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DID 101: A Hands-on Clinical Guide to the Stabilization Phase of Dissociative Identity Disorder Treatment

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This article provides clinical examples in the stabilization phase of the treatment of dissociative identity disorder (DID), formerly known as ''multiple personality disorder.'' I bring the reader into the clinical session with representative dialogs from clinical material with DID patients. Since Putnam's [1] classic 1989 work systematized the treatment of DID in one salient reference, a great deal has been written about DID treatment. For example, both Putnam [1] and Ross [2] give detailed clinical examples illustrating how they discuss a variety of issues with patients, ranging from informed consent for DID treatment to specific interventions related to working with alters, mapping, abreaction of trauma material, cognitive therapy, attachment issues, and fusion and integration, among others. Overall, however, these works, like most of the clinical literature, are more prescriptive than descriptive about many clinical problems. This article gives the reader a ''window'' into the clinical session as a trainee might experience it in a treatment program.

Every year, in The Trauma Disorders Program at Sheppard Pratt Health Systems, new psychology postdoctoral fellows rotate through the inpatient and outpatient programs, along with an occasional psychiatric resident on elective. This is a tertiary-quaternary care referral center with a patient population primarily consisting of severely symptomatic, multiproblem trauma patients, most with DID or severe forms of dissociative disorder not otherwise specified, referred for stabilization of acute safety problems or overwhelming dissociative and posttraumatic symptoms. They present with major problems in stage one trauma treatment, the phase in which the

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patient develops basic stability and safety to pursue the goals of long-term treatment [3,4]. Even those patients referred for putative stage two issues, such as intensive memory work, abreaction to stabilize, and so forth, are almost always found actually to need major stage one work.

As part of their initial training, postdoctoral fellows and residents are required to sit in with experienced clinicians to observe sessions with DID patients. This hands-on learning is often crucial for the trainee to see how interventions are used in actual clinical practice. The trainee can observe in vivo the stance of the therapist toward the patient, how the experienced clinician structures the interaction with the patient and helps resolve (or does not succeed in resolving) the seemingly intractable conflicts, contradictions, dilemmas, and predicaments commonly produced by DID patients. The trainee and mentor then discuss what has occurred.

This article presents something of that process: practical didactics to help the neophyte clinician develop a framework for clinical work with DID, based on specific clinical vignettes that illustrate common problems in negotiating stabilization. Case vignettes are drawn from my own clinical experience, illustrating modal themes and clinical problems. These vignettes are amalgams of several patients. Dialogue is not verbatim from clinical sessions, but is meant to represent typical interactions, tidied up to read fluently. Interventions described should not be taken as biblical pronouncements or viewed as applicable to all DID patients. Readers should use these notions as templates to adapt what seems helpful into their own style. Other clinicians may have far more efficacious and parsimonious ways than mine of handling these (and other) clinical problems. They represent, however, interventions and approaches that have helped me in assisting many DID patients achieve a modicum of safety and stability.

Case history 1

Ms. A is a woman in her 30's diagnosed with DID and posttraumatic stress disorder, referred to the Sheppard Pratt Trauma Disorders Inpatient Unit because of violent behavior toward herself and others. The outpatient therapist reported that the patient had had episodes of dyscontrol including shouting, fighting with her spouse, trying to jump from a moving automobile, stabbing herself in the legs with sharp objects, and switching to alter identities who were disoriented to current circumstances. These alters denied knowledge of the patient's husband, children, therapist, and job, and threatened violence to the therapist. By history, this symptom exacerbation began after the patient's accidentally meeting a male relative whom the patient reported had molested her throughout childhood. She had had several unsuccessful brief hospitalizations in her local community. In each, she had been in restraints for several days because of violent attacks on herself, threats against staff, and attempts at elopement.

On admission, the patient presented as a wiry, anxious woman who became increasingly agitated as the admission interview progressed. As she described the recent contact with her relative, she began to rock back and forth, appeared to go into a trance, and began to laugh inappropriately and repeatedly smashed a fist violently into her thigh. As the admitting psychiatrist, I attempted to use symptom containment techniques to de-escalate the situation and attempt to reground the patient. At this, however, the patient became more physically agitated, laughing more wildly, smashing her fist even more violently against her leg. She leaned forward threateningly, and hissed, "You're lucky I'm here. The other one wants to kill you. He's coming now." I quickly left the room and initiated an all-staff call.

The patient required a large number of staff to subdue her as she screamed, kicked, bit, and scratched at the nursing staff. Eventually, she was placed in five-point restraints and given intramuscular sedatives. The staff was upset and worried about the patient's potential for additional violence and disruption of the hospital milieu, especially with the history of dyscontrol in prior hospitalizations.

Shaken and scared, I decided, albeit reluctantly, to talk to the patient again to process the events and to see if a repetition of the situation could be avoided. The patient was more subdued, denied recall of the events precipitating being placed in restraints, and seemed very sad and scared by what had happened. She discussed finding herself in restraints in the other hospital and her fear, bewilderment, and profound shame at being told of her behavior. She did say that she found it difficult to look at me because I bore a physical resemblance to "my perpetrator."

I asked if the situation of being in restraints reminded her of anything in the past. The patient answered, "Yes. When my perpetrator took me away when I was 11. He tied me to the bed, and put me in child pornography." I asked if the patient could tell me any more about this, adding, "You don't have to tell me all the detail or feelings of this event, just a brief overview." The patient looked anxiously at me as if unsure how to do this.

RJL: "Do you have any idea how to talk about scary or traumatic stuff without going into flashback?" The patient shook her head, "No," looking increasingly scared and sick.

I then asked the following: "Have you ever read a newspaper?" The patient assented. I continued (the patient nodding assent with each idea), "You know how there is the big, big headline on the first page, 'Peace Declared! Soldiers to Return Home,' something like that. Then, under that, there's a headline in somewhat smaller type, and then another one in a little smaller type, then finally the story. Then the story might continue onto page 12 and onto page 14 and so on and so on. All you need to talk about today is the first two levels of headline, maybe the third. You don't need to go into the details of the story and definitely not anything continued on the inside pages. Makes sense?"

The patient looked relieved. In a more detached way, she described how, when she was 11, she had fought the perpetrator to prevent being tied to the

bed, even escaping her bondage and trying to run away. She cursed him and threatened to kill him when he caught her. Eventually, she stopped fighting because of his violent rage and threats to do "worse" if she did not do as she was told. She wasn't sure but thought that she had been drugged during this episode. She added that she "knew" that he let her go home later, and that she had "bits and pieces" of what happened after being tied to the bed.

I responded, "I'd like everyone to listen, especially the ones who were threatening me and trying to attack me. We, the staff and I, seem to have walked into your flashback with you here in the hospital. In trying to help you we have recreated what some of you must feel is just like what happened before, including many elements of what has gone on here today. We really want to help you all to separate that time and place from here."

I gave my name and the name of the hospital and the date, asking for assent by nodding or saying "yes" out loud to indicate that I was heard. The patient nodded. I repeated the information and the request for assent. The patient nodded more intently.

RJL: "It's important to recognize that the one's who were threatening me were actually trying to protect all of you, but in a way that would only make things more difficult, and maybe even more traumatic in the present. They need to know that they are in a place where people want to help and don't want to hurt anyone or be hurt by you. This is not a hurting place."

Patient (in an angry voice): "Why are you punishing us then? Why are you grabbing us and tying us up and all that. It's not help. You just want to do punishment!!"

RJL: "I'd like all of you to listen, please. Psychiatry is a very primitive medical specialty. We have very limited ways of preventing people from hurting themselves or others if they are not in control. Maybe in a hundred years we'll have a little gizmo, like in Star Trek. We'll just go 'zap' and you'll stop being unsafe and we can talk about what's bothering you. But nowadays, all we can really do when you're an immediate danger is stuff that's almost certainly going to remind you of punishments and mean things that have happened to you before, like the stuff you were talking about a moment ago about what your relative did to you.

"For example, we get a bunch of people, including big men, to grab someone, hold them down, give them medicine in their butt, wrap them in a big blanket, carry them to a room, and either lock the door or tie them up to a bed. For someone who's had a lot of trauma, it's likely that in all that will be a reminder of something that's happened before. Even if not, it's likely that the person will feel traumatized more by all this. That's why we really try to avoid all this stuff. We want to work with you to find ways not to have you be in restraints and all that, but we can't do it without your helping! We're going to ask you to check things out, talk about what your concerns are, not act in such a way that to protect you, and all the other people here, all of whom also have backgrounds of trauma, we have to do things that are going to remind you of upsetting stuff from the past. We

would like all of you to be able to decide freely whether we are planning to behave in a mean or hurtful way with you, or just trying to do our best to help you recover from all that has happened to you before.''

Patient (in a deep voice): ''You look like him. How do we know you aren't trying to trick us? He always tricked us. He told us it would be 'OK.' It was safe. That he was sorry. He wouldn't do it anymore. We could trust him. Then, he just got us worse.'' She gazed away with a sick, sad look.

RJL: ''That's a really hard thing. It makes it hard to trust one's own judgment when that kind of thing happens, doesn't it? Makes it hard to trust anyone else inside who might get you into a terrible situation by trusting. It makes it hard to trust anyone who suggests that you trust him. It's all a big trigger.'' The patient nodded assent vigorously.

RJL: ''It's really a matter of risking, isn't it? Risking that we can all work together on solving some of these problems. You took a risk in talking to me so openly just now, even though you were very mistrustful. How did it go?''

Patient: ''I guess OK. You don't sound mean or nothing, but I still can't look at you, you look like him. I keep seeing him here.''

RJL: ''Sounds like your mind, by having his image stay so strong for you, is still trying to warn you about being tricked. Maybe there are parts inside who are still very concerned that no one gets co-opted too easily. I think they are really concerned for your safety and should be appreciated for being so caring and concerned.''

Patient in a different voice: ''But I hate them, some of them sound just like him, cursing, threatening all the time. They hurt me, cut me, and put things up me. I can't stand them. They won't let me talk about him. They just threaten me.''

RJL: ''How did they feel about what you told me about him and the child pornography?''

Patient: ''They didn't get too mad about that because you didn't make me get all into the details. It was a relief to say something about it.''

RJL: ''What would have bothered them about the details?''

Patient: ''That gets too much into the really big secrets that he told us he'd kill us for sure if we told, and kill my parents too.''

RJL: ''Again, it really sounds like they're trying to protect you from something they see as worse: threats to you and your family. I really think they care and want to help. It's just that their methods make it hard for many of you to see that. I think we can help all of you find ways to be protected from harm, but do it in ways that you are not harming yourselves or others. What do they think about what I'm saying?''

Patient: ''They say that you make sense, but they're really not sure about all of this. It's all so different from how it's been. They're confused.''

RJL: ''Confused is good about all this, thinking about stuff is good. You can begin to keep an open mind about things you've been so sure of for a long time. I know it's a lot of new stuff. How about if they agree to think seriously about what we've talked about and back off from the threats, if

we agree to not have anymore discussion about this right now, and just work on separating what happened before from what's going on here in the hospital?'' The patient nodded intently and her expression changed again.

Patient (in the voice that she first manifested): ''This is what I hate. How can I get better when they stop me from knowing about all the important stuff all the time? How am I going to remember? They can't control what I say or do!! I need my memories! I need to just get it all out of me, once and for all, so I don't have to live with this shit!!''

RJL: ''Well, how has it gone so far working on the memories by doing it the way you describe''?

Patient: ''Not so good. I wind up lost in my car so I can't get to my sessions. I hurt myself. I've been in restraints a lot in hospitals before....''

RJL: ''So, it's safe to say that it hasn't gone so well, right?''

Patient: ''I guess.''

RJL: ''Let me suggest a different approach, because if you try the same thing over and over and it just doesn't work, it might be time to try something different, don't you think?''

Patient: She nods assent with a sad smile. ''Yeah,'' she said, ''that's what I tell my students. I'm a special education teacher for learning disabled children.''

RJL: ''OK. I'd like everyone to listen. Everyone listening? When everyone is listening, nod your head 'yes.' '' Patient nods. I repeated this request and received the assent several times. ''Everyone listening? It's important that we have some good listening. Everyone, inside, outside, known or unknown, anywhere in creation, please listen now.

''First, it's important for all of you to understand that the purpose of working on memories is not to just 'get it all out.' If that were so, we'd have everyone on this unit lined up just getting it all out. I know it really feels like that's what has to happen, like it's just this big thing inside that just should burst, but it doesn't work like that. You have to get safe and know how to work together with your system of selves before you can work on the memories with all the details and all the feelings. Even then it's not just letting it all hang out. It's a long slow process that is designed to overwhelm you as little as possible. We can discuss it in depth at a later time. Right now, your situation reminds me of a bunch of folks on a big sailboat that's taking on water. No one knows where the life vests are, or how to put them on. Half the crew is below decks refusing to come out, and the other half is fighting with each other. Then someone says, 'Ooh there's a hurricane, let's sail into that!' Doesn't sound likely that the ship and the crew are going to do very well there, does it? Sometimes, even if you're not prepared, a hurricane hits, but that's different from deliberately sailing into one.

''The first thing is that everyone needs to work on working together, getting safe from harm to yourselves and others. I really believe, from everything you've all said, that you've all been hurt enough. You don't need

any more harm coming to any of you or your body. You don't have to like everyone, love everyone, or even trust everyone inside. It's just a matter of seeing how you can begin to risk to work together.''

The patient began to look very tired and weary. I continued, ''You look pretty tired, we've done a lot of work and you're still in restraints.''

Patient: The patient nodded ruefully. ''When can I get out of these?'' she asked.

RJL: ''When you've really processed with the staff: how everyone is going to maintain safety here, that everyone has worked on understanding that this is a helping place, not a hurting place. If you're not sure, you wait before you go off and check out what's really going on, ask why people are doing what they are doing, OK?''

Patient: Nods assent. ''Everybody agree to that?'' She nods assent more vigorously.

RJL: ''I'd like to teach all of you something to help keep things here more separate from before. Do you know what a split screen is?''

Patient: ''Not really.''

RJL: ''Like on television. Daffy Duck is doing something on one side of the screen and Bugs Bunny is doing something on the other. There's a line down the middle separating them. You could put me on one side and your relative on the other and compare and contrast the two of us.'' The patient looked puzzled.

''Another way is to think of one of those big life-size cutouts of Ronald Reagan, George Bush, and Bill Clinton. You superimpose one on me. Then, we move it over across the room, over into that chair over there, and you check out the similarities and differences between us.'' Again the patient looked confused.

RJL: ''Another way is the 'Highlights for Children' way.''

Patient: The patient looked oddly younger. In a pleased childish voice, she said, ''I know about Highlights for Children!!''

RJL: ''OK, you know they have that section where you compare two pictures. You know, one house has two chimneys and the other has one; one has a square window and the other has a rectangular window....''

''I get it,'' said the patient in her first voice, looking relieved. ''You have different eyes. Your eyes are a different color, and you have a lot more grey hair....''

RJL: ''Thanks a lot!''

The patient laughed. ''And your eyes are nice, not mean like his.'' She shivered. ''He has these cold, dead eyes.'' She settled back, looking calmer.

RJL: ''OK, so we have a plan. You guys are going to work on separating the hospital and me from the perpetrator and the place where he took you. You're going to work on getting to know the staff here as people in 2005, not back when you were a kid. If everyone can agree not to do anything to hurt themselves or anyone else and really mean it, and agree to get help from staff before you do anything to harm anyone, you'll be able to

get out of restraints. Does everyone really hear me, especially those who were violent when we first met? I hope you guys really think about this too, because I don't think you need any more time in your life being tied up, even if it's to protect you now." The patient nodded vigorous assent.

I added: "I'm going to ask the one's who were threatening violence before to be more aware, closer by, observing what goes on here, so you can decide if we can be counted on to do as we say, within the limits of our being fallible humans working with 19 other patients in the hospital. If you have concerns or questions, I'm going to ask you to raise them by talking with me or the staff, not by action." As I said this, the patient's expression began to subtly change, looking more like the face of the patient before she lost control. She maintained control, however, and nodded assent thoughtfully.

Before leaving, I asked "those who were just 'up close' now, I'd like you to 'step back' now, on the count of three, to allow the one who was here at the beginning to be fully forward. One, two, three." The patient's expression changed back to the sad perplexed one I had encountered originally. She stated that she felt "tired out, but calmer. I don't really know why."

I asked Ms. A what she remembered of the discussion that we had had. She said that she remembered very little of it. She asked me to tell her what had been said by the "others". Instead, I suggested that she ask her "mind", or the "others" inside, to tell her what they felt she was able to know of the conversation with me. I pointed out that I could tell her, but if I did so, she wouldn't learn anything new about communicating with her "parts". If she relied on "outside people" to keep her informed, then, when she was alone, she would have no ability to find out things within her. In addition, the "others" might have a better sense than I of what she could tolerate knowing. I asked the others if they were comfortable with what I proposed. The patient nodded in a trance-like way. Then, I asked Ms. A to "listen inwardly" and to tell me what she learned.

She said, "They said, they had had a talk with you that they were going to think about a lot. They had heard about a lot of new ideas. They think we might learn some things here. That's all." I told her we would stop for now, but that I would see her the next day.

I concluded the interview and left the room. I talked with the staff about a plan to help the patient get out of restraints. The staff was to work on helping the patient maintain orientation in the present and to continue to separate past and present about feeling imprisoned by her relative, and other matters as they came up.

The patient rapidly came out of restraints and did not require them again during a month-long hospitalization. In therapy, the alter personality system was directly engaged to work on becoming more aware of a variety of reminders that precipitated flashbacks, switching, loss of current reality orientation, and urges to behave violently. She was helped to make connections to many aspects of her experience that served as subtle traumatic triggers and reminders of her reported abuse. For example, she became more

and more panicky as the day went on, usually feeling overwhelmed, asking for multiple extra medications, starting around 4 PM. When simply asked what occurred to her about this time of day, related to her earlier life experience, she recalled that, as a child, 4 PM was approximately the time that she would go after school to her abusive relative's house for "child care" while her parents worked. She was frequently left there alone with this man. She reported that this was when much of the early abuse with him occurred.

As the hospitalization progressed, she worked on strategies for real-world self-protection in her current life from her relative, who was said to be involved currently in a variety of criminal activities. She was also able to express anger at her family for having failed to protect her as a child and for rationalizing visible evidence that she was being hurt. Work was done with the patient and her husband to help him have a better appreciation of the patient's reaction to seeing the relative and to help him take more seriously her fear and distress about this.

Discussion

Reframing and the therapeutic alliance

Throughout my meeting with Ms. A, I continually reframe symptoms as psychologically explicable responses to her situation, especially those that she experiences as distressing and devastating. The alters, especially those who seem the most alien to the "everyday" self-states, must be understood as embodiments of the patient's survival, not evil or alien beings. To do otherwise serves to buttress rather than to moderate the delusional separateness so common in DID patients [5,6]. Similes and metaphor are helpful in making this comprehensible to the patient, using the DID patient's highly developed capacity for abstraction and self-observation (see the article by Brand et al elsewhere in this issue) [7,8].

For example, the patient can be asked: "If you were in the Underground in Nazi Germany, and someone asked for your identification, would you say, 'Oh, yeah. I'm in the Underground?' No. You'd act like the most convincing Nazi you could. That may help explain why [so and so, the persecutory alter] doesn't just acknowledge what he's actually all about when I suggest that he's really trying to help and protect with all his strength. He doesn't believe or doesn't trust that he's free of the Nazis now, or that I'm not just the cleverest Nazi he's met yet."

As I explain to patients, DID is a very logical disorder. The trick, however, is to understand the underlying logic. Patients find this process both relieving and disconcerting. They say things like, "This makes a lot of things in my life make sense for once. But I don't like any of this at all."

In addition, I begin working on the therapeutic alliance in the first interactions with the patient. Work on reframing, communication, and cooperation among the alters can be understood as development of a kind of

internal therapeutic alliance among the self-states to work toward recovery by becoming more tolerant, collaborative, and decent toward one another. Kluft [5,6,9] in particular has cited the development of the therapeutic alliance as one of the most crucial elements in successful DID therapy.

As described by most experienced DID therapists, I am very active with the patient, talking a lot, anticipating problems, suggesting solutions, and changing directions when new issues come up. I have very specific ideas about the basic issues that will be encountered in therapy: safety concerns, the need for improved internal communication and collaboration, separation of past and present, reframing, therapeutic alliance, responsibility for behavior, among many others. This does not preclude my listening with great care, however, and responding thoughtfully to what the patient presents.

Unconscious flashbacks

Putnam [1], among others, has discussed the seemingly uncanny way in which DID patients unconsciously recreate personally specific traumatic scenarios in their contemporary life, including the involvement of others in complementary roles in these situations. Blank [10] has described this as an "unconscious flashback" in which

> manifest psychic content is only indirectly related to [traumatic experiences].... The individual's state of consciousness, outwardly observed may or may not be altered. Memories, affects and impulses...come forth...without conscious visual or other registration. The subject...[carries] out complex integrated actions based on past experiences that are not consciously remembered, with no awareness that he is repeating anything.... As in post-hypnotic suggestion, the subject invents rationalizations for his or her behavior.

In discussing this phenomenon, in 1993 [11] I stated

> It is less commonly realized, however, that unconscious flashback experiences permeate the life of the multiple personality disorder patient and are frequently omnipresent in the therapy. In addition, projective identifications in the dissociative transference field may give rise to an uncanny phenomenon in which the patient and therapist appear to have "walked into the flashback together" as one of my patients described it.

Another window into the pervasiveness of complex, often multilayered, posttraumatic responding in DID is found in research on the psychologic structure of DID patients using psychologic assessment (see the article by Brand et al elsewhere in this issue) [7,8]. For example, the researchers had to develop a "traumatic content' score on the Rorschach, because repeated traumatic intrusions into projective testing were ubiquitous in DID, including going into full flashback with the Rorschach card as a stimulus.

Inquiry about whether the situation reminds the patient of something from the past is a surprisingly simple way to find out about posttraumatic

responding. At least a basic narrative of the material may be readily available to the patient's consciousness. Alternatively, a more specific question can be asked, such as "Is there anything significant (distressing, upsetting, traumatic—potentially more suggestive terms) that comes to mind about that 4 PM time, or late afternoon, that seems to be associated with getting so upset every day?" It may help to give a classical free association suggestion: "Tell me whatever goes through your mind, even if it seems silly or irrelevant. Just reflect inwardly, let your mind open up to your inner experience, and share with me whatever you may think, see, hear…." To be sure, cautions about the complexities of memory and its reliability should inform inquiries of this nature [4,6,9].

Talking over

I repeatedly use the technique of "talking over" [1] to communicate with alters without inducing a frank switch. This approach skims the dissociative surface [12], mobilizing the copresence of alters, frequently experienced as passive influence symptoms by the patient. As described by Kluft [6], Putnam [1], and Ross [2], I assume that alters need to be prompted to listen, often repeatedly, and that many alters experience themselves as disoriented to current circumstances, requiring concrete reorientation. Ideomotor signaling [13], asking the patient to assent nonverbally, can be quite helpful when using talking-over interventions. To be sure, the clinician must use other forms of data (verbal, behavioral, and so forth) to decide how to understand these ideomotor responses, just as one does with any communication by the patient.

With Ms. A, I targeted the violent and persecutory alters immediately and began to reframe their behavior and to attempt more of an alliance with them. In a patient who is not in an acute safety crisis, where these alters may be more hidden, I usually go more slowly, allowing the material develop with less active prompting by me. Nonetheless, one of my first tasks is to identify, access, and talk to the seemingly persecutory, self-harming, violent, dangerous, shaming, so-called "bad" alters. It is essential for the patient's stabilization to communicate with these self-states and to begin to understand their crucial helping function [1,2,6]. In addition, this kind of intervention is a kind of provocative test to begin to see how responsive the patient is likely to be to reframing interventions and attempts to engage the alter system to form an alliance with me and among its members. This allows me to begin to form initial hypotheses concerning the difficulties that may be encountered in the therapy, especially the depth of entrenched internal conflicts and the tenaciousness with which the patient holds onto his or her multiple realities [9,12]. Asking if there are any objections to a particular new strategy is especially important because these can be immediately addressed in direct or indirect conversation with an alter or group of alters. Often, objections are not volunteered and remain hidden. Accordingly, they

are much easier to work with if they are anticipated and inquired about, rather than waiting for sabotage of a healthier new strategy (and another crisis) to announce the presence of the objection.

Posttraumatic intrusions

The therapist needs to be active in detecting early signs that the patient is becoming overwhelmed by intrusive posttraumatic stress disorder symptoms. Here, the therapist must actively intervene to back off intrusive material and help the patient begin to develop strategies to distance or attenuate its impact. Ms. A's history and current dyscontrol indicated that she had limited skills to manage DID, let alone discussion of the trauma history. At the same time, however, in many situations in which the patient is overwhelmed by intense, inexplicable reactions, it can help the patient make sense of the experience to allow a brief, cognitive, distanced report of aspects of the event to connect the past trauma with current response [14]. Here one is attempting to help the patient separate past from present by understanding something specific about the traumatic memories that are affecting responses to current circumstances. This is in contrast to stage two therapy, where the goal is to bring the past into the present in an affectively intense and cognitively detailed way.

For example, another patient was packing to move to a new apartment. She became panicky, shaky, and kept having an intrusive thought that this activity was "dangerous." Suddenly it occurred to her that, as a child, packing was usually associated with vacation travel to visit relatives in another city where, over many years, she reported being molested by a family friend. She also recalled that by the age of 6, her family put her alone on the Greyhound bus, with her little suitcase that she learned to pack, to travel by herself for hundreds of miles to visit these relatives. Despite the distress at the recollections, she reported being, "Happy. Well, not really happy," at this recollection because it allowed her to understand why she had always panicked at the idea of moving. She had felt, "stupid, crazy, wacko," and deeply ashamed about this. Retrieval of the cognitive component of the memories reduced her sense of shame and ineffectiveness because of her inability, until now, to "make it go away" by repeatedly berating herself for having "these stupid feelings." The recollection made explicable her intense, seemingly perplexing emotional response. In turn, this allowed her to be more able to pack "in the present" without feeling endangered by doing so.

This process can sometimes be explained to the patient as an emotional flashback in which the affective component of the dissociated trauma memory [15] returns without the sensory or cognitive components. This term can also describe a pervasive emotional response to a current situation that fits the current situation, but is much more intense and compelling than can be understood by the current situation alone. This is illustrated in the next case study.

Imagery

With Ms. A, I began to use a distancing image very quickly when she showed signs that she was having an increase in posttraumatic stress disorder reactivity. The newspaper image seems to be one that most patients grasp readily. This kind of imagery, and the patient's ready acceptance of it, mobilizes the often-described high hypnotizability and dissociativity of the DID patient without formal induction of hypnosis [16,17]. These interventions can be immediately reassuring to the patient that there are tools to help reduce highly distressing symptoms that seemed without anodyne in the past.

It is important to tailor the imagery to the patient and to the clinical situation. Alternatives to the newspaper may include a more typical screen image as described by Putnam [1] with a mental remote control to modify the screen. As an initial quick intervention, I tend to use the newspaper image, and introduce the screen image later to help the patient work more systematically on containment of posttraumatic stress disorder intrusions. Some patients, however, especially those with a reported history of being in child or adult pornography, may have trouble using a movie or television screen image. A computer screen may be a useful substitute (with file folders to close, and so forth). Kluft (in Hammond [13]) has described the library image with a book that prints the painful material onto a blank page, only showing the patient as much as he or she can tolerate knowing at a given time.

These interventions may be crucial in giving the patient a sense of control over trauma material. A successful distancing intervention may be the first experience the patient has had that traumatic memories can be managed safely in a clinical context.

With Ms. A, I also introduced the idea of being in the flashback together and needing to separate past from present. Subsequently, I worked on the issue of free choice: the patient being able to decide freely that we want to help her, but she needs to separate from the past to do so. I often point out to patients that being in a flashback, conscious or unconscious, robs them of their freedom to choose responses to a given person or situation. I sometimes add, "You are free to judge that I am a jerk or a mean person, but please separate me from that person who lives rent-free in your head first. At least decide that I am a bozo on my own merits." For many DID patients, like Ms. A, the notion of trusting is associated with being repeatedly betrayed. I tell them that I have no intention of harming them or exploiting them, but that they must judge for themselves over time that I live up to that pledge.

As Ross [2] and others have described, I frequently ask the most suspicious alters to watch carefully and to speak up if they have any questions or concerns about what is transpiring. Further, I immediately start working on reframing the intent of the angry, violent, persecutory alters as attempts

to help and protect, although being careful not to validate their means (usually self-harm, internal emotional abuse, and so forth), and to support those alters who feel harmed as having a legitimate complaint.

Further, I introduced to Ms. A the idea that the alters may mistrust one another, not just outside people. In particular, this is a common occurrence when the patient reports that he or she has been prevailed on to trust abusive individuals, only to have this trust shattered. This may be especially difficult for the patient who reports that the abuser apologized, asked the patient to trust him repeatedly, then violated the trust. This may also occur under other circumstances (eg, believing a mother who promises repeatedly to leave an abusive spouse, but never does so). The intense shame, demoralization, and despair at giving trust and being betrayed repeatedly can lead to difficulty in trusting one's own judgment about many important life issues. In DID, this is often manifested as an internal war among the alters, sometimes resulting in complete paralysis and global withdrawal.

The idea of the patient taking a risk to work on issues is a helpful one that may better connect with the patient's experience of hopelessness about anything being helpful and fear that connections with others can only lead to disaster. The intense shame at being repeatedly tricked ("like Charlie Brown with Lucy holding the football," as one patient reported) may result in a person who completely doubts his or her own judgment about whether to trust again (she added, "and, she was Charlie Brown's psychiatrist!") Some sadistic abusers are reported deliberately to inspire trust in the victim to take pleasure in the repeated betrayal: "He only wanted to see the look in my eyes when he betrayed me one more time."

Similarly, in some DID patients, a motivation for repeated "snatching defeat from the jaws of victory" results from a belief that any confidence in the continuation of something good inevitably will be unpredictably shattered when the good thing is discovered and taken away or destroyed by the abuser. Accordingly, to control what is thought to be the inevitable outcome, the patient (in an alternate personality) sabotages himself or herself whenever the possibility arises of success, better relationships, improvement in treatment, and so forth. This may be a tenacious dynamic to overcome, because overcoming it results in the patient tolerating the anxiety associated with the idea of getting better, increasing the fear of having the "good" taken away again. In this situation, any adversity or obstacle, traumatizing or quotidian, can be seen by the patient as proof that this cognitive distortion is the truth.

Safety

Finally, I set clear limits about demonstrating safety before coming out of restraints. I made clear that there are expectations about the patient's maintenance of safety and, most importantly, honesty about difficulty managing safety. I also insisted that the patient is not given a free pass on issues of

personal responsibility (eg, getting out of restraints). Ms A had to demonstrate that she had made concrete efforts to change before a behavioral contingency would be modified.

I gave homework about this to work on separating past from present, dealing with fear by talking not acting, and working on specific goals for increased safety. I also discussed with the unit nursing staff the clinical situation, the safety issues, and what the patient needed to do to come out of restraints. In inpatient settings, particularly when a patient has been unsafe, it is vital that the treating clinician involve the nursing staff in understanding the treatment plan. If we are to ask the DID patient to communicate and collaborate effectively among the members of the inner team, we cannot ask less of the outside clinical team.

Case history 2

Ms. B is a woman in her early 40's who sought treatment with me for DID, posttraumatic stress disorder, depressive symptoms, recurrent self-mutilation, and repeated self-destructive behaviors in which she would, with great creativity, undermine any business enterprise that she started, once it became successful. Because she was a talented businesswoman with a gift for inspiring others, she created and then demolished a number of successful enterprises. This resulted in a kind of recurrent Phoenix-like pattern to her life. She began treatment with trepidation, having seen me in consultation some years before. At that time I had confirmed the diagnosis of DID. The patient spent the consultation switching continuously, however, returning to the bewildered, amnestic host alter self-state at the end of the consultation session. She fled from the office insisting that I was "crazy" for confirming her treating psychiatrist's tentative DID diagnosis.

Before the DID diagnosis being suspected, Ms. B had spent years in unproductive psychiatric treatment for refractory affective symptoms, requiring hospitalization after lethal suicide attempts on several occasions. Even after the DID diagnosis, she had seen several therapists over the years with little progress. When she contacted me again for treatment, she had begun a new business venture that was prospering. She had also hired her daughter and son-in-law, however, both of whom had major substance abuse problems. They had looted one of her last businesses, ultimately writing a variety of bad checks on her accounts. Despite costly legal problems that resulted from this fiasco, she believed she could not refuse her daughter employment. She blamed herself for the daughter's troubles, relating them to her deficiencies as a parent because of her psychiatric problems and tumultuous life history.

Ms. B grew up in a slum neighborhood in a large Midwestern city. Her memory for her early life was limited. She knew more about it than she remembered. Her mother had died before she was 2 years old. Her father was

unknown. Her uncle and aunt had adopted her. The uncle was reported to be a violent, cruel alcoholic. The aunt, a compulsively religious woman, was reported to have heard voices, believed that God spoke to her through the television, and that the neighbors could be heard talking about her through the walls. Ms. B had flashes of a memory, when she was 6 years old, of a violent fight with her uncle destroying the furniture, grabbing her, and taking her into the bedroom while her aunt screamed at both of them. She knew that during her childhood she was seen in the emergency department of the "charity" hospital in her home city for broken bones, vaginal bleeding, and infections. She knew also that she had been removed from her adoptive family's custody when she was 6, but had no recall of how or why she was returned to them when she was 8. She gave birth to her daughter at 15 and was married to a violent alcoholic by 16. She gave birth to a son when she was 17. Despite all this, she had excelled at school, finding it an island of peace. Several teachers recognized her intelligence, befriended her, and supported her intellectual endeavors, even after she was forced to leave school when she became pregnant at 14.

The uncle and aunt both died when she was 18. She divorced her husband and began to make her way in the world. While working several jobs, she obtained a high school equivalency degree, attended college, and eventually attained a master's degree in philosophy. She married again and moved with her husband to the Baltimore area. Divorced from him, she obtained better and better jobs. Eventually, she was able to move her family to a prosperous, suburban neighborhood and began her career as a businesswoman.

Ms. B's symptoms on initial evaluation included recurrent, dense, dissociative amnesia resulting in a variety of problems. These included buying clothing and other items that she could not afford; driving long distances and finding herself in other cities and states without recall for her journey; and finding herself cut and bleeding from cuts to her arms, legs, and genitals. Also without recall, she found that she had made a variety of brilliant business decisions, held successful meetings with customers, and introduced several new computer innovations to her company.

She heard voices in her head, arguing, berating her, and threatening her. Some voices spoke calmly and soothingly to her. Other voices sounded like those of her uncle and aunt, respectively. The uncle voice cursed her and called her a "whore," a "slut," and a "stupid cunt." The aunt voice spoke in religious homilies. Ms. B was filled with shame at her belief that she had utterly failed to live up to these latter directives.

In the second session with me, Ms. B sat nervously discussing her recent history. She had found herself in Washington, DC, the night before, about 50 miles from her home. She had lost a number of hours for which she had no recall. As she discussed this, she began to complain of a headache, looked stricken, fell silent, then looked away. When she looked up again, she spoke in a soft voice with a slight British lilt. She introduced herself as "Mrs. J," her former married name.

Mrs. J: ''Oh, she is so confused and getting more depressed, the poor child. She doesn't know what has gone on. I have to tell you, Doctor, that the driving is the least of the problems; she has been cut again, on her arm. Not that she needs stitches, this time, I can assure you. She's too ashamed of it to tell you herself. I think she's getting dangerous again, like those other times when she was in the ICU. That's really why I called to make the first appointment.''

She told me that she knew a number or alter self-states, but could do little to control them. She described several child self-states, a caretaker for them, a worker who ''built up these businesses for her, but has no social finesse,'' a driver who was said to be responsible for the long-distance travel, and several others. When asked about internal aunts and uncles, because of the voices that seemed to embody their traits, at least as Ms. B had described them, Mrs. J smiled and said, ''Nobody talks to them, they're so mean. They never come out.''

In a sad voice, she told me that she could not give me any information about who was responsible for the self-injury or the prior suicide attempts. ''B is the most suicidal one right now, that I can tell you,'' she said. She refused to show me her arm because ''they'' felt this was a private matter. When I stated that I would need to talk with ''them'' immediately to work on safety, Mrs. J replied, ''They won't talk to you. I assure you of that. I don't know why they insist on things being unpleasant. It's all so unnecessary.''

RJL: ''I'd like all of you to listen. Your safety is very important. I want to be your doctor and help you. I want the opportunity to listen to all of you and hear what you have to say. But, as long as there's an immediate threat to your safety, that's all we can focus on right now. I need to speak directly to the ones who have hurt your arm.'' This was followed by silence.

Ms. J: ''I'm sorry for their rudeness, but, they're just not going to speak with you.''

RJL: ''I'd like everybody to listen, Let me explain your problem to you. In order for you to not be hospitalized immediately, I need to know, in words that a simple-minded psychiatrist can understand, who is harming the body and who, in addition to B, intends to suicide, what is going on that led up to these events, and a plan for your safety from any sort of injury or death, at least until our next face-to-face meeting.'' Again there was silence.

RJL: ''I really want to talk this out with all of you to find a solution. You all came here today to see me, suggesting that, overall, there is a wish to get help. If you are silent, I can only assume that, deep down, you really feel you can't manage safety as an outpatient and that I'm going to need to hospitalize you today.''

Ms. B again seemed to look dazed for a moment, then shifted in her chair, her expression intent and angry. In a tough, deep voice, with a Midwestern accent, she said: ''I ain't going back in no damn hospital, I have

a damn business to run. Maybe she needs that shit. But I don't. She's so damn wimpy and candy ass. *She* needs a psychiatrist. You help her. I don't need any help. Besides, I have to be on the lookout that her damn junkie daughter doesn't steal the carpets off the floor. I've already locked up the checkbooks, pass protected the business accounts on the computer, and made it really hard for that little thief to start up again. And that J woman? All she knows is 'shop till you drop.' You don't know what I've had to do to keep up with her damn credit card bills!'' This alter was named ''TCB.'' She described herself as ''the businesswoman.'' TCB acknowledged that J, despite her spending, was good at business meetings, talking with clients, and handling employees. ''I hate that shit. Just let me be with the computers and a spread-sheet and I'm happy!''

RJL: ''I really appreciate what you're saying. It sounds like you're working hard and trying to help everybody by working and protecting the finances. I would like to work with you as your psychiatrist. I prefer outpatient treatment for you too. But, if you're severely injured or dead, you won't be able to work either.''

Ms. B: ''*Her* psychiatrist. I don't need a damn psychiatrist. But they're a whole bunch of depressed and upset people in there. They really need a shrink too. Or, you can just get rid of them. That would be the best solution. Then I could do my work in peace. But, I'll tell you what, that dead thing. I don't like that. But, the other, makes the trains run on time, honey. They're wailing and carrying on in there, and this stuff just quiets right down when they get to sawing on each other. They go to sleep.''

RJL: ''You don't seem to think that the injury to the body affects you, although you do believe that if she suicides you'll die.''

TCB: ''Quit getting me all confused! A little sawing never really hurt nobody if things get quiet. It's just a means to an end. Calms everything down. Of course, there is all the blood and shit. I don't do no cleaning, though. That Aunty creature screaming all that 'cleanliness is next to Godliness' shit. Jesus H. Christ. Then B who don't know nothing about nothing feels so screwed up about it, she cleans it all up so no one will see it. It's a mess.''

RJL: ''What do you know about how it happens, the ''sawing,'' as you put it.''

TCB: ''I don't pay much attention to all that. I know that there's about five of them that do it, for different reasons.''

RJL: ''Who did it last night''?

TCB: ''I think it's time for me to leave.'' Despite my attempts to get her to continue, calling her name, saying how important it was for us to continue to talk, the patient switched back to Ms. B. She was panicky, looking all around her. She said, ''What did I do? Did I do something wrong? Am I in trouble''?

RJL: ''Some of the others were here. No one has done anything wrong. You're not in any trouble. What's most important, though, they indicated that you're thinking a lot about being dead.''

Ms. B, breaking down into tears: "I can't stand this! I've been losing more and more time! I was in Washington, DC, last night and I don't know how I got there. I was in some terrible neighborhood and thought I was going to get killed. My daughter is starting to ask me for money again, and I have to give it to her, even though my head tells me it's just going to be a big mess again if I do. I wake up and find that I've been hurt and I don't know how it's happened. I just feel so tired and lost all the time. I don't want to go on like this, I just want to sleep."

RJL: "That tired and lost feeling, waking up finding yourself hurt, finding yourself in strange places, wanting to sleep, does this bring anything to mind, remind you of anything in the past?"

Ms. B, looking surprised: "It's like my whole life. When I was a kid, that's what would happen. I'd wake up and I'd be hurt or I'd be in that horrible hospital hurt. I just wanted to have some peace, get away from it all."

RJL: "Did you want to die as a kid"?

Ms B: "How did you know that? I've never told anyone that. I used to pray that I'd be taken to heaven." When asked if she attempted suicide as a child, Ms. B again seemed surprised. Ms. B: "I never told anyone. When I was 8, I took the pills in the medicine cabinet. I just slept for a day and when I woke up again, my aunt shouted, 'Idle hands make work for the devil!' and made me clean the whole house. I tried to get hit by the cars in the street, but I'd always find myself on the other curb and not know how I got there safely."

RJL: "Do you know what an emotional flashback is?" Ms. B shook her head in puzzlement. "You know what a regular flashback is, right? It's an intense reliving of something, usually with the sensations related to the event, with emotions from that event, seeing it, hearing it, feeling it, like you are in it again, pretty much. An emotional flashback is an intense emotion that belongs to a time long ago, but without the sensory or narrative part. For example, the kinds of thing you're going through now, the time loss, finding yourself hurt, you describe as very similar to what you went through as a kid. It results in the same feelings of loneliness, helplessness, hopelessness, not wanting to live. It's as if you're going through the sequences simultaneously in both the present and in the past.

"It's kind of a double whammy, like something is piggy-backing or supercharging your emotions in the present situation leading to more intensity than would be evoked by just the current circumstances. What helps is to begin to work on recognizing it, by working on separating the emotions from the past from those of the present, looking at what goes with what. It can be quite a challenge if the situations are reminiscent of each other and evoke very similar emotions, but the strongest cases are often the most helpful in the long run. For example, you can begin to get perspective if you think about getting some distance on all this. You can imagine that you are up in an airplane or on a mountaintop, looking down at the landscape. Things that seemed so large and overwhelming before, now become small. You

can see the relationships between things more easily, that previously were obscured when you are on the ground.

''For example, even though you feel overwhelmed now, among the differences are that you are a grown up person now with resources and supports that you didn't have as a kid to get help. You have your own friends, house, business, shrink, and so on. When you're real little, you have to depend on your family for everything. Early on, you couldn't read, write, get food for yourself, cross the street by yourself, let alone pack up and move out. You depended on your family for your whole reality.

''I'd like to work on all this with you. There's a lot of new stuff to think about. I can't work with you on this, however, unless you stay alive. I'm going to ask you if you'll agree not to hurt yourself or kill yourself, or anyone else inside or outside, accidentally or on purpose, at least until we see each other next. In addition, before you hurt yourself or kill yourself, and so on, you will call me, have me paged, and wait for me to call you back before doing any harm to yourself or others, inside or outside. If you can't wait for my call back, you'd go to the emergency room. If you can commit to this, I would like to see you tomorrow. I can fit you in at the end of my day.'' (This safety agreement structure is based on that described by Braun [1,18].)

Ms. B looked relieved. She said that she agreed. I helped her to repeat the words of the safety promise. I continued: ''B, I really need to make sure that when you promise something like this, you really mean it. If you asked me to do something important as part of your treatment, and I agreed that it was clinically appropriate, and made a commitment to do it, and turned around the next day and did the opposite, how would you feel''?

Ms. B: ''Angry. Betrayed. Hurt.''

RJL: ''Right. Well, trust is a two-way street. You guys have huge issues with trust, and I absolutely don't expect that any of you trust me now, or any time soon, actually. When you make a commitment to me, however, I have to have confidence that you're being honest with me, most especially about issues of safety. That is, if you really can't be safe, that you let me know that.

Ms. B: ''I understand. I don't break my word. I can last another day. I've survived this long. If I get in trouble, I'll call you. I don't want to have to go back to the hospital again.

RJL: ''Everybody listen, please. We still have to resolve the problem of the ones who cut and to see whether anyone else is planning to kill themselves. It is 1:20 now. Our session is over at 1:50. If I haven't gotten a safety commitment from the rest of you by 1:30, I'm making arrangements for you to go to the hospital, either voluntarily or by 911. You have 10 minutes.''

Ms. B switched suddenly. In an angry voice, she said: ''I'll be *fine*!'' This alter refused to identify herself by name.

RJL: ''Listen, everybody, just saying that is not going to work. I need to know very specifically how we are going to set things up so that everybody is

safe from harm to themselves or others, at least until our next meeting, which is scheduled tomorrow.''

Ms. B, tearfully: ''I don't know what you want. All I know is that I get peace when I do that. What's wrong with that? Nothing else stops it. I can sleep then.''

RJL: ''The problem is that hurting yourself is a short-term solution to a long-term problem. It's like an alcoholic who drinks to solve problems. He drinks a quart of scotch, numbs out his problems, and passes out. In the morning, however, all his problems are all still right there. Plus, he feels sick and ashamed that he's gotten drunk again. Because a lot of what people commonly want to numb themselves from is shame, you wind up with more of the problem you were starting out to solve. If this was a medicine that I prescribed for you, you'd sue me.''

Ms. B: ''But it's the only thing I know how to do to stop all this chaos inside. Why should I give up the one thing that helps. All those pills and junk you guys give me never helped like this.''

RJL: ''When an alcoholic or any other kind of addict hits bottom and decides to quit their drug of choice, you can predict one thing. They're going to feel worse. First, there's whatever withdrawal they're going to go through. Then, they have no coping skills other than drinking to handle problems. They have to learn new skills, even though they're feeling terrible. That can take a long time. In the long run, building new problem-solving skills that affirm life and safety feels much better than those old addictive short-term ways.''

Ms. B: ''I don't know what the big deal is. I didn't even get stitches this time. Why are you making such a big deal out of it. I even stopped her from taking all the pills this time by putting us to sleep.''

RJL: ''Consider this: if you're walking down the street and someone knocks you down and grabs your purse, you've been mugged. If someone knocks you down, steals your purse, and beats you up, you've been mugged. I agree that in the second case you've been harmed physically more, but in either situation, you've been hurt and traumatized, and who's to say which will be worse psychologically in the long term. Thinking that being unsafe to make yourself safe comes from living with trauma all the time. You don't get the sense that getting hurt is optional; you just want to control the timing and intensity as best as you can.''

Ms. B: ''That's exactly right. How did you know that? Oh, all right, they're telling me that you've got a good point.''

RJL: ''Also, you're setting up what I gather is a familiar situation: someone is hurting someone else all the time and no one can do anything about it. You're asking me to be a bystander who knows that someone is being hurt and doesn't do anything about it. I think these are old roles and scripts you guys are playing out, and I won't be a part of it. If you really can't work on safety, at least from session to session, or agree to go into the hospital, then I don't think that I'm the right doctor for you right now. Maybe you aren't

ready for the kind of therapy that requires an honest commitment to safety.''

Ms. B: ''OK. I'll try.''

RJL: ''Trying really isn't enough. If a drunk ''tries'' to get sober, it just means he's bargaining about when he's going to drink again. Like my colleague, Richard Kluft, says, 'Saying ''you'll try'' means that you're planning to fail, but you want to be approved of for your efforts.' There's only one way to get sober and that's to stop completely. For example, in A.A. you don't just quit and that's it. One gets a sponsor, goes to meetings. They're not asking one to stop so much as to delay acting while one does the alternative plan. I really believe that you can delay hurting yourself. You've sat here for almost 30 minutes and you haven't hurt yourself, right? What we're talking about here is all the unsafe parts delaying acting, at least until you all see me tomorrow at 6:00 PM.

Ms. B: ''What do I do about all these scared kids? They don't know about all these big words you're spouting. I can make an agreement like that for now, but they're out of control.''

RJL: ''Has anyone taught you guys how to find a safe place, or a safe place for them?''

Ms. B: ''No. What's that?''

I proceeded to discuss how each self-state could find a safe place, by imagining a place that could encompass all of them, or a unique place for each one; a place that the alter had been to, never been to, read about, heard about, always wanted to go to, was just thinking about it right now. Even a ''no place place,'' if places were not OK. Then, once this was imagined, entering into the safe place and absorbing themselves in everything about it: temperature, light, colors, time of day, time of year, and bringing with them whatever they need to make that place personally right just for them. Then letting a protective shield or barrier come down around them. A shield with a special quality: it immediately transports out all that is difficult, troublesome, worrisome, and so forth, and allows all that is safe, peaceful, quiet, serene, and so forth to enter into it. I discussed how only those alters who wanted to participate would do so. The rest could watch and listen to make sure that nothing untoward was occurring (Richard P. Kluft, MD, personal communication, 1988).

Ms. B entered a trance-like state while I discussed this. She indicated when asked that many self-states wished to participate. I repeated the imagery suggestions. Ms. B visibly relaxed. When asked how things were inside, she said: ''Peaceful, quiet.'' I asked if any wished to sleep in their safe places, with no need to awaken at least until a few minutes into our next session tomorrow. Ms. B nodded yes.

I said that first they could do whatever they needed to do to get ready for sleep, brush their teeth, find their stuffed animals, get a drink of water. Then they could settle down into their sleeping places, their eyes closing as they drifted down into a deep, safe, healing sleep, without any dreams or images,

not to awaken at least until a few minutes into our next session, sitting down for therapy.

RJL: ''Are they OK?'' She nodded yes. I suggested that she could open her eyes gradually, letting the others go even deeper into sleep as she gradually came back to her usual state of awareness, keeping the relaxed, peaceful feeling with her.

Ms. B, opening her eyes, looking more relaxed for the first time that day: ''That's much better. How did you do that?''

RJL: ''I didn't do that, you did. I just helped you use a talent for imagery that you didn't know you had. In our next sessions, we're going to have some discussions about your gift for imagery and trance, and how you can learn about this to help you in therapy For now, we still have to make sure everyone agrees to be safe before we can conclude for today. What about it?''

Ms. B: ''They say they will never make any kind of agreement with a man, but that they'll make an agreement among themselves to keep their promise. They don't want to go to the hospital.'' I repeated exactly what was being agreed to, and the patient reported that ''they'' all agreed.

I rechecked again that no ''part, person, presence, force, or entity, known or unknown, anywhere in creation'' (Richard P. Kluft, MD, personal communication, 1988) was unable to agree to the agreement to not suicide or self-harm. There was no objection.

I continued, ''Is Ms. B here, or does she need help in coming back? She walked in, she should walk out at the end.''

Ms. B appeared to go into a brief trance, then looked up, and, with Mrs. J's accent, said, ''She had to go to sleep too. She was so exhausted and overwhelmed. I'll take us home. She needs to come back tomorrow to see you, but I'll keep her safe until then.'' The session was over.

Mrs. J paged me urgently that night. Some of the ''little ones'' had ''awakened'' and were ''agitating everyone.'' A brief discussion revealed that the patient's daughter had called asking for money. TCB had answered the phone and ''told her off.'' Ms. B had ''woken up'' and was feeling guilty. I spoke with the Ms. B self-state about the need to find ways to work on this problem, together with the whole ''system,'' to forge more of consensus about handling the situation. She was able to reaffirm her safety commitment. She was able to return to ''sleep inside,'' along with the other newly awakened alters. Mrs. J asked: ''Does Verizon know that you do this on the phone?''

Despite these positive responses in the early sessions, the therapy continued to be stormy. A variety of safety crises continued to occur. Ms. B needed urgent hospitalization on several occasions because of severe self-mutilation, suicidal threats, and rageful, homicidal threats from the ''Uncle'' self-state. A far more elaborate set of ''safety plans'' was put in place to help the patient delay action. These included improved communication and collaboration among the alters. This allowed the patient to be more proactive in ''internal'' problem solving. She found activities that soothed the upset

alters, learned to use self-hypnosis, and found some helpful as-needed medications. She used supportive friends, who understood something of her situation, as supports. She made progress in setting limits with her daughter and making the daughter take more responsibility for her addiction problem.

Gradually, over the next 2 years, she was more and more able to maintain safety. This occurred despite a long series of life crises that resulted from prior self-destructive decisions she had made about her business, her daughter, and her finances. Self-states began to work together more efficiently. For example, TCB and Mrs. J worked out a budget for clothing and household items and began actively to cooperate about business issues. ''The Driver'' was allowed to take drives as long as there was prior agreement about where and when he drove. He was enlisted to help with driving, especially when other self-states were overwhelmed after leaving therapy. ''Older'' self-states were enlisted to do caretaking for the child alters. Child alters began to ''grow up'' and a variety of self-states fused as therapy progressed.

We began to understand more fully the traumas, abuse, and neglect that the patient had suffered throughout her development, including massive failures of the child welfare system to remove her from her aunt and uncle. Ms. B eventually found documented evidence that the authorities had returned her to her family, despite knowledge of the maltreatment by her aunt and uncle. Her current self-defeating, self-destructive behavior patterns, and certain phobic behaviors and other symptoms, often involved uncanny repetitions of specific traumatic events and scenarios that she recalled, or reactions to these.

Discussion

Safety management

In this case, I doggedly keep the focus on the patient's safety. I had to work on both suicidal ideation and parasuicidal behaviors. The emphasis is on a clear-cut, no loopholes agreement with a plan for dealing with an inability to maintain safety. The patient is not allowed to just affirm that he or she is safe (''I'll be fine''). Instead, the patient must give a more detailed and psychologically convincing discussion of what led to the lack of safety and how this will be managed subsequently. Otherwise, the patient is presumed to be a danger to self or others. Safety agreements are fundamentally about delaying action and having an alternative repertoire of skills and supports to manage difficulties that previously led to self-harm. One patient of mine calls her safety agreement ''the no-immediate-action plan,'' because the word ''safety'' is upsetting to her.

It is vital that the therapist become an advocate for safety and nonabusive values [11]. Compromise with the patient who attempts to bargain about how much ''unsafety'' is okay inevitably leads to the patient seeing the therapist as corruptible around basic values. DID patients often describe

many people including family members, doctors, teachers, and therapists who had some awareness that the patient was being hurt and did nothing. It is vital that the therapist does not fall into this trap and replicate this traumatic relationship theme [11]. I understand that, in many communities, DID patients must be hospitalized in general psychiatric units where DID is not recognized as a legitimate disorder, or, even if the diagnosis is accepted, there are limited resources for definitive DID therapy. However, the DID patient needs to understand this as part of the realistic consequences of being unsafe. In general, the DID patient may embody the values of those who hurt them: harming someone's body to solve your problems is without apparent consequence. I point out to the patient that, by harming his or her own body, he or she replicates the stance of the perpetrator: that it is okay for someone to solve their problems by messing up another person's body. As long as the DID patient engages in self-harm, he or she keeps himself or herself in the ''trauma world,'' reinforcing these old messages, delaying meaningful recovery.

I carefully structure sessions where I become aware of safety issues to attempt to resolve them within the scheduled therapy time. There are several reasons for this. First, if at all possible, it maintains the therapeutic frame, even in a situation of danger to self or others. Next, in most cases, it helps to preserve the structure of my day, and the next patient's session, if the index patient does require hospitalization (taking time to call to make arrangements, call 911, and so forth). It prevents interminable discussion about the patient's internal struggles that rarely produces a timely result. It emphasizes the patient's responsibility for safety, even if the patient has a limited understanding of this (''Let me explain your problem to you....''). It treats these issues as solvable, relatively routine, practical clinical problems, rather than matters of cosmic significance.

As in Case 1, I worked very rapidly on issues of the patient's responsibility for honesty and safety, building the therapeutic alliance, reframing alters as helpers and protectors, educating the patient about what is required in therapy, interpreting the traumatic transference around safety issues, and helping provide concrete alternatives to self-destruction for self-soothing [5,6,9,11]. Also, my availability was crucial in developing an outpatient safety contract and safety plan with a patient who was an acute danger to self and at risk for emergency hospitalization [19]. If an urgent appointment is not possible immediately, the therapist should be available by telephone or schedule brief, safety-focused telephone contacts with the patient until the next session. Scheduled calls can help reduce the possibility that the patient will feel that only a renewed crisis allows a telephone call. If, however, the safety plan begins to evolve into a situation where only frequent telephone contact seems to prevent hospitalization, this is not a stable long-term, outpatient solution to safety issues. In this situation, a more restrictive level of care, such as day hospital or inpatient hospital, should be considered. Similarly, extended telephone calls with additional lengthy

negotiations about safety generally suggest that outpatient management is not workable.

Posttraumatic responding

As in Case 1, I focused on the patient's multifaceted posttraumatic responding, here pragmatically conceptualized as an "emotional flashback." This is a very helpful concept for DID patients. Commonly, in DID intense emotional reactions to present circumstances are infused and influenced by affects and emotions from the past. If the patient can be made aware of these, and cognitively separate the different sources of emotion, it can be a very valuable intervention.

For example, the concept of emotional flashback can be particularly helpful with the patient who, under the weight of working on trauma, experiences the process as one without end: "every time I think it's finished, there's more," "I don't think I can survive doing this," and so on. The therapist should become attuned to these sorts of statements as possible representations of the patient's emotional experiences in the past, while undergoing the original traumatic events, now embodied in adult cognitive form.

Many DID patients report that they were suicidal as children, although usually acknowledge this only when asked specifically. Often, suicide is described as wanting to have control, to be free of intolerable danger and cruelty, to be at peace, out of unending misery, to be "in Heaven where grown-ups do not hurt little children," and so on. When a patient describes this sort of early history, I sometimes refer to it as "the life-affirming function of suicide." In its essence, this kind of suicidality often represents a wish to be free from trauma, cruelty, and abuse; to find some last modicum of control when all of it seems to have been taken away. As with so many DID symptoms, it can be helpful in working with suicidal self-states to reframe this as a logical response to trauma and as a wish to get relief and control in some way. The same aspiration can be pursued by living better in the present, becoming safe from exploitation, abuse, and trauma, at the hands of others or of oneself. Getting well is the best revenge.

Summary

I have presented two in-depth, clinical vignettes that illustrate basic issues from early sessions with DID patients in phase one therapy. In these examples, I show how themes that present in initial sessions, and work on their resolution, can set the framework for successful stabilization of the DID patient. Major themes have included unconscious posttraumatic responding, the therapeutic alliance, the patient's responsibility for safety, skill building and management of symptoms using imagery, and structuring the treatment frame to work on acute crises.

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