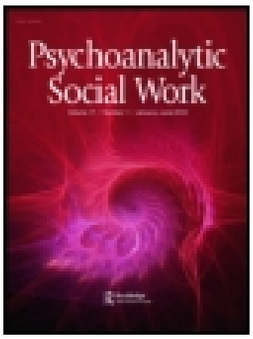

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Karen Baker

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From "It's Not Me" to "It Was Me, After All": A Case Presentation of a Patient Diagnosed with Dissociative Identity Disorder

KAREN BAKER

The Michigan Psychoanalytic Council, Ann Arbor, Michigan, USA

In cases of extreme childhood trauma associated with abuse and neglect, one's sense of self is seriously compromised. Attachment patterns, symptoms, defensive operations, and character formation will differ depending upon the level of interference and impingement. When repeated trauma occurs in early childhood, the dissociative response may become the first line of defense for the person to rely upon. In its most severe form, patients are diagnosed with Dissociative Identity Disorder (DID). This paper addresses the case of a woman diagnosed with DID. It describes the restoration of a cohesive sense of self from the eight parts of a dissociated and fragmented self in the course of therapy. The clinical case material presented is that of the child part of her, known as Lucy. Her treatment resulted in the integration of the "it's not me!" self to the patient's knowledge that "it was me, after all."

KEYWORDS dissociative identity disorder, dissociation, trauma, integration, abuse, neglect

INTRODUCTION

Healthy development is predicated upon a "good-enough" environment (Winnicott, 1960) in which a consistent, secure, and loving bond between the child and the caregiver facilitates the internalization of positive object relations and a secure integrated sense of self (Bowlby, 1969). These dependable attachment bonds, wherein the caregiver responds promptly and appropriately to the positive and negative states of the child, are vitally important to the child's development of his or her coping capacities. This

Address correspondence to Karen Baker, 555 E. William, Suite 25E, Ann Arbor, MI 48104. E-mail: kembaker1@comcast.com

progressive pathway in development is compromised when an individual grows up in a chaotic abusive and neglectful environment. The caregivers in these environments, due to their own pathology, are not apt to assist children in understanding their experiences nor do they facilitate a process of linking disconnected experiences that would promote psychological integration. Gold (2000) notes that in these family systems, the abuse survivor has grown up in an environment that functions at lower levels in cohesiveness, organization, morality, adaptability, and expressiveness and higher on conflict and control. He emphasizes that it is not only the trauma that has had an adverse impact on the child's functioning, but also that the child has grown up essentially alone. In addition, we have learned from research and clinical practice that such environments interfere in the process of integration, relational patterns, and the capacity to self-regulate and to develop a sense of trust and safety (Fonagy, 2001; Schore, 2003).

In cases of extreme childhood trauma associated with abuse and neglect, one's sense of self is seriously compromised. Attachment patterns, symptoms, defensive operations, and character formation will differ depending upon the level of interference and impingement. When repeated trauma occurs in early childhood, the dissociative response may become the first line of defense for the person to rely upon, as well as a mode of communication and adaptation (Davies & Frawley, 1994). While costly later in life, the dissociation is a defense against remembering and integrating childhood trauma (Loewenstein & Ross, 1992). It functions as an effective coping strategy to manage terror, betrayal, and other negative affect. It is what Putnam (1992) has called "the escape when there is no escape" (p. 104).

Furthermore, the hallmark of dissociation is the human mind's ability to adaptively limit its self-reflecting capacity (Bromberg, 1998). Bromberg states, "As a defense, dissociation becomes pathological to the degree that it proactively limits and forecloses one's ability to hold and reflect upon different states of mind within a single experience of 'me-ness"' (p. 7). Over time the dissociative response may become automatic and contribute to what Brenner (2001) calls a "dissociative character." The dissociative process of severing connections in mental functioning underlies eating disorders, substance abuse, borderline and narcissistic disorders, depression, and posttraumatic stress disorder (Bromberg, 1998; Farber, 2008; Howell, 2005).

In its most severe form, patients are diagnosed with Dissociative Identity Disorder (DID), previously known as multiple personality disorder (MPD). The renaming to dissociative identity disorder (APA, 1994) was intended to capture the contemporary advancements in conceptualizing dissociation. In addition, it was an attempt to recognize that the disorder was not one of too many personalities, but rather, a problem of not enough of one personality (Brenner, 2001). In other words, it's a disturbance of identity formation and cohesion. Each alter identity represents a self state that contains traumatic events with distinct affective, cognitive, behavioral, and somatic experiences.

CASE ILLUSTRATION

In this paper, I will present my clinical work with Jackie, whose story of brutal abuse in tandem with neglect left her severely traumatized in childhood and inter diagnosed with Dissociative Identity Disorder (DID). Her bravery and determination to face her emotional pain and memories, while a tumultuous process at times, resulted in the integration of the "it's not me!" self to a knowing that "it was me, after all" (Brenner, 2001). I will address the restoration of a cohesive sense of self that transpired through our work with the eight parts of her dissociated fragmented self. It is not possible to present the complexity and therapeutic process with all eight dissociated aspects of herself. For the purposes of this article, I will present the child part of her, known as Lucy, who held the abuse memory of being in the basement, which will be presented later in the paper. Her therapy lasted for six years.

It has now been several years since Jackie completed her therapy with me. My initial contact with her took place in the late 1980s. During the phone intake she told me that she was struggling with depression and was "shopping around for a therapist." When I inquired about what she was looking for, she assertively told me that she would know when she found her. We agreed to meet to discuss this further.

Jackie arrived for the initial consultation neatly dressed in a floral skirt and silk blouse that accentuated her blue eyes. I was struck by her confident demeanor, as she informed me that she was an incest victim struggling with depression, nightmares, flashbacks, and suicidal ideation. She was articulate but spoke in a voice absent of affect, as she told me that she was beginning to recall memories of abuse in bits and pieces and was seeking help to understand her experiences and to recover from them. This would be her second attempt at therapy. She had recently terminated her first therapy, feeling that it had provided her with very little relief from her suffering and confusion. "I didn't feel like she understood me. When I began to talk about the things that had happened, the therapist would start to cry or she would become angry and tell me that she had a right to be angry. Then she started to forget our scheduled appointments. I felt as though I had to take care of her. I hope I won't have to take care of you." I responded to her by assuring her that this would not be her responsibility.

In addition, I found this to be a curious transference/countertransference reaction and wondered if there might be distortion in Jackie's description of what happened. Was this how it actually came down? Was she externalizing? Were they her feelings or the therapist's feelings and reactions? I wondered if she was warning me of her anger and her forgetfulness. Was she warning me about her relational and attachment patterns? I kept this reverie to myself. Once the initial assessment was completed we began a once-a-week treatment. In the course of the next couple of months, we increased the frequency to three times per week due to Jackie's flashbacks and

suicidal ideation. At the time, I was not aware that just beneath this veneer of a seemingly high-functioning and competent woman was a terrified, desperately confused, and fragmented self suffering from a severe dissociative disorder. Her external presentation of a "put-together self" soon gave way to her internal fragmentation and psychic reality.

History

Jackie was in her early thirties and working part time as a nurse when we began our therapeutic work together. She had been divorced a few years prior to our meeting and was living alone. Her divorce was an amicable parting and Jackie attributed the breakup to her coming-out process as a lesbian, although she also noted that it was extremely difficult for her to feel close and connected to her husband. She preferred to have a lot of time alone to write poetry or to paint. They had been married only a couple of years. As our treatment relationship developed over the course of her therapy, she would periodically share some of her writings, paintings, and sculptures with me. It was quite evident that she was a creative and talented artist. In addition to the dissociation, I am convinced that her intelligence, creative capacities, and determination were some of the ingredients that helped her to survive her childhood traumas.

Jackie's family narrative is a painful story. She grew up in the Pacific Northwest with a brother who was 13 months older and a sister who was 4 years younger. Her brother was diagnosed with bipolar disorder when he was in his early twenties. Her family lived in substandard conditions. Occasionally the utilities were shut off due to lack of payment, and many times the family had an insufficient amount of food in the home. As a result, she and her brother would scavenge through the trash looking for food or rely on the generosity of a neighbor who would occasionally feed them.

According to Jackie, she and her siblings were all born before her parents were 21 years of age. Her mother had earned a high school diploma and her father had dropped out of school in the eleventh grade. Both of them worked odd jobs to provide financially for the family.

She recalled moving frequently during her childhood, but didn't know the reasons for the moves. She speculated that there may have been times when her family was evicted due to delinquent rent payments or her father's frequent loss of employment. She described her father as alcoholic and violently abusive both physically and sexually. Beginning in early childhood she experienced repeated violent sexual abuse by him. Initially the molestations included fondling her genitals and fellatio; they eventually culminated in his impregnating her in her mid-adolescence, requiring an abortion. She recalled that during the times of the molestations and rape he would say to her that "good girls know how to make daddies feel good." He would tell

her that this was between the two of them and was to be held in secrecy. In her helpless and powerless state, she frequently felt terrified that he would kill her. This intense vulnerability and degradation by her father left her racked with shame and confusion about her participation in the abuse. Her father raped her in several locations, including her bedroom and the back of their pickup truck. Her shame and guilt derived from the notion that she "played along" with him and would try to be as quiet as possible. In time, we learned that the times of being quiet were in fact moments of feeling paralyzed, immobile, or frozen, an adaptive response she employed since it was not an option to fight him off or to physically flee from the situation. She psychically fled through the process of dissociation.

Both siblings were abused as well. Jackie often felt in the caretaker role in relation to her siblings because of the inadequate care and lack of nurturance within the family system. She recounted several stories of her desperate attempts to provide for them because her parents were often intoxicated, passed out, sleeping, or not at home. Her family life was replete with terror, chaos, loss, abandonment, and anxiety.

Jackie excelled at school, a place that was a reprieve for her. She loved the intellectual stimulation and was gratified by the interest and the attention some teachers gave to her. These early attachments, along with time spent with her maternal grandmother, provided her with some solace and the experience of safe and loving relationships. These relationships provided her with the opportunity to develop her capacity for a more trusting reliable attachment with me.

Jackie's mother was passive in relation to her father and not able to protect her children or herself from his violent abuse. In relation to her siblings and herself, Jackie experienced her mother as harsh, cold, and unresponsive to her needs. Later in the course of her treatment, she came to view her mother as a frightened victim herself, who more than likely maneuvered through the world in a frightened dissociated state of mind as well. Not only did her father impregnate her during her middle adolescence but, prior to the impregnation, her mother began to make regular nightly visits to her bed. Midway in the course of her therapy, Jackie remembered that her mother would crawl into bed with her, speak in a sweet tone to her while playing with her hair, and then force Jackie to masturbate her. Occasionally she would fondle Jackie's genitals. These sexual experiences and how it made her body respond left her feeling confused, guilty, and ashamed. Often she felt isolated and bereft of protection and love, while longing and desiring to be close. "I wanted her to take care of me, to alleviate my fears and to comfort me. I desperately wanted this from her but got something completely different." She reported that there was no physical pain involved in this abuse and acknowledged that she felt bodily sensations that were pleasurable, even though in her head and stomach "it felt really bad." She commented that she felt as if her body had betrayed her.

Afterward her mother would have little to do with her. She remembered her mother saying that she didn't have to like or love her just because she was her daughter. Jackie's experiences of being used, seduced, and exploited by both parents contributed to her self-representation of being bad, unlovable, and needy. She never received any comfort or explanation after her traumatic experiences or other dysfunctional occurrences within the family that were upsetting and bewildering. The isolation she felt was profound. Once again she was deprived of a protective experience and of being loved and recognized in her own right as a separate person. These two significant sexual events in her adolescence, in combination with the earlier abuse and neglect, contributed to her reliance on dissociation as a means of protection and self-regulation.

Jackie's disintegrating veneer of a seemingly high-functioning woman dramatically revealed itself six months into the therapy. Up to this point, the content of her sessions focused on her feelings of depression, the challenges she faced in her relationships with co-workers and a handful of friends, and her painful family history: a truncated, dissociated version of herself slowly emerged through the course of her therapy. As the therapeutic alliance and her trust in me developed, she eventually told me about the "strange happenings" that she had experienced most of her life. These "strange happenings" included sleepwalking, which she traced back to her adolescence, finding herself in places in which she had no awareness of how she had gotten there, lost time, and finding unfamiliar clothes in her apartment. In this session she also told me about the dream she had had three days prior. In the dream, she reported having arrived for her therapy session, and when I invited her into the consulting room instead of sitting on the chair she opted to lie on the couch. She explained to me that in the dream, I stayed seated in my chair and patiently waited for her to begin. She said, "When I lay on the couch there were three of me and each one of them took their turn to talk to you. I don't remember anything that each of them said to you. I woke up right after that." When I asked for her associations, she told me that nothing was really coming to mind. In fact she noted that it was too scary to think about having three selves. I carried a similar anxiety within myself following the session. A week or so later, I started to receive phone calls and letters from alters, the personified parts of herself. It was during this time that I became aware of her DID diagnosis and a shared but unspoken concern regarding the major challenges we would face in the course of our work together.

I imagined entering into the dangerous and tumultuous territory of her internal world and navigating our way through the intense enactments as well as the transference and countertransference exchanges. As an experienced therapist, and a candidate in analytic training, I knew full well that the healing power rested upon the therapeutic relationship and that the greatest opportunity for change was in the analysis of the transference and countertransference moments. However, my confidence was shaken, as I felt

unknowledgeable and inexperienced in treating a patient diagnosed with DID. I immediately sought supervision and began to read and educate myself about DID and its treatment. I quickly learned to make some modifications in my technique by being more active and at times using a more structured and direct approach, which DID experts and traumatologists recommended (Kluft, 1993; Putnam, 1989). I also relied upon the theories of ego-psychology, attachment theory, object relations theory, and relational theory to use as my compass in understanding Jackie. My integrationist approach was informed by the work of Josephs (1995), who has cogently written about the relevance of character analysis and how this traditional approach is enhanced by integrating contemporary psychoanalytic perspectives. My model for understanding was also influenced by Brenner (1994) and Davies and Frawley (1994). And so, we entered into the difficult process of her treatment.

Process of Therapy

The clinical process that unfolded between Jackie and me rested upon the initial task of establishing the therapeutic alliance by focusing on safety, boundaries, consistency, and creating a good enough space (Winnicott, 1960) that gradually allowed Jackie to trust me. Only then could she bring her dissociated parts into the treatment, revealing her inner complex world that consisted of victims, perpetrators, rescuers, helpers, and exploiters. In so doing, she was gradually able to integrate the split-off affects and split-off self and object representations that were fractured by her traumatic experiences. In time we were able to understand their functions and meanings.

In the early phase of the treatment, after I received the phone calls and letters, many with different styles of handwriting, Jackie began to share her journal entries and poetry that she didn't recall writing. She complained of losing time and finding things such as matchbook covers from bars that she couldn't imagine frequenting. A second major task and goal of her therapy was to make available to her entire internal world the knowledge and secrets held by the different ego states. Making this knowledge conscious eroded her defensive need for separateness. According to Putnam (1989), developing "internal communication" is one of the major therapeutic processes that facilitates change in the DID patient, by breaking down the amnesic dissociated barriers. It was about this time that I began to actively speak to the whole person, not just to Jackie, inviting all the different parts of her to listen in, while I emphasized that there was one body and that each altered state represented an aspect of her. This technique of addressing "everyone" was necessary because of the memory lapses Jackie experienced. We had many sessions in which she would switch and an alter would appear to reveal some information about her or about her past. It is critical in the therapy to respect the subjective experience of the patient as sharing her body with the

inside people. This respect and empathic connection fosters the therapeutic alliance. At the onset of treatment, each of Jackie's alters knew little to nothing about one another, indicating very little observing ego or self-reflective function. Even when awareness of the others became known, Jackie held a conviction of separateness. This conviction served to protect her from the reality of knowing that these traumatic events actually happened to her.

Over the course of several months, I came to know each part, the reason for that part's appearance, and the pattern of behavior and feelings for each. The alters described themselves as being of different ages and genders, and as having different sexual orientations. In keeping with our usual standard of practice, we engage with our patients in whatever states of mind they present to us. For the DID patient this state of mind can be more dramatic in its presentation of the personified ego states. In the course of Jackie's therapy, each alter presented itself with its own subjectivity. However, this subjectivity was not highly elaborated and contained limited thoughts, feelings, and behavior. The predominant clinical themes that emerged were of danger, safety, abandonment, control, and the tension between knowing and not knowing.

During the second year of treatment, Jackie struggled with suicidal ideation and began cutting and burning herself. Hospitalization was required on five separate occasions. These self-mutilating behaviors were inflicted by the alter Carla, who was present during the rapes by her father. She carried the rage and functioned as both the seductress and the promiscuous night owl. She reveled in her sense of having power to seduce the other and then leave them "in the cold" or to assault them by biting or scratching them. We came to understand her as the part of Jackie that was attempting to master the rape trauma by turning passive into active and identifying with the aggressors, her perpetrators. In these self states, the cycle of abuse was being repeated both internally and externally as she oscillated between the masochistic victim state and the sadistic perpetrator state.

As time went on, and the work with the alters moved forward, our diligent efforts at creating a cohesive narrative began to develop and Jackie began to accept her alters. This fostered further internal communication, which in turn allowed her to become more known to herself. As this occurred there was a shift in experiencing the "not me" to the tension between "it happened to me but it didn't happen to me."

The Alters

I will present vignettes that pertain to the child alter Lucy, but before doing so it is important to know that eight alters were revealed to me in the course of Jackie's therapy. Early in the work we came to understand that the "birth" of these different parts of herself coincided with certain traumatic events in

relation to her parents. For example, she traced the "birth" of Carla to the rape that resulted in her becoming pregnant.

The scope of this article does not allow for the detailed explication of each part and its related treatment process. However, I will say that in working with the alters throughout the course of her treatment I did note commonalities throughout the process. This technique served to blur the separateness. I emphasized what was common among all the parts of her. For example, I would speak to how each part shared certain affects and served as protective helpers in order to survive the overwhelming trauma. I stressed how this was her mind's creative and "structured process" for survival (Loewenstein & Ross, 1992). For the sake of brevity, I will provide a list with some brief information about each part.

1. Jackie: The "host personality" who is the personality that brought herself to treatment. She was depressed and masochistic, and complained of a variety of somatic symptoms, in particular headaches and nausea.
2. Lucy: The five-year-old alter who held the memory of the trauma in the basement. She carried Jackie's anger and terror of men as well as the longing for and seeking for love.
3. The Magistrate: She functioned as an internal helper by negotiating between the different alters.
4. Carla: The 17-year-old alter who was the internal persecutor and identified with the aggressive sadistic father. She was responsible for sexual acting out, self-mutilation, and suicidal ideation.
5. Cassie: The nineteen-year-old who was an external helper who interfaced with the social world and worked for Jackie.
6. D: The adolescent boy who very rarely presented during our sessions. He was somewhat rebellious and carried the attitude that if Jackie were a boy this would not have happened to her.
7. Olga: Very little direct work was done with Olga.
8. Baby: In the background crying and representing abandonment and neglect.

Clinical Vignettes

The following vignettes are excerpts from sessions with the five-year-old alter Lucy, Jackie's dissociated traumatized child. Lucy lived in terror and was preoccupied with the events that occurred in the basement. She was terrified of men but yearned to be rescued and loved by an attuned mother. This series of vignettes depicts the clinical challenge that is inherent in the work with DID patients. That is, how does a therapist help the patient know, feel, learn, and accept whatever it was that may have happened to him or her? The material presented took place over an extended period of time.

In the session preceding this one, Jackie had reported a vague dream of being in the basement and having her head dunked in water. She had a blurred recollection of seeing a child in a basement tub but was unable to link the image to herself. She remained curious as to what this dream meant. In this session she began by stating that she had lost time and had no conscious memory of where she had been or what she had been doing.

Jackie said, "I do have something that I want to show you. I brought a drawing pad and these are two drawings that I found in it. I didn't draw them."

She gingerly opened her drawing pad, thumbed through a few pages and then showed me the drawings. The first picture was a childlike crayon drawing of a house surrounded by flowers and trees. There were two representations of birds in the left-hand corner. There was a large golden image on the right-hand side representing the sun. The words "Mommy, I love you" were printed in a mixture of lowercase and capital letters. Beneath that was printed "Do you love me. Love Lucy."

The second picture was a drawing of stairs leading to the basement. There was a tall figure, representing an adult, in the picture, and a child figure on the stairs with a chain connecting her to a pipe. There were blue and brown wavy lines across the bottom of the page. A black line was drawn across the middle of the page to delineate the top floor from the bottom floor. Above the line and above the stairs was another adult figure sleeping.

We proceeded to have the following exchange:

KB: You seem curious about these drawings. They are in your sketchbook but you say you have not drawn them. Tell me what you make of them.
J: I don't know. This one could be sweet if it actually came from a child.
KB: Meaning?
J: You know. A child separate from myself. I'm not a child.
KB: That's true. You are not a child yet these seem to come from some part of yourself.
J: I suppose so.

After a brief moment of silence we shifted our focus onto the second drawing.

KB: What about this one?
J: (She looked at it and suddenly turned her head away from the drawing. After a brief moment she said), Oh god, I don't know. It's in the basement. (There was a long pause here in which the anxiety in the room became palpable.) I know where it is and who all the people are, but I don't know what it is all about.
KB: Who are the people?
J: The man in the water is my father. I am the one on the stairs and my mother is upstairs sleeping. (With hesitancy and trepidation in her voice

she very softly said), He made us go to the basement a lot. I would try to leave but I couldn't. (Again, there was a long pause before she spoke.) That's what it was. Oh god! There was a dog chain. I think I was chained to the pipe and I could only go to the second stair. He had on boots in the water. I don't know why he was wearing boots.

At this point in the hour, I noticed that I was feeling lightheaded, distracted, and apprehensive as to what Jackie might say next. I had an urge to end the session, not wanting to hear what she might say next. Certainly I recognized the tension between wanting to know and to not know, something that Jackie and I had addressed many times in the course of our work together. However, more importantly in the moment, I was thinking about my strong urge to disconnect from Jackie in such a dramatic way as to prematurely end her session. Both of us wanted to dissociate to avoid the fear and feelings of terror and disgust.

J: (Finally after a brief pause she stated), I can't keep talking about this or thinking about it or I will go away and I don't want that to happen.
KB: There's a pull to disappear when you begin to remember something so painful and scary. I noticed your hesitancy and trepidation earlier before you spoke further. I was wondering what was happening in that brief silence.
J: What was happening? (Pause.) Nothing really. I don't know.
KB: Can you identify what you were feeling?
J: (Anxious.) But then I felt nothing. Nothing at all.

I was interested to learn more about the pictures and what they represented in terms of her experience but I also felt wary, as indicated by my desire to end the session early. At the end of the session, Jackie was disconnected from her feelings and in fact felt "nothing." Through the process of projective identification she had disavowed her unwanted affects of fear, terror, and disgust, leaving them for me to hold. Clearly, it was too difficult for her to stay connected to herself, and her thoughts and feelings that were associated with the pictures. At one level these pictures seemed to be recalling the violent abuse perpetrated by her father and the abandonment she felt in relation to her mother, who in this sleeping state was not available to protect her. At another level, the pictures functioned as a bridge to gaining access to her annihilation anxiety.

It was four weeks before Jackie returned to this material. On this particular day when I went to the waiting room to get Jackie I discovered the young alter, Lucy, sitting on the floor with her shoes off and holding a teddy bear. I immediately inquired how she had gotten herself to my office and was relieved when she informed me that the adult part of her, Jackie, brought her. In a jovial spirit, she entered my office and sat on the floor. She played with her bear for some time and then initiated a dialogue.

L: I like you. You're helping. But you make her cry sometimes. She cries when she feels sad. You know he is a bad man.
KB: Whom are you referring to?
L: The father. He's a bad, bad man. I am a bad, bad girl.
KB: You're thinking that you are a bad girl. What is it about you that causes you to feel that you are a bad girl?
L: I am not supposed to talk to you. I don't think he likes me around. I really want to hurt him but they won't let me. (Pause.) He's a bad man and the bad man had the chain on our arm and put our face in yucky water and pulled our hair. We had to stand in the yucky water. (Imitating a deep voice, she says), You stay down here for one hour, young lady. If I hear you, I'll come down and get you. We were scared. Sometimes we couldn't keep quiet. That bad man would put his bad finger in a bad place in us and made us say we liked it.
KB: It sounds like you think of yourself as bad because you talk to me about what happened to you and about your feelings. It must have been so hard to feel so scared and alone and try to keep quiet in that yucky basement.
L: Yeah and we wanted help and we wanted to be out of there but then he did bad things.
KB: Yes, he did bad things to you that you did not deserve. You were scared and tired of being in that basement. You did not deserve to be hurt because you made noise and wanted to be out of there.

A period of silence followed and Lucy returned to playing with the teddy bear. Eventually I resumed the conversation.

KB: We have been talking about something important. It's an experience you were remembering from a long time ago and then you became quiet and started playing with your teddy bear. Can you tell me what is going on or what you are feeling?
L: Tired. I feel tired. He's a bad man. He scared us. I have to go now.

Then she closed her eyes, and a few minutes later I was speaking with Jackie, who appeared mildly agitated and disoriented. She informed me that she had little to no conscious awareness of the past 30 minutes. At this point, I knew that she was relying on me to rescue her from the pain of her own suffering and knowing that which was amnesic to her. She was relying on me to make the connections. Through the course of our work, it was not unusual for me to function as a bridge between her different states of consciousness, particularly when there was little to no internal communication. I conveyed to her what had transpired while at the same time encouraging her to listen so that she could become more fully acquainted with these aspects of herself, thus diminishing the amnesic barrier, to create a more cohesive sense of self. Again, we sat quietly together, and it was she who interrupted the silence.

J: I think that I feel angry. Yes, I am feeling angry.

KB: Can you say more about your anger?
J: Yes. I'm angry about all the things my parents did to me that now I have to deal with. I am tired of trying to figure out where time goes
KB: This is difficult work you are doing. By knowing where time goes, you become more aware of and connected to your experiences and feelings. There's a part of you that is working hard to know and understand yourself and at the same time there is a part of you that doesn't want to know. The dissociation effectively protects you from knowing and feeling.
J: That may be so. It's too painful for me to bear.

In the session that followed several weeks later, Jackie quickly shifted into a trance state, allowing the part of her known as Lucy to be present again. In this re-enactment there was a more vivid portrayal and affectively charged recollection of the horrifying event in the basement. This time, however, as opposed to the previous work done with Lucy and the other alters, there was a diminishing of the amnesic barrier.

Lucy repeated a similar narrative but expressed more fear and desperation in her childlike voice.

L: We had to stay in the basement for a long time. Maybe the stairs would fall down and we would never get out.

It is here that an obvious shift occurred in which she closed her eyes and, while lying on the couch, visibly trembled as she said,

L: Shush. Shush. He's coming down the stairs. Oh no. He's gonna kill us. He's gonna get us. No. No. Make him stop!
KB: Tell me what is happening.
L: He is hurting us. I can't breathe. My head is under water. The water is yucky. He keeps putting our head under water. He's going to kill us. Make him stop!

As she was speaking she made a wincing movement and appeared more agitated, and gasped for air.

KB: Tell me what you're feeling and what is happening right now.
L: Scared. He's gonna hurt us. Don't let him hurt us. Make him stop.
KB: You are telling me of an experience you had years ago and what you were feeling then. It is not happening now. You are with me, Karen, in my office, and you are remembering and feeling something in reaction to that memory. This is a safe place to talk about these matters.

After a few minutes she became visibly less agitated and opened her eyes. I couldn't help but notice my own relief following this abreaction. This abreaction, as well as others, was a very intense moment and played an important role in Jackie's therapy. The abreaction was not merely the

expression and emotional discharge of unconscious material, but, more importantly, from a relational perspective,

> the analyst is *witnessing* previously un-witnessed experience and finding a way to be in relationship to that which heretofore could only be disowned and dissociated because there was no other way for the patient to be in relationship with it. As the analyst is able to be a witness to, and bear, the unbearable, the material can be articulated, metabolized and bridged to the rest of the patient's personality. (Schwartz, 1994, quoted in Bass, 2002, p. 81)

During the time that I was listening to her, my heart was thumping in my chest and my palms had become sweaty. These were clear signs of anxiety signaling in the transference and countertransference encounter a fast approaching sense of danger. After a few minutes of silence, I spoke first.

KB: In your silence, you seemed so far away. When that happens I don't know what is going on with you or what you are thinking or feeling.
J: (After a long pause.) I was thinking about what you said. That this was a safe place. (Another long pause.) I know what happened in the basement. (She was crying as she said), The water had sewage in it. It smelled disgusting. We were chained to the pipe and couldn't get away. (She cried for some time and then said), I feel exhausted. I have a headache.

Following these sessions Jackie focused on the memory and gradually connected to her feelings of terror, anger, helplessness, powerlessness, and the lack of understanding as to why her mother had not protected her. This left Jackie with the impression that her mother did not care about her. She often wondered if her mother hated her and was perplexed as to why she allowed these things to happen.

The following week Lucy presented in my office for the last time. Jackie entered initially and was silent. After a few moments Lucy appeared and sat on the floor behind the sofa sucking her thumb. After much consideration, I went and sat next to her.

L: Did you know my father?
KB: No.
L: He said that he loved me but then he did things to me and said I was a bad girl. He didn't really love me. I want someone to love me. (Pause.) Will you be my mommy?

In the moment this question stunned me, and I recall struggling with how to respond to Jackie/Lucy. I wondered what the deeper meaning of this question might be. In this poignant and evocative transference, she seemed to be expressing the wish for a mother she could depend upon to listen

to her and to protect her. Finally, I said to her that this was not possible no matter how much she wished it to be so. I explained to her that as her therapist I was an important relationship in her life, someone who was reliable, but I would never be her mother. I was someone who could listen to her and be helpful to her. I noted the sadness, disappointment, and grief she felt in not having the kind of mother she needed. There was a long pause here and then she asked me if I loved her.

Now she was bringing to the fore the complex question of love, her love for me and my love for her. What type of love was she referring to? Was it a healthy, mutually satisfying love between patient and therapist or was it a "love" predicated on pathological omnipotent sadomasochist patterns based on her history of trauma? Novick and Novick (2000) explicate two kinds of love between the patient and therapist that are based on the open or closed system of self-esteem regulation. In retrospect, a deeper examination of the role of love in our relationship could have been more profitable. At the time, I invited her to reflect upon her question and tell me her ideas and feelings about it.

L: I don't know. I am not sure about these things. I just want to know if you love me.
KB: Based on what you said earlier about your father, even if I were to say I love you, I suspect it would be difficult for you to believe it and to trust it. I do think that as you continue to grow and develop you will gain insight into the feeling of love.
L: Do you think that I can grow up?
KB: Yes. We have been seeing you grow and mature. You are becoming more knowledgeable about yourself and your feelings.

It was quite noticeable that during this interaction there was less prominence of Lucy and more of a presence of Jackie that could be heard and seen. A little embarrassed that she found herself on the floor, she acknowledged she was conscious of all that transpired between us.

J: I was near Lucy as she talked to you.
KB: Yes, you were wondering about love.
J: Yes. I want someone to love me. That's all I've ever wanted. I don't believe that I am loveable and I'm too scared to be close to people.

As a result of her psychological traumas stemming from her parents' pathology, Jackie's attachments were disorganized and her view of relationships was sadomasochistic. The phase of work that followed these sessions focused on a sense of herself as unlovable and bad as well as her unfulfilled wish to have had a different kind of mother. She expressed how painful it was to have grown up in her family system with parents who abused, neglected, and abandoned her. There remained the additional therapeutic task of examining her view of relationships.

A few weeks later while continuing to discuss and elaborate on her self-representation as unlovable and bad, Jackie reported that something was happening to Lucy. She was becoming more difficult to access.

J: I think that she is going away but I am starting to feel the terror and fear that she must have felt in the basement. (As she cried she stated), We should never have survived all of that. It was so awful. My father was crazy. I've been having nightmares about the basement and waking feeling as if my wrists are tied. I can smell the sewage and feel my head being dunked in the water. I felt stuck there, like we were never going to get out. It was like we would be locked down there forever. Where was my mother? Why didn't she come and get us? (She cried silently and then said it wasn't Lucy in the basement.
She sobbed for several minutes and then said), It was me he was hurting. It all happened to me. They existed in me, in my mind so that I could survive. If I hadn't dissociated and had all of them, then, I don't know, maybe I would have been psychotic or killed my father. (Through her tears of anguish she said),

Thank you for listening to me. I know all too well how awful this is.

The growing closeness and the dissolution of the amnesic barrier as seen in this process with Lucy had been occurring with the other parts as well. The new and significant turning point was Jackie's acknowledgment that this had all happened to her. This ushered us into a new phase of her treatment. In the weeks that followed she alternated between crying with grief and expressing amazement regarding her accomplishment. There was a shared sense of relief and pleasure in this mutual accomplishment. However, I registered a low level of anxiety finding myself wondering if this process of integration was real. She continued to focus on her desire to mature and experience being loved by a trustworthy and reliable person. It is my impression that the work with the child persona, Lucy, as well as all of her other personified parts provided Jackie with a new experience of being listened to, which allowed her to feel less isolated and despairing. A new therapeutic object relationship was emerging and being internalized. While it was true that a new object relation was developing, there was a good deal of additional work to do on the internalization of the father-mother-child connection, which possessed destructive and sadomasochistic (Novick & Novick, 1996) elements.

Over the next few months she integrated the other parts, which was an interesting process. She reported to me that certain parts would become close to one another; for example, Lucy and Baby would become close and in turn would become nearer to Jackie and then integrate. Once she became aware of the encapsulated trauma and accompanying feelings that each part held, she expressed empathy and gratitude for "them," which seemed to help her eventually feel the pain of her traumas and to own her experiences. We

spoke about the power of the mind finding ways to protect itself from being overwhelmed or from becoming psychotic. Her way was to dissociate and create personified parts that were separate and led to a "not me" perception.

With the shift from the "not me" to the "it was me, after all" Jackie began to think about saying goodbye to Lucy, Carla, Cassie, the Magistrate, D, and the others. She decided she would do this by writing a letter or an essay. Authors that were writing in the 1980s about DID, then referred to as MPD, described using hypnotic techniques or integration ceremonies (Braun, 1984; Kluft, 1982; Putnam, 1989). I wasn't trained or comfortable with these techniques so I elected not to do or suggest either. It seemed that for Jackie her integration was a natural by-product of her strong desire for help and the work that occurred within our therapeutic relationship. I reminded her that while there were no longer such distinct parts within her internal world, all that "they" knew, experienced, and felt would always reside inside her newfound cohesive self.

The integration was met with ambivalent feelings. As she began to mourn the loss of the dissociative defense, she complained of feeling lonely and became angry with me, accusing me of having taken "them" away from her. As we worked through her anger, I interpreted to her that what had actually been taken away from her was a childhood of safety with secure and loving attachments. Her anger toward me was a defensive response to her grieving and an attempt to move away from the reality of her history of trauma. I said to her that the next task of her therapy was to integrate and accept the sad and tragic reality that she would never regain what she had lost and the trauma that she endured would always be a significant part of her. Her anger gave way to the expression of her sorrow as she sobbed and told me that she knew this was so. We continued to work together on these issues for a couple of months until she announced to me that she had been thinking more about her future and her wish to terminate her therapy. On the one hand, her therapy was successful. She was living a significantly more cohesive internal and external life since the dissolution of the severe dissociation. She became involved in community activities and, as she thought about her future, she considered going to graduate school and possibly moving out of state. I thought the termination was premature, and attempted to address this with her. However, she had remained persistent, and so we went ahead and set a termination date. While I was of a different mind regarding the termination, I respected her decision and did not want to interfere with her autonomy. This ending was different from the one she had experienced with her previous therapist. However, I couldn't help but wonder if she was ending prematurely to avoid aspects of the working-through process. Because she was vulnerable to abandonment, I also wondered if this was her way to take control and leave me first. Despite my efforts to examine these ideas, her therapy ended and we experienced a good-enough goodbye. There was sadness when we parted, and I was

left with a mixture of feeling good about our work and feeling that we had unfinished business. We had not fully worked through her sadomasochistic view of relationships. I recall having a feeling of being brushed off or dropped, and I reminisced about the work we had done pertaining to the sexual abuse by her mother. In this final transference and countertransference encounter, I was left wanting and longing to remain connected and to continue the therapeutic work. She had something else in mind.

Since the therapy ended I have not had contact with Jackie with the exception of one card in which she expressed gratitude for the work we accomplished together. I have no way of knowing if her integration has held up under life stress that she may have encountered. She moved from an "it's not me" to "it all happened to me" position, while leaving with an "I'm finished but not entirely finished" self. I do hope that Jackie has been able to consolidate aspects of our work together and is living a more connected and engaged life.

SUMMARY

I have presented the intensive psychoanalytic psychotherapy of Jackie, who had a history of parental sexual abuse and neglect and who was diagnosed with Dissociative Identity Disorder (DID). The process of the dissolution of her dissociative disorder was addressed by presenting the case material from the child persona, Lucy. The quality of Jackie's life was seriously disrupted by her dissociative symptoms, nightmares, flashbacks, suicidal ideation, and self-destructive behavior. The severity of her dissociation critically limited her capacity to reflect upon different states of mind. While this may not be considered an optimal termination, Jackie finished treatment feeling more competent and in charge of herself. She reported a subjective sense of internal unity and continuity in her daily life that created a sense of predictability.

The process of change and resolution of the "not me" to "it happened to me" first encompassed the process of getting to know the personified ego states, her "inside people." By engaging with these parts of her, both of us came to know and understand the encapsulated memories and affects they contained. As seen in this vignette with Lucy, the engagement was first brought into the treatment through the drawings. The pictures served as the first step in introducing the basement memory and Lucy, who was the part of her that held the secret of this particular victimization. She contained the split-off feelings of terror, intense longing for attachment, and love as well as the self-representation of being bad and unlovable.

An important aspect to the work was to enter into the dissociative experience of Lucy as well as all the personified parts that presented themselves to me. In entering her dissociative world, the frightening, horrifying, and confusing experiences began to emerge, which often propelled us into intense

transference and countertransference encounters playing out the roles of sadistic abuser, helpless victimized child, and the wished-for rescuer. While I entered into her dissociative world, I kept in mind her subjective experience of her "inside people" while communicating the reality that there was one body and, when possible, would blur the boundaries of separateness by emphasizing the commonalities that were shared by the alters. The dissolution of the amnesic barrier gave way to a greater sense of consciousness and internal communication, which eventually facilitated her process of integration and mourning. In one of our final interactions she paraphrased a theme from Steinbeck's book *The Grapes of Wrath* (1939), which she found especially relevant to her life with its injustices and inhumanities—that there are experiences that one has that another cannot fathom. She admitted that at times it is still difficult for her to fathom all that happened but that she was leaving feeling that she understood and consciously knew more about herself.

NOTE

The title of this paper originates from Brenner's (2001) book, *Dissociation of Trauma: Theory, Phenomenology, and Technique*.

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