards the therapist. Although they may appear to threaten or undermine the therapeutic alliance, these defenses function to protect the self from retraumatization. It is important for the therapist to welcome these parts of the patient, to respect their protective function, and to engage them in a therapeutic alliance. These aggressive alters are often quite helpful in treatment once a foundation of trust has been established (Putnam, 1989). Failure to empathize with these parts of the person, as when the therapist misunderstands their motivations, can lead to violence and episodes of acting out (Schwartz, 1994). When the patient's anger is transformed within a dialogue of exploration, the aggressive alters will experience containment and subsequently experience vulnerability. It is imperative for the therapist to acknowledge empathic failures in order for the patient to learn that restitution can follow disruption.

In discussing the patient's hostility and the therapist's countertransference Ferenczi (1932, cited in Dupont, 1988) states:

> One cannot help feeling inwardly hurt—at least I cannot—when after years of work, often quite exhausting work, one is called useless and unable to help, just because one cannot provide everything, to the full extent, that the poor suffering person needs in his precarious position. (p. 55)

He advocates "honest admission of our pain at not being able to help." This revelation of the therapist's limitations is often accompanied by the recovery of the patient's trust, and stands in stark contrast to the hypocritical stance of the patient's family.

The patient's alters believe in their omnipotence because they have been raised by caretakers who threatened retaliation and/or abandonment when needs and feelings were expressed. These needs and feelings were experienced as powerful, dangerous,

and potentially life-threatening, and the parents were unable to "survive" these "attacks," (i.e., assertion of the patient's needs). It is a pivotal function of the therapist to survive the patient's expressions of need without responding defensively or with subtle or obvious threats of abandonment (Schwartz, 1994). Winnicott (1969) emphasized the importance of the analyst's survival of these attacks over that of interpretative work in helping the patient to place the analyst outside of the self. If the analyst cannot be viewed as surviving these attacks, the patient will continue to view the analyst and others as a projection of a part of the self.

Lerner and Lerner (1996) provide an additional perspective on omnipotence, entitlement, and masochism in the DID patient from a contemporary structural viewpoint. The emergence of feelings of entitlement often manifests as a negative therapeutic reaction (NTR), resulting in the patient's resistance to being successful and making progress in therapy. Lane, Monaco, and Gregson (1997) discuss the masochistic and omnipotent underpinnings of the NTR and emphasize the positive aspects of this defense. Success in the treatment becomes intolerable for the DID patient because success is associated with destructive, forbidden competitiveness and a hostile triumph over their early care givers. This triumph is linked with inevitable retaliation from these caregivers, in the form of humiliation, sadistic punishment, and annihilation. In addition, loss of this sense of suffering is unconsciously associated with dreaded ordinariness, and with the loss of the treasured attachment to the pathological object (Lane & Goeltz, 1998). Inner misery and helplessness fuel the patient's sense of omnipotence, and make her feel alive; the absence of pain and suffering is experienced as deadness.

THE EROTIZED TRANSFERENCE

Dealing with sexually seductive alters poses another set of challenges. Wilbur (1988) comments that even when actual sexual contact between therapist and patient is averted, the therapist may experience enough countertransferential sexual desire to reduce the therapist's effectiveness. The therapist may react with "erotic horror" (Kumin, 1985) to the growing awareness of sexual desire, and respond by retreating from the patient. The patient may continuously engage the therapist in a relational paradigm where one is the seducer and the other, the seduced (Davies & Frawley, 1994). The patient and therapist will exchange roles and continue to play out these dramas until they are mutually recognized, explored, and worked through.

Blum (1973) elaborated on the various functions of the erotized transference, such as drive gratification of oedipal and preoedipal strivings, repetition of trauma (parental seduction) for purposes of mastery, regulation of self-esteem, and ego adaptation and defense. Blum (1973) explains that erotized transference is a specific subtype of an erotic or sexual transference that is characterized as particularly intense, vivid, irrational, and ego syntonic. In such an erotized transference, the patient evidences an erotic preoccupation with the analyst, has turbulent demands for physical contact with the analyst, insists on entering into the real life of the therapist, and lacks the capacity to explore rationally these erotic feelings, desires, and demands. Many authors believe that erotized transference is difficult to analyze and often makes analysis impossible, whereas erotic transference is a workable component of therapy or analysis. Bernardez (1994) focused specifically on the relationship between dissociation and the erotized transference, and recognized (as did Blum) the erotized transference as

a major reenactment of childhood sexual abuse. The erotized transference occurs when memories of sexual abuse have been dissociated or repressed. Given the prevalence of childhood sexual abuse in the histories of DID patients, coupled with presence of severe dissociation in these individuals, it seems that an erotized transference is more likely than not to occur. Bernardez (1994) views emergence of an erotized transference as an indicator of childhood sexual trauma and that through the enactment with the therapist, the therapist and patient can reconstruct what hitherto has been unknown to the patient. In this way the erotized transference is viewed as a vital communication, telling the therapist that the patient was sexually aroused by a parent and taught to respond erotically to the parent's pathological needs.

Working within this kind of configuration can be extremely challenging and anxiety-provoking for the therapist. Bernardez (1994) acknowledges two potential problems in the countertransference. The first concerns the therapist's "fear of discovering incest," which could result in a failure to view the erotized transference as an enactment of earlier abuse. This scenario may lead the therapist to deal only with the hostile or provocative aspects of the client's behavior or with the patient's early narcissistic deprivation. Second, the therapist may be fearful of responding to the patient's seduction, resulting in distancing behavior on the part of the therapist. Here, the therapist may find the patient to be uncooperative and difficult. At the same time, if the therapist overemphasizes the wish to protect the patient, this attitude may lead to a foreclosure of further exploration of the patient's erotic communications. It may be most useful to acknowledge and appreciate the patient's erotic wishes. This attitude can then be combined with an inquiry into their origins and functions, as advocated by Mitchell (1988) and others. The balance between exploring the patient's erotic wishes and providing containment will be different for each patient (and at different points within each patient's therapy), and the therapist is in a precarious position in attempting to stay with the patient and yet avoid overstimulation.

DEPENDENCY AS A NORMAL DEVELOPMENTAL NEED

The rapid and intense dependency on the therapist that develops in some alters can be startling. Child alters may be like orphans who feel that at long last they have discovered the perfect parent in the therapist who will rescue them from their nightmarish existence. These dependency needs in the patient are the result of normal developmental needs which were frustrated by caregivers and subsequently went underground, manifesting themselves in child alters. In many cases, dependency was not just unacceptable to the parents, they also may have played out a role reversal in which they burdened the child with their own dependency needs. It seems almost miraculous that dependency needs were preserved at all, given the hopeless scenarios with which these patients are confronted as children.

As a result, these patients were never provided with an emotional environment in which they could move from normal dependency to increased autonomy, or more mature dependency (Fairbairn, 1952). Complicating the matter further are the inherent dangers involved in depending on an abusive parent. The patient is left craving dependency despite the terror of the attendant vulnerability at the hands of the abuser. This conflict saddles the patient and therapist with a transference which revolves between extreme dependency and flight from the threat that is posed by excessive dependency and the possibility of merging (Lane & Goeltz, 1998).

Wilbur (1988) makes specific recommendations as to therapeutic technique in dealing with dependency. She notes that it is critical to reassure the infant and child alters that their dependency needs are normal at their age, and relates an example of a 3-year-old alter who wanted a stuffed animal to sleep with, but a more mature alter, feeling foolish, was reluctant to buy the younger alter the doll. The therapist encouraged the more mature alter to assist the younger alter to feel more secure, so that maturation could occur. After purchasing the doll, the younger alter felt happy and shortly thereafter reported that she had now reached the age of 5. The therapist's and patient's acceptance of the dependency needs of the younger alter permitted such maturation.

COUNTERTRANSFERENCE AND DIFFICULTIES IN CONTAINMENT

One of the easiest mistakes for therapists to make is to believe they can cure the DID patient with kindness, often under the guise of providing a "corrective emotional experience." Given that many of these patients have had a primary attachment to an abuser, it is likely that any approach taken by the therapist will be perceived as potentially abusive, or as separating the patient from her pathological relationship. It may be helpful to the therapists to remind themselves that a successful psychotherapy with a DID patient will be turbulent at times, a reflection of early relationship patterns.

Davies and Frawley (1994) note that the therapist may feel overwhelmed by countertransference experiences and projective identifications that challenge the therapist's ability to be helpful. They describe specific somatic or body sensations they experienced when working with survivors of sexual abuse. These symptoms include nausea, body size variations, tingly skin, numbness in an extremity, headaches, dizziness, vaginal pain or contractions, and states of sexual arousal, which may be experienced as disorienting and ego-alien.

In the midst of these intense emotional and physiological reactions, which create a chaotic climate for both therapist and patient, the therapist may yearn to withdraw from the patient and the therapy. Given the intensity of countertransference experiences, it becomes crucial for the therapist to maintain an observing ego as a way of containing both therapist and patient. Consultation with colleagues may be a necessary measure to assist the therapist in the containment of intense affective reactions.

Individuals with DID are extremely sensitive in their ability to hone in on the specific, personal vulnerabilities of the therapist (Wilbur, 1988). Severely regressed patients have an uncanny ability to "'understand' the analyst's motives and to 'interpret' behavior. This talent may occasionally give the impression of, or perhaps even amount to, telepathy, or clairvoyance" (Balint, 1968, p. 19). DID patients are exquisitely aware of and sensitive to the feelings, reactions, and inner workings of those with whom they interact. It is important that these insights into the personality of the therapist are not lost on hostile alters seeking to protect the dissociative defenses of the patient.

These transference characteristics may prove to be a difficult balancing act for the therapist, and can potentially evoke equally intense and varied countertransference reactions. The therapist becomes the vessel for the containment of dissociated aspects of internalized self- and object-representations; both those of the patient and the therapist (Davies, 1996). Davies (1996) communicates the immediacy of this experience:

> As I come to occupy my patient's internal world, to reside experientially within it, I surely come to know, in the most intimate of ways, my fellow inhabitants, her internal objects

> and their accompanying self-representations. I interact with them, I act like them, ultimately I will become them! (p. 209)

To empathize with sadistic, self-injurious alters can be a taxing experience for the therapist. The therapy will be experienced by the therapist as a continual testing of limits and boundaries by the patient. Due to the patient's communications through enactment and projective identification, the therapeutic dyad becomes the traumatic dyad. Schwartz (1994) discusses how therapeutic work with DID patients can be traumatizing for the therapist. He notes that a normal part of the therapist's treatment experience may include reactions such as excessive concern about the patient, intrusive thoughts about the patient, feelings of inadequacy and incompetence, paranoid feelings, omnipotent rescue fantasies, and stimulation of the therapist's own traumatic memories.

These experiences can be intense for the therapist and for this reason, therapeutic errors are more likely to occur. For example, the therapist may overmedicate, hospitalize unnecessarily, or exceed session length. In addition, the therapist may overcharge or undercharge, overuse hypnosis, offer excessive availability, use physical restraint procedures, or engage the patient in contracts to overdo or avoid doing memory work. These errors on the therapist's part may contribute to a repetition or replay of the patient's past relationships, leading to feelings of betrayal. In commenting on this transference-countertransference process Bromberg (1991) notes that it is as if the patient feels that the only possible way to be known is if the analyst too, "loses" his or her mind. It is the therapist's responsibility to supply organization and meaning to a disorganizing, chaotic, and terrifying experience for the patient.

The therapist may be tempted to enact countertransferential rescue fantasies through efforts at reparenting the patient. The danger here is that the therapist may avoid dealing with the patient's rage and distrust, which resulted from the patient's early attachment to bad objects. The therapist needs to invite these feelings into the therapeutic dialogue. The therapist's experience of being viewed by the patient as "bad" or "abusive" can be alien and uncomfortable. It is all too easy to reject these perceptions, to regard them as transference, rather than engaging in an empathic inquiry of these perceptions.

Overnurturing and overdirecting by the therapist may prevent the patient from necessary grief work. According to Schwartz (1994), these attitudes may lead to a foreclosure of the exploration of feelings of rage and distrust, reinforce compliance, and recapitulate sadomasochistic relating patterns. The patient needs a balance between perceiving the therapist as the original abuser and as a new, good object. In this way, the old traumas may be reenacted and worked through while the new, good object of the therapist may be internalized.

THE ISSUE OF NEUTRALITY

There has been considerable controversy over the issue of neutrality in treating the DID patient. Lerner (1994) felt that he was maintaining neutrality with a DID patient by *not* directly encountering alter personalities. Lerner and Lerner (1996) argue that it is important not only to know the content of dissociated states, but also to understand why these contents continue to be dissociated. They contend that the therapist should understand why these contents need to be introduced into treatment in a dissociated manner, that is, through direct contact with an alter. Bromberg's (1995) perspective argues that the only way the patient can communicate these contents is

through direct contact with the self-states—it is the only way the patient knows how. One should not ignore the dynamics of dissociation simply because one speaks directly to alters. On the contrary, analysis of resistance is carried out with all dissociated self-states. The dissociated self-states are not seen as aspects of the host; rather, the host is viewed as one of the other self-states. When these various self-states are integrated they form a whole ego, which at this point is only a potential.

Davies and Frawley (1994) emphasize that adhering to a neutral stance and thereby remaining in a more or less exclusively interpretive role, poses the danger that the patient will experience the therapist as reenacting the role of the uninvolved parent who permitted abuse. Barach (1991) noted that the therapist's stance of empathic neutrality (referring to traditional psychoanalytic technique) in response to the reactivation of attachment behavior in the DID patient may be perceived as an abandonment. He asserts that this abandonment is "more real than transferential," and poses significant risks to the therapeutic alliance. If this kind of enactment occurs, the patient will in turn escalate with regard to violent or dangerous behavior. This may continue until the patient is able to get the therapist to be involved more directively in an attempt to control the patient's behavior. For example, a patient may begin to self-mutilate during a session in which the therapist has maintained a purely interpretive stance. The therapist may feel forced to respond by physically restraining the patient. At this point the two are engaged in an enactment; the patient's internalized sadistic object has elicited a physically violent response from the therapist, thereby perpetuating this particular relational paradigm. Conversely, the patient may respond by moving into a state of detachment (Barach, 1991) in which intellectualized or numb alters are summoned. The therapist must constantly strike a balance between being too disengaged or neutral and a stance of being overinvolved or intrusive.

A CASE EXAMPLE

A case vignette may be helpful in illustrating possible therapeutic errors which can arise within the transference-countertransference matrix. In this example, the therapist had been treating "Amy" for 3 years, but it was not until the third year of therapy that Amy began to dissociate in session and it became apparent to both the therapist and Amy that she had dissociative identity disorder (Amy herself was a therapist).

One of the first significant challenges to the therapeutic relationship occurred 9 months before the emergence of Amy's multiplicity. Amy had become increasingly depressed and suicidal. The impetus for these suicidal feelings was not readily apparent to Amy or the therapist. In an attempt to be helpful, the therapist focused on cognitive distortions and contracted with Amy to keep herself safe. These interventions served further to involve both parties in an enactment, resulting in a foreclosure of any exploration of Amy's feelings. Her increasing despondence prompted the therapist to respond with more and more directive interventions as the therapist became increasingly anxious and sought to alleviate concretely her own anxiety. Amy experienced the therapist as unwilling or unable to tolerate her feelings of despair. This resulted in an empathic rupture and contributed to a week-long hospitalization which served to disrupt the evolving bond of trust between the therapist and Amy. In subsequent sessions, Amy avoided honest revelation of her feelings to the therapist and the next 9 months were spent rebuilding trust.

Eight months after the hospitalization, Amy became more active in exploring her feelings of distrust towards the therapist. Feeling reassured, she permitted herself to be increasingly dependent upon the therapist. It was at this juncture that a 6-year-old alter appeared in session, the first emergence of multiplicity. Shortly thereafter, Amy and her therapist discussed the diagnosis. Amy was concerned that the therapist would no longer work with her. However, the therapist responded that Amy need not be concerned, that the therapist would seek consultation to assist the treatment. Although Amy was exceedingly relieved, this raised questions as to the therapist's competence.

In subsequent sessions, the 6-year-old alter, "Kelly," continued to appear in session, expressing sadness about needing a "good mommy" and lamenting that all she ever had was a "mean mommy." The therapist attempted to hold Kelly empathically, and during one of these sessions a 14-year-old male alter, "Matt," appeared and angrily accused the therapist of encouraging Kelly to "get her hopes up about finding a good mommy." The intensity of the affects expressed by the alters was at great variance with the host's affective intensity. The therapist had never before treated anyone with dissociative identity disorder, and the presentations of these alters and their varying transferences to her had an understandably disorienting and disorganizing effect upon her.

Matt continued to confront the therapist about her attempts at reassurance, to which the therapist responded with apparent defensiveness. She attempted to explain her actions to Matt rather than respond to him with empathic understanding. Matt accurately perceived the therapist's anxiety and communicated this to the therapist. The therapist's anxieties and inexperience resulted in her own denial of Matt's perspective. Shortly thereafter, Matt and Kelly occupied Amy's consciousness for 24 hours (no alter had ever been out for this length of time during the treatment). Matt and Kelly went to a local arcade, drove all over the county, went to a carnival, and in the early morning hours returned Amy to the therapist's parking lot. Needless to say, Amy was bewildered and frightened to wake up in the parking lot and anxiously called her therapist in an attempt to find out what had happened. It is likely that this acting out was unwittingly precipitated by the therapist's empathic failures and the precipitant inability to hold and contain the patient. One possible intervention could have been to empathize with how chaotic things may have seemed to the host-patient, and to explore the meaning of what the patient was trying to convey through her actions. The therapist needed to focus on the patient's behavior as an enactment of what was transpiring within the therapeutic relationship.

After this episode the therapist met with Amy and informed her that she would be moving out of the state. She acknowledged that Amy would be likely to perceive this as an abandonment, but reassured her that the need to move was an unexpected development. She informed Amy that she would continue to see her until the time of the move, which would occur in 10 months, and added that she would also assist Amy in finding another therapist. The therapist erred here in that she foreclosed the possibility of exploring Amy's experience of abandonment by concretizing external reality. External reality was secondary in importance to Amy's, Kelly's, and Matt's feelings of betrayal and abandonment. In order for a therapist to continue to "hold" the patient, he or she needs to empathize with these feelings and encourage their exploration, not only with regard to the past but within the present relationship. The therapist needs to welcome and inquire about the patient's hostile and hurt feelings, perhaps even before reassuring the patient of the "real" reasons for termination. The message sent to

Amy and her alters was presumably that the therapist had difficulty dealing with and tolerating these feelings about her leaving.

As one might expect, this empathic failure led to further acting out. Matt again disappeared for several hours, and another alter, "the Black," emerged. This alter's sole purpose was to commit suicide. When Matt again emerged, he telephoned the therapist and explained how dangerously close Amy had come to killing herself. In the following session, the therapist told Amy that she probably would have to transfer her to another therapist in the very near future because she, the therapist, did not feel competent to deal with the escalation of the patient's acting-out behavior. Amy was understandably upset, especially since *she* had not engaged in the acting out. Kelly became hysterical, and Matt felt further betrayed and enraged at the therapist. In response to Kelly's inconsolableness, the therapist told her that she needed to "stay inside" and that from that point on she would only work through Matt.

The therapist's anxiety and lack of experience with DID contributed to a number of errors in the treatment. The therapist attempted to suppress an alter and enlisted the help of another alter to assist her in this suppression. This is a clear violation of the relational model of therapeutic neutrality, in which the therapist needs to work with all alters to preserve the integrity of the patient and facilitate integration of the dissociated parts. It appears that the therapist in this instance was unaware of her countertransference and was responding with increasing defensiveness. She reacted strongly to the patient's acting out by threatening abandonment and by responding more directively and confrontationally as she became increasingly overwhelmed. The therapist wanted to de-escalate the situation, but she was taking the route of attempting to control the patient, rather than working to understand her. Due to her own anxiety, the therapist had affectively disengaged herself from the patient, and this resulted in a cumulative increase in empathic failures.

In the following sessions, Amy attempted to block the emergence of alters for fear of destroying the therapeutic relationship. The relationship, at this point, appeared to hinge upon how "good" the patient could be; if she continued to act out, the therapist would likely leave, and thus the therapy became a recapitulation of past relationships. The therapist was probably feeling helpless, dominated, enraged, and impotent to deal with her suicidal, acting-out patient, and resorted to directiveness and confrontation to manage her mounting anxiety. The patient behaved in a complementary manner as the sadistic abuser, yet at the same time, due to the empathic failures of the therapist, she felt like the unseen, neglected child. The therapist appeared to be unaware of these enactments and therefore could not illuminate them for herself or the patient. As a result, little was accomplished and much was acted out, a stalemate.

Amy regained more control as the therapist became more controlling, but this occurred at the expense of the suppression of rage and disappointment. At this point, but Matt and Kelly, the reservoirs for these feelings, felt misunderstood and betrayed, and decided that they no longer wanted to talk to the therapist. Through the next couple of sessions, the therapist maintained her directive and emotionally unavailable stance despite the fact that the patient was no longer in crisis. Amy began to raise the possibility that the therapist was becoming emotionally distant due to countertransference reactions, but the therapist avoided discussing this issue and focused instead upon Amy's "transference."

At this point it became necessary for the therapist to analyze her own participation in the enactments with her patient (either on her own or in supervision) and then admit her errors to the patient. For example, the therapist could say, "Perhaps you are

right about my becoming distant. What has this been like for you?" Thus the therapist would have communicated to Amy that she was willing to entertain this possibility and was interested in exploring it. Not only would there be value in exploring the content of this particular enactment, but the validity of the patient's perceptions would be affirmed as the therapist presented the possibility of her own fallibility. From this point on, the patient would be expected to be more willing to take risks in telling the therapist her true feelings. This development is critical in the treatment of DID because these individuals are accustomed to adapting to the needs of others, while excluding their own needs, thus preserving the dissociation.

Amy became more frustrated and eventually dropped out of treatment after finding a new therapist. Her former therapist eventually sought supervision for the case, but unfortunately it was after the patient had already terminated treatment.

The errors discussed above served to erode the foundation of trust which had been previously built up over 3 years. The therapist was never able to acknowledge her technical errors, and this led to acting out and a forced termination. The effects of these errors reverberated throughout the patient's personality and brought forth old and new feelings of rage, hopelessness, and grief.

SUMMARY AND CONCLUSION

Contemporary relational psychoanalytic theory has sought to address potential problems within the framework of the transference-countertransference matrix, and illuminate these complexities for the therapist working with the DID patient. The technical use of empathy, enactment, and projective identification with all alter personalities form the core of the treatment within the relational model. This model posits that the dissolution of dissociative barriers, and subsequent integration, is best achieved through direct contact with alter personalities. Because each alter is directly addressed in treatment, the transference-countertransference matrix is variable and complex. Aggressive, erotized, and dependent transferences are highlighted, as well as corresponding countertransferences. These treatment issues were further illuminated with a case example. In the best of therapeutic circumstances where the therapist is aware of these issues, the treatment of DID is complex, difficult, and at times tumultuous.

Acknowledgment—Special thanks to W. Bradley Goeltz and Andrew L. Martin for their reading of this paper and many helpful suggestions.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders.* (4th ed.). Washington, DC: Author.

Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanalytic Dialogues, 1*, 29–51.

Aron, L. (1996). *A meeting of minds: Mutuality in psychoanalysis.* Hillsdale, NJ: The Analytic Press.

Balint, M. (1968). *The basic fault.* Evanston, IL: Northwestern University Press.

Barach, P. M. (1991). Multiple personality disorder as an attachment disorder. *Dissociation, 4*, 117–122.

Bernardez, T. (1994). The eroticized transference: A tool for the reconstruction of childhood sexual trauma. *Journal of the American Academy of Psychoanalysis, 22*, 519–531.

Blum, H. P. (1973). The concept of erotized transference. *Journal of the American Psychoanalytic Association, 29*, 61–76.

Bollas, C. (1987). *The shadow of the object*. New York: Columbia University Press.
Bromberg, P. M. (1991). On knowing one's patient inside out: The aesthetics of unconscious communication. *Psychoanalytic Dialogues, 1*, 399–422.
Bromberg, P. M. (1993). Shadow and substance: A relational perspective on clinical process. *Psychoanalytic Psychology, 10*, 147–168.
Bromberg, P. M. (1994). "Speak!, that I may see you": Some reflections on dissociation, reality, and psychoanalytic listening. *Psychoanalytic Dialogues, 4*, 517–547.
Bromberg, P. M. (1995). A rose by any other name: Commentary on Lerner's "Treatment Issues in a Case of Possible Multiple Personality Disorder." *Psychoanalytic Psychology, 12*, 143–149.
Bromberg, P. M. (1996). Hysteria, dissociation, and cure: Emmy von N revisited. *Psychoanalytic Dialogues, 6*, 55–71.
Davies, J. M. (1996). Dissociation, repression and reality testing in the countertransference. *Psychoanalytic Dialogues, 6*, 189–218.
Davies, J. M., & Frawley, M. G. (1992). Dissociative processes and transference-countertransference paradigms in the psychoanalytically oriented treatment of adult survivors of childhood sexual abuse. *Psychoanalytic Dialogues, 2*, 5–36.
Davies, J. M., & Frawley, M. G. (1994). *Treating the adult survivor of childhood sexual abuse*. New York: Basic Books.
Dupont, J. (1988). *The clinical diary of Sandor Ferenczi* (M. H. Balint & N. Z. Jackson, Trans.). Cambridge, MA: Harvard University Press. (Original work published 1932)
Emde, R. N., Gaensbauer, T. J., & Harmon, R. J. (1976). Emotional expression in infancy: A biobehavioral study. *Psychological Issues, 10*, 1–200.
Fairbairn, W. R. D. (1952). *Psychoanalytic studies of the personality*. New York: Routledge.
Greenberg, J. (1991). Countertransference and reality. *Psychoanalytic Dialogues, 1*, 52–73.
Kluft, R. (1984). The treatment of multiple personality disorder. *Psychiatric Clinics of North America, 7*, 9–29.
Kohut, H. (1971). *The analysis of the self*. Madison, CT: International Universities Press.
Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.
Kumin, I. (1985). Erotic horror: Desire and resistance in the psychoanalytic situation. *International Journal of Psychoanalytic Psychotherapy, 11*, 3–25.
Lane, R. C., & Goeltz, W. B. (1998). Identity confusion, bisexuality, and flight from the mother. *Clinical Psychology Review, 18*, 259–272.
Lane, R. C., Monaco, M., & Gregson, K. (1997). The negative therapeutic reaction: A summary for practitioners of psychoanalysis and psychotherapy. *Journal of Contemporary Psychotherapy, 27*, 31–45.
Lerner, P. M. (1994). Treatment issues in a case of possible multiple personality disorder. *Psychoanalytic Psychology, 11*, 563–574.
Lerner, P., & Lerner, H. (1996). Further notes on a case of possible multiple personality disorder: Masochism, omnipotence, and entitlement. *Psychoanalytic Psychology, 13*, 403–417.
Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.
Ogden, T. (1982). *Projective identification and psychotherapeutic technique*. New York: Jason Aronson.
Ogden, T. (1989). *The primitive edge of experience*. Northvale, NJ: Jason Aronson.
Putnam, F. W. (1985). Dissociation as a response to extreme trauma. In R. P. Kluft (Ed.), *Childhood antecedents of multiple personality* (pp. 65–97). Washington, DC: American Psychiatric Press.
Putnam, F. W. (1989). *Diagnosis and treatment of multiple personality disorder*. New York: The Guilford Press.
Putnam, F. W., Guroff, J. J., Silberman, E. K., Barban, L., & Post, R. M. (1986). The clinical phenomenology of multiple personality disorder: Review of 100 recent cases. *Journal of Clinical Psychiatry, 47*, 285–293.
Putnam, F. W., & Loewenstein, R. J. (1993). Treatment of multiple personality disorder: A survey of current practices. *American Journal of Psychiatry, 150*, 1048–1052.
Racker, H. (1968). *Transference and countertransference*. Madison, CT: International Universities Press.
Schwartz, H. L. (1994). From dissociation to negotiation: A relational psychoanalytic perspective on multiple personality disorder. *Psychoanalytic Psychology, 11*, 189–231.
Smith, B. L. (1989). Of many minds: A contribution on the dynamics of multiple personality. In J. Fromm & B. Smith (Eds.), *The facilitating environment* (pp. 424–458). Madison, CT: International University Press.
Stern, D. B. (1997). *Unformulated experience: From dissociation to imagination in psychoanalysis*. Hillsdale, NJ: The Analytic Press.
Van der Kolk, B. A. & Van der Hart, O. (1989). Pierre Janet and the breakdown of adaptation in psychological trauma. *American Journal of Psychiatry, 146*, 1530–1539.
Wilbur, C. B. (1988). Multiple personality disorder and transference. *Dissociation, 1*, 73–76.

Winnicott, D. W. (1953). Transitional objects and transitional phenomena. *International Journal of Psycho-Analysis*, *34*, 89–97.
Winnicott, D. W. (1969). The use of an object. *International Journal of Psycho-Analysis*, *53*, 711–716.
Winnicott, D. W. (1971). *Playing and reality*. New York: Basic Books.
Young, W. C. (1988). Psychodynamics and dissociation: All that switches is not split. *Dissociation*, *1*, 33–38.