TREATMENT OF DISSOCIATIVE IDENTITY DISORDER:
"Tortured Child Syndrome"

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The observations and case material in this paper came from my clinical work with several individuals who had the diagnosis of multiple personality disorder (MPD) or dissociative identity disorder (DID). I had the opportunity to interview and help five diagnosed DID patients admitted to the short-term inpatient unit where I formerly worked. In addition, the case material is from thousands of hours of outpatient intensive psychoanalytic psychotherapy with several patients who had this diagnosis.

LITERARY AND HISTORICAL BACKGROUND OF MPD/DID

Mythology, folktale, and literature has described the phenomenon of the double. Greek and Roman mythology have the stories of Zeus shape-shifting from god to a swan or bull, depending on whether he needed to be charming and beautiful or powerful and frightening in his conquest of a beautiful woman. In Europe during the Middle Ages, the belief in shape-shifters was wide spread and prevalent. Shape-shifters were purported to be individuals who could assume the physical form of any animal, bird, or even insect of choice. What has survived of this belief today are the werewolf and children's fairytales, such as Beauty and the Beast.

Hawthorn (1983) studied an international body of literature, comparing the portrayal of the double in novels with the psychiatric symptoms of MPD. Interestingly, he used examples of individual and societal splits in describing what is and is not multiplicity. The United States during the Civil War was split, but was not a double, primarily because of the conscious nature

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of the division. St. Paul's conversion was just that, because he knew and remembered himself before and after his experience going to Damascus. By contrast, Stevenson's Dr. Jekyll was a double personality because he remembered the process of transformation (what today we would call dissociation), but not what he did while he was Mr. Hyde.

The literary double, transforming to the multiple, has been portrayed in film as well. In 1957, Chris Costner Sizemore, named "Eve" in the book *The Three Faces of Eve* (Thigpen & Cleckley, 1957), became widely known to the public in the movie of the same name (1957). The story of "Sybil" (Shirley Mason), first detailed in a book (Schreiber, 1973), then dramatized on television (1976), visually made clear the horrendous torture and near-death experiences that have since become accurately implicated in the etiology of DID. In "Eve" and "Sybil," the literary and the scientific merged. The American public was educated about the phenomenon labeled multiple personality disorder, now known as dissociative identity disorder in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; American Psychiatric Association, 1994). There have been other autobiographical accounts, but none of them has reached the prominence of the two mentioned here.

In both accounts, the therapeutic treatment that both women received was an integral part of their stories. The positive, upbeat ending to both stories was attributed to the success of their therapy. However, reality was much different for "Eve." Sizemore (1977) wrote her own book, I'm Eve, and described how her psychiatrists' interventions lead to increasing deterioration, and how she was exploited by them. For example, there were elaborate preparations for the release of the movie in Augusta, which she was excluded from. She "thirstily" read all information she could find about the movie, "frantically searching for some mention of herself, some indication that this was all about her, that this was her story. But there was none" (p. 390). The end of the movie showed "Eve" integrated and on the road to a good life. The good life actually came about twenty years later. "Sybil" apparently reached a point of contentment following her therapy; however, what has been called into question is the authenticity of the childhood abuse and torture, as well as the diagno-

sis. "Sybil" is deceased and is not around to ask; unlike Sizemore, "Sybil" did not publish an autobiography. There is a report that just before her death she revealed her identity and said that everything in the book was true.

However, both accounts are consistent with what I found in working with several patients with this disorder—that the diagnosis in itself could be a barrier to the individual getting the help that was needed. These individuals are especially prone to exploitation after the diagnosis is made because the phenomenon evokes fascination and fear, a combination that can be sensationalized and marketed. At one time, the diagnosis also carried a mystique in the mental health field, which posed a countertransference problem for many professionals. With time, this reaction in the professional community fortunately seems to have diminished.

Alternatively, these individuals have been viewed with superstition. For example, in India these individuals are often perceived as being possessed by the spirits of dead ancestors. In the United States, there still exists a misconception that individuals with DID are possessed by evil spirits: Two of my patients were given exorcisms by their well-meaning pastors. Both experienced increased alienation from church members, and increased confusion and despair after the exorcisms. The exorcisms were harmful; they were not possessed by demons or spirits.

The label itself may be contributing to various distancing and disrespectful responses. The diagnosis multiple personality disorder inaccurately describes the personality structure of these individuals. Dissociative identity disorder as a label also has problems. A difficulty with both diagnoses is that they are based on the apperception that the individual has several distinct "alter personalities" within one brain and body, each one being well developed and integrated, having a life of its own. Textbooks for Introduction to Psychology, a class which college freshmen are usually required to take, to this day still describe the disorder in this way. However, the truth is that this is one individual with a fragmented personality. In working with individuals with DID, I observed the fragments are not well developed and do not have independent lives of their own.

Finally, the question of authenticity continues to be made about the phenomenon, regardless of the label that is given.

There is an argument that there are many societal rewards for acting DID, for both the patient and therapist: money and fame. Additionally, a conspiracy theory was put forward in the past that unscrupulous therapists created the disorder. This was sometimes the defense used in court cases where the plaintiff, usually a woman, was suing the defendant, often a male relative, for damages incurred as a result of child abuse. Separately, there continues to be professional debate whether infants and little children can remember traumatic events. There was a time when surgery without anesthesia was performed on infants, the reasoning being that infants cannot feel anything. We have gotten as far as admitting that infants and babies can feel pain. Now the revisited question is whether they can remember pain, or whether the memory just "fades away." Paley and Alpert (2003) summarized the literature that indicates without question that infants and children do remember painful events. They remember nonverbally, visually, somatically, and verbally, the variation depending on their age and the duration of the event.

PSYCHOLOGICAL STUDY OF DID

The psychological study of DID has a relatively long history. Freud (1936), in a paper titled "A disturbance of Memory on the Acropolis," made reference to "dual conscience." The Acropolis is known today for its ruinous condition after centuries of looting and destruction, an apt metaphor for the psychological state of individuals with DID. Quoting Freud (1936):

> A surprising thought suddenly entered my mind: "So all this really does exist, just as learned in school!" To describe the situation more accurately, the person who gave expression to the remark was divided, far more sharply than was usually noticeable, from another person who took cognizance of the remark; both were astonished, though not by the same thing. (p. 241)

Freud described his feeling as derealization. He believed that derealization had two forms. In the first form "the subject feels either that a piece of reality or that a piece of his own self is strange to him. In the latter case we speak of 'depersonalization'; derealizations and depersonalizations are intimately connected" (p. 245). He went on to say that "Depersonalization leads us on

to the extraordinary condition of 'double conscience,' which is more correctly described as 'split personality'" (p. 245). Freud's translator noted that "double conscience" is a French term for "dual consciousness."

In studying healthy children, Piaget discovered the mental ability he called accommodation, where the child or adult's thinking matures and changes by adjusting to new information. Accommodation is essential in order to find and stay in touch with reality. In an individual who has been severely and repeatedly traumatized, this mental ability is limited to areas that are not emotionally charged. So for example, the individual might accomplish excellent grades in school, yet not be able to remember, use, or teach anything that has been "learned" because the emotional meaning of the material might prevent it from being integrated. For example, a child who had learned how to read was convinced by his mother that he needed her help in doing his homework, and grew up to be a nonreader who believed he could not read. When the emotional meaning of the "reading disability" was understood, he became a voracious reader.

Ferenczi (1949), in "Confusion of Tongues between Adult and the Child," observed the split that occurs within the personality of the child who is required to meet the expectations and communications of a parent who is confusing and causes pain.

V. K. Alexander (1956) who worked in India, wrestled with the meaning of the symptoms of his fefteen-year-old female client, Soosan. Soosan's father brought her to Alexander with the complaint that she was possessed by two evil spirits, a young man who suicided by the name of Kotchu, and a grandaunt named Anna. Kotchu had died when Soosan was three years old, and Anna died before Soosan was born. As Anna, Soosan complained to Alexander about how her mother spanked her. It was Anna who experienced the pain when Soosan was being hit. The actual Anna had been beaten by her husband. As Kotchu, Soosan could insult Alexander , torment her younger sister, talk loudly and lewdly about sexual matters, and wanted to use women. Kotchu liked snakes, and Soosan was afraid of them. Alexander discovered that Soosan had an "abnormal love" for her uncle who was twice as old as she and the same age as Kotchu. He noted that in India, the child's paternal uncle is usually the father image

and is addressed as "little father." The discussions between Soosan/Kotchu/Anna and Alexander leave little doubt that Soosan was actually sexually molested at a young age by a man, probably her uncle. As Kotchu, Soosan could feel rage and talk about how she wanted to hurt women, which she had been taught through firsthand experience; she also had very good reasons to hate and want revenge on her mother. As Soosan, she could not be angry and still be loved by her mother.

Alexander believed that multiplicity is "the same ego that acts in disguise in the various personalities" (p. 276), and described how the defense mechanisms of repression and identification work together to form the phenomenon and solve an unconscious conflict. He rejected the idea that the personality was divided up into different bits with the secondary personalities growing up in the unconscious mind.

Schore and others are integrating neurobiology, developmental and infant attachment theory, and psychoanalytic theory and technique toward a new understanding of emotions and psychological symptoms. In discussing dissociation, Schore (2003) stated:

> The maladaptive deficits of affect regulation that accompany pathological dissociation, a primitive defense against overwhelming affects, are expressed in a spectrum of severe self-pathologies, from reactive attachment disorder of infants . . to psychotic experiences . . dissociative identity disorders . . . posttraumatic stress disorders . . . and borderline personality disorders. (p. 136)

Schore has demonstrated that dissociation is an even more primitive defense than repression, and is always the response to overwhelming affect states. Furthermore, he showed that infants without a doubt have the same capacity as adults to use the defense of dissociation.

After birth, the mother–infant dyad prompts and assists growth of the structures of the brain, the growth of synapses (connections between brain cells), and how the brain learns to manage emotion, to name just a few of the activities that occur after birth. The developing brain of an infant who is in relationship with a terrifying, unpredictable, and confusing mother will respond accordingly by forming particular neurological path-

ways and failing to form others; the infant's brain will develop in a way that favors the use of dissociation as a defense and other autoregulatory functions, rather than turning to mother or father (or others) for help.

Teicher (2002) speculated that there were evolutionary reasons why the brain structures are impacted in the way they are by ongoing stress. If one lives in a very dangerous world, the brain is going to adapt to that reality in order to better guarantee survival of the individual. Following Teicher's reasoning, many children are raised today in family and cultural environments in which they do not know if they will survive. Of particular interest in Teicher's research was the finding that the corpus callosum in an abused child does not develop in the same way as in nonabused children. He and others have shown that memories of abuse are stored in the right hemisphere. If the connecting tissue does not work in the usual manner, then the left, reasoning side, is not going to be able to help with memories it does not know about. Teicher described research by Schiffer, Teicher, and Papanicolaou (1995) who measured hemispheric activity in adults during recall of a neutral memory and then during recall of an upsetting early memory. Those with a history of abuse appeared to use predominately their left hemispheres when thinking about neutral memories and their right when recalling an early disturbing memory. Subjects in the control group used both hemispheres to a comparable degree for either task, suggesting that their responses were more integrated between the two hemispheres (p.73).

The implication of this research is that dissociation is certainly not mystical at all, but has a human, interactive origin; furthermore, the research points toward ways to bring about healing. For example, Siegel and Hartzell (2003), in working with parents who are abusive to their children, makes use of what is known to date about the neurobiology of child abuse in explaining to parents why they act in the way they do. Siegel and Hartzell (2003) have found that parents generally want help, and that their nonjudgmental method of explaining brain development and patterning brings cooperation and openness to the admission of needing help. They encourage abusive parents to put their own traumatic memories into words, verbal and written. Although this

task is difficult for the parents, it is necessary in order to connect the parts of the brain that were never in communication because of the brain's adaptation to early abuse and stress. This communication can slowly bring about integration of the personality.

One of the puzzling symptoms of DID is that the person has various names for himself or herself. It follows from the preceding research that a very young person, under age five, might actually assign different names to unintegrated, unaccommodated major experiences, because that is the subjective experience and self-representation. This is especially likely if the child is called by different names by the parents, as is usually the fact with individuals with DID. Costner, for example, was referred to by her parents as Chris, Top, Toppy, Teeny, Christine, Daughter, Young'un, and Baby. The descriptions of my patients' parents suggested that all of them suffered from profound dissociation. As a result, they apparently were not able to hold in mind the relationships with their children. One DID patient who had raised a child said that at times she could not recognize him as her own, but felt he belonged to some other part of herself who had been "Mother." Stern (1985) eloquently described the absolute necessity of the baby and child being perceived by the mother as a whole, separate individual, and the attunement that is necessary for the child to learn how to modulate emotions and integrate experience. Fundamentally, she needs to be able to know the child as her own.

Individuals with DID do not have separate alternative personalities within one brain and body; instead, this is one person who has had real life-threatening events early in life, which have necessitated an impressive array of desperate psychological defenses and neurological adaptations. The history of torture, neglect, and intrusion beginning before age three is accurate. Rather than DID, an accurate label or diagnosis would be "tortured child syndrome"; therefore, for the remainder of this paper, "TCS" will be how I refer to individuals in this specific form of psychological pain. When a specific patient has been given the psychiatric diagnosis of and treated as MPD/DID, this will be noted.

Among the real difficulties of the adult with TCS are blanks in memory, inability to think clearly, emotional overwhelm and

riptides, an expectation of being hurt or killed by everyone, poor or no relationships, inability to work and enjoy life, and often self-destructive symptoms such as self-mutilation, a history of suicide attempts, and sometimes a long psychiatric involvement. One of the ways that an individual with TCS is sometimes detected in the psychiatric system is that none of the psychotropic medications work to make the self-destruction and suicidal intent stop. This does not mean the person is not heavily medicated, however.

Alexander's Soosan came to his office with dramatic changes in voice and behavior, amnesia, and names that we generally associated with DID. My patients at the hospital where I worked and those in my private practice have been more or less dramatic and have made me realize that the stereotype does not fit all, or perhaps even the majority of these individuals when they first come to treatment. I have found that there are at least four different circumstances under which symptoms of TCS may be observed (there may be others):

1. When the individual obviously and unconsciously changes behaviors and style in relating to others. The individual is unaware that this is happening. This is confusing to others, especially the inability to remember. However, the purpose of the defense is to remain hidden or to appear as normal as possible, so the individual learns how to appear as if he or she remembers. It is difficult to really get to know someone with TCS.
2. During an early stage of psychotherapy: The individual has come into treatment for problems with depression or anxiety. The patient does not call himself or herself by different names, and the changes in behavior and style may be very subtle and unnoticeable to the casual observer. Therapy allows the fragmentation to become obvious, especially if the patient is seen more than one time a week. In the past, therapists elected to use hypnosis or sodium amytal to confirm their suspicion of TCS. A careful reading of Costner's book reveals that she first began referring to herself by different names in outpatient therapy.
3. When the TCS individual is having a psychotic break: The in-

dividual may receive services for the first time during an acute crisis, and may be diagnosed as schizophrenic.

4. When the treatment accentuates the dissociative symptoms of the patient and leads to deteriorated functioning or stagnation, even psychosis. This circumstance is the focus of this paper.

CLINICAL WORK WITH MPD/DID PATIENTS

I was able to interview and briefly work with five women who had been diagnosed as MPD and were hospitalized because they were suicidal. Four of them had been treated for MPD on an outpatient basis. All of them had experienced infantilization, intrusion, and calling out of personalities as the framework for their psychotherapy. One MPD patient who had been treated for substance abuse but not multiplicity provided a contrast to the four "treated" patients. A sixth patient was so frightened and confused that I could not obtain a coherent history from her. An outpatient psychiatrist had diagnosed her as MPD, told her she had different people inside her, and then turned her care over to the local community resources, who were at a loss as to what to do with her. They finally correctly judged her to be a hazard to herself and hospitalized her; however, this had more to do with the intervention of the psychiatrist than the patient's pathology. Our small unit quickly transferred her to a state-run facility.

The five MPD patients who provided histories ranged in age from 25 to 45. Two of them had young children. Four of them had started outpatient treatment for anxiety or depression. One of them only received treatment for alcohol dependence. All of them had been diagnosed within the past five years of the most recent hospitalization. All of them were using various names in their understanding of themselves and in relating to others. The four who were in treatment for MPD insisted that the staff and other patients address them by their various names; the patient who was in treatment for substance abuse always went by her given name, keeping the "alter" names to herself. The four who were in treatment for MPD were having repeated hospitalizations since the time of diagnosis and were on major psychotropic

medications, after diagnosis. Two of them had been given amytal interviews to establish a diagnosis. All of them suffered from debilitating psychosomatic symptoms. All of them were acutely suicidal, and a crisis in therapy had led to hospitalization for symptoms of acute suicidal ideation and intent. By contrast, the one untreated MPD patient was admitted for suicidal impulses precipitated by a recent trauma in her life. All had at least high school educations; two of them had college education. All of them had work histories, but none of them were working at the time of admission. The four treated MPD patients had histories of extended absences from work or had gone on disability due to their symptoms after diagnosis. The one untreated patient also had extensive work absences due to substance abuse. All of them were on general assistance at the time of admission. One of them stated that her mental health worker encouraged her to quit her job because the memories were too much for her. All of them had the expected catastrophic trauma in childhood, which they partially remembered. The four treated patients had memories that, instead of responding to being worked through, repeatedly overwhelmed them. Remembering was not leading to mastery, but to retraumatization. To add to this, the four treated MPD patients were known by their community hospitals and were unwanted because they were experienced as malingering, frightening, attention-seeking, and manipulative. This was not the case with the one untreated patient. In short, everything that was described by Costner about deterioration occurred to these women.

The primary intervention that the staff used was not to call the patients by different names. In my discussions with these patients, I assured them that all the parts inside were actually one personality. While it might feel that they were different people, they actually were not. Most of them had heard this from their therapists. What was done differently, however, was to act consistently with what was said to the patients, that is, staff did not contradict the information by then calling the patients by different names. When a patient insisted that she was someone else, she was asked how old she felt, and what was she remembering or thinking about. We also helped the patients to focus

on positive aspects in their lives, which was something none of them had thought about for some time.

In all cases, the behaviors that made these patients unwanted on other units occurred in a greatly diminished form or not at all on our unit. They talked with other patients, had short hospital stays, and with one exception, did not injure themselves.

What the staff was doing was providing what the person originally needed from a parent: being understood, thought of, and held in mind as one person. Honestly telling a patient that the staff was very concerned about her, that they would like to know how to help, and that they did not want her to be hurt alleviated the pressure to self-mutilate, a symptom that occurred with frequency on other units. Hearing that a staff is concerned came as a surprise to these patients. I believe this interpreted the transference that the staff wanted control over the patient's life and activities, just as the parents used to control every aspect of her life. Furthermore, the patients internalized a very different kind of parent: The staff was genuinely concerned and did not want the patients to be hurt, by themselves or others. I was fortunate in that I worked on a unit that had a humanistic rather than a mechanistic philosophy of patient care, and which therefore was open to trying my suggestions.

The therapeutic techniques that had originally been harmful to these patients were the therapist's addressing the patient by different names and calling out personalities, with or without the use of hypnosis. In conjunction with this, the therapist's talking to and acting toward the adult patient as if to an infant or young child is destructive. Some examples of harmful approaches include shutting down the patient's memories because the therapist thinks the patient cannot tolerate them, instilling doubt about the ability to manage emotions and actions, and giving an adult patient children's toys for each child personality, which again solidifies the splits. Frequent holding, rocking, hugging, and touching of the patient is another example. These are techniques which strengthen and reinforce the original splits. Unfortunately, the therapist also becomes crucial as the individual who is in charge of the patient's behaviors, which can have a disasterous outcome. In the hospital, it was usual for patients treated for MPD to report instances of expecting the outpatient therapist to

control an "alter personality" who was suicidal. In other words, the individual had abdicated any control over the suicidal thoughts and impulses; if the "alter" loses control and a suicide attempt ensues, this becomes subjectively experienced as the fault of the therapist.

Fortunately, previous therapy does not have to determine the final outcome. Sizemore and Huber (1988) described the last therapist Sizemore saw as treating her as one person rather than a body inhabited by separate entities. Sizemore's therapist "would not address them, for example, as Eve Black, Eve White, Jane, the strawberry girl, or whatever, he called them all Mrs. Sizemore . . . . Dr. Tsitos helped immensely by refusing to recognize the personalities as separate entities" (p. 61).

In my own practice, I hold dissociative patients in mind as one person. "Judy" was a 35-year-old woman who came for treatment for worsening symptoms after a diagnosis of MPD/DID. Her previous therapist thought of Judy as having twelve personalities and made a practice of calling them out. However, she did not share information with Judy about what she had learned from the "alters." After an appointment in which her therapist told her to stop talking about a specific childhood memory, because she (Judy) could not tolerate them, Judy entered a dissociative state and crashed her car. Fortunately, she was not hurt badly. Because she was unable to replace her car, Judy went through the yellow pages looking for a new therapist in the area.

Judy and I did not see eye to eye on dissociation, but the relationship helped to stabilize her anyway. I was able to help her reduce her medications a little, which was a lot for her. About the time that she found out her brother was moving out of state, Judy decided that she would not/could not control her urge to secretively damage property (a behavior that repeated what her father did). She adamantly refused to believe that she could take responsibility for her actions, like tampering with property when she was angry at me. She was too convinced, first by her mother and then her previous therapist, that she was not to be trusted with her feelings. She became increasingly threatening, yet required me to act as if that was permissible; we had to end our work together.

Judy and other individuals with TCS come from back-

grounds in which there has been horrific, ongoing trauma from a very early age. In Judy's case, her father was involved in Satanism, and included her in meetings. Without exception, my patients with TCS have had parents or other relatives who were Satanists or who belonged to criminal or hate groups and usually included their children in group atrocities.

With the exception of two patients, the individuals I have worked with in intensive psychoanalytic psychotherapy did not require hospitalizations and eventually stopped using all psychotropic medications while in treatment with me. The two who remained on psychotropic medications also required frequent rehospitalizations. All but one of the TCS patients I have worked with had previously spent time in psychiatric hospitals and had been on many psychotropic medications when they started therapy. All but two of these patients worked part- or full-time or attended college while they were in treatment. One who did not work outside the home was raising a small child, and had chronic pain due to a medical condition that had been untreated in childhood. Judy was the only patient who was physically healthy but did not work, attend school, or care for a child.

During the course of this kind of work, acute physical memories often appear before visual memories surface, and then disappear when the memory is put into words. While all of my patients had psychosomatic symptoms, these were not incapacitating. The traumatic memories surfaced, usually in fragments, to be worked on, and then receded until more of the memory could be tolerated. Allowing the memory to be put together slowly in this way probably is what prevented repeated flooding by the same memory and retraumatization as described by the patients in the hospital. I met with these patients as frequently as schedules allowed (once a week, up to five times a week), but I did not have marathon sessions. I was available by telephone. I used psychoanalytic techniques in working with all of these patients, including dream interpretation, use of transference and countertransference, and explanation of human psychological development and, very importantly, the unconscious. I do not give patients a directive to remember, and I do not use hypnosis. With all of my patients, I start with whatever the patient brings to a session. When a memory begins to become conscious, I help

with such barriers as the patient's terror, shame, embarrassment and guilt so that the memory can be put into words.

The specific clinical work that follows is from my work with a woman whom I saw over several years. The example I have drawn is typical of how traumatic memories that have been dissociated surface in fragments, sometimes over a long time span, before the full meaning can be tolerated by the patient.

One day, this patient, whom I will call Jenny, told me that she had dead little girls inside her. She had talked about other parts of her who were very much alive. At the time, she could tell me nothing more about the dead little girls. In therapy, she sat frozen and frightened and talked but did not look at me. Later she told me that she had not wanted to draw my attention. Finally, many sessions later, she remembered that when she was a little girl, she was placed in the center of a circle formed by several men, her father being one of them. They would not let her get out of the circle, despite her efforts to get between them. They teased her, and called her humiliating names, such as slut and whore. Then she remembered being in a room on a table. As she told me about this, she said that the light in my office became dim until it was nearly black. She felt crushing weight on her. She felt that knives were being pushed into her vagina, but she did not see knives. She felt as though she were being turned inside out. She said that she died from the pain, and then came alive again, and died again, repeatedly until she finally died for the last time. My patient said that the men took turns raping her.

A child could have been killed by such an assault. When she was a girl, my patient believed that she died because that is what she was told. She said, "They told me that I had died and that now Satan lives in me. " The experience of going unconscious, that is, everything going black, had been misunderstood by her as dying. This was one of the meanings of her telling me that she had dead little girls inside her.

The next meaning of the experience that we talked about was an adult's understanding of what had happened. What she could remember was that the number six was sacred to the Satanic cult, as was the circle that had been formed around her. There probably had been six men who took turns assaulting her. The ceremony itself of six men participating in the rape of a

victim was one that the cult commonly used to "draw Satan's presence," which was believed to increase the power of the members.

The religious disguise and mysticism of the cult was deciphered. I believe that it is important for the therapist to tell the patient that there is no separate evil spirit called Satan. Therapists who believe in the existence of evil spirits and are frightened by the recounting of these events are going to be very limited in how they can help these particular patients. For example, a different patient recalled being told by the cult that Satan himself had appeared and raped her (the patient). She thought she had seen a human-like figure walking in a fire, which added weight to what she was told. The therapist's conclusion that this indeed must have been Satan colludes with the perpetrators, and places a limitation on the effectiveness of the therapy. The patient benefits from knowing how pain, thirst, hunger, and fear all cause sensory disturbances. Seeing someone walking through a fire might be simply a matter of the angle that one is viewing this. Fireproof garb also can be used to impress viewers, especially children and adolescents. One patient went into some detail describing the various ways that the adults tricked children into thinking that spirits were present. Finally, any child would prefer to think that Satan was the rapist, rather than a father or other familiar adult.

The patient needs to be consistently reminded that the therapist believes the reality of the memories. Usually, in the first reporting, the traumatic memory is a very sterile description of what happened. As the person gets better, the memory becomes worse because more detail can be tolerated. The patients I have talked to often have had the experience of perpetrators assuring them that they (the patients) would never be believed if they tried to get help. Satanic cult members especially count on the disbelief and denial of the public, courts, police, and therapists so that they do not have to worry about prosecution. The therapist's treatment of memories as delusional or fictional is sure to make the patient's symptoms worse. Likewise, asking the person to talk about himself or herself, and then telling her to stop, is very destructive.

The therapist needs to stay with the patient and encourage continued talking about the experiences as they surface. The pa-

tient who is on the verge of remembering, or in the process of reliving, will be very afraid of the therapist at times. The therapist should tell the patient that he or she will not hurt the patient. If the reliving is very intense, the patient should be reminded that he or she is in the present, and the memory makes it feel as though the past is happening right now. At times, it helps to remind the patient that he or she is feeling much younger than her actual age. All of my patients have told me that this help to ground them in the present.

I have always taken the patient's suicidal and self-mutilative thoughts and feelings seriously. I encourage the patient to tell me as much as possible about these impulses. Thoughts of suicide frequently come from a wish to escape and feeling that there is no other way out of the misery of her life. These impulses also come from rage, hostility, and the wish to make the parents sorry for what they did, thus turning them finally into good parents. The impulses sometimes come from the order, now unconscious, given to the patient by the perpetrators. More than one of my patients remembered that she had been ordered to kill herself if she ever even thought about talking of the atrocities committed against her. Getting help was absolutely forbidden under the threat of an excrutiatingly painful death. I have found that encouraging the patient to talk about whatever comes to mind, believing the patient, and telling the patient that he or she does not have to follow those orders is critical in changing the suicidal impulse. Some of my patients who come with this sort of background decide to end ongoing contact with their families, for obvious reasons; sometimes the hurtful parent or relative is already deceased or lives in a different state. In this case, the patient still needs to come to terms with the memory of and identification with the parent.

Impulses to self-mutilate can be understood frequently as a repetition compulsion (doing to the self what the parents did to the child). My patients who hurt themselves have taught me that when they become unbearably enraged about what was done to them, they feel they have to hurt something that is alive. To protect someone else, they hurt themselves instead. Often, but not always, the patient has a memory that accompanies the impulse to self-mutilate; sometimes the memory becomes conscious at a

later time. However, the therapist can always safely assume that every act of self-mutilation is a reenactment of an actual painful experience that is now more or less unconscious and also an attempt to solve the problem by cutting out or cutting off the memory. Sometimes the self-mutilation may be displaced from another part of the body, and the form of the hurting may symbolize what the child felt and thought was being done. For example, I have very frequently found a connection between self-inflicted cutting of the arms and wrists and the patient being raped or sodomized in childhood. Another reason for self-mutilation is the profound physical numbing that these individuals experience, as a part of the remembering process, and as a way of not feeling anticipated pain in the present and anticipated for the future. The very serious drawback to physical numbing is feeling unreal; thus, hurting one's self occurs in order to feel real again.

I always support the patient's talking about feelings of rage toward the parents. The patient struggles with impotent rage that the parent "got away with it" and with the unfairness of that. I ask my patients what they would like to do to the persons who hurt them. This usually results in fantasies that mirror what was done to the patient as a child, and I make that observation. Asking the patient to talk about fantasies and anger diminishes the possibility that the impulses will be acted on. I find that this also helps the patient begin to comprehend the enormity of the violence survived. When necessary, I remind the patient of the real-life consequences of acting on murderous impulses and will say something like "going to prison will only make life more miserable and will not change the past." I have noticed that the wish for love from the parents is linked to a patient's reluctance to verbalize murderous fantasies.

Explaining the difference between actions and fantasies is important in every therapy. An equally difficult challenge to the therapist is explaining the difference between acts of volition and being forced to act. I worked with a TCS patient who as a young boy was forced by his father to beat up other children or face his father's beatings. Patients who were raised in Satanic cults describe being forced to participate in the murder and torture of victims or be killed themselves. A recommended intervention with patients who have been political prisoners is to tell

them that they were not responsible for anything they were forced to do in captivity. I have used this intervention with my patients who suffer tremendous amounts of guilt and have found that this helps at a conscious level. Additionally, the perceived cause and effect connections between unconscious wishes and actual events needs to be discussed. The patient naturally wishes that someone else was being tortured. When this is followed by an experience of being forced to hurt another victim and being glad that for once it is someone else, then self-torturing shame and guilt are the result. The rage often seems to be withheld from the perpetrators because it feels so dangerous. Of course, the perpetrators help to create the illusion that the victim is responsible for his or her actions and willingly hurt someone. All of the different facets of the patient's guilt need to be meticulously talked about so that the patient is freed from the power that these memories have over his or her life and future. Likewise, therapists must understand any of their own feelings that the patient is guilty or could have done something differently; these feelings, if conveyed in tone or attitude, are very destructive.

The adult survivor tells his or her story in many ways: through the eyes, the posture, gestures, and dress. The story is told by the pain felt in the patient's body, disturbance of sexuality and menses, and psychosomatic illness. The patient communicates in dreams and in sensations and emotions that are not understood. Finally, in therapy, this can all be put into words when the patient talks to someone who sincerely wants to understand, so that all the parts are recognized as the same self. Probably every treatment of a TCS patient eventually includes a discussion regarding the patient's belief that integration will mean the death of the personalities. This is a logical extension of the patient's subjective experience of being different people inside. What I have found to be somewhat helpful is to ask the patient to please explain how that could occur. Of course, the patient is losing the fantasy and wish that the terrible experiences had happened to someone else, and that the parents had been good to the patient. He or she is also losing a method of protection that allowed the self to survive the most horrendous of experiences.

The patient's hatred of his or her experiences and memo-

ries is expressed by the different fragments disliking one another, wishing one or more were dead, and caustic and devastating remarks directed against the self. Struggles within the personality about which part is going to be "out" and which one is going to dominate are to be expected because of the internalization of the original, dominating parents. It is at times like this that some therapists might utilize "quick fixes," such as medications, hypnosis, and calling out of personalities, all of which is understandable as a countertransference reaction of wanting to make the patient more predictable and not so anxiety-producing for the therapist. The therapist must be able to tolerate feelings of concern for the patient. Furthermore, feelings of ineffectiveness and impotence need to be understood as being reflective of the patient's own struggle with the parents. The therapist strives to provide a new model that can be internalized of being empathic to all the experiences, but at the same time respecting the capacities of the patient for self-care. While the patient's self-hatred may continue for a very long time, the therapist's consistent care for the patient and refusal to take sides kindles hope that someday the patient will entirely love himself or herself.

Without exception, I have found that the parents or close relatives of the patients were the ones who caused the greatest pain and confusion. While the parents may have allowed or even invited others to torture the child, the worst scars were left by the parents by their betrayal. My patients and I talk about their parents and why they committed atrocities, or exposed the child to atrocities. Jenny's father had murderous rage and envy toward women. He and his cohorts vented their impulses on a small victim who was powerless to defend herself and who would not be believed if she tried to tell anyone. We could speculate that she represented his own mother and father, and himself, and that what he did repeated what was actually done to him, or what he saw done to others. Such atrocities, if they are unconscious, exert enormous, compelling pressure for repetition. Any guilt that was experienced by my patient's parents was displaced onto her or banned from their conscious awareness. We have a great deal we must learn about why some victims of childhood torture do this to their own children, and most do not.

The countertransference responses with TCS patients, in my observation, revolve around the problems we all have with

the dark side of our human nature. The fascination response that the TCS patient illicits, and the opposite, disbelief, have much to do with something being outside the way we would prefer to see the world. The natural feeling is to control, avoid, destroy, or punish what makes us uncomfortable. As analysts, we aspire to effect change through understanding ourselves and our patients. The TCS patients I met in the hospital were struggling with their therapists over control of the "personalities" and punishment for noncompliance.

Other critical countertransference issues with these patients include struggles with our own personal devil and monsters (parents) and identification with the aggressor. In the latter case, the therapist may begin colluding with the parents by feeling that the patient should have done something to avoid some of the hurt, and that he or she is to blame for what happened. The patient may be perceived by the therapist as manipulative, too dependent, demanding, and hurting the therapist. Sometimes, in moments of great fear, a patient might become threatening to the therapist. It is important that the therapist take care of himself or herself and not allow the patient to hurt him or her. I have quietly informed patients who were very afraid and who were trying to frighten me that, in fact, they had succeeded in frightening me, and I was of no use to them when I felt that way. If the threatening behavior continued, I asked the patient to leave, or I left the office, or, on a couple of unusual occasions, I called the police. Any of these actions lets the patient know that I will protect myself, and that it is all right for the patient to protect himself or herself as well whenever he or she is threatened. Some patients do not know they have that right.

Another difficulty is identification with the victim, which is characterized by feelings of uselessness, hopelessness, and belief that nothing can help the patient. Identification with the victim can be conveyed in statements that imply or actually state that the patient cannot get better but can only hope to make an adjustment to his or her problems, or in unusual distress about what the therapist feels he or she is going through in working with the patient. All clinical work is difficult; however, I believe unusually powerful feelings of unhappiness, dread, or distress are indications of an identification with the child whose life was absolutely miserable. The therapist must be able to carry hope

for the patient for a very long time. I will tell discouraged patients simple things like "This will get better," "You will not always feel this way," and "It helps to talk about the memories so that you can forget more easily."

I worked with an eight-year-old boy who was referred because he was encopretic, destructive, and fighting all the time, and who got up at night and ransacked any cupboards he could get into. Any food that was left out was partially eaten and the rest smeared over countertops. He tried to set fires in the house. I saw this boy off and on for about two years. He was adopted at the age of four and had come from an extremely abusive home. He had symptoms of being sexually abused, although this was not one of the abuses that came out in court. His adoptive mother knew that his mother had burned him with cigarettes. In our sessions, this little boy was like Alexander's Kotchu. He would not stay in the office; he insulted me; he threatened to cut and kill me, to break things in the office, to run out in the street and get hit by a car, and to tell his adoptive mother that I had hit him. All of these were desperate efforts to drive me away. He said that at night he turned into a werewolf, his real parents came from the moon, and they killed people. I think that I saw the werewolf twice in my office, and he looked like a little boy who had been knocked around until he was senseless.

The first ten minutes of our sessions were usually fairly quiet as he checked out the office and myself for any changes. He was eating a snack one day during this time and told me to read to him. He selected *Where the Wild Things Are,* by Maurice Sendak (1976). This book is about a little boy dressed in a wolf costume who gets out of control and is sent to his room by his mother to simmer down. In a fantasy or dream, he goes to an island where the wild things are: huge monstrous animals and birds. He is king of the wild things, and they have fun until he becomes lonely. He sets sail for home. When he arrives, his mother has his warm dinner waiting for him, and the little boy takes off his wolf costume.

In the book, just as the boy is setting sail for home, the wild things are begging him not to leave. One of them says, "Oh please don't go—we'll eat you up—we love you so." When I reached this line, my young patient stopped me and said read

that part again. I did. He said read it again, and I did. He said read it again, and I did. He laughed a little and repeated the line out loud. In a session not long after that, as he was making "food" for himself and me with Play-doh, I asked if he sometimes wished I were his mother. He shouted, "I dream that you are my mother!" In that same session, as he began to roam the office, threatening what he would do to me and saying that he did not want to come back, he took a pen and piece of paper and drew a picture of me. He said, "This is you." He crumpled the paper and stuffed it into his mouth. Around the paper, he told me he was going to swallow it. One side of me thought, "He might choke—stop him"; another side of me was understanding his starvation for love, and I began to say something like that to him. As I did, he spat out the piece of paper, glared at me and said "pick it up," then proudly walked away.

One of my adult patients told me that she did not want to love her parents because then she could not hate them for all the terrible things they had done to her. Yet it was her wish for love that bound her to parents who continued to torture her into her adult years. She was swept over by murderous rage and eventually by heart-breaking longing. Becoming aware of her longing for a loving mother involved the tremendously difficult work of coming to tolerate intense rage, grief, and despair that she could never get her mother to love her and to see that she was good.

TCS patients crave and are terrified of love for very good reasons. They are terrified that their own love will destroy the therapist or that the therapist's love will destroy them, yet it is love that tames the wild, overwhelming rage and impulses to do to others what was done to one's self. The process of remembering is as important as the memories themselves. This is the key to healing: A therapy in which patients experience the patience and love of the therapist enables the memories to come into consciousness and to heal, so that the patients can live life as they choose. The abreactive model of unearthing memories is not a useful or advisable model for these patients. Within a valuable relationship, the patient's life in its entirety becomes valuable to him or her. Rather than being baggage or a statement of who the person is, the experiences and memories can shift into

a form that do not overwhelm and can be recognized and felt as being from the past, and not the present. This latter requires a second important step in the therapeutic process. Remembering is the first part, but it's not enough; moving beyond the memories into their meanings and into relationship with others is the second and by far the more important part.

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