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Inner worlds as social systems: How insights from anthropology can inform clinical practice

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ABSTRACT

Dissociative Identity Disorder (DID) is characterized by severe disconnection among parts of the personality to the extent that they are experienced as separate identities or selves. A primary clinical goal is often the reintegration of these parts into a singular. core self. Through the case study of one young-adult client with DID, an anthropologist-clinician challenges this imperative for a unitary self and builds on anthropological insights to offer an alternative approach for working with internal dissociation.

The first time Ella time traveled in my office it took me a few moments to realize what was happening. She was sitting in the same chair she had been in for the past half hour, back straight, feet flat on the ground, hands folded in her lap. When it happened, there was no dramatic fanfare, no shuddering or twitching, nothing anyone who didn't know her would notice. But I saw it–a slight alteration in how she held her body, and her face softened. I heard it, too–her voice sounded different, pitched just a smidge higher than usual and bouncing along with a singsong quality. Those were the only signs. Even then, I didn't think much of it. At least not until I asked her how old she was. "I'm seven," she said. Ella was twenty.

I am a professor of anthropology and a licensed clinical social worker with a private psychotherapy practice. For 4 ½ years I worked clinically with Ella, who experienced horrific sexual abuse as a child. When she came to see me for therapy she was experiencing daily nightmares, flashbacks, body memories, and hypervigilence. In the course of our work together, it also became apparent that she had what is diagnosable in the DSM as DID–Dissociative Identity Disorder (formerly called Multiple Personality Disorder).

DID is a highly controversial diagnosis with many clinicians and laypeople alike doubting whether it is even real. I can say from my work with Ella that I have no doubt DID exists. But what this means and what I think should be done about it are different for me as an anthropologist than it seems to be for most clinicians, and this has pushed me to think differently about "the self" in ways that have been both useful and unexpected.

Ella did not come to therapy talking about DID or her different "parts," as she refers to them. It wasn't until about a year into the therapy that she began to share experiences of finding drawings and writings scattered around her room that looked childlike, which she found extremely frightening. She also found herself wanting to hold stuffed animals and to be close to her mom in ways that felt regressed and uncomfortable for her. She wasn't at all sure what to make of all this.

Then, one day in session, in the middle of a conversation, Ella became unusually quiet. She closed her eyes for so long that I was just about to ask if she was ok, when they popped open. Ella then began to talk in an unusual, childlike voice, looking confusedly around my office. I tried not to visibly react, mindful of my potential impact on whatever it was that was happening. She looked at me as if she'd seen me but wasn't at all sure I was to be trusted. We talked for a few more minutes and she persisted in the childlike voice and in her confusion, becoming increasingly distressed. I asked her if she knew who I was and she said yes, that she had seen me my office before in a dream. Given her childlike presentation, that's I asked her how old she was and she told me she was seven. I took in this information, again careful not to react, and decided to follow her and see where things would go from there. We talked amiably for a few minutes. Then she closed her eyes, gave a shudder, and twenty-year-old Ella looked back at me through newly opened eyes.

Ella then proceeded to talk in her regular voice about what we had been discussing before the interlude, apparently with no awareness of what had just happened. She noted my hesitation and asked me what was wrong. When I told her about what had occurred, she, to put it mildly, *freaked out*. She was terrified. She jumped up out of her chair and wedged herslef into a corner, hands held up in front of her as if to ward of something dangerous. Crying, she pleaded with me to tell her I was joking. She began to hyperventilate. I have no doubt in my mind that this young woman was scared out of her wits that she had dissociated into a seven-year-old part and spoken to me, and then had no memory of it. She quickly ended the session, gathered her things and hurried out of my office.

After this first incident, Ella began to dissociate into younger parts fairly regularly in session. Sometimes, this seven-year-old part came out and would talk and play contentedly. We would sit on the floor of my office and color or do art while we talked, sometimes discussing what was happening in Ella's current life, sometimes talking about things that had happened in the past. Other times, other parts came out in full flashback mode and had to be talked down from states of sheer terror. Some parts were unable or unwilling to speak at all but would write or draw what they wanted to communicate, though writing was sometimes backwards, in mirror form, when a part emerged for the first time. To distinguish among among parts, Ella asked them to use a different colored markers when they wrote or drew. The first part to come out to me—the seven-year-old part—chose blue as her color, and as her name. Since then, she has been known as Blue.

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In Ella's case, the number of active "parts" ranged from four to fourteen at any given time. Her parts were different ages, and all but one were versions of her. Different parts were adept at dealing with different situations and feelings and would "come out" – take over as the main "self"—when the feelings in question were especially pronounced or when a situation related to that part's functioning required practical action.

For example, a part named Ada—aged sixteen—was created in the wake of an abrupt and catastrophic rejection by a high school guidance counselor in whom Ella had confided about the abuse. Ada trusted only very, very tentatively and was quick to lash out with an acerbic tongue when hurt. She could also be moralistic and self-punishing, particularly when she felt she had allowed herself to trust someone who then disappointed her. Other parts, like Blue, were very different. Blue trusted easily and loved generously. Blue and Ada were often at odds, and this sometimes erupted to all out internal warfare (particularly early on), with Ada, the older and stronger, generally prevailing. At such times, in order to punish Blue, Ada would often hurt "the body" by hitting and biting her arms and legs and holding a pillow over her face until she passed out, behaviors Blue experienced as a reenactment of the abuse that created her. During these "battles," other parts would become very agitated, often entering their own crises.

How does one work clinically with such a situation? DID is extremely rare, and most clinicians will go their whole professional careers without encountering it. It's not something most people are trained in managing, and I certainly was not. As my work with Ella progressed, I consulted extensively with clinicians practiced in working with DID, I read every book I and article could get my hands on, and I learned as I went.

It soon became clear to me that while my clinical training was critical, the skills that most helped me in my day-to-day work with Ella came from anthropology. This is because I realized that what I was dealing with was not simply a young woman in distress, but a *community*–a community of selves within one individual, but a community nonetheless. Anthropologists have ample tools for engaging and understanding communities, and I approached my work with this community as I would any other, as I will describe in a moment.

But Ella's internal world was also *unlike* any other community I have encountered. Most communities are composed of multiple bodies all sharing the same temporal location. In Ella's case, the community was composed of one body and multiple temporal locations. That is, some parts existed only in the past, continually living and reliving original traumas. Others lived in the present, aware of when they were "made" but they had essentially gone off-line until they came out again years later, having few memories of what happened in between. Blue, however, was special. She was created when the body was seven and she had memories of the original abuse, but unlike other parts had remained largely present in the background of Ella's life between then and the present, with memories of what happened during the intervening years. With her unique perspective on Ella's internal world across time, Blue became what anthropologists call my key informant.

I use this term "key informant" mindfully, and this takes me to the three ways I brought my anthropological training to bear on working with Ella's inner community: (1) cultivating a stance of knowing unknowing (2) discerning telescoping temporalities, and (3) challenging dominant concepts of health.

"Knowing unknowing" is how I have come think of my therapeutic stance when working with clients and borrows much from anthropology. When anthropologists go into the field, we prepare by reading the existing literature on a place, working to understand current theoretical debates related to our topics, and obtaining training in qualitative methods. In this sense, we go into the field as experts, or at the very least, specialists. But, at the same time, upon entering the field we become acutely aware that the map is not the territory. When it comes to real life and how it is lived, felt, and experienced by others, we are novices rather than experts. We rely on our interlocutors to guide us, to help us learn the local language and customs, the myths and stories that have become part of a people's history, the symbols and rituals that animate social life.

This is how I work with clients. Existential psychotherapist Irvin Yalom (2017) has argued that one must create a new therapy for each client, because each person's internal meaning system is different, and therefore the ways they experience and manifest existential concerns will be unique. I couldn't agree more. Building on Yalom's view, we might say that each person's inner world is a unique *culture*, with its own history, language, values, practices, symbolic systems. Creating a therapy for a client, then, is intimately tied to an ethnographic exploration of the client's inner world. And just like any ethnography, this takes time and patience, and is built on foundations of trust in human relationships. You must learn to speak the local language. You must understand the symbolic systems and ritual practices and the dominant themes that reverberate in different ways in different domains. Most of all, however, you must remember that you are a guest, and that however much training and knowledge one my have as a therapist (or an anthropologist), we can never truly *know* what it is like to be a person from that culture or a client with that inner world. The client, ultimately, is the expert on her own experience. Always. This is why I call this orientation a stance of knowing unknowing. And this is how I became acquainted with Ella's different "parts." I followed how Ella experienced herself at the time. Neither the origins nor the resolution of Ella's DID were givens for me. I let her lead me.

The second contribution from anthropology came directly from my earlier research in a very different context. In an article I wrote about time in a Roman Catholic convent in Mexico (Lester, 2003), I argued that one way new initiates to the Order came to understand their religious vocations was through developing a new phenomenology of time whereby they learned to read the "self" across different temporal scales simultaneously–one based on the everyday world and one based on the eternal time of God and creation—and that they did so through a refiguring time as circular repetitions of key themes, such as sin and redemption or bondage and freedom. I called these "cross-temporal correlates," and suggested that coming to read the self vertically across stacked circular versions of time, rather than along a singular horizontal timeline, enabled the nuns to shift their understandings of self in profound ways.

I saw something similar in Ella's experiences of self, in that different parts existed at different times—yet also in the present–and she struggled to form a coherent sense of herself as a result. Ella herself thought of this as what she called a "telescoping process," with parts stretching back across time while also being present in the present day. Parts were therefore not solely located in any one temporal domain but telescoped time. Furthermore, while some parts remained the age the body was when they were made, parts of any age could be created at any time. So in addition to telescoping time, parts could actively use temporal displacement as part of their communicative function. If I had not done the work with the nuns or been aware of the anthropological literatures on varieties of temporal reckoning, I am not sure I would have picked up on the significance of temporal telescoping in Ella's ongoing process of healing.

This leads me to my third and final point, which is the question of what should be considered success when it came to helping Ella. She and all her parts were absolutely adamant that they did not want integration. Most clinicians would see this as a challenge to be overcome. But my anthropological training has taught me that the western notion of one coherent, consistent, stable, and enduring self per body is a historical and cultural peculiarity. While it is true that Ella is of this time and place and therefore her experience of having multiple selves can be diagnosed as "disordered," my concern was less with the *number* of selves she had than *how those selves worked together* –or not—in her daily life.

The problem for Ella was that the barriers of awareness between her parts made it difficult for her to function, and crises could occur when those barriers unexpectedly were breached. My goal with Ella, then, was not "integration" into one self, but *community building*. We focused on increasing communication between and among Ella's parts and

brainstormed strategies for doing so. Not everything was shared among parts, and there were strong sequesters of thoughts and feelings. But the parts gradually learned to work as a sort of team of specialists, with one who was good at taking tests, one who was comfortable talking to authority figures, one who felt more at ease with emotional attachment, one who held feelings of hurt but eventually came to cry softly in the background instead of taking over and making functioning impossible. Even Blue and Ada began to collaborate and to make lasting present-day attachments.

With greater collaboration came better functioning. Over time, Ella's inner community came to work together smoothly. She graduated college, obtained a graduate degree, got married, and recently became a mother. She is thriving. She says her parts are still present, but things feel much more coherent and collaborative.

Notably, it was Ella herself who encouraged me to write this piece. She wants people to understand that DID is not always solely pathological and that integration is not necessarily the healthiest state for everyone. In truth, I don't think Ella is that different from the rest of us. We all have "parts." Part of me is excited to write this piece and share what I've learned. Another part of me is overwhelmed with other work and is mindful of all the things not getting done while I write. Another part is wary of how it will be received. Another part is eager for feedback. What's different for me than for Ella is that my parts don't each have a separate consciousness with barriers of awareness between them.

What mattered most for Ella was not internal integration, but developing a conceptual framework and set of tools for managing the existential consequences of trauma. Trauma rips people out of their daily worlds and pushes them to the edges of their existence. It is like going to outer space and looking back at the Earth in its entirety—a perspective that can never be unseen, even once ones feet are back on solid ground. Working with Ella has taught me that, for individuals who have experienced trauma, the transcendent and the everyday are forever fused, and those two perspectives must be held *together* in processes of healing, even as we work to re-tether people to the world through empathic human connection (Lester, 2013).

This opens up new possibilities for thinking about recovery from trauma. If trauma is thought of as a discrete event or set of events that happened in the past, we are significantly constrained in how we understand recovery. We cannot go back in time. We cannot undo the event. It is over and done with. The best we can do is try to lessen the impact, reduce the intrusion of memories, calm the "what ifs" and the ruminations about what could have been done differently. But if we broaden our understanding of what trauma is from the event itself to the event *plus* its ongoing psychic, emotional, embodied, interpersonal life, telescoped *across* time, then we have a different story. Ella may no longer have been in imminent danger by the time I met her, but many of her parts are still in the midst of the trauma. As she has continued to bring those parts into her present, everyday life, and to re-tether them to the world through safe human connection, she has finally been able to work towards what was foreclosed to her so long ago: a different ending.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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