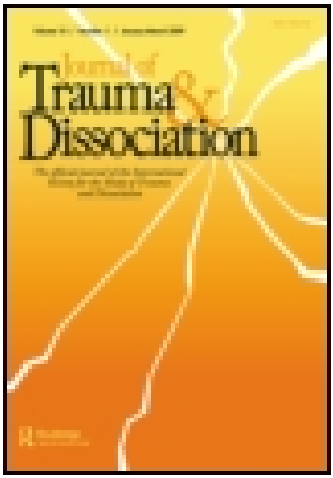

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Using Psychomotor to Treat Dissociative Identity Disorder

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Using Psychomotor to Treat Dissociative Identity Disorder

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ABSTRACT. Pesso Boyden System Psychomotor Therapy (Psychomotor) is offered as a useful approach to treating Dissociative Identity Disorder. Originally developed for group work, this therapy can be modified so that the alters can learn to play roles for one another that promote resolution of childhood injury, enhance internal communication and cooperation, and ultimately support the prospect of integration. Psychomotor is unique in that it helps in the creation of synthesizing memories that provide antidotes for early traumas; not only can childhood abuse and neglect be metabolized, but also images of needs being met can be added. Moreover, Psychomotor develops the "Pilot" or adult functioning so that there is less likelihood of regression or dependence on the therapist. A four-stage progression of treatment is outlined: development of the "Pilot," teaching the system's adults to engage in parenting the child alters, healing the wounds and the defensiveness of the "Protector/Controller," and the internalization of the image of "Ideal Parents" so that the client can continue to resolve any surfacing memories of trauma or inadequate rearing.

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INTRODUCTION

Pesso Boyden System/Psychomotor (PBSP[1] or Psychomotor) is an experiential group psychotherapy that fosters both conscious self-awareness and resolution of intense emotion and psychosomatic symptoms. Originally developed out of expressive dance by Albert Pesso and Diane Boyden Pesso, it has become a theoretically sophisticated psychotherapy, and has particular application to healing trauma (Pesso, 1991, p. 169) and resolving injuries that occurred in the family of origin (Napier, 1988, p. 21). For these and other reasons, Psychomotor has much to offer in the treatment of Dissociative Identity Disorder (DID) and what follows is a report on the results of ten years of clinical experience in using PBSP with this challenging population.

Psychomotor seeks to maximize the conscious decision-making ego process or the *pilot*[2] of the client. Pilot is a Psychomotor term for the higher ego functioning of the client including the ability to self-monitor, make choices and assert will. Such processes entail being in a fully adult state of consciousness. The development of the *pilot* involves active collaboration between the client who reports conscious experience of thoughts, emotions, and sensations, and the therapist who focuses the client's awareness on typically unconscious manifestations of emotion manifested nonverbally. New perspective can be gained when old experience is reenacted in the present. The *pilot* will have more understanding and resources than were available in the past. Moreover, the therapist can keep the client aware of longings and possibilities (e.g., for safety, for empathy) that were historically denied.

Central to Psychomotor is the belief that we carry in our genetic makeup the knowledge of and hunger for the types of experiences that give rise to satisfaction in living. Even when personal history has not offered needed experiences people unconsciously seek the types of interactions that were needed. The guiding formula for Psychomotor sessions is: *energy action interaction satisfaction*.

The *energy* may be psychophysiological pain, tension, or psychological symptoms. Energy, in the form of such symptoms, has a trajectory toward gratification, although learning from unhappy personal experience likely frustrates expectation of satisfaction. The client may lean into the arm of the couch in a way that suggests a wish for support. When the therapist asks if there is such a desire, the client may well agree but then present the blocking belief that "no one would let me lean on them." This may have been based on a literal remembering of a parent saying "you're too clingy, leave me alone." Alterna-

tively, it may have been abstracted from general experience of being unsupported, generating an anticipation of the future, the Voice of Negative Prediction[3]: "people will never let me lean on them."

In Psychomotor, it is believed that important human needs are inevitably fulfilled or frustrated by other people. This is the *interaction* element. Initially the Voice of Negative Prediction might be enrolled so that the client can react to hearing from the outside: "people will never let you lean on them." Often there is a fleeting rebellion against this externalized message. So, if the client becomes aware of a wish to lean, then the therapist might encourage experimenting with *action* ("How would it be if you let yourself lean?") and *interaction* ("Who would you wish to lean on?" or "What would be the qualities of just the right person to lean on?"). The session might develop into a series of trial enactments of receiving support. Typically there are cycles of emerging needs and the experiences that frustrate them, leading to clear memories of life-shaping historical events: "When I was four and my mother was trying to calm my colicky baby brother, she slapped me when I tried to lean on her side." So symptoms in the present point back to the history that created the impasse just as they point forward to the resolution. The therapist might help the client create an image of a different mother, perhaps not stressed by a baby, or endowed from a happy childhood of her own with more acceptance of a four-year-old's need to cuddle. Such an *ideal mother* would welcome a four-year-old leaning on her. The client could then experience the symbolic *satisfaction* of the need, imagining being four in the arms of a mother who would welcome such support seeking.

As the client moves through the sequence of *energy action interaction satisfaction*, old injuries are exhumed and metabolized. Importantly, the focus is not on the past, or on a prolonged and regressive reinvolvement in the injury, but on the resolution. Psychomotor helps clients create synthesizing memories of new and satisfying outcomes to old dilemmas.

These memories are comprised of complete sensori-motor gestalts. They are multisensory: the right words, spoken with the right tone of voice, incorporating the desired facial expression from the *ideal parents,* and with tactile elements as needed. Attention is paid to how the meaning of the new memory is internalized, so that the needed interaction is understood to have been experienced by the child of the appropriate age. By drawing together the adult's perspective with child states of consciousness, just as by replacing focus on frustration or trauma with experience of satisfaction, Psychomotor offers a powerfully integrative impetus for clients whose lives have heretofore been characterized by dissociation.

For those readers with little prior exposure to Psychomotor, the following section offers a brief introduction to the unique language and theory of this powerful approach.

INTRODUCTION TO PESSO BOYDEN SYSTEM PSYCHOMOTOR

The term "psychomotor" literally translated means "soul-movement" (O.E.D., 1971). The energies of the *soul* (or what we could potentially become) show up in postures, body movements, facial expressions, and in symptoms. The therapy supports exploration of how these energies can move toward expression and resolution. Traditional Psychomotor practice has been to offer individual therapy sessions, called *structures*, done in the context of a group. Group members *accommodate* for each other: that is, they take on roles. Such role-playing, unlike psychodrama, involves no improvising. By having repeated the precise messages desired, the client can focus on the message with almost hypnotic clarity and depth of impact. The individual's internal consciousness is enacted in the therapy group. Inhibiting or punishing messages (e.g., a Shaming Voice saying: "you are worthless and have no right to exist") are less likely to be accepted as truthful once they are externalized and spoken by a role player. Surfacing emotion or impulses to move, often the first indicators of an area where growth can occur, are made conscious by having a Witness Figure compassionately label them (e.g., "I see how you collapse in dread when you hear the Shaming Voice tell you that you are worthless."). If the client affirms this urge to collapse, a Supportive Figure might be enrolled for the client to lean on. Each step in the client's developing awareness of this *true scene* is made into an interaction with a role figure.

The therapist helps the client track and become conscious of inner messages and offers observations about emotional or postural shifts that occur in response to the interaction with the role figures. It is the therapist who would check out with the client how to name the role figures and direct them in what to say. For example, the therapist might say: "When the Shaming Voice spoke, you looked stricken and rocked forward as if you might collapse onto the floor. Would it be right for the Witness to say 'I see how you collapse in dread when you hear the Shaming Voice tell you . . . .' " Note that the therapist assists the client in this tracking process but is not the primary figure in interaction. This minimizes transference to the therapist while highlighting the client's conscious, choiceful, adult awareness, i.e., the *pilot*.

Externalization of the inner experience amplifies the client's emotional reality while creating distance for her[4] to consider how to react. The *crossfire* of different enrolled figures helps the client sharpen awareness of a focal conflict, both in the mind and in the body, which can then be seen as a reenactment of a *historical scene*, a specific and decisive moment in the client's personal history. The Shaming Voice may come to be seen as a representation of a rejecting parent figure from childhood. The Supportive Figure might represent the wished for presence of a different kind of parent who would welcome and respond appropriately to the emotions of the client/child. By exploring the devel-

oping flow of awareness as it is externalized and brought into interaction, historical wounds can be identified and re-experienced. The emotional, embodied energy originating from the past is mobilized and expressed in the present within the safety of the group. The client might, for example, express the latent rage at the parental rejection or be supported in crying with the pain of being shamed.

Finally, the emerging consciousness of what would have been needed in history can be honored with the introduction of *ideal parents* who would have responded appropriately to the developmental needs of the child, supplying an *antidote*, a healing resolution to the injury. The role of the Support Figure, for example, might be expanded to an *ideal mother*, who might cradle the head of the client/child, make the kind of eye contact that confirms the message, "I'm glad you are here," and reverse the toxic message by promising, "I would never tell you that you are worthless," again using the client's own wording. As the client is vitalized by the release of suppressed energy, the drama might reach its climax in the client/child playing joyfully with the *ideal mother* and an i*deal father* or resting quietly in their arms as they tell about their excitement throughout the pregnancy and birth of the client/child. In this way, the piece of work ends with the client having an individualized, cognitively and physically satisfying reversal of the old trauma, now formed into a retrievable memory, which fosters a more trusting and assertive presence in the world.

More complete accounts of *structures* can be found on-line (PBSP@aol.com) and in the literature (Crandell, 1991; Pesso, 1973, 1991).

PBSP works with the intentional projection of symbols (Clarke, 1991). Historical figures need not be literally present so long as they can be projected onto people or objects in the present. Trauma can be revisited within the assured safety of the group or the consulting room. It is worth noting that a structure can be easily done in the context of a one-to-one session. Clients who are capable of using imagery, as most clients with DID assuredly are, can project voices onto symbols or objects in the room. A pillow may be enrolled as a Critical Voice and a blanket and an encompassing armchair may become *ideal parents*. Many clients can create vivid internal images of the interaction. It is often possible to develop the kind of co-consciousness in which one alter can play a positive role for another alter. The essential features of the Psychomotor structure can be completed in the individual session. Clients with DID are typically treated in individual therapy rather than the group; they prefer the exclusive focus of the therapist's attention as well as the privacy for exploring personal material; and they respond well to the challenge of working with the imagery or projected symbols. Kluft (1995) has noted that those with multiple personalities also suffer from "multiple reality disorder" in that the external reality is used as a crude set on which is projected the shifting needs and fears of the alters. This tenuous link to consensual reality, typically a weakness, can be-

come a strength in that Psychomotor offers a guided path through a synthesizing reality in which healing is fostered.

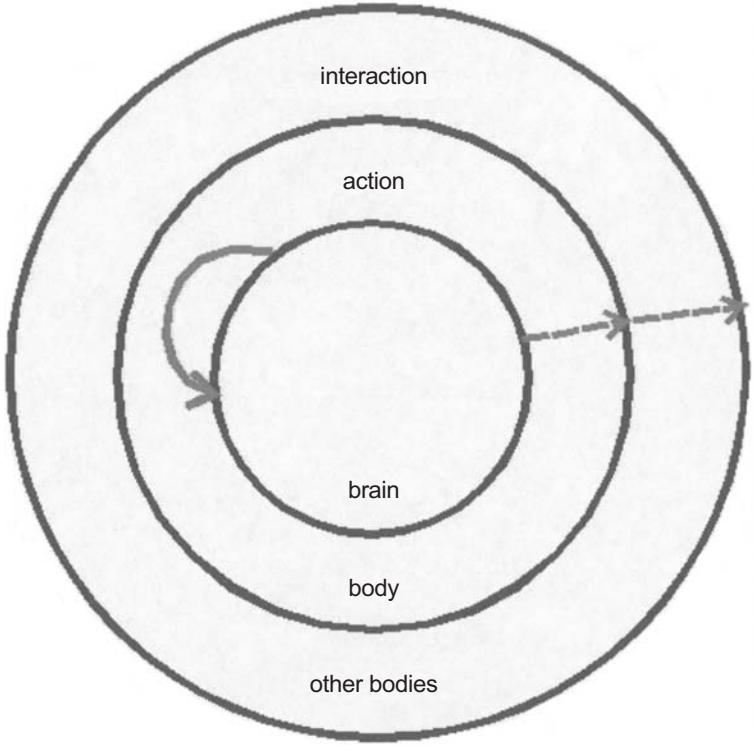
For those readers with little prior exposure to Psychomotor, the following section offers a brief introduction to the unique language and theory of this powerful approach. Some cautions should be noted concerning the use of Psychomotor with DID clients. Psychomotor and other experiential/expressive therapies should be practiced only by clinicians who are well trained and experienced in these modalities. DID clients, particularly those with coexisting severe personality disorders, may have serious potential for regression, especially concerning the gratification of unfulfilled needs to be nurtured. Clinicians must, therefore, be able to determine which clients are able to use Psychomotor to establish their own internal reparative structures, versus those who might become dependent on external caretaking. In addition, clients must be able to distinguish between historical reality and their own created internal psychological structures. Other cautions and training suggestions will be given further attention in the paper. PBSP is not represented as the only or as a magic solution to the problems of treating Dissociative Identity Disorder but is offered as a useful adjunct to a general course of clinical treatment.

PSYCHOMOTOR PERSPECTIVES ON DID

From a Psychomotor perspective, DID is a *noninteractive solution*. This means that the client tends to live in a closed system in order to avoid interaction with an external world that is seen as dangerous. The extreme, repeated, and early traumas cause the client to withdraw her energy from a world seen as pervasively unwelcoming. She relates to the interpersonal world, as she must, but in a ritualized way that is seldom more authentic than acting, revealing her expectation that the world will punish her. Such a client is suspicious, testing, and ready to play the role of victim to yet another expected perpetrator. She readily dissociates, leaving the present and her own body to retreat into a world of inner symbols. Figure 1 shows how the interpersonal energy, which should animate the body and be directed to others (the dotted line), is instead redirected to internal symbolic processes or into the body.

Even when it appears that the energy is directed interpersonally, the main focus is on the inner symbolic world. For example, there may be a sexualized alter who is skillful at seduction and lovemaking. Yet she will confess that her partner is forgotten at the first touch since her primary mission for sexual contact is to obtain such experiences as nurturing, power or control for her system. Her primary relationship is not with her partner, but with her inner world of alters.

FIGURE 1. Shunting of Interpersonal Energy to Inner Symbolic Processes. "The dotted line represents the normal pathway for interactive energy and the solid line what occurs" when this energy is shunted internally. "The body is left relatively untouched by interactive energy and the interactive energy amplifies the internal processes in the brain to an extreme degree" (Pesso, 1993, p. 63).



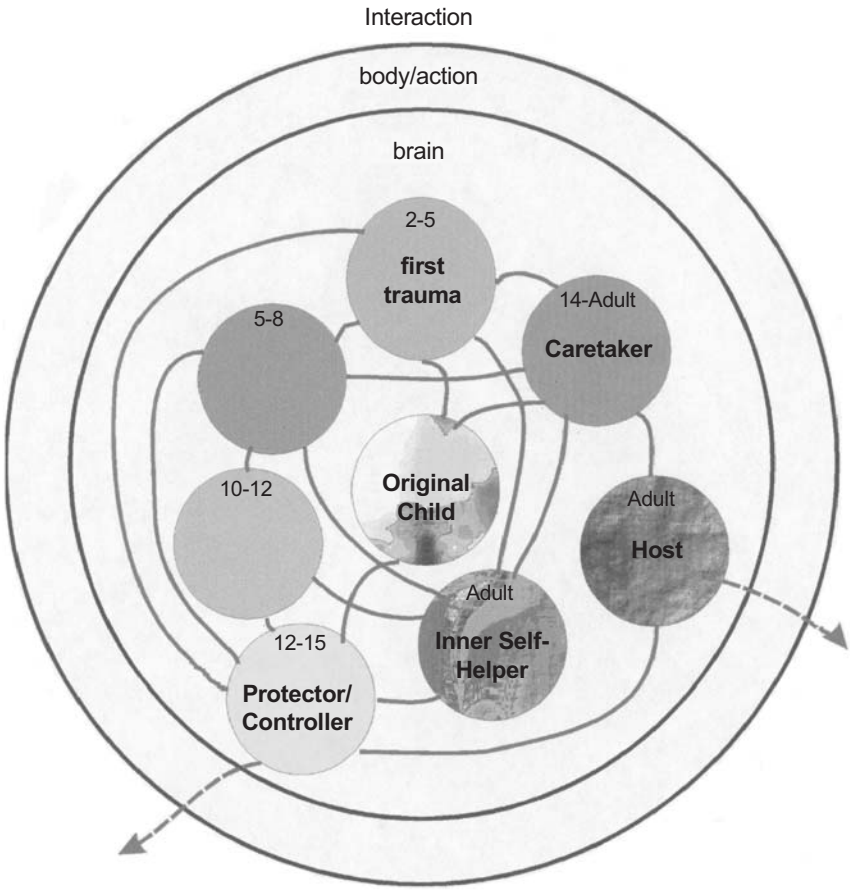
There is a core belief that help will not come from others in the external world. The task of the therapist is to help decipher the basic needs and wants from the client's private symbols and to help her risk more authentic interaction with safe others around her.

In DID the central circle (representing symbolic processes in the brain) is elaborated into distinct personalities who interact in a way that appears to exemplify *interpersonal energy* (Figure 2). It is clear, however, that the thrust of the interactions is aimed at avoiding or reenacting rituals of old traumas and that the external world recedes in importance. The client may sit in the session with eyes fixated and face impassive, yet report an intense inner drama in which an abusive/protective alter is beating a child alter for planning to tell the

therapist about a wish for nurturing. In successive moments the therapist may disappear entirely from the client's consciousness or, in unpredictable sequence, become the parent who frustrated the nurturing need, the abuser who punished, the gratifier who must nurture for the drama to have a happy ending, or the victim at the mercy of the perpetrator (Gabbard, 1994).

Figure 2 portrays the possible alters for a hypothetical client with DID. While these will not be reviewed in detail, it is important to acknowledge that

FIGURE 2. An Example of the System of a Client with Dissociative Identity Disorder. Most alters do not interact directly with the outside world, although child alters may emerge if triggered by the environment.



some are skilled at dealing with the outside world. A significant part of therapy is to capitalize on their skills and develop what is available for interaction.

In PBSP theory, there is a contrast between the mature internalization and symbolization of adequate parenting and the defense of turning to self-parenting when external parenting is missing or harmful. This defensive self-parenting is seen as pathological because it leads to the internal shunting of interpersonal energy, it depletes the energy for engagement with the outer world, and because it leads to solipsistic or magical solutions to problems. Termed the *Magical, Omnipotent, Interior Parent*[5] in Psychomotor theory, it defends against further injury from outsiders but continues the cycle of abuse within the internal family. In the system of multiple personalities this part is often first evident as an internal persecutor, which we have come to call the "protector/controller."

In our experience, this alter regularly comes to be seen as an older preteen or young teen who learned to accommodate the abusive environment. This part internalized the expectation that needs would be frustrated or punished and, acting on this awareness, becomes a protector/controller who assumes executive functioning in the system, at least at times, interrupting both the emergence of any part seeking to express needs and the satisfaction of those needs either internally or externally. This may be seen as modeled on an abuser, and so it may continue the cycle of abuse perpetually in the inner life of the person with DID. But there is a benign intent of preventing further disappointment or injury. The protector/controller should not be discounted as offering no contribution to the inner family. Unfortunately, this alter carries the self-fulfilling prophecy that the personalities cannot get their needs met in the outside world. Until this alter can be engaged in the reassessment of core beliefs, interpersonal energies are likely to be suppressed. The therapist alternately engages the protector/controller, respecting its past role, and challenges it: by holding out the hope of more satisfying current interactions or noting the emergence of basic needs seeking satisfaction through relating to the outside world.

PBSP OFFERS UNIQUE SKILLS IN THE TREATMENT OF DID

Psychomotor makes a number of practical differences in the way that clients with trauma history, including those with DID, are approached in treatment. While comfort with intense emotional expression is an important part of the training of a PBSP therapist and particularly helpful in working with clients with DID, it is the way in which new meaning is created that makes this therapy unique. Psychomotor insists that there be a cooperative effort between the child state of consciousness, whose historical wound is being explored, and an adult who can make choices with the resourcefulness and awareness of new

possibilities that the child lacked. It is the *pilot* whom the therapist usually addresses. With an adult present to assist in finding meaningful resolution there is less likelihood of regression and a greater probability that the memory of the work will be available throughout the system.

Psychomotor also regards abreaction as merely the first step in creating new meaning. The injury is tapped only so long as needed to make clear the needs and potentialities that were stifled. The focus then shifts to creating a synthesizing memory in which the needs and potentialities are honored. For example, the focus shifts from the abuse to the experience of protection that was missing. The client is invited to live in the solution and not in the problem. This ultimately creates hope and lessens the likelihood that an identity will be consolidated based on remaining victimized. New meanings help the client live in a present seen as different from the past, in a world in which outside resources are seen as helpful rather than injuring, and where the yearnings within the client are seen as valuable rather than being degraded.

In PBSP, the inner drama is reenacted externally. That is, voices and messages that are heard internally are projected outward, shifting the experience so that external response is possible. These internal messages, previously accepted as truth and as emanating from the self, can come to be seen as representing the distortions of historical figures. "You're dumb" is heard differently if from an enrolled negative parent than as a self-evaluative truth. Such messages can then be challenged. To the extent that inner persecutors are internalizations of interactions from childhood, this approach to externalizing the message can allow recognition, resolution, and relief.

In Psychomotor theory, the therapist functions as a guide in support of the client's conscious choices. This collaboration with the *pilot* fosters awareness without regression, even as deep wounds are healed. The fact that healing messages come from role figures other than from the person of the therapist minimizes dependence and parental transference to the therapist. PBSP understands how to support reparenting without becoming the parent figure. Kluft (1995) warns that there are major boundary violations possible in treating the DID client, usually because the therapist attempts to meet the early needs directly in the relationship. This transferential trap may appear, for example, when child alters ask if they can live with the therapist; instead, Psychomotor therapy enables adults in the system to create a safe home internally. It is certainly preferable to have such self-parenting and ideal parenting rather than have the therapist attempt to meet the needs of the client. In the same way, there is less regression and dependence in treatment because PBSP teaches how to deliver the corrective emotional experience symbolically rather than literally, in the synthetically created past rather than in the present, and with another rather than the self of the therapist providing the antidote.

Working collaboratively with an inner adult alter, which PBSP terms the *pilot*, to manage the course of each structure reinforces adult capacity for choice, awareness, and compassionate engagement with inner children. Clients will often enter treatment having extensive prior therapy in which regression was encouraged. Initially, they will resist or complain, but will later see as the most valuable part of treatment the insistence that there be an adult present at each stage of the work. This adult presence is often based on what has been termed in the traditional literature on DID, the host or the internal helper. PBSP seeks to develop and strengthen the *pilot*. This conscious self-guiding awareness is ultimately the greatest need for the DID client who may have operated with a succession of child states independently running the show.

PBSP therapy treats all of the energies arising from the soul as valuable. Even murderous energies can be accepted within loving limits. From this mindset, it is possible to approach each alter with respect, even when it seems that the impact of the alter on the system is destructive. One of the classic mistakes in treating DID is to assume that one part is evil and must be extirpated (Ross, 1989). It has been our experience that even the inner persecutors are trying to be protectors, and their determination can be harnessed to the difficult work of risking change. In this way PBSP training prepares the therapist to see the value in every aspect of the self.

Psychomotor theory is furthermore unique in highlighting five basic human needs, which must be met both literally and symbolically throughout the lifespan. Those needs are: *place, nurturance, protection, support* and *limits*. These provide a template for helping the therapist to anticipate the corrective experience that clients may not be able to imagine. The basic need for place is particularly prominent in those with DID, not only in the external environment of the therapeutic setting, but also in the internal family system where parts may be unaware of the existence of each other, or be unable or unwilling to "share space" once co-consciousness is attained.

Likewise, *protection* is crucial for those with DID. To begin to establish *protection* early in treatment we have given powerful relief to clients by simply describing the following thought experiment: The client images herself as a scared child huddled in a corner, and then considers how her feelings would change if a protective figure were to sit in front of her and remain alert to danger. Here the therapist can take the role, sitting alertly with her back toward the client and her attention outward, scanning for any external threat. Such an enactment helps instill both hope and the idea that there can be outside help in managing the child's needs. Repeated experience with this faith that there can be an antidote honoring true emotions of the child parts leads to gradual replacing of the *Magical, Omnipotent, Interior Parent* function. "To hold traumatic reality in consciousness requires a social context that affirms and protects the

victim and that joins victim and witness in a common alliance" (Herman, 1992, pp. 9-10).

PBSP encourages the pseudo-multiple experience of having an adult state of consciousness monitor what is happening within a child state of awareness. Because there is an antidote that works for both ego states, there is no dissociation and a more unified sense of self develops. In the same way, DID clients feel no pressure to fuse and yet find they become more unified in their functioning from doing Psychomotor work. If, as our clients contend, PBSP is really a way to teach singletons to function as effective multiples, it is equally true that PBSP is a natural way for clients with DID to learn to function as a unified self.

CLINICAL EXAMPLE

The following clinical example demonstrates two of the key Psychomotor contributions to treating DID: (1) The attention to building *pilot* in the interplay between the adult and child ego states; the motives of each are benignly reinterpreted to the other so that a cooperative solution involving their teamwork results. (2) Minimization of focus on the historical traumas since the primary goal is to develop a believable antidote experience that honors the needs and feelings that were not honored in the original trauma. This work represents the initial attempt to draw on Psychomotor techniques in working with this client, to test her readiness to work in this manner. Perhaps because she had previous therapy, she proved readily able to use the imagery developed collaboratively.

In this clinical example, the client begins her fourth session with apprehension about discussing the flashbacks and nightmares surfacing from Pretty, an alter representing the ages of four to eight. The adult self of the client, with the help of the therapist, begins to be assured that she can be supported in handling the imagery, and she is reminded that she does not now have to decide if the repugnant memories are really true (although she acknowledges that Pretty has never previously lied). Moreover, if the memories are found to be too much for her to face, I (J.S.C.) offer my belief that Pretty could be asked to contain them for a while longer. With these preliminaries, and with the promise that the last third of the session would be reserved for her to process the experience, she agrees to this initial attempt to metabolize trauma.

The adult shares an image of a child's little hands wrapped around her brother's erect penis as he moves and ultimately ejaculates. She is embarrassed and confused, intuitively sensing the wrongness of this activity. She then feels a growing sense of anger. I ask her what the child would have needed, enlisting the adult in being active on behalf of the child. First, the child wants protection.

The adult suggests that either she or Papa might have intervened. So the image offered to the child is of her (the adult) knocking down her brother while Papa enfolds her (the child) in a safe hug.

There is initial relief in this image (and note that within three minutes we have shifted away from re-experiencing trauma to completing the emotional gestalt). But there are recriminations to be shared and discussed. The adult wondered why the child had not in fact sought the father's help. I suggest that perhaps she was afraid she might lose him. The adult, later with Pretty's validation, guesses that she didn't have words to describe what had happened, that she was cowed by the brother's threats, and that she was indeed afraid that her father might leave her if he was pained with knowing about such trauma. The adult can also reassure the child that it would have been all right to tell him, even though she understood the child's motives in keeping the secret. The child then surfaces and shares her hurt that the adult had not believed her from the outset. But she is easily mollified when I note that it is more that the adult wishes the memories were not true. Pretty can then accept the adult's help.

The client sits tensely in the chair even as Pretty appreciates her Papa's hug. When asked what else she would like to do to her brother, she shares a revenge fantasy of nailing his testicles to the floor of an old shack, giving him a rusty knife, and then leaving him the dilemma of how to escape when the shack is set afire. In this image, she counts on the adult to have the power to exact revenge, imagining herself safe in her father's arms. She imagines her brother as too cowardly to castrate himself and so dying in the flames. She is gratified to see his charred remains and then to join Papa in burying him beneath tons of dirt and rocks. This graphic revenge fantasy is tremendously satisfying and relieving; Pretty now is animated in her chair.

The adult had previously expressed fear of being literally violent toward her brother, and so the therapist saw *limits* as being as necessary as *protection* for the resolution of this traumatic image. Pretty is asked permission to develop an additional scene with the adult. At the therapist's suggestion, she images that the father intervenes after she has knocked the brother down. He would license the naturalness of her wish to kill him but then express his unwillingness for her to be saddled with such action. Instead, Papa would take the brother off to jail or hospital, promising to keep him away from Pretty. In this variation, the revenge scenario is treated as a satisfying fantasy shared between the adult and child alters. This amended version is satisfying to the adult and so is offered by her to Pretty, who likewise finds it entirely acceptable. This confirms the centrality of the basic need for *limits*; PBSP theory here suggested a perspective that the client could not consciously create but could recognize to be healthy.

After ascertaining that Pretty is comfortable and knows she can return to the adult's or to Papa's arms if she is frightened, we review the work with the adult. She has been co-conscious when Pretty is present. She now can discuss

more her understanding of how helpless a child would feel in such a situation. She is not only compassionate to Pretty, she is able to be somewhat detached from the terror that "had trapped me." The antidote images allow her to move beyond, what she now accepts as, the literal past. She verbally and nonverbally expresses a sense of completion and satisfaction with the work. This fosters confidence that she can work with Pretty to process related memories. As we end the session and she moves to the door, Pretty surfaces momentarily, to offer a deeply felt "thank you" The session provides enough relief and sufficient teamwork for the adult and Pretty to process the remaining unshared memories that Pretty had retained and ultimately to integrate.

Pilot is developed as satisfaction replaces terror; basic needs are honored; shared memory replaces dissociation; cooperation in creating new possibilities replaces internal mistrust. Antidotal experiences come to the foreground of the therapy work and focus on historical trauma is minimized. The imagery work guided by PBSP principles aims for the recovery of memories to proceed with the least amount of retraumatization or regression.

OVERVIEW OF THE SEQUENCE OF TREATING DID USING PBSP

Pacing and Therapeutic Alliance

Psychomotor must be modified to be used successfully with clients with DID. It is usually a nonsequential therapy in that following the highest energy in the moment is the focus. For effective treatment with this population, however, it is necessary to follow a sequence, both in completely processing any given piece of work and in the organizing of a course of therapy. We recommend following the tri-phasic model (Chu, 1998; Herman, 1992) in which safety precedes metabolizing trauma, which precedes grieving and reconnecting. It often takes time and specialized techniques for those with DID to learn internal communication, cooperation, containing, and contracting (Putnam, 1989). Well into the treatment, there will be new alters or recovered memories that overtax the *pilot*; expect to work within the context of dependence and the periodic need to carry the *pilot* function for the client. Nonetheless, therapy remains a collaborative process that honors the client's need to experience control. As previously mentioned, we will introduce a trial structure early to assess the client's readiness for PBSP work. But we proceed carefully, emphasizing safety over trauma work until we are confident of the client's coping skills, particularly our ability to engage the client's *pilot* to help guide the work.

As Herman states:

> The alliance of therapy cannot be taken for granted; it must be painstakingly built by the effort of both patient and therapist. Therapy requires a collaborative working relationship in which both partners act on the basis of their implicit confidence in the value and efficacy of persuasion rather than coercion, ideas rather [than] force, mutuality rather than authoritarian control. These are precisely the beliefs that have been shattered by the traumatic experience. Trauma damages the patient's ability to enter into a trusting relationship . . . (1992, p.136)

There are preliminary skills the client must master before *structure* work begins. The relationship and contract work entails an often-extended process of learning to trust the therapist, and what may be an even longer process of accepting the diagnosis. Hosts must learn to care for alters rather than compete with them for "body time." Alters must learn to cooperate and communicate; overcoming the dissociative boundaries intended to keep them separate. Contracts must be made and honored internally to block familiar but outgrown and counterproductive ways of coping.

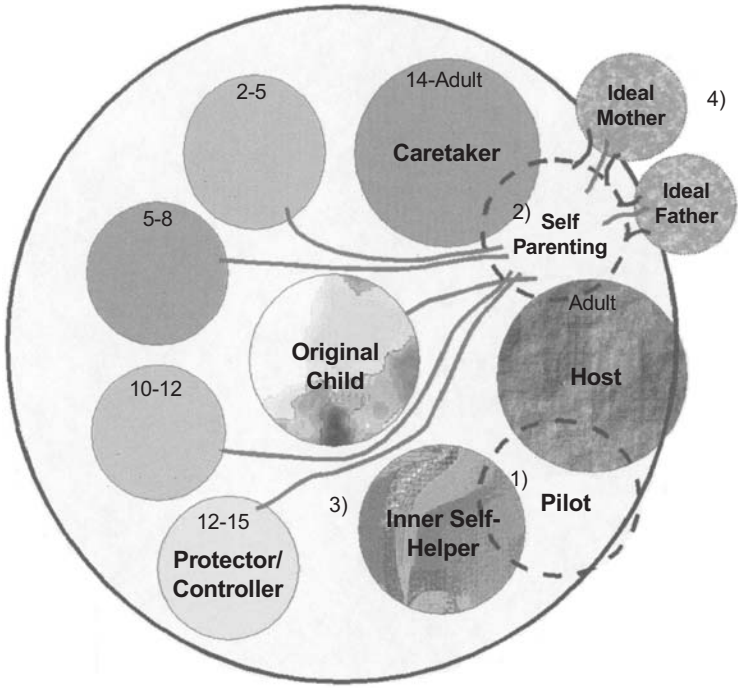
PBSP supports the attitude of acceptance, valuing, and hope that the convoluted energies will find satisfying expression. PBSP helps establish boundaries based on the convictions that at some level clients know the solution to their dilemmas. In time, as this is internalized, multiples begin to trust that they can express their emotions and beliefs. PBSP exercises help them highlight childhood strivings that remain active in their bodies and to develop at least elements of *pilot* functioning on behalf of those child states. If interpersonal energy is still shunted internally, at least there is willingness to report outwardly what is happening in the inner world. When there is some degree of communication and respect within, and the therapist is accepted as a partner in the journey, then more formal structure work can be used regularly to address the traumas.

PBSP will lead to functional and structural changes in the client with DID. Figure 3 illustrates the sequential changes sought over the course of treatment. This is a general set of expectations and should be applied with the understanding that each client will be unique and a partner in determining the way her therapy progresses.

Developing the Pilot

In clients with DID, *pilot* function is often isolated in one or two alters and poorly developed. Through the early relationship and mapping work, we watch for opportunities to enhance *pilot* functioning and seek to identify alters that can best carry it. In higher functioning clients, the *pilot* is already well de-

FIGURE 3. The Structure and Function of the System with PBSP Therapy. (1) The inner self-helper, the host, or other adult parts assume the pilot functions of internal monitoring, reporting experience in therapy, and coordinating communication among parts. (2) Inner self-helper, caretaker, and/or adult parts assume responsibility for caring for the inner children. This self-parenting creates a prototype for ideal parenting. (3) Relieved of caretaking responsibility, the protector/controller can revert to being a child and experience healing. (4) Symbols of ideal parents become available for the system.



veloped in the host. In lower functioning multiples, there is often a prolonged process of cultivating it. Often an internal helper is the best candidate because of its dispassionate understanding of each alter and the relationship patterns within the system. But self-helpers tend to be detached and inactive; to achieve the desired compassionate stance may be a shift that requires discussion and modeling. Often an effective adult presence is best achieved through a combined effort of the host and the internal self-helper. When the *pilot* function is developed enough that honest reports of inner experience and motivation are available even in the face of shaming messages, the next stage of work opens up.

Developing Self-Parenting

There is latent self-parenting in the way that the protector/controller roughly suppresses or a teenage alter baby-sits the frightened child aspects. Structure pieces, discussions of what the child needs, and trial enactments of *basic need* scenarios all heighten the awareness that there must be appropriate parenting for the child to grow. Some with DID, especially those who have developed compassion for children out of their own painful histories, have a strongly developed sense of empathic parenting. This does not imply that they are ready to accept *ideal parent* images, although we will explore their use from the beginning. Often the initial step is to discuss what the needed parenting is and have the inner adult parent figures offer them to the children in imagery. For instance, an adult may be invited to act on her awareness that she would have interrupted an abuse scenario by removing the child to a safe place. Imagery of this process is intensely relieving to the child alter and empowering to the adult. Such imagery helps attune the children to what they experience as outside support, develops the therapy partnership with adult alters, and weans the system away from depending on dissociation and suppression as means to respond to the children. Increasingly, the care of the children is removed from the province of the protector/controller. Other, more fully adult, alters assume the role of advocating for the child needs.

Many with DID have only adults who feel helpless or contemptuous toward the inner children. So it is crucial is to develop a commitment to self-parenting. Often the therapist has to carry the role of advocating that the child's needs are legitimate and of fostering discussion of appropriate parenting. In raising the child's needs to adult awareness, the therapist helps one or more alters function as a more mature internal supervisor of the child alters. It may be the host, the internal self-helper, the older adolescent baby-sitter, or some combination of them who develops this sense of accountability. They will remain active partners in the work, supervising the children so that they are not retraumatized during other alters' work. They will also be the conduits for ideal parent messages.

The emphasis on self-parenting raises the theoretical concern that this fosters the *Magical, Omnipotent, Interior Parent*. Quite the opposite is true. In most with DID, that function is personified in the protector/controller alter who resists outside parenting as an intrusion. By lessening the care taking responsibility of the protector/controller, self-parenting makes the multiple more accessible for interactive solutions. Learning alternative approaches to parenting also entails openness to new strategies as suggested by the therapist; the movement is away from solipsism to interaction.

Healing the Protector/Controller

The protector/controller then becomes more available to experience healing. Typically there is relief at lessened responsibility for the children. But this is quickly replaced by a sense of vulnerability and worthlessness. The protector/controller asks, "what is my role then?" Such doubts are the authentic emotions, which become the starting point for the next phase of structure work: with the protector/controller as client. As this alter's true scene is elaborated, the discouragement about outside parenting can be understood in its historical context. Almost universally, the protector/controller arises out of the preadolescent cynicism about trustworthy parenting being possible, and the resulting conviction that seeking satisfaction outwardly is the surest path to more abuse. Such beliefs require antidote experiences to instill hope and reduce defensiveness. This healing work yields essential changes: a reduction in the critical and shaming messages in the system, a new openness to emotional expression and corrective parenting, and greater access to the younger children. As structure work resolves the early trauma, there is less need for the dissociative boundaries. The protector/controller may become younger until it reconnects with the original child; the system begins to think less distinctly of individual children and more of a collective sense of "the children."

Another session, again from early in treatment, exemplifies this work. Watching home movies was triggering for the client, who felt frightened and dissociative. As she related this, she indicated she felt like she was two years old. When asked if there was anywhere in her past that a child of this age would have been safe, she remembered sitting in her grandmother's lap. As an adult, she imaged herself carrying the child to the grandmother, watching the fear dissipate, and then beginning to introduce herself with the reassurance that the child had survived and grown up. The intent of this work was to introduce the idea of adequate parenting from both historical (grandmother) and self-parenting sources. It succeeded in defusing the fear and reengaging *pilot* functioning so that the imagery work could be reported and modified. But there was a paradoxical reaction. The child became distressed, filled with the conviction that she was poisonous. She warned the adult to get away, wanting to protect her from the child's self-imagined toxicity. At that point the "protector/controller" entered the scene and started yelling so that the child would stop. Here the therapist intervened with instructions for the adult, who then thanked the protector/controller but reassured her that she was not frightened of the child. With the session near the end, the only resolution attempted was for the adult to approach the child and tell her that they could continue to work together without either being damaged. The child was skeptical but engaged.

Here we see the self-parenting beginning to supply a needed bit of *limiting* of the child's shame-based conviction that she was toxic. This offers an alter-

native to the protector/controller having to verbally batter the child into silence. While early and partial, this work defused an experience of fear and anger, building a new base through calm parenting for both the two-year-old and the protector/controller.

Internalizing Ideal Parent Figures

As the protector/controller assumes its original identity as a child needing parenting, there is more attention to the type of parenting that is available. This takes several forms: appreciating the historical figures that did offer something (such as the grandmother in the scene above), developing nurturing relationships in the present, active self-parenting about familiar issues, and a greater awareness that there are some issues that will require entirely new parenting experiences. It is at this point that the *ideal parent* figures are consolidated, as symbolic external figures that can offer needed emotional reeducation.

Premature introduction often leads to rejection of the *ideal parent* symbol by many alters. The literal parenting was often abusive, fostering a negative expectation of all parents. We usually start by seeking to develop self-parenting ability since this builds on the inner structure that exists. But we also use a graded series of exercises to begin to imagine external parent responses. It helps to inform the *pilot* to simply ask at different moments of reviewing history or child states: "What kind of parenting would have been needed here?" or "What would have been just the right response to the way the child was feeling?" Such questions can be followed by imagery and drawing assignments that help the client identify the appearance and character desired in *ideal parents*. Alters can be invited to explore what it would have been like to receive appropriate parenting in response to basic needs for *place*, *safety*, *protection*, *nurturance*, and *limits*. For instance, the therapist can enroll her gaze and smile at the client in the way that a doting parent might have gazed at a newborn to convey a welcoming sense of *place*. Since most with DID have had little sense of being welcomed into this world, such a gaze may awaken powerful grief and longing. This can then be resolved in imagery work with *ideal parents*.

Clients can be asked to complete variations on the Ideal Parent Exercise, in which they can explore the responses which would have been most helpful as an alternative to points in history then there was inadequate parenting. In classic form, the *ideal parent* exercise involves enrolling a female and a male group member as *ideal parents*, who are then available to help the client create a satisfying alternative to a historical situation that was injuring. In one-to-one sessions, variations can be made in which objects are enrolled to represent the ideal parents (e.g., the couch as a supportive *ideal father* or a blanket encircling the client to represent the arms of the *ideal mother*) or the client creates the interaction in imagery. If there had been a confrontation in which the historical

father had become terribly violent, then an *ideal father* might have calmly stepped between him and the children and escorted the historical father outside until he could calm himself. Alternatively, the client might have imagined a very different *ideal father* who would have promised not to hit or yell. Such exercises help the client with DID to identify healthy resolutions for historical injuries and to learn that effective parenting is possible. With repetition, most clients create effective symbols of *ideal parents*. In time, clients learn to use their own unique images of *ideal parents* outside of therapy sessions. The images can be available "on demand" to calm a frightened child, help in the management of a spontaneous abreaction, or to offer loving limits to a resurgent urge to act out.

Clients at this stage have been able to join structure groups and quickly recapitulate self-parenting work, now savoring the experience of external figures providing touch or soothing words. Others continue to work with objects or imagery. Whatever form, the *ideal parents* are used with greater creativity to provide new experiences that help the child grow.

One of us (K.W.) came to Psychomotor after having done work with DID for a number of years. After an experience of training in using PBSP in one-to-one therapy, this approach was tried with a long-time client who had already done a significant amount of trauma metabolism. After the session in which we worked with the concept of using *ideal parents* her comment was "I don't know how this works, but this is different from anything else you have done with me." *Ideal parenting* had been attempted with one particular alter. Then other child alters wanted to do their own *ideal parent* work. This seems to have stabilized the system and allowed parts to be more accepting of each other. They no longer fought for therapy time as individual alters. They learned more about cooperation, even though this had already been the focus of much work. Psychomotor seems to teach cooperation in a much more efficient manner.

At this stage in the treatment process, the client with DID functions as a unified whole. Because in PBSP it is customary to work with different ego states (e.g., adult and child), there is no insistence on unity. This means that we have not expected our clients to fuse their ego states. Such fusion may happen spontaneously. But even if there are distinctly different identities, there is an adaptive focus on how to function collectively.

One issue that emerges at this stage is how to handle intimacy. There is grief over missed opportunities and lost years, profound loneliness, resurgent fears of sexuality and violation, and yet renewed hope and determination. Another issue is the shy attempt to now claim and practice some of the unique skills that have previously been disparaged and submerged. Because of its focus on developing identity (what our clients have labeled "becoming the person I was meant to be") PBSP helps the client make the shift from an identity as a victim

to acknowledging special gifts and abilities. No longer relying on dissociated alters to function; the client becomes indistinguishable from other clients with a history of trauma.

Issues of Safety and Containment

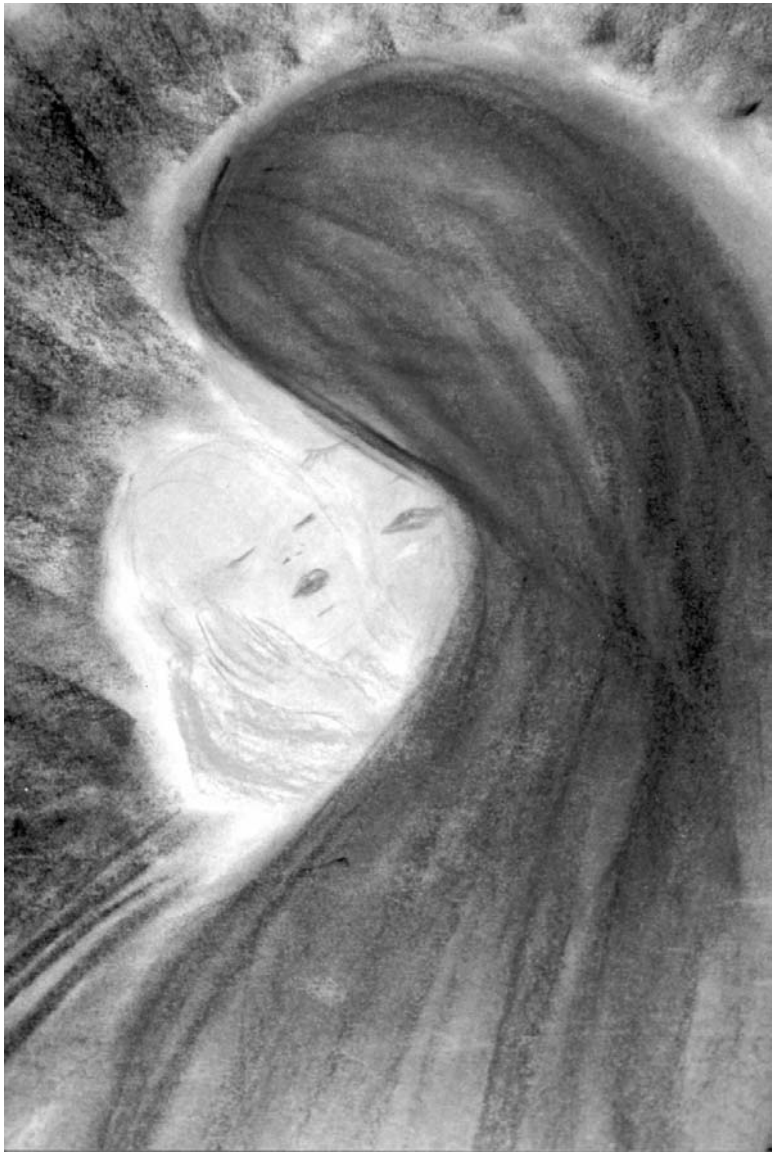
PBSP invites powerfully emotional reconnection with the past. This can be potently healing; it can also overwhelm defenses. It should be used thoughtfully, cautiously and with appropriate training. An experienced therapist can quickly adopt the focus on antidote experience, with its hope-inspiring sense of what could be. Likewise, the early shift from trauma history to the needed interaction for healing is generally recommended. With some practice, it is safe for the therapist to introduce the Ideal Parent Exercise. Preliminary work might invite the client to draw an ideal family portrait (Figure 4) or to write detailed descriptions of the qualities wished for in their own *ideal parents*.

It is then easy to return to a relatively mildly distressing situation in the past and bring the *ideal parent* symbols into play, imagining or role-playing how they would respond to change in the situation and what they would say to the client. As the scenario unfolds, the client can be instructed to attend to what is felt and needed in terms of additional interaction. This Psychomotor approach can be readily adopted regardless of theoretical orientation.

The work with the body, because it can easily flood the client with memory or emotion, should be endeavored only with significant training in the approach. Full structure work should likewise be attempted only by practiced Psychomotor therapists and used only with clients who have demonstrated well developed *pilot* functioning. This article, therefore, is not offered as a routine for treating DID. Instead, it offers some of the rich possibilities to be mined as Psychomotor is applied with this population.

Containment, to a Psychomotor therapist, involves a sense of trusting the body. Whatever the energy, even that encountered in the midst of profound abreaction, there are ways for the experienced practitioner to respond therapeutically. So long as physical contact preserves the client's sense of bodily integrity, there is little risk of sustained regression. Intervention may involve the use of pillows, blankets, or even judicious touch on the arm or the crown of the head, all of which help the client know that her emotion is sustainable and meaningful. If there seems to be excessive regression, grounding and orienting techniques can be supplemented with the types of questions that engage the *pilot* (e.g., "What would the child need now to know she is safe now?"). Ultimately, containment lies in the client coming to believe that any energy encountered in her work can come to a good resolution by following the *energy* → *action* → *interaction* → *satisfaction* sequence. The resolution may come in the release of movement or emotional expression, in the hope that

FIGURE 4. Client Drawing of Ideal Family Portrait.



comes from imagery of alternative interactions, or the validation that comes from a collaborative relationship with the therapist. Psychomotor is safe and respectful of the client, even while strong emotion is central to the work.

CONCLUSION

Our work with individuals having DID has been the most challenging and the most deeply satisfying of our careers. The early and repeated injuries leave them with not only multiple personality but also multiple reality disorder. Distortions about a sense of worth and what is possible for them in the world present great obstacles to recovery. As Will Rogers said, "It's not what we don't know that gets us in trouble, it's what we know that ain't so!" Those with DID begin assuming that the world is dangerous and that they themselves are somehow to blame for the abuses they experience. DID means living in a world of private language, unshared symbolic meanings, and the conviction that there is no place in the world where these can be understood. To develop trust under these circumstances, takes patience, intuition, and persistence. It is taxing work. More profoundly, it is holy work, like midwifery to the process of giving birth to a new person. Psychomotor provides the attitudes and many of the tools that permit our participation. To be able to read meaning in the body when words are not yet available, to anticipate the emergence of *basic needs* and the direction of their satisfaction, and to trust that the *soul* will awaken to possibilities for genuine living even in contradiction of the old beliefs–all of these come from Psychomotor. With no other clients have we seen it applied in such transforming and satisfying ways as with those overcoming Dissociative Identity Disorder.

NOTES

1. In earlier literature PS/P is the abbreviated form for this theory. In later literature it is replaced with PBSP or Pesso/Boyden System Psychomotor Therapy.

2. Words in italics are key theoretical constructs of PBSP or Psychomotor Therapy.

3. The Voice of Negative Prediction is one of myriad internal figures that the client can, with the help of the therapist, identify and name. Throughout this text there are other examples of such *fragment figures*. They are capitalized for emphasis.

4. We have chosen to use the female pronoun throughout this paper. While we are well aware that DID occurs in males, we have worked more with female clients.

5. *Magical, Omnipotent, Interior Parent* is a term that is both italicized and capitalized to show that it is a theoretical construct as well as a self-figure.

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