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ENCOUNTERING THE SINGULARITIES OF MULTIPLICITY

Meeting and Treating the Unique Person

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If colleagues relatively new to the dissociative disorders field were to immerse themselves in articles and books about the dissociative disorders dating from the early modern era of the study and treatment of Dissociative Identity Disorder (DID), the 1970s through the late-1980s, they might experience a degree of confusion and disorientation. Likewise, colleagues oriented to the thinking of the early modern era might find the discourses of the second decade of the twenty-first century somewhat unfamiliar and perplexing.

In the early modern era, DID was understood to be characterized by discrete problems with memory and identity caused by the impact of trauma. High hypnotizability and symptoms expressing familiar hypnotic phenomena were considered core components of the disorder. Hypnotherapeutic interventions were seen as major elements of its treatment. In contrast, recent publications and trainings emphasize the importance of disturbances in attachment and the dysregulation of neurobiological systems. Relational approaches and modulating strategies, psychological and biological, attract attention. Concern with dissociative structures has become less prominent than attention to dissociative processes. Conflations of DID with Complex Posttraumatic Stress Disorder abound. Many texts and investigators now make little or no mention of hypnosis, notwithstanding its documented roles in dissociative psychopathology (Dell, Chapter 14, this volume; Frischholz, Lipman, Braun, & Sachs, 1992) and effective treatment (e.g., Kluft, 2012).

Subpopulations of DID patients have been described who recovered rapidly, integrated in relatively brief treatments facilitated with hypnosis, and retained their gains on prolonged follow-ups (Kluft, 1984a, 1986a, 1986b, 1993b), in some cases for over 40 years. Although neither attachment issues nor Complex PTSD were concerns of the field at the time, their manifestations were not prominent in these cohorts. This and their clinical courses distinguish them from the majority of DID patients described in the recent literature.

The existence of this cohort demonstrates that neither disordered attachment, Complex PTSD, nor their combination is either necessary or sufficient to provide an overarching explanation for, or conceptualization of, DID. They commonly coexist with DID, but do not constitute its foundation. Ergo, both the paradigms of the early modern era and those of newer vintage merit intense and respectful study. Neither is sufficient to replace or supplant the other.

When DID patients confront painful attachment and Complex PTSD difficulties, they exert powerful influences upon the initial stages of treatment. Accordingly, to facilitate focusing on beginning the treatment of DID *per se*, I turn to an individual from the subpopulation I have described as "high-functioning DID" (Kluft, 1986b). Such patients share much in common with the simpler rapidly resolved cases noted above, but demonstrate greater dissociative complexity. Therefore, they typically require treatments that are longer in duration, thereby allowing more extensive opportunities to observe and address DID itself.

Presentation and Initial Evaluation

The patient who has allowed me to publish this account was an advanced post-doctoral fellow and instructor at a prestigious university some distance from Philadelphia. She came self-referred, and chose Mariska Kurtz as her pseudonym.

Mariska requested my objective evaluation of her situation, an explanation of what treatment options my findings suggested, and recommendations for possible therapists. She expressed misgivings about the diagnoses, opinions, and suggestions offered by previous consultants. Mariska raised concerns about confidentiality that might be seen as paranoid

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today, but were commonplace when diagnoses of dissociative disorders were often met with skepticism, hostility, and ridicule.

We scheduled double-length consultation sessions for two successive days the following month. My notes illustrate my own interventions and thinking. Mariska's spoken and journaled observations give lucid expression to her experiencing and observing the impact of our work upon her own particular configuration of dissociative processes and structures.

Mariska Kurtz, Ph.D., age 36, was a striking dark-haired woman with a strong, firm handshake. Tall, athletic, and ready to smile, she made good eye contact, and surveyed me and my office with lively curiosity. She spoke with subtle traces of an accent I could not place. From time to time, signs of fright raced across her otherwise poised features, and departed as quickly as they had appeared. She took frequent furtive glances both toward the door and the lower half of my body.

A few months previously, Mariska became depressed. Then, panic attacks began, along with increased anxiety, disrupted sleep, and nightmares about sexual violence directed against herself or some unknown female. She hastened to insist that she had never experienced such mistreatments. Both a therapist and a psychopharmacologist concurred in the diagnoses of Major Depression and Generalized Anxiety Disorder. When she did not respond to the initial medications prescribed, the psychopharmacologist rediagnosed Mariska with Bipolar II Disorder, Depressed, rule out Borderline Personality Disorder. Mood stabilizers were prescribed. When she developed migraine headaches, difficulty concentrating, a sense that some things seemed unreal to her, and occasional lapses of memory, she was sent to a neurologist. After evaluation, he prescribed an anticonvulsant for migraine prophylaxis and to improve affective control. This regimen caused cognitive dulling and was not helpful. Mariska feared her consultants suspected severe problems they would not name.

Mariska was accustomed to rapid success. When she could not pull herself up by her bootstraps and failed to respond to the treatments prescribed to help her, she felt defeated. Until then, she had been confident she would have a gratifying career, find love, and be able to raise a family. Now, plunged into deep despair relieved only by terrifying bursts of panic, she was terrified that the future that always had seemed within her grasp would slip through her fingers.

Mariska reviewed her case unflinchingly. She threw out her medications and began a relentless search of the literature. She found reason to doubt the diagnoses she had been given, but found reason to fear she might have a condition she was sure she could not have – a dissociative disorder. Her literature search led her to me.

"You are miles and miles away from my life. And some people say bad things about you." She laughed, smiled, and remarked that she probably would never see me again. Inwardly, I translated, *"Yeah! Go to someone weird, different, and light years away from your real world. You're already set up to rationalize blowing off whatever I say and call me a nut case."* Inwardly, I reflected on her glances toward the door. *"She's sizing up her escape routes. Why?"*

Mariska's narrative of her past was complicated, but essentially benign. Her parents came from European manufacturing and banking families of affluence and renown. Although accomplished, they were more dedicated to their frenetic social lives and avocations than their purported occupations. They delegated much of the care of Mariska and her younger sister to a series of *au pair* girls and nannies. Nonetheless, the sisters always felt loved and cherished. In her late teens Mariska herself became caught up among those she called "jet-set trash."

"And I probably was as bad as the rest of them for a while," she said. She excelled academically, but occasionally interrupted her coursework or transferred universities impulsively to pursue diversions or relationships. Finally, she became fascinated with cutting-edge hard science and decided she wanted to do something with her life.

Fiercely determined, Mariska won her degree and doctorate rapidly. Her marriage to a fellow graduate student fell apart when she discovered that he was more interested in her family's affluence than in building a loving relationship with her. She retained her married name both to avoid bureaucratic complexities and the unwelcome attention often occasioned by her family's prominence.

Already well-published and eager for a fresh start, Mariska obtained a desirable research fellowship and teaching post in America. Although her scholarship remained impressively productive, she gradually became miserable, upset, and, to her mortification, in need of help. Apart from depression and anxiety symptoms, she mentioned phenomena I thought indicated occasional derealization, and instances of embarrassing forgetfulness. When I tried to explore what was happening in her life immediately before and during the onset of her symptoms, Mariska assured me that her mind was blank. While saying that, she looked downward, smiled, and shook her head. Because it seemed that something must have occurred to her, I inquired. Mariska seemed puzzled by my asking.

Mariska had been speaking freely, presenting both her story and her concerns in a controlled and rational manner. Nonetheless, I had already seen more than enough to suspect the possibility of a dissociative disorder. For example, one particular issue captured my attention. When Mariska denied knowing what might have been connected to her becoming upset, *she looked downward and smiled before shaking her head, "No."* She seemed puzzled when I notice this and

wondered aloud whether something had occurred to her. Although both depression and shame may be manifested by looking downward, neither affect usually coexists with a relatively normal smile. Further, nothing she shared matched either affect, or that expression. And Mariska seemed puzzled by my observation that something might be going on. What had I seen? Could they be minor perturbations of the "dissociative surface" (Kluft, 2005); that is, suggestive but not diagnostic indirect indicators of something transpiring in her inner world?

Dissociative identity disorder (DID) and allied forms of dissociative disorder are "psychopathologies of hiddenness" (Gutheil quoted in Kluft, 1985). DID patients average 6.8 years in the mental health care delivery system before receiving an accurate diagnosis (Putnam et al., 1986). Why should a condition so often assumed to be dramatic and florid prove so difficult to recognize?

The natural history of DID would be hard to infer from its overt manifestations when they are clearly apparent. What we usually see in most DID patients most of the time is the "dissociative surface" (Kluft, 2005), the facade under which dissociative structures and processes function. Alters need not assume executive control to influence the course of events. These "ripples" on the dissociative surface indicate the covert efforts of alters and/or dissociative processes "behind the scenes" to influence/express behaviors, attitudes, feelings and perceptions, or demonstrates the unintended leakage of some alters' feelings, issues or intentions into others. Such intrusions are often subjectively experienced by the alter apparently in control as "made" passive influence phenomena, like many Schneiderian First Rank Symptoms of schizophrenia (Kluft, 1985, 1987a; Ross & Joshi, 1992). Potential contributions/contributors to what is seen at the dissociative surface are listed in Table 43.1, and characteristic observations creating an index of suspicion for the activities in Table 43.1 are found in Table 43.2. Appreciating and decoding the dissociative surface requires effort and experience.

TABLE 43.1 The Dissociative Surface – Possible 'Influences"

I	The host, or, the "usual patient"
	The semblance of the host or "usual patient" by other alters
	A. Passing for the host
	B. Isomorphism – nearly indistinguishable alters
	C. Rapid defensive switches among such alters ("Tag-Teaming")
II	Copresence phenomena – Demonstrating Changing, Transitional, or Confusingly Combined Features from Different Alters
	A. Mixed presentations – two or more alters at surface in a variety of relationships ranging from collaborative to conflictual
	B. Fluctuating presentations – the changing presentation of two or more mixed forms
	C. One-plus presentations – Incomplete switch transitions, single or in a series
III	Varieties of Passive Influence Phenomena – Alters' Atypical Behaviors or Presentations Due to Inner Pressures
	A. Instructed Behavior – Presenting alter is being directed by another
	B. Intrusions – Other alters impact the feelings or thoughts of the presenting alter without emerging or declaring themselves
	C. Imposed or "made" behavior - Other alters impact motor behaviors of the presenting alter without emerging or declaring themselves
IV	Rapid switching and/or shifting – serial transient phenomena reflecting severe fragmentation or terror

Source: (Revision of Kluft, 2005, p. 636)

TABLE 43.2 Typical manifestations of dissociative surface processes at work

1 Brief amnestic moments, apparent amnesia or forgetfulness about matters under discussion or subjects of ongoing concern within the treatment, or abrupt changes in the subject of discourse.
2. Derailing of an ongoing conversation by the patient's appearing spacey, perplexed, or surprised by what is coming out of his or her mouth.
3. Transient anxiety or distress.
4. Palpable but difficult to characterize alterations in the manifestations of an alter.
5. Changes in the attitude, emotions about, and stance taken toward matters under discussion.
6. Fluttering of eyelids or rolling of the eyes (suggesting an autohypnotic process).
7. Apparent distraction by attention to internal stimuli.
8. Appearances that often suggest a "double exposure" in which one alter's characteristic appearance seems superimposed upon or rapidly oscillating with the appearance of another, or gives the impression of blending two known alters' patterns of expression.
9. Certain aspects of facial expression being discordant with other aspects, such as smiling while the face otherwise expresses fear of sorrow, or one side of the face (or the ocular region compared to the oral region) expressing one affect while the other side (or region) expresses another.

Source: Kluft (2005, p. 637)

My early studies on the natural history of DID indicate 80% have windows of diagnosability when stressed or when triggered by some significant event, interaction, situation or date. Otherwise, their processes and structures remain covert. Only 20% had an overt DID adaptation on a chronic basis, and 14% (70% of this 20%) of them deliberately disguised their DID manifestations. Therefore, only 6% of DID patients seem uninvested in disguising their conditions. Ninety-four percent of DID patients showed only minimal or suggestive evidences of their conditions most of the time (Kluft, 1984b, 1985). Yet, on inquiry, cooperative DID patients often will acknowledge that their personality systems are actively switching and/or far more active than it would appear on the surface (Kluft, 1985, 2005; Loewenstein et al., 1987, 1991).

I heard no freely offered admissions of severe memory problems, no description of unexplained out-of-character behaviors or possessions, and no history of overwhelming childhood events. Yet this brilliant woman, whose initial account of herself made only minor reference to possible indices of dissociation, had come to me because she feared she might have a dissociative disorder.

So, two (or more) mutually incongruous realities were at play, with no apparent awareness of their incompatibilities (Kluft, 1991). This could be due to many things, but prominent among my suspicions was trance logic, that toleration of mutual incompatibilities so characteristic of the highly hypnotizable. In the first reality, Mariska acknowledged a few mild dissociative symptoms and an unusually privileged but otherwise unremarkable background. In a second reality, she experienced sufficient distress to research her situation, suspect she had a dissociative disorder, seek out a specialist in dissociation and trauma, demonstrate a need to camouflage her background, and make non-verbal communications suggestive of fright and apprehension of harm. If she did have a dissociative disorder, perhaps Mariska had entered my office conflicted over what to share, and/or may even have dissociated awareness of most of the symptoms that had prompted her concerns. That notwithstanding, here is a list of the phenomena which drew my attention:

1. Strong suggestions she endorsed alternative realities. This could indicate trance logic. Mariska has come to be evaluated for a condition she has researched, yet hints she knows she could not have. A scientist of her caliber usually arrives at my office having done an adequate literature search. Perhaps she both knows and cannot allow herself to know about a wider range of dissociative phenomena she has both experienced and found in the literature. This knowledge may be in one or more alters able to handle this information. Alternatively, it is possible that the apparently well-functioning alter in apparent executive control thus far is unable and/or unwilling and/or not being allowed to retain it. I had not yet assessed Mariska's hypnotizability, but I knew that patients with DID are highly hypnotizable (Dell, 2006; Frischholz, Lipman, Braun, & Sachs, 1992). Indicators of high hypnotizability constitute one of the six symptom-cluster areas in Loewenstein's (1991) mental status examination for chronic complex dissociative disorders.
2. Brief waves of fright beyond awareness, with glances toward the door and the lower half of my body. These suggest the possible impact of fearful concerns, possibly alternate personalities' apprehensions that they are in a dangerous place from which they may need to escape, with a potentially dangerous person they must monitor for threatening indices of sexual arousal.
3. She appears unaware that by smiling, looking down, and shaking her head and then denying there were any thoughts in her awareness about the onset of her symptoms, she may be demonstrating prevarication, deliberate withholding, an indication that she is at least somewhat ashamed of something and planning not to speak (Nathanson, 1992; Kluft, 2007), or possibly a brief amnestic moment and/or an intrusion or transient switch, among other possibilities.
4. She shows mild hints of a constellation of symptoms not uncommon in the aftermath of trauma, yet no trauma history has been given. Often trauma returns to awareness in a piecemeal and/or enacted fashion, with the appearance of coherent conscious narrative memory a relatively late event.
5. She has not responded to medications appropriate to the conditions she was thought to have, which suggests that she may have a different condition. This is one of the classic suggestive diagnostic cues to DID (Kluft, 1987c; 1991, 1999, 2005).
6. I note Mariska's major life-style changes and relocations. They may be related to completely different factors, but such transitions, often abortive "geographic cures," dissociations in space, are not infrequent in DID, and will be kept in mind.

No one of these findings is pathognomonic for DID. Each could have several alternative explanations. Taken together, however, they offer food for thought and suggest possible entryways into the diagnostic evaluation of a dissociative disorder. I chose to return to Point 3 to begin my inquiry. (Mariska's actual evaluation was comprehensive. Here I restrict my remarks to the subject at hand.)

DR K: Mariska, I am still in the very early stages of getting to know you and the way you express yourself. In order to better understand you, I will often ask questions that may seem unusual.

MARISA: OK.

This was the lead-in to my first active intervention beyond making initial inquiries. The direction I choose, whether determined by conscious design or by the joining of non-reporting elements in the nascent bipersonal field, may convey expectations capable of affecting the future course of our work together, should that transpire. In the privacy of my mind, many alternatives approaches contended for expression. For example, I could have phrased my effort in terms of "parts of the mind." That might reassure a patient worried about whether I would pick up on dissociative processes, and begin socialization along that line of inquiry. But that pathway might prove intrusive and invasive to a person fearful of showing too much or appearing too obviously symptomatic or sick. A patient concerned about iatrogenesis or apprehensive about being talked into accepting someone else's ideas might find it unduly suggestive. Besides, Mariska is not my psychotherapy patient. Should I risk opening up something I cannot be sure will be safe and that I may not be able to address adequately? No. I will stay on the surface.

Another consideration… Here, I am analyzing myself in hindsight because no conscious choice of stance occurred at the time. Of course, I would be a warm and friendly person. But, beyond that, reasoning from the realm of self psychology (e.g., Kohut, 2014; Kohut & Wolf, 1978; Lessem, 2005), should the first thing I say present myself primarily as a reliable, knowledgeable authority with whom she can feel safe, inclining my selfobject presentation toward that of an idealized selfobject? Should I move toward a stance that builds a bridge of similarity and affiliation, toward a twinship selfobject function? Or perhaps, should I prioritize expressing the understanding, empathic attunement of a mirroring selfobject? Mariska's life has been full of powerful individuals. She has come to me already disappointed by prestigious clinicians.

Expectations of wise expertise may have been compromised, and any pretentions of authority might have problematic implications, inviting a power struggle. There are so many concrete differences between us that the rapid building of a bridge of fellow-feeling might be quite a stretch. I chose the third route, realizing as I do so that I feel drawn to understand Mariska and to work with her. I was surprised not by my positive countertransference, but by the way it snuck up on me.

I will make countless decisions as we move toward evolving a way to help or to help someone else help Mariska. Some will involve my efforts to arrive at an accurate descriptive diagnosis, while others will address psychodynamic diagnosis. I want to know, either to use or to pass along, not only what Mariska has, but how her mind works in a relational context. Some choices will be deliberate and planful, some will develop as I stumble into them and they prove to make sense. Some will result from theories the guidance of which I will only appreciate in retrospect, some will come from ideas my patient will provide. Some will be co-created within our relational matrix, some will remain obscured forever in the non-reporting processes of my mind, noted only when I sense the recurrent presence of something I cannot formulate contributing to the treatment process. My evolving model will be mosaic, kaleidoscopic, chimeric, and unique to each particular patient I treat, and consequently utterly exasperating and infuriating to anyone searching for paradigm-congruent security, predictability, and safety. It will be based on the four most experience-near of Waelder's (1962) six basic levels of observation and conceptualization, peaking at clinical theory, and omitting both metapsychology and the intrusion of personal philosophy.

DR K: When I asked you whether you were aware of something that might have been going on for you around the time your symptoms began, you told me that you were not. But then you lowered your head with a smile, which might indicate there was something you thought of, but might for some reason have been too embarrassed to say. Sometimes our shame or our misgivings cause us to hold back something that would be very important for our recovery. I couldn't help wondering if something like that was happening for you.

MARISKA: Do I really have to say everything?

DR K: No, your privacy belongs to you. But when things are kept out of the therapy they often undermine it. They become secrets, and if we let them stay hidden, pretty soon more and more secrets are allowed to hide out, and treatment becomes a shot in the dark.

MARISKA: That's Freud, isn't it?

DR K: It sure is.

MARISKA: OK. It's about my name. When I came to the States and got into an apartment with some other girls, I was telling my roommates one night that I was glad they were willing to call me "Mariska," because it is such an unusual name here. They told me that they all knew the name because some actress named Mariska is on TV all the time. [*falls silent*]

An empathic outreach indicating an appreciation of the potential pain and mortification so common in these treatments is a useful opening. Here, it drew a significant response. Mariska realizes that she has actually said "yes" to my question. She may be bargaining, either in her total personhood or per a cautious alter(s), or seeing what I will do with this secret before revealing others of greater substance. I make a note to myself to be on the alert for secret people with secret names. For the moment, I will consider her revelation a screen secret (my neologism), an emotionally fraught revelation covering over one or more of greater import.

DR K: Were you curious enough to watch some program she was on?

MARISKA: Yes, I was. But what a horrible show! I mean, it's a great show, but all of that violence, all of those rapes. Have you ever seen it?

DR K: I'll respond to that question in a little while. I'd appreciate it if you could say more about your reactions to that actress Mariska and the show she is on before I do.

MARISKA: Sure. At first I was just fascinated with her. I even flattered myself that I looked a little like her. But then I started getting nervous when I watched that show. It was as if I was enjoying the show on one level, but at another I was getting more and more terrified. When the cases on the show were about little girls who had been raped or bad things like that, I began to hear screaming inside my head as if so many little girls were screaming at once. And the dreams began.

DR K: The dreams?

MARISKA: Yes. Sometimes I would have dreams about the cases on the show. But then sometimes I was the little girl being hurt, or the actress Mariska was being hurt. And sometimes what was happening was not where it was in the show. It was in my house, from when we lived in Zurich or Berlin.

DR K: Those dreams sound awful. What did your therapist say?

MARISKA: She said I shouldn't watch "Law and Order SVU." [*We both laughed.*] But I was fascinated. Especially when I learned Mariska Hargitay's character had been raped. I was impressed that she could still be so strong. I had to watch her… [*voice drops*] and learn.

Years later I would learn that in fact, part of the back-story for Hargitay's character was that she was conceived after her mother was raped, not that she herself was raped. Mariska's information or memory was inaccurate. I came to think that my patient's attraction to this name referred to her seeing her dissociated selves as the product of rapes. To her, "Mariska" expresses feminine strength powerful enough to surmount the blows of a traumatic world.

DR K: So, as you watched this strong woman live in spite of what had happened to her, you took something very meaningful from each show.

MARISKA: Yes, I did. [*becomes tearful*] I don't know what I'm crying about. It makes no sense.

DR K: I'm sure it makes sense in a way neither one of us can appreciate at this moment in time.

MARISKA: So, I must be experiencing that show, and God knows what else, in several different ways at the same time. If we could become aware of them all, I would probably know what is causing all this. I wonder if I really want to.

In acquainting Mariska with the power of shame to both mimic, trigger, and reinforce dissociation (Nathanson, 1992; Kluft, 2007), and with its role as a major determinant for the withholding of important information, I had offered Mariska a way to understand her conscious wish to withhold the material that caused her discomfort and moved her toward taking new perspectives on what was withheld from her own awareness as well. She began to appreciate the nuanced importance of sharing what she had planned to hold back. Furthermore, my observations appeared to have aroused the interests of other aspects of Mariska, one of whom may have intruded to make a remark of its own ("and learn"). When she switched to the first-person plural, I had reason to wonder whether, among other possibilities, she was making an open or an unwitting acknowledgment of multiplicity, mirroring me in implicitly looking toward our working together (if "we" referred to us as a dyad), or both. Implicitly, we had moved beyond defensive notions that her symptoms had developed without any appreciable antecedent. Before our first meeting ended, Mariska had begun to question whether her symptoms had been triggered by exposure to events on "Law and Order, SVU" that bore some resemblance to events beyond her awareness. Without any revelation of specific early trauma, her initially benign view of her past was being challenged by an unwelcome glimpse of darker possibilities.

I decided against reacting to the apparent brief intrusion or switch ("and learn") or the use of "we." I was worried about overwhelming Mariska by prematurely confronting her about having alters whose activities might be discernable

by others. Also, I feared that this more intrusive type of comment might telegraph the message, "He's really interested in alters, not you as a person." I considered it imperative to minimize the risks of destabilizing or confusing the situation, or allowing the interview to become distracted from its agreed-upon goal – achieving a comprehensive evaluation.

Therefore, I explored some areas unrelated to dissociation before returning to the assessment of possible dissociative phenomena. Then, I inquired about the experiences of autohypnosis and spontaneous trance in Loewenstein's (1991) mental status examination for dissociative disorder patients. Positive findings included Mariska's easily becoming absorbed in a good book, a movie, or music to the point that she either failed to respond to someone's calling her name, or was actually startled when her focus of attention was disrupted. The capacity for deep absorption is associated with high hypnotizability, which characterizes DID patients as a group (Dell, Chapter 14, this volume; Frischholz et al., 1992). Bliss (1986) held that DID was created and maintained by the involuntary abuse of autohypnosis. I maintain that trance logic and absorption are necessary to maintain most compartmentalized dissociative boundaries (Kluft, 2012).

Standard tests of hypnotizability should not be done before acquiring a reasonably comprehensive understanding of a patient's life circumstances. Under some circumstances and in some jurisdictions persons who have been hypnotized are considered tainted, or even disqualified as witnesses to their own life experiences in legal matters. (Interested readers are referred to: ASCH Committee on Hypnosis and Memory, 1995; Brown, Scheflin & Hammond, 1998; Laurence & Perry, 1988.)

I had no idea whether legal considerations were relevant. Such concerns notwithstanding, it is feasible to test a phenomenon that co-occurs with high hypnotizability without inducing hypnosis. The eye roll sign, part of the Hypnotic Induction Profile (Spiegel & Spiegel, 2004), co-occurs with high hypnotizability and can be tested without inducing hypnosis. The eye roll is scored from 0 to 4 based on how much of the iris, the colored part of the eye, is visible when patients, having looked up as if looking toward the top of their heads, are asked to let their eyelids flutter down and close. For a score of 0, the iris is completely visible; for a score of 4, only sclera, the white part of the eye, is visible. If half the iris is visible, and half obscured, the score is 2, etc. Low scores in persons under evaluation for most dissociative disorders suggest consideration that the condition is being malingered (Kluft, 1987b).

Mariska scored the maximum 4, remarking that doing the eye-roll made her feel "weird." She added that friends had noticed her rolling her eyes, usually when she was becoming upset.

MARISKA: That test – It gives me shivers. Shivers I have felt many times.
DR K: Can you say some more about the "shivers?"
MARISKA: No. Just shivers.
DR K: Under what circumstances do you get the shivers?
MARISKA: Stress.
DR K: Stress?
MARISKA: I know I am being vague. I don't know. [*sighs, then in a flatter voice*] When sh- … when I feel disliked, scared, rejected. And …
DR K: It sounds like it costs you a lot of effort to answer, and that you might be reluctant to share part of the answer.
MARISKA: I don't want to say this. Freud again?
DR K: Yeah. Talking about this stuff can be an exercise in titrated mortification.
MARISKA: Well, I can answer if I tell myself I'll never have to see you again. [*silence, then a deep sigh*] Sex.
DR K: Is sex connected with feeling disliked, scared, or rejected?
MARISKA: I don't think so, but it's funny.
DR K: Funny?
MARISKA: Well, I like sex. I'm uninhibited. But … I guess I get a little scared before I get into it, and when I get into it, I am so into it I never even remember it afterwards. So [*blushes*] what I said first is what men tell me.
DR K: Again, so difficult to talk about. Feel free to disregard my next question. Is there anything else your lovers have said that you found funny, interesting, or surprising?
MARISKA: [*laughing, making bold eye contact, and tossing her hair*] I definitely will never come back here again. They say I tell them to call me "Helga."
DR K: Helga?
MARISKA: What?
DR K: You had just mentioned the name, Helga.
MARISKA: [*confused*] Helga? In Berlin I had a nanny named Helga. [*fearful*] Was I talking about her?

In exploring Mariska's reaction to the eye-roll we encountered several unexpected and intriguing phenomena: 1) Doing the eye-roll unsettled her. 2) The eye-roll created sensations she associated with psychosocial stress. Does this, along with others' observations, suggest Mariska employs autohypnotic defenses when anticipating/facing danger? 3) Mariska starts by claiming to like sex, reveals she is fearful as sex nears or begins, and then becomes amnestic for uninhibited sexual encounters. 4) Mariska lapses into talking about herself in the third person ("when sh-"), a suggestive sign of DID (Kluft, 2005), but rapidly corrects herself, suggesting that a covert switch may have occurred to an alter who experiences Mariska as object rather than as subject, and that perhaps yet another alter intervened to contain that emergence. 5) There are suggestions that a number of alters are listening in and reacting, including an alter whose voice and demeanor is more saucy than subdued, perhaps the mysterious Helga. 6) We may have witnessed what is called a microamnestic event (Kluft, 1985), in which Mariska does not know what has just transpired, and is upset. 7) We put aside for future reference, making sure we do not use it in a manner that suggests a line of thought to Mariska, that while in Berlin, in Helga's care, she may have witnessed and/or experienced events relevant to her patterns of response to sexual matters.

After the above, I briefly pursued topics I hoped would not elicit anxiety. Then I asked Mariska to complete the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), a self-administered 28-item instrument widely utilized to screen patients for dissociative symptoms. While not diagnostic, and vulnerable to both malingering and dissimulation, it makes useful inquiries about the individual's experiences of dissociative phenomena. Scored from 0–100, adults with DID and allied forms of dissociative disorder typically endorse to some extent all items unrelated to driving, and have average scores of 30 or more. In clinical practice scores above 19 may trigger further assessment for dissociation. I use the original DES (Bernstein & Putnam, 1986) rather than the more popular DES-II (Carlson & Putnam, 1993) because its response format facilitates the acknowledgment of less frequent dissociative experiences.

Initially, Mariska's DES score, 15, shocked me. Normally 15 would not trigger additional assessment, but careful scrutiny of Mariska's instrument revealed that every question that would trigger suspicion of DID was marked at zero, or even below! These included all eight questions that would later be considered a taxon for pathological dissociation (Waller, Putnam, & Carlson, 1996).

Mariska was scrutinizing my face intently as I finished the scoring. She had told me she did not want to have a dissociative disorder. On the DES she had disavowed the very sorts of behavior she had just shown me. Clearly, we were involved in an intellectual chess match, and Mariska was well-prepared.

I hypothesized that Mariska's desire to be understood and healed was balanced by her desire to deny and cover over the possibilities of having both a dissociative disorder and an unwelcome history of trauma. At some level and/or in some alters, there was an appreciation that she may already have let the cat out of the bag, giving rise to a strong compulsion to undo the revelations and once again lay claim to the dubious citadel of denial.

MARISKA: You sure studied those papers a long time. What do they tell you?

DR K: Your average score was 15, which is probably within normal limits for a European woman.

MARISKA: That's good, then?

DR K: I'm not sure. Let's come back to it when we complete the evaluation and can understand it in the context of everything else we find. [*Wishful thinking!*]

MARISKA: You don't want to tell me what it means? Doctor, are you trying to protect me from something? Why wouldn't you answer me directly?

DR K: [*squirming a bit*] I'm not sure it would be helpful. [*Mariska stares stonily. I decide that trying to be evasive would be ineffective, countertherapeutic on a relational basis, and modeling the very sort of behavior I am trying to discourage.*] OK. Let's discuss what it tells us about you and your diagnosis. The DES score is invalid, but the instrument tells me you are very gifted intellectually, have a great memory, and are very conflicted about coming to grips with your situation.

MARISKA: Invalid? What do you mean?

DR K: You have been thoughtful. You have denied every symptom associated with DID or pathological dissociation. You acknowledge every symptom that would depict you as a high hypnotizable person who can get really absorbed in something, and who can get spacey from time to time.

MARISKA: So?

DR K: And, for overkill, some items are scored as less than zero. I call that the "Methinks thou dost protest too much!" sign. Usually I see it in mental health professionals who have hit the books to create a false negative diagnosis for some reason or other. You have really done your homework.

MARISKA: I beg your pardon! [*changes facial expression, giggles delightedly, abruptly becomes sad and shakes her head*] I heard myself do that. I even watched it happen. My God!

DR K: I guess in your shoes I might feel strong temptations to convince myself that this couldn't be happening to me, that nothing traumatic had ever happened to me and I could never have a dissociative disorder.

MARISKA: I really don't want this. I don't need this.

I was able to convince Mariska to permit a full and candid exploration of her situation with a then pre-publication *Structured Clinical Interview DSM-IV Dissociative Disorders – Revised* (SCID-D-R) (Steinberg, 1994) to facilitate making more reasonable decisions about whether to address her problems or leave them untreated.

The *SCID-D-R* obtains background information before studying five core dissociative features: Amnesia, depersonalization, derealization, identity confusion and identity alteration. It also explores nine types of phenomena associated with DID and allied forms of DDNOS, and requires a closer assessment of two. These are selected to follow up on those previously elicited answers most suggestive of the presence of alter personalities. The *SCID-D-R* also elicits the clinician's observations of dissociative phenomena, and allows the tentative diagnosis of a dissociative disorder.

Mariska attained maximal scores in all five major symptom categories. She acknowledged experiencing most of the associated symptoms and manifested several signs of dissociative processes. Illustrative responses included: 1) for amnesia, she had lost blocks of time since childhood, she could not remember most of her eighth and ninth years of life; she had been told of angry outbursts she did not recall. 2) For depersonalization, she often saw herself going through life as if she were watching a movie of herself. 3) For derealization, she often was unsure if certain people and places were real. 4) For identity confusion, she had often been conflicted about who she really was. 5) For identity alteration, she revealed that often, in private, she found herself acting as if she were a child. Helga had emerged and volunteered a roster. Under associated features, she often was aware of inner dialogs. She sometimes found herself enacting these dialogs out loud or having written both sides of a dialog in her journal, in different handwritings. These dialogs sometimes involved her interacting with another aspect of herself, but usually involved her overhearing conversations between or among alters. Rarely, she overheard two conversations at once.

What impressed Mariska most during the *SCID-D-R* was that the answers to many questions came to her from voices within her head, and that these answers indicated that her dissociative symptoms were frequent and longstanding. She was both terrified and amused by answers which indicated that being addressed by other names had been a recurrent feature of her life, but that all such incidents other than the "Helga" episodes were completely strange and unfamiliar to her. When I compiled all the identities that had been reported to me by Helga, there were about ten, nine clearly stated and another she could not describe.

The *SCID-D-R* diagnosis of DID was clear. Confirming a clinical diagnosis with findings from a reliable and valid instrument has many virtues, clinical, scientific, and self-protective. In a litigious world in which the DID diagnosis has been challenged retroactively in lawsuits, accompanied by accusations of iatrogenesis, there is much to be said for using a state-of-the-art instrument that is widely used and widely cited in the literature. In addition, I have been impressed over and over again that the *SCID-D-R* interview pulls for information that otherwise might not emerge until much later in the treatment, while allowing empathy to build for the patient's experiences, facilitating the therapeutic alliance.

Mariska and I discussed the *SCID-D-R* findings in depth. She acknowledged that because she had been forthright in answering its questions, she had to accept its conclusions, however reluctantly. Now, Mariska both accepted and denied the diagnosis of DID. With perfect trance logic, she entertained both alternatives despite their incompatibility. Such stances are not uncommon. They may persist for extended periods of time, occasionally renewed even after a successful integration.

After we discussed several exceptional therapists she might see, Mariska asked me to take her into treatment. She accepted the inconvenience of a lengthy commute. Seeing me allowed her to minimize the risk of encountering her therapist outside of the therapist's office, or of being seen entering or leaving the office of someone identified with the treatment of trauma or dissociative disorders. Also, we had felt comfortable together and resonated with each other's sense of humor. Further, scientist to the core, she knew from her reading that I had reported the successful treatment of a large series of DID patients (Kluft, 1984a, 1986a, 1993b). She respected the evidence. We agreed to meet for a double session once weekly, understanding that what emerged in treatment might require us to reconsider that arrangement.

The phenomena alluded to in the *DSM-IV-TR* (2000) and DSM-5-TR (2022) diagnostic criteria embrace only a small fraction and narrow construction of the dissociative manifestations of DID (Kluft, 1985, 2005; Loewenstein, 1991; Dell, 2006). Attention to a wider range of these phenomena facilitates more efficacious diagnosis and treatment. Of

the phenomena subsumed under the rubric of dissociation in Table 43.3, several categories overlap, and some items are linked to more than one heading. This redundancy respects several relevant literatures and their different approaches to conceptualizing and grouping dissociative phenomena. Items already noted at this point in my work with Mariska are indicated by an asterisk. The remainder emerged as treatment progressed. Viewed retrospectively, Mariska's apparently undisrupted performance and her having experienced three or more mental health evaluations without clinicians' suspecting the DID diagnosis identifies her as a "High Functioning DID" (Kluft, 1986b).

Table 43.3 Categories of dissociative phenomena noted in Mariska

1. Alters, also known as personalities, identities, personality states, etc.*
2. Identity confusion*
3. Amnesia*
4. Compartmentalization/modularity phenomena, including
   a) Alters, as above*
   b) Segregation of some subsets of information from other subsets of information in a relatively rule-bound manner (Spiegel, 1986)
   c) Ablation or segregation of BASK dimensions (Braun, 1988a, b)
5. Detachment (as in depersonalization and derealization in the perception of self and/or others,* concerns over whether memories are real or unreal, and in alters' lacking senses of ownership or responsibility for actions of other alters)
6. Absorption*
7. Phenomena traditionally associated with hypnosis, autohypnosis, and spontaneous trance*
8. Failures of compartmentalization* such as intrusion phenomena, including both alters, memories, and intrusive expressions of BASK dimensions (Braun, 1988a, b)
9. Simultaneous operation of separate self-aware processes or states of mind,*
10. Simultaneous executive activity by separate self-aware processes or states of mind (co-presence phenomena [Kluft, 1984b])
11. Inner world and third reality phenomena (events within that inner world that are accorded historical reality and which sometimes intrude into ongoing experiences, and/or impact ongoing experiences from behind the scenes (Kluft, 1998)
12. Switching* and shifting*
13. Multiple reality disorder (Kluft, 1991), for which dissociative identity disorder, formerly called multiple personality disorder, is the delivery and maintenance system*

Evaluation Continues as Preliminary Interventions Begin

Mariska's journal entry after our second consultation meeting was written in several handwritings. Some excerpts were:

> Before I began to write tonight I looked over the last several pages. I thought that I was writing my own journal, but for the first time I see I was not alone. Why couldn't I see all those other entries? Why can I see them now? Who made them? What does it all mean?
>
> I am amazed that I agreed to see that man! I'm not sure this is a good idea. I'm not sure I like him. What did I do? I didn't! I watched myself explain why I needed to see someone far away from my university, far away from where I live. What does that mean? Did some other part of me drag me into therapy, afraid that left to myself I'd just push the consultation out of my mind and limp along?
>
> You all will have to speak English. If you can forgive him this, you will find that he can speak to us about emotions, about feelings – the languages which all of us have failed to master.
>
> Every time he spoke I wanted to check my buttons, to cover myself because I felt completely naked. When he explained what he thought, I felt penetrated, painfully penetrated. Yes, he knows a lot, and that's supposed to be good, but I don't like it.
>
> Knowing that much gives him power. I don't want anyone to know me that well, to have that much power over me.
>
> I only wanted the best for you. I never hurt you. Those were just dreams. Bad dreams. Don't let him convince you that I did something to you that I did not.

You never listen to us. You hear our screams and you try to block us out. If you won't let us talk to him, we'll scream louder.

You are not to tell him about the forbidden things. Any transgressions will be punished severely.

Mariska's journal testifies to the complexity of her moment-to-moment flow of dissociative phenomena, some experienced within awareness, but some usually inaccessible. Appreciating the confusion, helplessness, terror and conflict that these phenomena caused Mariska helps us to understand how difficult and potentially painful it is for dissociative patients to commit to treatment. Yes, Mariska also experienced a degree of relief and a surge of optimism. She felt I understood her and might be able to help her. Yet, she leapt ahead to the likely consequences of being understood. She did not relish confronting painful material, accepting and addressing the existence and activities of alters who might prove very different from herself, grieving her previous more benevolent view of her past and of important people in her life, facing inner conflicts among the alters, and dealing with a man whom she feared might exploit his ability to understand her.

Mariska pushed beyond her misgivings and continued sharing her journal entries with me. I was glad she did. I did not understand her efforts as simply an expression of trust or motivation, although I appreciated that those dimensions might play a role. Instead, I felt that at times her journal was written submissively, but sometimes in ways that allowed her to probe and anticipate my reactions to feelings and experiences that she needed to talk about, but feared to address directly. She often put subjects forward and waited, scrutinizing my reactions and remarks, as if to determine whether it was safe to take the risk of proceeding further.

As we began, I welcomed full discussion and exploration of every topic, every misgiving, and every apprehension. In order to expand the therapeutic alliance, I invited the participation of all alters, most still unknown to me, socializing them to what the treatment would be like and to what it would ask of them.

We went through the journal entries and discussed every concern they raised, even those Mariska could not relate to herself. In this process, I invited any other parts of her mind that might have concerns or reactions to share their remarks with Mariska, so she could share them with me. I call this approach "invitational inclusionism" (Kluft, 2000). Later in treatment I might ask them to either pass their remarks along or to speak to me directly, but I thought the Mariska(s) who usually presented might feel either very uncomfortable or bypassed dismissively if I did so this early in our work.

These discussions were Mariska's first experience with my working with both the whole patient and the alter system. Encouraging all of the alters to become involved in the treatment is a way of diminishing dissociative barriers, promoting a free flow of associations and information across alters, diminishing the alters' "not me" attitudes toward one another (Brenner, 2004; Chefetz & Bromberg, 2004; Kluft, 1995), and encouraging them to become stakeholders in the treatment. (See Kluft [2006] for the benefits of engaging alters directly.) This welcoming stance, the principle of invitational inclusionism, is not unconditional. It opens the door for the alters to participate when their involvement is neither problematic nor disruptive to either the patient's well-being or the flow of the therapy. I advocate for the alters' considerateness for one another, promoting a 'golden rule' mentality. I try to undermine pressures for irresponsible autonomy, insisting that "you are all in this together," that "everybody wins, or everybody loses." I appreciate that in treating at once the whole person and the separate alters I often am doing double book-keeping and making double appeals. Acknowledging and working within the alters' and the total patient's subjective realities allows me to help them test and measure their misperceptions and misattributions against the consensual objective reality in which they exist, even if their subjective senses of reality are quite different and conflicts over positivism vs. intersubjectivity continue to bedevil scholars. I move quickly to address issues of shame, narcissism and masochism, which often govern alters' understandings of their situations and roles.

Two vignettes illustrate these efforts. In the first, we were discussing entries that questioned Mariska's safety with me. She started by apologizing for those remarks. I normalized her misgivings, stating that it seemed reasonable for anyone who had been mistreated, or who wondered whether they had been mistreated, to proceed with caution in entering a relationship with a person whom appeared to hold a power differential that might be used either in her service, or against her. I then invited Mariska to pass on to me any other observations or questions she might be hearing or sensing inwardly.

MARISKA: I hear a few voices, but they are all talking at once.

DR K: Every observation is important, but if they are all said at once nothing except Mariska's distress and confusion will come through. One at a time, please.

MARISKA: But there are so many! [*stares at me*] I've noticed you've used that "A journey of a thousand miles starts with a single step" line a couple times already. This would be a good time not to say it again!

DR K: OK. But it's worth the effort.

MARISKA: OK. I hear a little voice, speaking in German, saying, "Please don't hurt me."

DR K: How does that voice think I might hurt her?

MARISKA: She won't talk. I feel myself wanting to roll up in a little ball and rock. I feel like crying.

DR K: If that part doesn't feel it's safe to talk further, that's fine for now.

MARISKA: She asks, "Are you going to hit me?"

DR K: I will not hit you.

MARISKA: "Are you going to hurt me down there?" I'm sorry. That's what she said.

DR K: No, I won't hurt you down there. You may feel hurt down there when you are worried or when you remember something bad, but I won't hurt you down there.

To myself, I thought, I won't ask whom, if anyone, has hurt her down there. First priority is to provide a safe environment for the therapy. If I ask her prematurely, she may start to relive a trauma or to experience a body memory. I will be seen by that part or by a protector part as having needlessly inflicted pain, fulfilling the fear that I will hurt her, or take pleasure in her pain. Furthermore, she may hear me as encouraging her to speculate, or demanding that she offer an account of an event and identify her assailant. There would be a legitimate concern that an inaccurate account might be generated to please me and/or propitiate me. It could mobilize disruptive parts linked to aggressors and/or their apologists and/or their victims.

MARISKA: I hear a male voice, also speaking German, telling the little girl that grown-ups don't do that sort of thing to little children. She must have heard something bad in school and worried about it.

DR K: I wonder why this man would say something like that.

MARISKA: It is saying that little girls who tell lies will be beaten. It says nothing bad has ever happened to her, that she should be ashamed to speak of such things.

DR K: I look forward to talking with that voice and better understanding why it says what it says.

MARISKA: The short version is "Fuck you!"

DR K: Someday, hopefully someday soon, we can have a more serious discussion. For now, anything else?

MARISKA: Another male voice says, "Doctor, I'll be watching you every minute."

DR K: To that voice: Good for you. That sounds wise.

MARISKA: It says, "You can joke with the others, but not with me."

DR K: I appreciate that. You are on duty, and you take your duty seriously. You are welcome here, and I look forward to talking more with you.

MARISKA: It says, "We'll see." There is one more. I really don't want this to be part of me.

DR K: Embarrassing?

MARISKA: Very. I can't. I just can't. [*She becomes very distressed, tearful, wrings her hands.*]

DR K: Let's back away from having you speak it out loud. Can you write it down?

MARISKA: I'll try. She's calling me all sorts of names. [*Dr K hands her a clipboard and pen. She writes:*] "I can handle you. It might be fun, screwing my shrink. But I don't think you can handle me. Helga." I don't believe this. [*tears up the sheet of paper*] I really don't think I can do this treatment.

DR K: Helga upsets you. You don't want her to be there. Her being there mortifies you.

MARISKA: That's for sure.

DR K: I'm not sure that I'm right, but it might be that Helga came out to reassure you, to say that if I misbehave she will protect you by bearing the brunt of what you fear I might do to you, that the most vulnerable parts of you will be shielded.

MARISKA: But she comes out for sex! She loves sex!

DR K: That "loving sex" may be defensive, too.

MARISKA: What do you mean?

DR K: Putting one's self in harm's way is difficult. One may have to distract one's self from what is really happening by focusing on a few aspects of what is going on, and convincing one's self that it is OK. I don't want to jump to any conclusions. I don't want to judge a book by its cover.

MARISKA: Two things at once. I was thinking that your sayings and clichés are already driving me nuts [*laughs*] and Helga is saying that maybe you are not as dumb as you — as she thinks you look.

In this instance of invitational inclusionism, I reach out to a number of alters and they respond, beginning to build a relationship with me. I am impressed that the voices have responded as they have, bringing their dynamics with them. My experience is that the alters and their interactions with one another and with me express and/or enact crucial dynamics

and subjectively experienced historical material whether in available memory or outside of awareness. I am allowing myself to hope that Mariska's personality system and, therefore, she, will be more readily accessible than in most DID patients. Although I have studied Helga-like alters and how to work with them in depth (e.g., Kluft, 2017), making further inquiries or observations here would have risked doing too much, too soon.

The second example regards working with a dream Mariska reported in an early session (see Kluft, 2000, 2015):

> I am taking a walk with Helga [Her nanny]. We meet Herr G, who was my father's business partner. They step away and begin an animated discussion. I am bored and walk toward a puppy someone has on a leash. There is a sudden noise and a tornado catches me up and whirls me around. Things from our house are whirling around me. I feel so bad that all my parents have is being destroyed. I feel dizzy and sick and I hurt all over. Then the wind begins to die down and I see I'm going to hit the ground. I can't look down. I wake up screaming, with one of my roommates telling me loudly to wake up.

Mariska's associations were limited to her puzzlement that Herr G would be walking about during business hours, and that their conversation seemed so lively. Herr G was usually rather distant with those he considered below him. She thought that she "stole that dream from the *Wizard of Oz*." She could make no connection between the dream and any recent experiences.

DR K: OK, Mariska has shared her reactions to the dream. Are there other thoughts or points of view?

MARISKA: It's very faint, but a little voice says, "He's a bad man."

DR K: Would that voice like to say anything more?

MARISKA: I feel her fear, and I hear a man's voice, "She can't say any more. The little bitch has said too much already."

DR K: I want to remind that second voice that we have agreed that there are to be no reprisals for what is said in therapy.

MARISKA: He says his usual, "Fuck you!"

DR K: Anything further?

MARISKA: Someone is saying that that is no dream. The first part is a memory, and the tornado part says how bad it was.

DR K: How bad it was?

MARISKA: It says, "The part no one is allowed to remember."

DR K: Anything further?

MARISKA: And now Helga says, "It's true that Herr G usually had nothing to say to those below him. But I was below him so many times that we developed quite a relationship." No! Doctor, Herr G was my father's business partner, his best friend! He trusted him completely. In fact, when my parents went on long overseas trips, Herr G would visit the house every day to be sure that everything was being done correctly, and to be sure that we were alright. [*Suddenly looks shocked.*] Helga was in charge when my parents went abroad. Oh! I'm going to be sick. [She *wretches, grabs a waste basket, bends over it, and wretches repeatedly. Then, her voice and facial expressions change.*] Doctor, she cannot be allowed to know about Herr G. She idolized him. She dreamed she'd grow up to marry him or someone just like him. This would kill her.

DR K: Can you say some more?

MARISKA: [*switches back*] What are you talking about?

DR K: I think you may have lost a moment there.

MARISKA: Helga is saying Herr G was a pig. I don't… I can't believe that. Helga says the day residue you were looking for was another episode of *Law and Order: SVU*. I'd forgotten that. I can't remember the plot now. Just that it really upset me.

By inviting contributions from many parts, the exploration of the dream is deepened and enriched (see Kluft, 2000, 2015). Without making intrusive inquiries, the simultaneously active and engaged parts, some of which were restricted from knowing about any trauma, and some of which were not, have provided ample food for thought. I put aside for future consideration the possibility that Herr G had taken advantage of Mariska's parents' trust in him to debauch Mariska's nanny Helga, and expose Mariska to inappropriate activities, whether vicariously or directly experienced. I did not assume this construction represented historical accuracy. Rather, it generated hypotheses which might prove useful.

The vignettes above occurred during the first phase of Mariska's DID treatment, *Establishing the Psychotherapy*. In a definitive DID treatment, the phase or stage of *Safety* in Herman's (1992) three-stage model of trauma treatment consists of *Establishing the Therapy*, *Preliminary Interventions*, and *History Gathering and Mapping* (Kluft, 1991, 1993a, b, 1999). *History Gathering and Mapping* are included under *Safety* in a definitive treatment, because it may (and usually does) prove unnecessarily dangerous to proceed to trauma work without appropriate intelligence about what the treatment is likely to encounter. In a supportive treatment, *Safety* would not include *History Gathering and Mapping*, because there would be no intention of exploring and addressing traumata systematically and exhaustively, and because such efforts risk destabilizing more compromised DID patients.

The major tasks of *Establishing the Psychotherapy* are listed in Table 43.4. Mariska is an ambivalently cooperative participant, and I am pleased to be working with her. Her affluence and flexible schedule means there will be no logistic impediment to beginning and sustaining the treatment. Mariska comes to her appointments and talks about relevant concerns. That is as good as it gets in working with those whose capacity to trust has either not developed adequately, or has been damaged by betrayal.

TABLE 43.4 Establishing the psychotherapy

1. Mutual Voluntary Participation
2. Pragmatic Arrangements
3. A Facsimile of Trust
4. Aspects of Safety
5. The Treatment Frame
6. The Therapeutic Alliance
7. Self-Psychological Interventions
8. Demonstration of Expertise
9. Dealing with the Diagnosis

Source: Kluft (1993a).

Safety considerations are crucial. Nothing suggested Mariska was at risk for suicide or self-injury. I worried that any self-destructiveness might be expressed in sexual misadventures. Mariska brought preformed traumatic transference elements to the treatment, probably including fears that I might prove to be harmful, and established dysfunctional coping strategies liable to prove challenging. The material about Herr G alerted me to the possibilities that Mariska would be scanning me carefully for signs I might transform into an overt predator, and that simultaneously she was likely to try to block out signs I was dangerous in order to protect the relationship. Further, she was at risk for developing a false positive submissive transference (Kluft, 2000), replaying an implicitly masochistic relationship with an abuser who insisted on being treated as if he were deeply beloved.

I did not think Mariska was likely to endanger me in any way. The first expressions of sexuality and seduction weaponized as defenses had been addressed uneventfully. It appeared that Helga and I were beginning to form an alliance based on my respectful recognition that she was a dedicated and specialized protector rather than pursuing sex for its own sake.

Clarifying the treatment frame, we agreed that absent true emergencies, Mariska could review all necessary communications with third parties and suggest reasonable changes prior to their being sent. We also agreed that absent the emergence of some compelling matter, she would not have access to my therapy notes.

Early sessions often addressed the developing therapeutic alliance. We were both confident that we could "work well together," but we soon learned that we entertained very different notions about what that expression meant. Mariska complied with all reasonable expectations. In addition, she shared an ongoing series of "observations" about our work that both praised me to the skies and deprecated my perceptiveness, intelligence, empathy, my commitment to Mariska and her treatment, and my choice of interventions. When I asked her to consider the implications of what she was saying, she professed to be puzzled and distressed by my concerns and occasional consternation. Why was I unable to hear her remarks as objective observations that reflected both her dedication to her treatment and her intellectual curiosity as a hard science researcher bringing her observational skills to bear on a healing art derived from the softest of sciences? I had much to teach her, Mariska agreed, but she might have a great deal to teach me.

My exasperation with Mariska's "objective observations" grew with unanticipated vigor. I wondered if I had let Mariska's attractiveness, intelligence and wit blind me to some deeply rooted character pathology that would turn our work together into a painful ordeal. I felt bursts of humiliation and mortification. I fought to contain my strong impulses to enact shame scripts (Nathanson, 1992). I wanted to withdraw, to deny the impact of her words or distract myself with some pleasurable reverie, to join Mariska by attacking myself, or to attack Mariska.

Fortunately, despite my distress and my becoming somewhat distracted by Mariska's incessant, ostensibly disingenuous attacks, I was able to ask myself what projective identifications were slipping past my attention, what enactments might be in the process of becoming, and what unrecognized transference paradigms I might be responding to. After my initial efforts to bring Mariska's behavior to her attention "went down in flames," I empathized with her frustrations with me. These efforts enraged Mariska: "You are not empathic in the slightest. Your remarks are condescending and supercilious." Mariska wondered if she had overestimated my knowledge, skills, and qualities as a person.

Despite our mutual misgivings, we continued to discuss Mariska's life and relationships. In a weird but wonderful way, the negativity with which we were struggling was not derailing the treatment, only declaring it derailed – an interesting dissociation in and of itself. We were apparently switching between two competing incompatible constructs of the nature of our relational interaction.

I took some verbatim notes during the times Mariska was critical of me, and studied them with Luborsky's *Core Conflictual Relationship Theme* (CCRT) methodology (Luborsky & Crits-Cristoph, 1998). Oversimplified, episodes of interaction are studied to find the components of the model, "X wants Y from Z, but X's failings and shortcomings (or strengths), and/or Z's failings and shortcomings (or strengths) prevent X from succeeding (or allow X to succeed) in getting Y from Z."

Again oversimplifying, I found that Mariska's dominant CCRT formulation was approximately: Mariska wants to be safe and taken care of by a powerful and helpful man, but Mariska is unworthy and uninteresting, and the men she looks to are inattentive and incompetent. A secondary formulation was: Mariska wants to be loved by a good man, but she is dirty and makes good men do bad things, and the men she looks to for help prove to be exploitive and hurtful. Sex is the price of support.

I inferred that two patterns of transference and enactment might be at play when Mariska depreciated me. In the first, I was seen as a good man who failed to protect her because my attention was elsewhere and she could not get me to direct it toward her, and/or I just did not know what to do to help her. In the second, I was seen as a man who would pretend to be helpful or start to be helpful, but would hurt her, because I was a bad man who recognized her as a dirty girl who deserved my mistreatment, or because I was a good man corrupted by Mariska's filth and seductive power.

These formulations were present, but predominant only when I was being attacked. I hypothesized that although Mariska was not making overt switches very often, her verbalizations reflected several underlying configurations. Could those changes reflect the impact of various alters or groups of alters on the dissociative surface? Could those alters or groups of alters reflect experiences and expectations that colored the transference/enactments at particular moments in time? Could the two CCRT patterns be describing two of the common transferences of trauma victims observed by Davies and Frawley (1994), perceiving the therapist as a perpetrator in one formulation, and as a failed protector in the other? Was Mariska telling me that she had been victimized by one man whom she had initially seen as a good person, and had not been helped by another man whom she had relied upon to protect her (or that both of these patterns were characteristic of one particular important relationship)? My associations tentatively nominated Herr G as the man she had loved who betrayed her by molesting her, and her father as the man she loved who had betrayed her by not appreciating her distress and/or taking action to protect her. I kept these ideas to myself. Sharing them would have been premature, and probably experienced as manipulative blame-shifting.

As we progressed, Mariska took increasing notice of her profoundly discrepant attitudes toward me, and that transitions among these attitudes generally occurred rapidly, without apparent explanation. I told her that I had noticed these changes as well, and experienced them as surprising, even jarring at times. She handed me her journal. The previous day's entry included:

Watch out for him! Yes, he's nice. Too nice. She still gets fooled so easily. Remember the last one!
But we have to trust someone!
Trust!! What an illusion! First impressions are deceiving. They almost always start out nice. The men who are strong enough to be worth anything will try to screw you. The men who stay nice are useless. They can't help you. They can't even let themselves see that they should be helping you.

DR K: So, your expectations are conflicted about how I'll betray you, but they all concur that I will betray you, sooner or later. [*Mariska nods vigorously.*] I have asked you this before, but what you just said moves me to ask it again: I know that these dynamics come from your early years, but have you ever had an experience in which a health professional or a mental health professional behaved toward you in a way you experienced, or came to believe, was inappropriate?

MARISKA: [*switching as I made my last remark and speaking in a deep harsh voice*] Leave this alone, Doctor. She can't handle this.

DR K: We have a problem. You all are behaving in ways and promoting ways of thinking that are likely to sidetrack or even undermine our work together. For reasons that I am sure are powerful and reasonable because of

experiences we have yet to talk about, you all are reacting to me as if I may prove either unable or unwilling to help you, or as if you are certain I will come after you. That makes this office a difficult place to be in. I have no problem with your entertaining such notions about me as long as they are understood to be grist for the mill of therapy. But I am getting the impression that some parts of the mind feel, even if they know they don't rationally think so, that I will do you no good, and may do you harm. We should be in a position to discuss your misgivings and understand where they come from. And try to keep this in mind: Once many things were too much for you and apparently there was no help to be had. Now you may remember your helplessness then not as part of your traumatic memories, but as an accurate appraisal of your vulnerability in the here and now. Addressing myself to the part or parts that have the misgivings… Without getting feedback from any others, what year do you think this is?

MARISKA: This is ridiculous. I hear three answers: One is this year, one is 15 years ago, and one is around 25–30 years ago.

DR K: Making me think that betrayal and mistreatment during childhood was followed by betrayal and mistreatment during your early 20s, perhaps by someone to whom you turned for help. Naturally, you are on your guard with me. Whenever you are ready to talk with me about those things, it will be important to do so. For the sake of our work together, I hope that will be soon.

MARISKA: [*with the deeper voice*] She is not ready to know this, doctor, but I see you may need to in order to help her. [*She startles, tears up, and continues in her usual voice.*] How could I have forgotten this? This is too embarrassing. My first therapist screwed me. I went to him to figure out why I was so out of control and promiscuous… and he screwed me. [*Holds her hands to the sides of her head*] Helga says she had to come out then … This is awful. [*Switches*] It's like when she tried to tell her father that Herr G was getting after her. She didn't even know the right words to use, so maybe he didn't understand what she was saying. But that's nonsense. The truth is that her father chose to believe that his good friend and business partner could not have done anything to her. He was sure she had misunderstood some affectionate gesture or must have had a crazy dream. [*I shook my head.*] After a few times she gave up trying to convince him, and just convinced herself it couldn't be happening. [*She returned to the usual Mariska, who cried.*] I guess I have always known this stuff and not known it. Parts of it never left my mind, but it seemed so unreal, so surreal, that it had to be a nightmare or fantasy. [*sighs*] I can't recall them now, but there are a lot of weird thoughts I have that I convince myself can't be true, so I don't feel right in telling them to you. I worry – What if I am wrong? Isn't it awful to say horrible things about someone that may not be true?

DR K: So, your sense of right and wrong reinforces the notion that you can't be sure whether you are reporting an injustice to yourself or committing an injustice against someone else. You wind up thinking that what you hold in your mind should be withheld from our conversations, yet the very patterns you feel you cannot share show up in your feelings about me, and we are drawn into patterns that, while you continue to deny such things occurred in the past, you experience as occurring in the here and now, between us, and it feels as real here as it feels unreal about the past.

MARISKA: You should write that down. I can feel myself pushing your words away, losing them in some inner fog.

DR K: It is very painful to hold onto awareness that some of the people you have loved the most have betrayed you, hurt you, and condoned your being hurt.

MARISKA: I don't know if I can live with this.

DR K: Some parts of your mind have been living with it for decades.

MARISKA: They are saying inside, "She's not going to help us. We protected her for years and she's going to leave us with this shit."

DR K: They are afraid you will repeat your father's behavior – see it, know it, turn a blind eye to it, and convince yourself it was just fantasy, just dreams, just a little girl's imagination.

MARISKA: I said I don't know if I can live with this knowledge. I am sure I can't live with just walking by them and their pain. [*sighs*] Watch me betray my good intentions in spite of myself. Please keep me on track. Inside they are saying, "If he doesn't, we will, and you won't like how we do it."

DR K: How about if those inside feel that anyone – I, Mariska, or any part of the mind, is messing up, you let me know in no uncertain terms rather than inflict anything on one another? There's been too much suffering already.

MARISKA: They say they will think about it. But they are not sure I will listen.

Here we are working on working together. Many components of what I recommend in building an alliance are demonstrated. Mariska comes expecting to be an active participant in the therapy. The journaling had been assigned. Assignments and patients' reaction to them and management of them often are instructive about the patient's degree of

identification with the therapeutic process. If she had taken a passive stance, I would have focused on helping her become a more proactive participant, employing both dynamic and psychoeducational interventions.

Exploring what transpired in prior psychotherapies is crucial. It is always a narcissistic error to assume that one is so skilled, knowledgeable, and sensitive that one can avoid all of the pitfalls encountered in previous therapies. Here I learn that Mariska was sexually exploited by her first therapist, and that Helga (and possibly other alters) played a role in coping with that. I learn that Mariska's dissociative capacities have remained vigorous in dealing with contemporary adult trauma. I have to wonder how many alters are watching our therapeutic work without making themselves known, sizing up me and my reactions and the degree of risk I pose to them all, and preparing a variety of responses should they be perceived as necessary. I can infer that some alters may be prepared to take an active role in matters sexual, in order to control the situation and the risk of damage, and that Mariska can be expected to erase threatening material from her mind soon after it is discussed – the "magic slate" effect.

I hope I am teaching Mariska how I expect her to behave in therapy, to explore rather than to avoid, to communicate rather than to act out, and to begin to understand the importance of transference and enactment in our work. This is part of socializing the patient to psychotherapy.

In these segments I was neither dealing with informed consent nor giving Mariska a map of what we might encounter (anticipatory socialization). My remarks had some psychoeducational aspects, but Mariska's aggressive literature searches preempted any extensive such efforts on my part. When she asked for recommended reading, I had recommended an early edition of Jon Allen's (2005) *Coping with Trauma* and Donald Nathanson's (1992) *Shame and Pride*. She breezed through Allen's book, but bogged down in Nathanson's in a way that told me that she was too shame-bound, too phobic of her own shame, to continue. Shame is a great instigator, maintainer, and enhancer of dissociation (Kluft, 2007). I anticipated it would be a central issue in our work together.

Part of my effort to establish the therapeutic alliance involves addressing relational and intersubjective concerns. At this early point in the treatment, I felt it was premature to share my reactions, lest they be disruptive or perceived as criticism. Mariska and I discussed how we would handle her questions about my thoughts and feelings. For the moment, she accepted my stance that while at times answering her questions might be helpful, at others it could be detrimental. We agreed I would share my misgivings about sharing potentially unsettling information and rely on my own clinical judgment, reserving the right to withhold if I had significant concerns.

Preliminary Interventions

As we got underway, empathic observations were my major interventions. Mariska seemed to find my empathy accurate most of the time. It is important to help DID patients deal with their diagnosis. Mariska and I went back and forth over her simultaneously endorsing and denying her DID. As long as we were working on relevant topics, I saw no need to debate diagnostic issues.

Helping DID patients manage relationships with concerned others often proves difficult. No problems arose with Mariska. She had minimal but cordial relationships with her parents, whom she saw infrequently. She was not involved with a significant other. Absorbed in her work, she socialized primarily with colleagues. These relationships were enjoyable, but not close.

I find it important to demonstrate some degree of expertise in order to help the patient appreciate that therapy can "do something." At the outset of DID treatment the achievement of major therapeutic goals is often well beyond any horizon DID patients can actually envision. By demonstration of expertise I refer not to wizardry or erudition, but to the therapist's skill in providing accurate understanding and imparting useful strengths and coping strategies to the patient.

As painful material began to emerge, the foundations of Mariska's original understandings of her life and family underwent slow erosion. She suffered increasingly frequent moments of severe distress and somatoform symptoms, which, by their nature, seemed likely to be body memories (e.g., flashbacks or reenactments of the physical discomforts seemingly associated with traumatic experiences).

Communicating empathically attuned understandings of Mariska's distress and apprehension was crucial in helping her appreciate she would not be left in painful isolation with her suffering and her fears. Also, I taught Mariska two particular autohypnotic techniques, safe place imagery and glove anesthesia and its elaborations. I use the latter for trance ratification, enhancing mastery, and containing discomfort.

DR K: In order to create a safe place, we need to find either a place that feels right and safe for you all, or a series of places that will be envisioned simultaneously. A place or places where those of you who need rest, respite or recharging can go.

MARISKA: That's easy. The gardens at Mainau! Do you know them? Probably not.

DR K: Actually, I attended a professional meeting in Konstanz some years ago. I remember them well, especially the dahlia plantings.

MARISKA: It is an amazing place. Some of my earliest childhood memories are from Mainau. From before things went bad … [*describes the gardens in detail*].

DR K: OK. Great! If you are alone, you can use the Spiegel eye-roll induction you've learned.

MARISKA: Great! I'll look like a fool, rolling my eyes up…

DR K: Well, if you are alone, it doesn't matter, and …

MARISKA: Voices say, "You don't get it!" One or more of us is always watching the body.

DR K: Well, I have got to say I missed that. No one has ever told me that before. So, let me demonstrate two public methods. [*I bow my head slightly and place my right hand in front of my eyes, as if fending off sun glare.*] That is one way to hide it in public. Another is the "two hands for beginners" approach. Watch this. [*I rub my forehead with the fingers of both hands, covering my eyes with my palms as I do so.*] Of course, the most protective would be to do either method, but to start with your eyes closed. It will look like you are fighting off fatigue, or a headache.

MARISKA: That will work. I'll just "remind" my colleagues about my migraines!

I also taught Mariska to create numbness in either hand. With her permission, I used a sterile pin to demonstrate effective numbness. When she opened her eyes and saw a pin sticking upright on the back of her hand that she had not felt as it pierced her skin, she was impressed. Such demonstrations lead to trance ratification, the patient's conviction that he or she really is in trance, making the often vague and nebulous concept of hypnosis convincingly tangible. [*I no longer use pain-related trance ratifications. My techniques vary, patient by patient.*]

Next, I taught Mariska to transfer the numbness to other parts of her body by rubbing the numb hand on those parts. This method has limited applicability in public settings, and may prove problematic for use for sexually traumatized areas. Therefore, I also taught her to let the numbness travel through her bloodstream to the afflicted areas. A few sessions later, Mariska remarked on her use of these techniques:

MARISKA: I don't know how to say this right, but I have this sense of being stronger, and an occasional little flash of glee. I don't know … I feel like I am becoming armed.

DR K: You are learning to use your dissociative and autohypnotic talents in the service of your recovery.

MARISKA: Kind of like some martial arts, using the opponent's strength against them.

With these skills acquired, Mariska became more confident in herself, our relationship and the treatment process. She was eager to learn still more. As our work progressed through the stage of preliminary interventions, dissociation was no longer a set of phenomena to be noted, nor a series of abstract definitions. Instead, it was a lived process between us and within Mariska, infiltrating our relatedness and our experiences of ourselves and one another, and becoming a new lens through which Mariska became more able to comprehend and unravel the knotted skein of her life and her psyche.

As we had moved smoothly into and beyond the phase of preliminary interventions (Table 43.5), emerging material and memories shared across alters caused Mariska to become increasingly symptomatic. We were both aware that the symptoms of the moment might prove to be the protruding tips of large and menacing icebergs.

TABLE 43.5 Preliminary interventions

1. Alleviating punitive superego attitudes
2. Shame management
3. Gaining access to alters:
   - dealing with "you can't get there from here."
4. Contracts
5. Fostering communication and cooperation and expanding the therapeutic alliance
6. Ego strengthening and system strengthening
7. Offering symptomatic relief:
   - medication
   - simplification
   - exploring disruptive symptoms
   - controlling spontaneous abreactions and flashbacks
8. Hypnosis with an emphasis on temporizing techniques
9. Ascertaining Core Conflictual Relationship Themes (CCRTs) (Luborsky & Crits-Cristoph, 1998)

Source: Kluft (1993a)

Victims of childhood trauma are usually oppressed by guilt and shame. DID patients often express such feelings in the actions taken by some personalities against others. Such instances often reenact punishment patterns from the patient's childhood and/or are understood to be protective. One example concerns information that the patient, as a child, was instructed to keep secret. Abused children are often threatened with dire consequences to themselves and/or others if such information is revealed. Typically, an alter will begin to share some secret information only to be punished in the inner world of the alters, or suffering a punitive wound to the body inflicted by an alter that does not experience himself or herself in the same body.

I hoped to prevent the enactment of such pattern among Mariska's alters. In discussing how we might proceed, I invited comments from all parts of the mind. Some predictable comments were communicated from within: 1) insisting nothing bad had ever befallen her; 2) telling me Mariska had been a liar since she was a little girl; 3) warning "They know what will happen to them if they talk"; 4) ordering me to "Leave her alone! She belongs to me!"; and 5) insisting "Those people would never, never, never do anything to hurt you." In addition, Mariska heard crying and screaming in the background.

It was easy to hypothesize that there were parts that would oppose the treatment process and that alters based on abusers and those who had either colluded with the abusers and/or failed to defend Mariska (and alters closely attached to such alters) would have to be worked with before the treatment could proceed safely.

DR K: So, enthusiasm for pursuing this treatment is far from universal?

MARISKA: Inside, voices are saying "Fuck you!"

DR K: Let me address this to those of you who are most concerned that this treatment is wrong-headed, or directed against them. You and all the others are all in this together, no matter how it feels to you at this moment. I don't expect you to believe what I am saying, because right now it is so important to many of you to be not-Mariska, to be anyone anywhere who was not ground zero for all of the bad stuff that was experienced. You've heard me tell you, "Either everybody wins, or everybody loses," because, at the core of it all, you are all one person. I don't want to see any of you trash the health, the body, the mind, the relationships or the career that you will ultimately appreciate is yours, and then finally get the idea and realize that you've really screwed yourself. At this point this sounds either like nonsense or a threat to many of you. But all of you, even those of you who make it your business to harm or sabotage one another, were created to defend one human being and to allow her to survive under intolerable circumstances, circumstances about which I still know very little. Therefore, at the deepest level, we are all on the same side, even though at the level you tend to experience, I just don't get what's going on and I may mess things up or seem to be your enemy. Sometime down the road, we are going to be getting along much better, and laugh about how things are now.

MARISKA: Just curses and laughter.

DR K: OK, in order to understand your concerns and elicit your advice, because you probably know a lot of important things I don't know, I am going to ask for a list of those who have misgivings about, or just plain oppose, the treatment. Then I will offer every one of you on that list a chance to come out, or to speak from within, and share your objections, concerns and advice.

MARISKA: They say, "You're full of shit. No one listens to us anyway."

DR K: I can promise to listen to you and treat you with respect. I can't promise to agree with you or collude with you in any way that might undermine the treatment or hurt you or any participants in the total human being, Mariska.

MARISKA: [*in a masculine voice*] What do you want?

DR K: Cooperation with the treatment and a complete moratorium on anything whatsoever that would compromise the present or future of the woman known to others as Mariska, or cause internal pain and chaos.

MARISKA: [*in the masculine voice*] You are asking a lot. A lot.

DR K: Hey! For you, nothing but the best!

MARISKA: [*in her usual voice*] They are laughing. Some will give you their names and talk. Others are going to wait and see.

DR K: Are those whose names I will be given volunteers, or have they been shanghaied?

MARISKA: They laughed again, and I heard, "To answer that would be to reveal classified material."

This was not mapping, to be discussed below. It was my way of showing respect for the parts primed to take an adversarial role, and attempting to assure that their concerns were appreciated. I tried to avoid proceeding in a way likely to be experienced as adversarial or otherwise negative. We spent about four months dealing primarily with alters' misgivings, and clarifying the role of shame in keeping information out of awareness. Mariska was reluctant to acknowledge or reveal awareness of alters who expressed anger or performed sexual functions.

MARISKA: I can't deal with the idea that there are parts of me that reveled in being sluts, whores, I don't know what to call them. I am beginning to have vague memories of coming on to Herr G when I was just a little girl. How can I live with that? There are some doors I don't think I ever can open, and still live with myself.

DR K: What's your understanding of those behaviors?

MARISKA: I'm a little piece of shit, and I got what was coming to me.

DR K: That offers you a perverse but straight-forward explanation for everything. It's appealingly simple, not much strain to the brain.

MARISKA: That's how it is. I'm waiting for you to throw me out of your office, or … [*silence*]

DR K: … or to finally appreciate your true nature and to respond accordingly?

MARISKA: I hate you for saying that, and I hate me that you are right.

After Mariska completed an extensive trashing of herself, during which she interrupted my every effort to intervene, I was able to get a word in edgewise.

DR K: The behaviors you are so ashamed of, and the alters that were involved in carrying them out, were created to manage unavoidable situations involving sexual demands upon you. Those who initiated sexual encounters probably had already learned one or more of four lessons: One, that if they resisted, they would be hurt in order to make them submit, and used anyway. Two, that some of the sexual options for victimizing them were more intolerable than others, so that initiating an option that was less intolerable might save them pain and difficulty, and offer them a modicum of control over what happened. Three, that their abuser insisted on being dealt with as if he or she was wanted, welcomed and desired, and efforts were made to provide that scenario – again, lest worse happen. Or, four, their own fear of abandonment by their abuser was so intense that they made every effort to demonstrate their love and devotion in the kind of encounter that their abuser clearly desired.

MARISKA: I hear inside, "He understands us," and "Do we have to fuck you, too?" and "What do you like to do?"

DR K: My replies are, "I'm glad, and I look forward to working with you," "No, you don't have to," and "I like to see people like you get well, and get in control of their own lives."

MARISKA: Some of them feel OK about you, and others say, "Wait and see. He's just like the others."

DR K: It's very hard to be in treatment after a previous therapist has exploited you. You have every right and reason to be skeptical about my intentions.

As alters initially opposed to treatment became increasingly supportive of the endeavor, it became safe to contact the alters associated with the experiences of abuse. My interactions with them were geared toward building a relationship in which they could feel safe. I did not explore for historical material, but did note what historical material was freely offered. I came to understand that Mariska had been molested both by Herr G and by some of his friends and mistresses over the years, that Mariska's parents had an open marriage, and that several of Mariska's mother's lovers, a rogues' gallery that included Herr G, had abused Mariska. Herr G had seduced Helga, Mariska's nanny, and involved her in sexual encounters with Mariska.

We did encounter a mild version of the "you can't get there from here" problem.

MARISKA: You will never reach the ones from before I learned English. They can't understand a word you say.

DR K: Well, let's not be so pessimistic. I would like to address myself to all of you who know English and know the languages of those who speak no English.

MARISKA: Many of us.

DR K: Are there any among you who would be willing to help by telling those who don't know English what I am saying, and then translate their response for me?

MARISKA: Hmm. I guess there will be no problem.

These interventions offer some indication of how I approached the matter of contracts. Fortunately, Mariska was not inclined to hurt her body or attempt suicide, and had eliminated substance abuse from her life prior to our work together. However, we had to work very hard to contain Mariska's use of sexual encounters for tension release, self-punishment and self-degradation.

Mariska loathed herself for these behaviors, but felt compelled to put herself in situations in which they were likely to occur. She also feared something awful would happen if she discontinued them. It was her idea to invite every alter to comment on this issue in her journal in between appointments.

MARISKA: This is the most humiliating thing I've ever done!

DR K: To what are you referring?

MARISKA: My most outlandish sexual behavior is less embarrassing to me than this journal. I almost burned it rather than bring it in. It was easier to believe I was nothing more than a slut. When you started to tell me about using sex as a defense, you scared me to the depths of my soul, but I wasn't convinced. Here are things that show that this whoring around is acting out things I don't want to remember. And it's acting like my mother, whose sex life I had completely blocked out of my mind. I find I have parts based on her. My God! And Herr G and the others inside – they get off on it! They pretend they are my partners and that once again, I belong to them. While one of them feels he's doing it to me, the others are watching, laughing, and sometimes taking pictures.

DR K: While they are believing they are doing this to you in your inner world, are others in your inner world experiencing themselves as being mistreated?

MARISKA: Yes. But the others wouldn't let them write it down.

DR K: These are incredibly important insights, and incredibly painful and humiliating insights. We'll be spending a lot of time addressing them. But I've got to say that many of you are breaking your contract for safety. We have to talk about that.

MARISKA: [*as Herr G*] The terms of the contract were clear. We have hurt no one!

DR K: I don't think those who experienced themselves as being raped by you and your buddies would agree, although you might coerce them to say they agreed.

MARISKA: [*as Herr G*] This is alright. I have been left in charge.

DR K: Let's spend as much time as we need to understand what drives you to think that I would accept such nonsense.

MARISKA: [*as Herr G*] This is how it has always been, and how it always will be.

DR K: So, you gave me your word, as you gave your word to Mariska's father, that you would take care of things, be in charge, keep her safe. And as you did to Mariska's father, you break your word to me, and still hope that I can be convinced that anything that seems wrong is quite all right.

MARISKA: [*as Herr G*] It has to be this way!

DR K: I am beginning to wonder if you set the stage for these episodes when you feel threatened by what is happening and what is coming up, and need to reassure yourself that you still are powerful, the one dishing it out, the one who never has to take it. What has been happening in treatment that is scaring you and your friends?

MARISKA: [*as Herr G*] Nothing. I have nothing more to say to you. [*switches to Helga*] The great Herr G is beginning to realize he has a vagina. Now that many of us are more connected, some of the men are feeling the pain of some of the abused girls.

After a few more confrontations, during which I tried to empathize with the abuser alters' fear of coming to grips with the fact that they had been abused, they settled down. The alters based on Mariska's mother proved recalcitrant, determined at once to portray mother both as a sexual adventuress without peer, and as a good mother who had always been protective of Mariska and encouraged her healthy enjoyment of sex from an early age [sic!!!]. Mariska, of course, wanted to preserve mother as a good object, but found increasing reason to appreciate that her mother had abandoned and betrayed her repeatedly. This inner battle continued almost to the end of the treatment.

During this portion of the treatment attachment issues assumed a more prominent role. We addressed countless instances of Mariska's mother's being unresponsive, uncaring, unempathic, and always on the verge of abandoning her. Our relationship was strong enough to allow Mariska to understand and work with her intense attacks on me and her expressions of disappointment in me in the transference. As she remarked, "Oh well, if you have not failed me in fact, I can always imagine or invent something horribly wrong with you."

Mariska demonstrated a pattern seen in many DID patients whose traumatization followed relatively stable early years with "good enough" parenting, especially maternal caretaking, either directly or through caring surrogates. When issues of maternal failure occur after the establishment of a good foundation, the fragmentation and dysregulation that follows is usually not as pervasive, long-lasting, and overgeneralized in its impact. Such patients are more resilient; regressions are generally less extensive and prolonged. Across the range of the maternal failings, the responses of the patients are remarkably consistent with the patterns of response to narcissistic injury described in Kohut and Wolf (1978), and usually respond rapidly to the interventions these authors describe. Conversely, serious damage in the attachment

system that is early in onset and persistent over time is far more difficult and demanding to address, and is not found in DID patients who respond most rapidly to treatment.

My efforts to bring Mariska symptomatic relief included numerous medication trials, none of which were helpful. While the personalities based on Mariska's mother attempted to undermine efforts to remove stressors and unnecessary burdens from Mariska's life and did not respond to my efforts, more and more alters joined forces to contain their sabotage. Mariska's various symptoms were explored by making inquiries, usually without hypnosis. An illustration follows:

Mariska was one of the few women in her field, often the only woman in a gathering of colleagues. She began to experience severe headaches on these occasions.

MARISKA: I have to do something about these headaches.
DR K: You have described the headaches very well, but for the sake of completeness, I want you to tell me about anything else you experience along with the headaches—ideas, images, feelings, sensations …
MARISKA: [*interrupting*] No!
DR K: Well …
MARISKA: [*interrupting*] No! Why don't you leave my headaches to the neurologist? Such questions you ask! No!
DR K: It seems from what you are saying that the headaches reflect both the intrusion of some uncomfortable material and your attempts to push that material away. Elements of the material succeed in pushing through as physical orphan symptoms, unconnected to the context in which they occurred.
MARISKA: I'd rather have the headaches. I'm not ready for this.
DR K: Well, that's a problem. Often I can get a symptom to subside, but that's usually associated with promising whatever parts are behind the symptom a chance to be heard.
MARISKA: I really can't go there now. I have too much on my plate and a grant application that is due in two days.
DR K: OK. Will you allow yourself to go to sleep while I talk with the others?
MARISKA: I don't like this, but OK.
DR K: [*I induced hypnosis, sent all personalities other than those behind the headache to a safe place, and suggested hypnotic sleep*.] It seems that there is something really important that you need to say today.
MARISKA: Yes. But *she* needs to hear it. Not you.
DR K: You may be right, but let's start with me.
MARISKA: Her mother sent her an e-mail.
DR K: An important e-mail?
MARISKA: A terrible e-mail. Herr G is coming to the US on business. Her mother gave him her e-mail and real address, and assured him that Mariska would be glad to put him up for a few days. Mariska is trying to push it out of her mind, and Helga says she is not going to take care of things. We have to do something. And we don't think we can say "No!" [*switch to Helga*] It's about time they stood up instead of saying "Helga! Helga! It's time to spread your legs." No more! No more!
DR K: Thanks. You can step back. Mariska, everybody, please listen. There is real danger here, and pushing it aside will put you all at risk. Mariska, this time I think you all need to listen.
MARISKA: I hear it. I remember. What can I do? My parents don't know about Herr G. They will think I am horrible. [*switch*] We would like to see Herr G. [*switch*] Do you see why we tried to push through?
DR K: Mariska, is it true that your parents don't know about Herr G?
MARISKA: [*cries*] I told my father over and over again, but he didn't believe me. My mother knows – she was in bed with Herr G and me. Why don't I just kill myself?
DR K: I think that when it seems easier to consider killing yourself than saying "No!" we have a lot to talk about.
MARISKA: [*smiling weakly through her tears*] You think I have a problem? You think I need something like psychotherapy?
DR K: The thought had crossed my mind.

Mariska devised clever plans to avert the potential dangers of Herr G's visit. We negotiated our way through myriad symptoms, which seemed to occur mostly when self-protective needs were in conflict with attachment needs. Mariska quickly mastered how to initiate inner dialogs to explore incipient symptoms, to get the alters involved to step back, and to bring their issues to session. Often these alters left gargantuan telephone messages to assure I would be aware of their issues in case other alters "forgot" them.

Mariska developed her own way of controlling spontaneous abreactions and flashbacks, based on techniques used in session. She relied on the basic psychodynamic question: "Why is this happening now?" Pursuing this throughout her inner world, she would find the alter or alters who had become upset, or whose issues were triggered, engage them

empathically, and persuade them to use a technique I had taught Mariska, hypnotically putting the upset alters to sleep between sessions, promising to call them and their issues to my attention. I quickly learned that I had to question Mariska about whether she had shut down anything to which we had to return, because she often "accidentally on purpose" gave herself what amounted to suggestions for permissive amnesia.

Many hypnotic techniques (or techniques derived from hypnotic techniques) proved useful at this stage. These included accessing alters, alter substitution (inherent in next example), reconfiguring the system (as I did when Mariska was put to sleep so I could converse with alters whose communications she wanted to avoid), provision of sanctuary, time-sense alteration (e.g., putting alters to sleep), and symptom relief (Kluft, 1993a, 1994, 2012). I also was gradually learning the key dynamics of additional alters' CCRTs (Luborsky & Crits-Cristoph, 1998).

History Gathering and Mapping

Although much history had been taken *pari passu*, it was only now, with much shame-reduction work accomplished, abreaction containment skills in place, and a reasonable therapeutic alliance attained (mother parts excepted), that I believed a sustained effort to take an overall history was possible. Each known alter was asked to tell its story. Gaps and apparent and real discrepancies were pursued. If any alter became too emotional or disruptive in recounting an event, another alter that had witnessed the events in question, but was less prone to upset, was asked to continue the narrative.

Only one additional piece of historical information will be shared. Near the end of the history-gathering a child alter said it missed "Heinrich." Another alter, speaking harshly, told her to be quiet. No alter could or would explain "Heinrich." Assuming Mariska had given me honest answers, I wondered if Heinrich was an alter largely unknown to the others. I told Mariska I would try to see if there was an alter named Heinrich. Mariska gave no indication of distress.

When I induced hypnosis and tried to check for a Heinrich, an alter emerged and said, "I'm surprised I got out. They put me in prison and threw away the key. They pretend I don't exist." I was beginning to assure Heinrich that I would be glad to hear his story when the usual Mariska took over.

MARISKA: There! We put him back in jail! Now forget about him. You will never hear about him again!

DR K: Forget about him? I'm pretty confused by all this.

MARISKA: You understand Kaddish? The Mourners' Kaddish? I figure you are Jewish. You take off for the Jewish holidays.

DR K: Yes. I understand about the Mourners' Kaddish.

MARISKA: When someone dies, you say the Kaddish. My brother is dead.

DR K: I'm sorry.

MARISKA: Don't be. He is dead to me. I heard that Jews also say the Mourners' Kaddish when someone, even if they are alive, becomes dead to them. I learned about it in a class at university. He is dead to us. Just that one little brat wants to visit him in jail—the jail in my mind. My brother and I were inseparable. My parents always running here, running there, Herr G fucking our nannies… Every stupid one hoping he'd leave his wife and marry her. Idiots! Herr G married into money. He'd never leave his wife. I told my brother about what Herr G was making me do, and he got all excited and tried to do the same things to me. It's complicated. I can't say any more now. [forcefully] I have said the Mourners' Kaddish for Heinrich. There is nothing more to say.

I was completely blindsided by these revelations. Mariska both took pleasure in how well she had hidden her secret and was ashamed that it finally had been revealed. She had not thought I could reach Heinrich. Her understanding of "Why is this happening now?" was that, in spite of her conscious plan never to speak of her brother, at a deeper level her mind knew it had to reveal this material if she were ever to recover. In reflecting on these revelations, I was startled to realize that although I knew Mariska had a younger sister, she had never been mentioned after the initial sessions.

With much history learned, we were on the verge of processing traumata, but still being surprised. It was time for mapping. Sometimes I map before going for history, sometimes after. For Mariska, her intense shame about finding more alters exceeded her distress with learning about traumata. Mapping was delayed until her shame about having alters had diminished.

I used Catherine Fine's technique (Fine, 1991, 1993). I asked Mariska to write her name in the center of a piece of paper. Next, all alters were invited to place their names or to instruct Mariska where to place their names on the paper, situating their names closest to those to whom they felt most close. I also asked those who had no names or who were not ready to share their names to represent themselves with a mark, a circle, a check, a line, etc.

A half dozen names clustered around Mariska. These alters were similar to Mariska. They could pass for her or one another should the alter on the surface become tired, overwhelmed, or otherwise unable/uncomfortable about remaining at the surface holding apparent executive control. Just beyond them to the upper right was a cluster called "the smart kids." They inspired her scientific accomplishments and "could fix anything." To the upper left was a cluster of "good girls" who could always "do the right thing" with impeccable manners and social grace. They usually dealt with the parents, social situations, and covering over recent trauma. Below "Mariska" were two heavy dark lines. They stood for two powerful figures of uncertain gender and age who kept another group of alters, whose names were just below these lines, from acting out sexually without permission from elsewhere in the mind. That group included Helga, Helga 2, and Helga 3. In the lower left corner was a cluster of over two dozen names, which referred to a series of children and adolescents holding encapsulated memories of particular abuse experiences. At the lower right corner was the name "Heinrich," covered over by vertical lines, signifying the bars in his prison's window. Surrounding this corner was a fascinating series of paired German and Jewish names. The German names represented Teutonic Knights who guarded the prison and kept Heinrich in check. Accompanying each Teutonic Knight was an Orthodox Jewish Rabbi, perpetually chanting the Mourners' Kaddish for Heinrich. Closer to Mariska than these protectors was a teardrop, representing the alters that endured Heinrich's abuse. Between Mariska and the teardrop was a cluster of names with young ages. These alters were based on fantasies of having evaded traumatization. "They are untouched," Mariska said. Pointing to the teardrop, she added, "I can't let that happen to them." Across the top of the sheet, from left to right, were the names of alters based on Mariska's parents, Herr G, Herr G's friends (who were also business associates of her father), and the names of two doctors. "I couldn't let myself tell you that it happened with a second therapist as well." I asked if the traumatization by the doctors had led to additional alters. Mariska became tearful. "I can't even write that down. I was no child or teenager then. I was an adult. No! Nothing more about that today!"

I asked if there were any parts that had not checked in, but which would now be willing to do so. Mariska took back the map, and made more entries. Now, scattered across the top among the abusers were several circles, completely filled in with black. "Those are the parts that are what is evil in me. They make me my own worst abuser." I assumed, and later confirmed, that these included alters associated with her sexual exploitation by mental health professionals, and that more work would be needed for her to place these experiences in perspective.

I had no illusions that this mapping was definitive. For example, no alter admitted to knowledge of or connection to her sister. However, it provided an elementary road map and basic appreciation of Mariska's dissociative complexity. Without it, we might easily have moved on to the phase of what Herman (1992) calls "remembrance and mourning," and which I refer to as "the metabolism of trauma," without understanding what precautions and safeguards might serve to better protect Mariska and her treatment from destabilization.

Metabolism of Trauma

At this point, Mariska's treatment was well underway. We agreed that we had established a solid foundation. Mariska was well-equipped to process her experiences in relative safety, and to preserve good function as she did so. We had become a team, both identified with the goals of the treatment and able to retain our connection with one another despite the vicissitudes of transference and countertransference. We accepted as inevitable that intrusions from the past might become manifest in the present in myriad ways, and that they might test and try our alliance, but would not break it.

The organization of our thinking about Mariska's dissociation had undergone a series of transitions. We had begun by studying and appreciating dissociation from our different perspectives as a series of complex phenomena that we needed to observe and understand in order to determine the nature of Mariska's problems. From Mariska's perspective, they were a series of mortifying and confusing "not me" experiences and manifestations, not appreciated to be part of who she was. From my perspective, they were vital bits of information that might help me understand a patient in difficulty and pain. As we discussed and further explored them, we better appreciated their patterns and the implications of those patterns.

We learned that dissociation not only characterized Mariska's diagnosis, but that it also was a major determinant of the interpersonal field and the relational processes in which we were engaged. Dissociation underlay and played a role in determining how and who and what she was in relationship to me and among her many selves. As early interventions clarified and contained aspects of Mariska's dissociative disorder, it became possible to decode Mariska's dissociative processes and structures, and thereby make better informed interventions. Working with dissociation to cure dissociation pervaded the therapeutic process.

Mariska was able to build on the foundation we created together during these early stages of treatment as we moved into the metabolism of trauma. Although there would be many difficult moments in coming to grips with her mother's role in her traumatization, in dealing with those parts identified with mother, in learning about her sister's role in her life, and in addressing her brother's betrayal and mistreatment of her, Mariska was well positioned to process her experiences and issues.

Mariska's mother may have been an excellent parent in most respects until Mariska reached her later Oedipal period. By this time, the combination of the normal pressures of that stage, sexual abuse by Helga and Herr G, plus the sexual adventurism common in her parents' circle swept Mariska into a realm of activities which her mother foolishly encouraged, only to find that her traumatized and overwhelmed daughter not only had become precociously sexualized, but also had become an object of fascination and desire to her lovers. Her mother withdrew from the warm and empathic closeness that had characterized their relationship, and treated Mariska as a competitor. Mariska dissociated her mother's abuses and failures during childhood. However, Mariska responded to her mother's contemporary failures and betrayals with symptom complexes shared by both disorganized attachment and disintegration/fragmentation/dysregulation as described by Kohut (Kohut & Wolf, 1978). Both the firm initial mother-daughter relational foundation and Mariska's dissociation of mother's subsequent profound failures and instances of betrayal seem to have prevented a disorganized adaptation from becoming a primary determinant of her character (see Kohut & Wolfe, 1978; Lessem, 2005). As might be imagined, Mariska often experienced me as an idealized individual who abruptly failed, betrayed, mistreated, or abandoned her.

The Rest of the Story

After five additional years of treatment (seven and a half years in all) Mariska's complete integration was stable, her therapy goals accomplished, and sessions were gradually tapered to periodic follow-up visits. Mariska and a fellow scientist with a similar background met at a meeting abroad. They fell in love, married, took positions at a prestigious European university, and began their family. When she speaks in America, we schedule a follow-up session or two. Her life is good.

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