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**“My Soul is Scattered”:
A Psychotherapeutic Treatment Narrative Highlighting
Symptoms and Dynamics Associated with
Dissociative Identity Disorder**

by

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ABSTRACT

This dissertation reviews issues in the literature relating to the psychotherapeutic treatment of Dissociative Identity Disorder (formerly Multiple Personality Disorder). Over the last three decades, significant developments have been made in the areas of dissociative disorders research and clinical practice. Dissociative Identity Disorder (DID) is generally regarded as the most controversial of the diagnoses, and yet is considered by those working in this area to be fundamental to the dissociation paradigm. Countering its image as a bizarre and intractable disorder, clinicians are currently building up a body of literature which indicates that it is in fact eminently understandable and treatable. Studies of the aetiology of DID link the disorder to severe and chronic abuse (including sexual abuse) experienced in childhood, and specific theoretical principles and techniques have been developed for the psychotherapeutic treatment of this group of patients with integration as the ultimate - but not exclusive - goal. The understanding of DID and its treatment, as presented in the literature, is applied to an individual case, seen over a 14-month period in both inpatient and outpatient settings. The dual purpose of this case study is firstly to describe patient symptoms and dynamics, and secondly to illustrate the progression of a psychotherapeutic treatment of DID in the context of issues raised in the literature review. A discussion of the case provides reflection on some of these issues. It is thought, furthermore, that in the South African context where, in spite of a high incidence of reported and confirmed child abuse and child sexual abuse, this diagnosis is seldom made nor the disorder generally recognized as a legitimate condition, an exposition of this kind may prove useful.

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Do not persist, then, to retain at heart
One sole idea, that the thing is right
Which your mouth utters, and nought
else beside.

Sophocles: *Antigone*

CHAPTER ONE

INTRODUCTION

Dissociative Identity Disorder (DID), formerly known as Multiple Personality Disorder (MPD), has been, and still is, a subject of deep controversy. The concept of multiplicity, in which the objective perception of a single self is disputed by the individual's subjective and literal experience of many selves, is not universally accepted. This is in spite of its current acknowledged place in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM IV) (1994). The ongoing debate regarding the existence and prevalence of DID is largely a North American phenomenon, with recent and increasing participation from Britain. In other countries it appears to be in an incipient phase. In South Africa, this debate has not yet been publicly addressed, and accordingly there is almost no literature emanating from South African sources on the subject.

While the controversy surrounding DID is acknowledged and some of the central arguments of the debate outlined, for the purposes of this dissertation it is accepted that DID exists as a legitimate condition within the spectrum of mental disorders. Likewise accepted is the prevailing view, among clinicians working in this area, that psychotherapy, though a complex and demanding process for both patient and clinician, forms the foundation of DID treatment, with psychopharmacological treatment serving an adjunctive role primarily for symptoms of anxiety and depression. Accordingly, this dissertation largely circumvents the more polemical issues associated with the topic in order to focus more effectively on the psychotherapeutic treatment itself.

At the same time, however, this dissertation operates from the premise that at least some of the controversy stems from the fact that there is no homogeneity of either attitudes towards or understanding of the phenomenon of DID, as it presents in the psychotherapeutic context. Those who have witnessed and worked with a patient's unsolicited switching of alters do not question its credibility, while those who have not often arbitrarily choose not to believe that it is possible. In South Africa, where the disorder has either been written off as a North American peculiarity, or engaged with

only in the privacy of individual therapists' consulting rooms, the gap between "believers" and "non-believers" is potentially even wider.

The questions posed for this research, which is aimed at increasing understanding of the phenomenon of DID, are therefore at a very basic level. They are concerned with how DID may manifest in therapy, the internal dynamics according to which it may function, and the possible course, nature, and success of a psychotherapeutic treatment which is initiated to help alleviate distress. The descriptive, single-case study design, which can offer a window onto observable and expressed phenomena not readily available to the majority of those interested in the subject, is considered an appropriate format within which to address these questions.

Chapter 2 reviews the literature dealing with selected major issues related to the psychotherapeutic treatment of DID. Some attention is given to the historical origins and understanding of the disorder, its aetiology and complex symptomatology, as well as key features of the debate. Certain specific treatment issues including different approaches to treatment are then reviewed. Treatment for DID patients who are simultaneously survivors of Satanic ritual abuse is also briefly addressed, as are issues pertaining to psychotherapeutic treatment of DID in a South African context.

Chapter 3 reviews the central features of the methodology for single-case study research and applies them to the questions posed in this dissertation. Motivation for the writing of the dissertation and relevant ethics are detailed.

Chapter 4 comprises a history and formulation of the case, and the course of the therapy is outlined.

Case study material is presented in Chapter 5. The material is presented chronologically, as a treatment narrative, and relevant sessions or parts of sessions are related in some detail. The therapeutic process provides the context in which the patient's relevant symptoms and internal dynamics may be meaningfully described. Factors associated with the therapy's psychodynamic orientation, such as transference and countertransference, as well as the influence of outside events, are acknowledged where deemed helpful in understanding both the patient and the overall therapeutic process. Finally, the therapist's reflections on the case study in the context of some of the issues raised in chapters 2 and 3 are considered in a discussion of the case.

Chapter 6, the conclusion, provides a brief reflection on the key treatment issues pertaining to the case and generalizes from there to the South African context and the challenges facing both individuals struggling with DID and the health professionals who are attempting to help them.

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CHAPTER TWO

LITERATURE REVIEW

The literature available on the topic of dissociation, and in particular Dissociative Identity Disorder (DID), formerly Multiple Personality Disorder (MPD), reflects its complex history and ongoing controversial status. Exploration of the pathology of dissociation began before Freud and Janet (Greaves, 1993; Hacking, 1995), but they are considered to be the first to have developed comprehensive theories to explain its manifestation and shape principles of treatment (Nemiah, 1998). That dissociation as a focus of empirical study and discourse became neglected in the course of most of the twentieth century, is generally attributed to the development of Freud's theories of intrapsychic conflict and his repudiation of the seduction theory, as well as the increasing inclusion of MPD type symptoms within the diagnosis of schizophrenia as formulated by Bleuler (Putnam, 1985; Kluft, 1993).

The history of the development of the concepts of dissociation and repression in relation to trauma has been explored from various angles and at greater depth than it is possible to do here. Nemiah (1998) has written on the subject both clearly and concisely, outlining the theories of mechanisms of dissociation and repression as they were initially developed by both Janet and Freud. Freud's early understanding of hysteria as aetiologically linked to trauma, his development of a theory of repression and the use of abreaction in his and Breuer's treatment of Anna O, are contrasted with Janet's formulation of a theory of dissociation. Based on clinical observations of patients with hysterical symptoms, Janet surmised that, in contrast to the prevailing understanding of consciousness as unitary and continuous, "there may coexist within one and the same individual two or more separate, dissociated streams of consciousness, each existing in isolation from the others, and each with a wide spectrum of mental contents such as memories, sensations, volitions, and affects" (p. 7). Nemiah goes on to delineate Janet's understanding of these dissociated streams of consciousness as stated in Janet's work *l'Automatisme Psychologique*, published in 1889. What emerges is a

picture very similar to what we might now conceptualize as classic Dissociative Identity Disorder:

Although the primary consciousness is entirely unaware of the dissociated, unconscious complexes, the latter often engage autonomously in a wide range of mental functions characteristic of ordinary consciousness. They remember; they experience sensations, affects, and desires; they keep track of time, plan ahead, think logically, and solve mental problems; and, when they are endowed with a personal identity, they constitute an independent, self-aware co-conscious personality existing and functioning contemporaneously with, but outside the sphere of awareness of, the primary personality. (p. 7)

Janet found that by using hypnotic suggestion to alter painful memories, intrusive and debilitating dissociative symptoms could be effectively reduced. Ultimately, however, it was Freud's reformulation of the causes of pathology, focusing on libidinal impulses and the resulting intrapsychic conflict, which had the most profound impact on Western theoretical understanding of mental disorder in the twentieth century (Greaves, 1993; Nemiah, 1998).

As a result of events such as the First World War the relationship between external trauma and pathology was never completely rejected. Investigation of the phenomenon of trauma and its psychological sequelae in a range of contexts led to the development of trauma theory, which in turn has had a major impact on the way many health professionals view and treat their patients' symptomatology (Bloom, 1997; Herman, 1992). More specifically, over the last three decades, the causal link between external trauma and dissociation has been empirically reviewed and re-explored. In the 1980's a body of literature grew which queried the classification of Posttraumatic Stress Disorder (PTSD) as an anxiety disorder (Ulman & Brothers, 1988) and the idea of reclassifying PTSD symptoms such as reexperiencing and numbing as dissociative phenomena was posited. At the same time, types of childhood trauma and their short- and long-term effects were being investigated (Eth & Pynoos, 1985). Empirical investigation of the role of child abuse (including child sexual abuse) in the development of dissociative disorders indicates that dissociation functions as a defense most easily accessed in childhood against the overwhelming experience of trauma, and that the more chronic and severe the trauma, the more severe the symptoms of dissociation which emerge

(Braun & Sachs, 1985; Chu, 1998; Goodwin & Sachs, 1996; Kluft, 1991, 1993; Putnam, 1985). Within this context, DID has come to be understood as an extreme form of dissociation, while at the same time epitomising “the characteristic response of the human organism to severe psychosocial trauma” (Ross, 1994, p.xii).

In its relatively short history the diagnosis of DID has undergone several significant refinements, including a change of name (American Psychiatric Association 1987, 1994). The investigation of issues related to diagnosis is well documented in the literature (eg. Coons, 1984; Putnam, 1989; Ross, 1989, 1997) as is the question of the differential diagnosis and its implications for appropriate treatment. Kluft states that patients who eventually receive a diagnosis of DID have spent an average of 6.8 years in the mental health system before being correctly diagnosed, and have usually had more than three diagnoses over this period (1991, p. 171). It is the sheer range of symptomatology both among patients and within a single patient over time, as well as patients' own reluctance to divulge or exhibit pathology, which can complicate the diagnostic picture (Kluft, 1985). Citing previous studies (Bliss, 1980, 1986; Coons et al., 1988; Horevitz & Braun, 1984; Putnam et al., 1986; Ross et al., 1989), Kluft (1991) provides a useful collation of data on polysymptomatology indicating that DID patients may experience combinations of any of the following: anxiety symptoms, affective symptoms (predominantly depression), allied dissociative symptoms such as amnesias, somatoform symptoms, sexual dysfunctions, suicide attempts, self-mutilation, psychoactive substance abuse, eating disorders, sleep disturbance, symptoms suggestive of schizophrenia, symptoms of Posttraumatic Stress Disorder, and the stigmata of Borderline Personality Disorder (Kluft, 1991, p. 175). Referring to previous literature (Putnam et al., 1984), Kluft suggests that DID “is best understood as a superordinate diagnosis, under which a vast array of symptomatology suggestive of other diagnostic entities may be subsumed” (p. 175). This understanding of the disorder has important implications for prognosis and treatment.

Although some consensus has been reached regarding diagnosis and treatment among those working in the dissociative disorders field, it would be inaccurate to focus on these contributors alone, without briefly addressing the literature which is either critical of or openly rejects the empirical data and theoretical basis for the disorder. Recent findings in fact indicate that not only the psychiatric community but mental

health professionals generally in the United States are significantly divided even on the fundamental issue of the validity of the diagnosis of DID (Pope et al., 1999). A similar situation exists in Britain, where considerably less academic and clinical attention has been given to the subject (Sinason, in press). Several issues dominate the debate. Piper (1994) cites the discrepancy between the large and ever growing number of cases of the disorder reported in North America and the relatively few reported in Europe, suggesting that overly vague diagnostic criteria, since revised in the DSM-IV (1994), are to blame. To illustrate his argument Piper highlights what he considers to be contradictory statements made by leading professionals in the field regarding phenomena associated with the disorder, saying that if MPD's implausible range of symptoms are acknowledged as experts recommend, "it is only a short step from this position to one of considering every psychiatric patient to have MPD" (p. 602). A criticism of Piper's article is that it focuses on the problematic aspects of DID's complexity, for example its range of presentations, without ever acknowledging the complexity of the disorder itself. This lack of tolerance for complexity suggests to what extent modern psychiatry may have come to depend upon a neat surface cataloguing of symptoms to make sense of mental disorder, at the expense of a more dynamic understanding (Nemiah, 1998). It is, perhaps, the pressure of this paradigm shift underlying the debate which renders the arguments of DID's critics so intensely polemical.

Central to the scepticism around the recent "astronomical" (Spanos & Burgess, 1994, p. 139) increase in reported cases of DID (an increase predicted by some practitioners in the field, eg. Ross & Gahan, 1988), is the issue of memories of child sexual abuse retrieved in therapy. This is a vast area of debate which can only be dealt with here inconclusively and in the briefest manner, yet its implications for clinical treatment are profound (Sinason, 1998). DelMonte (2000) provides an up-to-date, nonpartisan overview of research on both sides of the general debate and outlines the distinction made between normal and traumatic memories in the literature, concluding that "evidence tends to support the reports that memories of sexual abuse can be partially or wholly forgotten and subsequently retrieved – even many years later" (p.10). Those in the dissociative disorders field have used their clinical population to investigate the question with similar results. Kluft (1999b), for example, has recently

collated findings from a number of studies demonstrating both the potential for trauma to be forgotten and for it to be recovered in therapy in the form of verifiable memories. Similarly, Chu et al. (1999) found in a recent study that “childhood abuse, particularly chronic abuse beginning at early ages is related to the development of high levels of dissociative symptoms, including amnesia for abuse memories” (p. 749).

DelMonte (2000), however, also cautions therapists to monitor carefully their work with patients to avoid imposing “ideologically motivated ‘explanations’ and ‘interpretations’” (p.10) on the sensitive material which is exposed during the recovery and exploration of memories in therapy. This issue of the susceptibility of the patient in therapy to the suggestions or constructions of the therapist has found a focal point in the controversy surrounding DID, and is expressed specifically in the debate on the iatrogenesis of DID. On the one side are critics such as Spanos (1996), who refute the idea that DID is a “naturally occurring mental disorder”(p.3). He argues instead, as others have done (eg. Hacking, 1986; Merskey, 1992), that DID can only be properly understood as a sociohistorical construct:

patients learn to construe themselves as possessing multiple selves, learn to present themselves in terms of this construal, and learn to reorganize and elaborate on their personal biography so as to make it congruent with their understanding of what it means to be a multiple. (p. 7)

Spanos goes on to assert the core of the iatrogenesis argument, namely that

according to this perspective, psychotherapists play an important part in the generation and maintenance of MPD. Some therapists routinely encourage patients to construe themselves as having multiple selves, provide them with information about how to convincingly enact the role of “multiple personality patient”, and provide official legitimation for the different identities that their patients enact. (p.7)

On the other side of the debate are those working with DID patients, who argue that there is no evidence to support the argument that DID can be consistently, spontaneously, and intentionally created and maintained in adulthood in the context of therapy. Foote (1999) outlines the key features of their argument:

1. there is a naturally occurring presentation of DID, prior to therapist suggestion;
2. patients do not embrace the DID diagnosis willingly, ...finding it extremely ego-dystonic;
3. DID symptoms do not disappear when ignored (although the patient is likely to stop reporting them); and
4. the disorder actually begins in childhood, in the context of overwhelming trauma, and therefore could not possibly be created by the therapist together with the adult patient. (p. 321)

Many therapists are also consciously conservative in their diagnostic procedures, requiring a history of amnesia and dissociation, and avoiding the use of hypnosis in making the diagnosis to preclude the possibility of false positives (Coons, 1986). Some also require the therapist's clear and repeated observation of switching before making the diagnosis (Ross, 1988). Added to these points is the issue of the relationship between culture and dissociation (Spiegel 1994). Findings from recent studies done in the Netherlands, Norway, and Turkey indicate that, as in North America, DID occurs in between 3-6% of psychiatric inpatients, suggesting that it is neither rare nor culture-bound (Kluft & Foote, 1999). Interestingly, Chu et al's (1999) study, which included participants' self-reports on the circumstances of their memory recall, also found that abuse memories were more likely to be recalled "while at home, alone or in the presence of family and friends" (p.749) than in the therapy room. Many of these memories of abuse could be independently corroborated. A criticism of this and other similar studies, however, is the limitation, acknowledged by researchers, of the self-report method which, relying on memory, can itself prove fallible.

Given that DID patients present with a complex pathology, and to help counter the criticism generated by sceptics which threatens to invalidate what happens in the therapy room, clinicians working with these patients have been at pains to develop and elucidate principles and techniques of therapy which can be realistically applied in mental health settings. Though still limited, the literature focusing on types of therapeutic treatment for DID, has grown considerably over the last few years, and with it the understanding that "psychotherapy remains the cornerstone of the treatment of dissociative identity disorder" (Kluft, 1999a, p 315). Notably, psychopharmacological treatment, while often useful in improving certain comorbid conditions such as anxiety

and depression, is not considered to be an effective treatment tool for relieving essential DID symptoms (Kluft, 1999a).

Psychotherapeutic treatment approaches cover a range of techniques such as mapping, the use of hypnosis, and journal-keeping (Phillips & Frederick, 1995; Kluft, 1999a), as well as psychodynamic and cognitive-behavioural treatment modalities (Barach & Comstock, 1996; Fine, 1999; Putnam & Loewenstein, 1993). While the degree of emphasis on particular techniques or theoretical frameworks may differ, there is some consensus concerning the goals of treatment. Kluft (1991) outlines these goals in a concise overview:

The tasks of the therapy are the same as those of any reasonably intense change-oriented approach. However, these tasks are pursued in an individual who lacks a unified personality (and hence observing ego). The several personalities may have different perceptions, memories, problems, priorities, goals, and different degrees of involvement with and commitment to the treatment and to one another. It usually becomes essential to replace dividedness with unity, at least of purpose and motivation, for any treatment to succeed. Work toward this goal and possible integration of all personalities distinguishes the treatment of MPD. (p. 176)

Kluft also provides an operational definition of integration as consisting of “3 stable months of continuity of contemporary memory, with the absence of behaviourally evident separate identities” (in Ellason & Ross, 1997, p.833).

While most clinicians are agreed on what integration entails, some feel that, particularly in contexts where facilities or funds are limited, cooperation among alters, with an emphasis on improved functioning constitutes a more realistic goal. This approach, focusing on “managing here-and-now difficulties” (Kluft, 1991, p. 176) has been termed adaptationalism, and is somewhat similar to personality-focused and systemic approaches which are geared to problem-solving in the group context of the different alters, without trying to unify them (Erxleben & Cates, 1991; Kluft, 1999a). The relative advantages of each have been explored in several follow-up studies. These suggest, as might be expected, that on the one hand, those patients who achieve integration experience a consistently higher quality of life specifically in the absence of ongoing and disruptive dissociation, while those who do not achieve integration yet

receive appropriate treatment over a reasonable period can experience a significant improvement in a range of symptoms associated with the disorder (Ellason & Ross, 1997; Kluft, 1993).

Irrespective of whether the goal is integration or coexistence of alters, the literature on psychotherapeutic treatment repeatedly acknowledges that different treatment techniques, drawn from more than one theoretical framework, may be appropriate at different times during the course of therapy (Horevitz & Loewenstein, 1994). Going one step further, some clinicians writing on the subject routinely make the point that in fact the success of the therapy depends to a significant extent on the ability of the therapist to provide treatment which is both "eclectic and flexible" (Bloch 1991, p 50; Kluft, 2000). The danger of this has often been the temptation to take an "anything goes" approach at the expense of an underlying theoretical structure or even professional good sense, usually resulting in an increasingly chaotic and desperate treatment process and an overwhelmingly negative outcome (Kluft, 1999a; Ross, 1995). In an effort to counter this and build up a "unifying paradigm" for treatment, Kluft (1993) has outlined twelve fundamental principles which address all aspects of the treatment of DID and the application of which he has found to be essential to the success of the therapy. Kluft advocates the "maintenance of a secure frame and boundaries", a "focus on achieving mastery", the "establishment and maintenance of a strong therapeutic alliance", the "necessity of dealing with buried traumata and sequestered affect", "reducing separateness and conflict among alters", "working to achieve congruence of perception", "treating all personalities evenhandedly and with consistency", "restoring shattered basic assumptions", "minimizing avoidable overwhelming experiences", "modeling teaching and reinforcing responsibility", "taking an active, warm and therapeutic stance", and "addressing and correcting cognitive errors" (p. 20). Of these basic principles, Kluft emphasizes that it is "the therapist's consistency across all of the different alters [which] is one of the most powerful assaults on the patient's dissociative defenses" (p. 37). Interestingly, Kluft's emphasis on the therapist's consistency is affirmed by DID patients themselves who focus on trust, control, and boundary setting as crucial aspects of a successful therapeutic treatment (Cohen, Giller & W., 1991). Cohen, Giller & W.'s book, (in which "W." is the pseudonym of an individual diagnosed with DID who co-authored the work), is a collation of the experiences and

opinions of DID patients in their own words as edited from written responses to a simple mailed questionnaire. As such, it provides a unique glimpse into the world of those living with the disorder. At the same time, the material contained in the book underlines both the complexity and uniqueness of each individual, and the value of a treatment paradigm which can accommodate that complexity.

Most commonly, any treatment framework for DID is psychodynamically oriented (Kluft, 1999a), thereby giving the therapist a theoretical base from which to create and explore the therapeutic alliance so essential to effective treatment, while at the same time providing a sound context for the complex and difficult transference and countertransference issues which invariably emerge within the boundaries of that alliance (Horewitz & Loewenstein, 1994; Loewenstein, 1993). Psychodynamically oriented treatment is also generally acknowledged to be more effective for such patients over the longer term, and therapy is therefore typically between two and five years in duration (Bloch, 1991). However, moving from this common acknowledgment of therapeutic process and the fundamental importance of the relationship between therapist and patient, the various approaches begin to diverge. While some therapists work from a more purely psychodynamic or psychoanalytic perspective, many others favour a more structured approach, following a stage-oriented process based on treatment principles for trauma survivors. This process comprises three essential stages, beginning with an initial stage of establishing safety, moving through remembrance and mourning, to a final stage of reconnection (Kluft, 1999a). Applying this approach to the treatment of DID patients, Kluft (1991) and others have subdivided the three stages into nine stages specific to the dynamics of DID and which represent a synthesis of the formulations of many clinicians working in this field.

Therapy begins with establishing safety but also focuses on the nature of the therapy and the treatment alliance (including psychoeducation and informed consent) in order to positively prepare the patient for "what may be a long and difficult process" (Kluft 1991, p. 178). Contracts regarding therapy and destructive behaviour are then made with the host personality and as many alters as are prepared at this stage to communicate with the therapist and possibly with each other. When a measure of stabilization has been reached, an intensive exploration of the patient's inner world can be initiated. This involves a mapping of the personality system, whereby the patient's

internal dynamics, as manifested through a dysfunctional group of identities, as well as their origins and rules of interaction are investigated. Once these internal dynamics are better understood by both patient and clinician, traumatic material can begin to be processed. This work forms a central part of established therapy. As recovered material is processed by the personality system as a whole, communication and cooperation increase until distinctions between alters become blurred either to the point of resolution (collaboration) or full integration. The final three post-integration stages emphasize the fundamental nature of the changes which have taken place. They focus on learning new coping skills, consolidating gains, and follow up to ensure a stable outcome over time.

Research in fact indicates that a continuation of therapy in some form after integration is beneficial as patients adjust to a very different way of interacting with their environment. (Kluft, 1988, 1999a). Kluft's study (1988) of treatment issues related to the period after integration indicates that, because of the nature of the many challenges facing the recently integrated DID patient, it is not helpful to consider integration as the end-point in therapy, but rather to consider it somewhere between a half-way to 2/3 point for most patients. Tasks challenging the integrated patient include coping with both physiologic and psychological changes associated with unification, interpersonal adjustments, and developing new coping strategies to replace maladaptive behaviour such as autohypnotic evasion in times of stress.

Clinicians who follow a stage-oriented approach are also encouraged to make use of hypnosis to minimize harmful acting out, not only during the initial stages of therapy, but also more generally, as a tool for exploring the DID patient's inner world (Horewitz & Loewenstein, 1994; Kluft, 1999a). Horewitz and Loewenstein (1994) make the important point that techniques related to hypnosis may also be used in the context of a therapy in which hypnosis per se is not employed. At the same time however, they suggest, as do other advocates of hypnosis (Kluft, 1999a; Phillips & Frederick, 1995), that the effectiveness of communication between alters, one of the goals of therapy, is greatly enhanced through the use of this tool:

Hypnosis is useful, for example, when nonhypnotic means to elicit the appearance of an alter fail or a specific communication to a specific alter must be guaranteed to forestall a crisis. Often there are deeply dissociated

alters that do not respond or reveal themselves through ordinary means and must be searched for aggressively with hypnosis. (p. 301)

Because dissociation is itself a form of autohypnosis, skills such as relaxation and visualization, which are associated with hypnosis, can often easily be acquired by DID patients. These techniques can help to contain overwhelming material at the end of sessions as well as to maintain functioning between sessions.

Cognitive techniques are also commonly used to facilitate overall progress, and the fundamental cognitive error of separate parts of the self is addressed throughout therapy (Ross, 1995). Given that many clinicians favour a more fundamentally cognitive approach, Fine has developed what has been termed the tactical integration model (Fine, 1993, 1999). This therapeutic model is founded upon cognitive theory, but draws significantly on hypnosis techniques as well. It operates on the premise that "MPD patients are noteworthy for the delusional quality of some of their beliefs as well as for the number and rigidity of their cognitive distortions" (Fine, 1993, p. 138). Like other structured approaches, this model follows the stages of stabilization, exploration ("suppression of affect phase" (p. 140)), and trauma work ("dilution of affect phase" (p. 140)), but divides the overall therapy into two distinct parts, namely preunification and postunification phases of treatment. One of the techniques employed in the dilution of affect phase is the "blending of personalities" (p. 143) for the purpose of collective abreaction. This is achieved through hypnosis and allows for a shared as well as a more planned and therefore manageable abreactive experience.

The tactical integration model places emphasis on the collaborative nature of the relationships not only between alters, but also between therapist and patient. Fine (1993) stresses that collaboration facilitates the replacing of distorted cognitions with a more reality based context within which to begin working with overwhelming affect:

The cognitive strategies within the tactical integration model allow for the exploration of conflicts, detailing of the affect associated with conflicts, and their eventual integration into the mainstream of consciousness. (p. 151)

The collaborative aspect of the treatment also encourages increasing responsibility as the patient "is clearly expected to monitor and interpret the progress in the therapy

work” (p. 151). According to this model, by acquiring the tools for cognitive mastery, the patient develops an increasing capacity for an awareness of feelings without the interference of dissociative defenses, and is thereby able to experience an increasing continuity of self.

In contrast to the above approaches and techniques, clinicians such as Barach and Comstock (1996), advocate a rigorously psychodynamic approach, virtually excluding a range of specific, often therapist-induced techniques such as hypnosis and abreaction, which they perceive as being counterproductive if relied on too heavily:

By focusing primarily on dissociative behaviours and specialised techniques for managing them, the therapist turns away from the psychological functioning of the patient as a whole. The therapist inadvertently adopts the dissociative patient’s worldview, perceiving related events as separate. In contrast, an integrative psychodynamic treatment approach is more consistent with the goal of producing an integrated patient (pp. 413-414).

Barach and Comstock argue compellingly for a treatment focused on the resolution of certain developmental issues such as secure attachment, toleration of affect, and the formation of a cohesive sense of self rather than emphasizing the elimination of dissociative phenomena. This is done by means of traditional psychodynamic psychotherapy and in particular the consistent interpretation of defence mechanisms such as splitting and projective identification. Similarly, Mollon (1996), working within a more psychoanalytic frame, queries “the idea of a standardized therapy for patients with MPD/DID” (p. 140). He also discourages the use of hypnosis, suggesting it has an association with loss of autonomy, and prefers to follow the simple approach of listening carefully and moving slowly and gently through therapy, the end goal of which he stipulates, may or may not be integration. Significantly, in the context of this therapeutic approach, Mollon maintains that therapy may or may not be indicated where the hostility of some alters is too extreme or dedication to the perverse is too entrenched. In some cases even the severity of the original traumas may preclude therapeutic exploration. Whether this is more suggestive of an extreme degree of pathology or the limitations of Mollon’s approach, it is difficult to establish. On the subject of Kluft’s (1993) principles of successful treatment Mollon simply observes that

they are “only what should be expected in any good psychotherapy, in terms of the realistic, empathic, reliable and benign stance of the therapist”(p. 146).

In what appears to be an effort to bridge this gap between the treatment paradigms of essentially cognitive-behavioural and psychodynamic/psychoanalytic modalities, Kluff (2000) explores the nature of psychoanalytic psychotherapy of DID in the specific context of trauma therapy. He highlights the “long, if uneasy, uncomfortable, and often mutually avoidant relationship” (p. 259) between psychoanalysis and the study of dissociation, and differentiates between literature which focuses on treatment of DID within the psychoanalytic paradigm but does not incorporate incompatible aspects of trauma and dissociation theory, and literature which consciously attempts to incorporate these aspects into a psychoanalytically based treatment approach. He also provides extremely useful material on the role of alters in therapy, and the possibility of maintaining what Barach and Comstock (1996) have called the integrative approach while acknowledging the individuality of alters and maximizing their individual strengths and resources in the interests of a positive therapeutic outcome.

An issue crossing the boundaries of all treatment modalities is that of Satanic ritual abuse. Although the literature on this subject often focuses on the complex legal and ethical concerns which can impact on therapy, principles of treatment for Satanic ritual abuse survivors with DID are not considered to be substantially different from those applied in the therapy of DID patients who have not suffered ritual abuse (Noblitt & Perskin, 1995; Ross, 1994, 1995; Sinason, 1994). Ross (1995) points out that “the survivors differ from people with non-ritual [DID] only in the content of their memories ..., though clinically they have more alter personalities and personality fragments” (p.145). Almost invariably, one or more of these alters will have taken on a Satanic or demonic identity and therefore become alienated from the rest of the system through terrorizing the others. Because this alter can maintain a powerfully destructive and paralyzing dynamic within the system, Ross advocates that “a major guiding principle of therapy with Satanic ritual abuse survivors is ‘making friends with Satan’” (p.152). He bases this on the psychodynamic principle of projection of the bad self and the need to reverse this process, a principle which underlies the dissociative paradigm as a whole. Ross’s direct approach has the potential advantage of effectively debunking the myth

perpetuated by the patient's internal structures - and even the clinician's own unconscious belief system - that Satan is somehow a real and powerful presence:

Almost every Satan or major internal monster I have worked with has turned out to be a child in disguise. ...The Satan image was a scary disguise designed to frighten away the rest of the system and outsiders. As well, the identity of Satan helped to keep the host personality from coming anywhere near the memories and therefore was also protective to the host. (p.153)

Cognitively reframing the patient's negative perception of a Satanic alter to accommodate the alter's positive function can therefore be an important intervention. What Ross tends to overlook in his discussion, however, are the potentially devastating effects on the patient of actively reaching out to make contact with alters who have for a significant period of time been synonymous with the experience of extreme terror and malevolence.

Without exception, the literature cited above is of North American or British origin. A South African literature search produced only four listed works relating to DID (Heathcote, 1997; Louw, 1991; Mason, 1997; Ngcuka, 1997). Their abstracts reflect a range of foci however, addressing general dissociative issues, cultural issues, the influence of Satanism on adolescents from a Judao-Christian perspective, and an individual's autobiographical account of her experience living with the disorder. This small number of works is an indication that the subject has effectively been ignored as an issue in South Africa. Why this should be so is puzzling, and perhaps disturbing. Given that DID is aetiologically linked to severe and chronic abuse, including sexual abuse, beginning in childhood, and bearing in mind the high incidence of abuse perpetrated against children in South Africa (Pienaar, 1996), one could speculate that the disorder is not so much uncommon as undiagnosed. Interestingly, during the brief period of intervention with my patient, I spoke to or heard of three other clinicians in the Cape Town area who were treating individuals whom they had diagnosed as having DID. These realities raise at least two questions: firstly, what do clinicians consider to be the range and complexity of the impact of trauma on mental health, and secondly, how consciously and consistently do clinicians assess for abuse and its psychological sequelae during history-taking and evaluation of patients?

The related issue of the mental health of individuals involved in Satanism, raised by one of the South African authors, is also one that is potentially underestimated either because of lack of knowledge or clinicians' disbelief. Els and Jonker (2000) provide a comprehensive account of Satanism in South Africa, its history, the meaning of symbols, how it may manifest in organised rituals, and the physical and psychological effects of Satanic ritual abuse. They reiterate the argument of Ross (1995) and Noblitt and Perskin (1995) that effective interventions for individuals who appear to have suffered trauma associated with Satanic ritual abuse requires some knowledge of the history and psychology of Satanism. Their book also provides accounts of several police investigations which lay to rest arguments disputing the existence of organised Satanic cults in South Africa. At a more anecdotal level, Smith (2000) provides accounts of individuals previously involved in Satanic activities in different parts of South Africa. Although as Ross (1995) points out, a focus on content and the verification of memories is more suited to a court of law than the therapy room, an awareness of the complexity of the issues raised when a patient begins to recount memories of Satanist abuse is essential for a positive therapeutic outcome. The literature in fact overwhelmingly indicates that this an important rule of thumb for all aspects of psychotherapeutic treatment associated with DID.

CHAPTER THREE

METHODOLOGY

The purpose of this chapter is to outline briefly the methodology of single-case study research, and to apply relevant aspects of that methodology to the present context. The aim of the present research, which is to describe the manifestation of symptoms and dynamics in a patient diagnosed with Dissociative Identity Disorder in the context of a therapeutic process, will be examined in terms of the methodological principles upon which it is based.

The case study, as a research method, has struggled over time to acquire the status associated with other forms of research (Yin, 1984). At the same time, it has provided researchers not only with a distinct alternative to empirical research where the latter has been either inappropriate or impossible, but also with an avenue to a substantially different yet complementary kind of scientific understanding. Yin (1984) distinguishes the case study strategy from other research strategies accordingly:

A case study is an empirical inquiry that investigates a contemporary phenomenon within its real-life context when boundaries between phenomenon and context are not clearly evident, and in which multiple sources of evidence are used (p. 23).

Because of its suitability in such situations, the case study method of necessity also draws in the researcher as part of the "context", creating an additional and more overt blurring of the boundary between researcher and subject than do other forms of research. The resultant supposed dilution of objectivity, often considered the major weakness of the case study method, has prompted debate on the nature of objectivity generally in social science research (Bromley 1986). Alderfer (1984) has dubbed the inevitable involvement of the researcher in the research as "self effects" and suggests that the various professional and personal "selves" of the individual researcher "are repressed and suppressed by the positive approach to methodology that most of us are taught and accept" (p. 37). Alderfer moreover considers researchers' unwillingness to acknowledge their own influence a major impediment to valid and useful research.

In selecting whether or not to use the case study method, Yin (1984) suggests that “the form of the question provides an important clue regarding the appropriate strategy to be used” (p. 19). He considers the case study to be most suited to exploring questions formed around the “how” and “why” of a subject over which the researcher has little or no control. Yin further points out that while the case study cannot be used to generalize to a population, it can be used to generalize to theoretical propositions, provided it is underpinned by a workable research design. He differentiates between single-case and multiple-case design, outlining the particular applications of the single-case study:

Overall, the single-case design is eminently justifiable under certain conditions where the case represents a critical testing of existing theory, where the case is a rare or unique event, or where the case serves a revelatory purpose (p.49).

As a fundamental part of its design the case study requires an appropriate unit of analysis, operationally defined, which is relevant to the research question -or questions- initially posited. For the single-case study, this is usually an aspect of the case, or simply the case itself. The significance of the case as a critical, unique, or revelatory example in the context of current scientific understanding will help to determine which unit or units of analysis will become the focus of research.

The research method employed in the present study is based on the approaches outlined above. It is considered that the phenomenological, single-case study design is appropriate in view of the seemingly rare nature of the material in the South African context and the essential revelatory purpose of the research. Naturally, were there both a significant body of South African literature already existing on the subject as well as easy access to material relating to South African clinicians’ treatment of DID patients in individual therapy, a case study of the kind undertaken here would be of little value.

The dual assertion that the case study material is indeed both seemingly rare and potentially revelatory in the South African context stems from the two propositions which form the core motivation for the research. The most fundamental of these is the proposition, backed by literature on the subject, that DID patients present in individual

therapy in a way that is significantly different from the presentation of other disorders in the therapeutic context. The manifestation of alters, an essential feature of DID, constitutes the core differentiating criterion in the DID presentation, as based upon DSM-IV criteria. This leads directly to the second proposition, namely, that the way in which a DID patient presents in therapy significantly affects the form as well as the course of therapy in certain ways. The fact that longer sessions are generally required for what often becomes group-style therapy provides an example in support of the validity of this proposition.

Supporting these propositions and the consequent assertion that this study has relevance in terms of the nature of the material it contains, are both the investigation of the South African literature as well as my informal and ward round discussions with a range of mental health professionals –both South African and English - during the course of my internship year. Most importantly, however, the patient's account of her previous experiences in hospital settings and my own informal observations of the fundamental lack of understanding and knowledge where issues specifically related to treatment of Dissociative Identity Disorder were concerned, confirmed that an exposition of the kind contained in this study could prove useful. Questions such as "how did you know she was dissociating?", directed to me at an informal colloquium in which the case was briefly presented to a small group of clinicians in the public health sector, support these observations. Discussions and my observations suggested, moreover, that apart from a legitimate lack of knowledge regarding DID, there exists also a preconceived and non-scientifically based scepticism towards the very idea of DID. It would appear that these issues have not only not been resolved in South Africa, but have not even properly entered into public scientific debate.

It is important to note that, for the purposes of the present research, the varied opinions and actions of health professionals connected with the treatment of the patient who forms the subject of this study fall outside the scope of the investigation and are therefore not included in the case study. At the same time, however, the therapy context with which this case study is concerned was naturally and inevitably affected by the attitudes and behaviour (both positive and negative) of everyone involved in the case, as well as by the realities of financially constrained hospital systems with no facilities specifically for patients with DID. Accordingly, in certain instances where the

experience of outside attitudes and/or behaviour appeared to be or was expressed by the patient as being a significant factor in determining the course of the therapy at any stage, references to these have been deemed relevant for inclusion in the case study.

The propositions outlined above relate directly to the two subjects under investigation in this study. The first of these subjects is the patient's symptoms and internal dynamics as expressed through observable behaviour and discussion, and as presented in an individual, psychodynamically-oriented long-term therapy. Here, symptoms are understood to refer to those clinical features ascribed to DID in the DSM IV (1994), the most essential of which is "the presence of two or more distinct identities or personality states that recurrently take control of behaviour" (p. 484). In line with the general discussion on case studies outlined above, it is my belief that part of the value of a case study such as this is the generalizability –however limited- of this study of symptoms and dynamics to other patients diagnosed with DID. Its usefulness for other health practitioners is therefore highlighted. The second, related, subject is the progression of the therapy itself. It is similarly believed –and supported in the literature- that, though the specific events of the therapy naturally cannot be generalized to other instances of psychotherapeutic treatment of DID, nevertheless the overall character and course of the therapy, with its multiple crises and interruptions, may be viewed as a useful example of what might be encountered in a similar context. In addition, as the literature reflects, scepticism associated with DID centers largely around the process by which a diagnosis is made. Sceptics challenge the context (i.e. the therapy) in which DID symptoms manifest, and specifically the possible role of the therapist in eliciting symptoms (iatrogenesis). Part of the value, therefore, in a case such as this is its elucidation of that process. Issues relating to the historical accuracy of traumatic memories, another area of scepticism, remain, however, beyond the scope of this case study.

Important to consider, particularly in view of the personal material contained in the research data, are the ethical issues involved. Although I did not initially approach this case with the intention of making it the subject of my master's thesis, my more academic interest in the case was a natural outgrowth of my need to understand better, for the benefit of the patient, what was happening in therapy. My internship status had already been made known to the patient not only as a consequence of our both arriving

on the ward virtually within the same week, but also because the transparent role of the hospital as a teaching institution made this evident. This meant that we were both aware of my lack of experience in all areas of therapy, but how this may have negatively impacted upon the patient's ability to place her trust in me, or upon the therapy in general, can only be conjectured.

Whatever negative effects my lack of familiarity with the treatment of DID and Satanist abuse may have had on the course and outcome of the therapy, I believe that they were offset to some extent by the efforts I made in attempting to understand the patient's pathology. I highlight this because those efforts were greatly enhanced by my decision to use this case as my research subject. Early on in treatment I began exploring literature on the subject, made detailed notes of sessions, sought out comment from other professionals in the system, and raised the issue of her diagnosis and its implications for treatment in ward rounds and other appropriate settings. In particular, my reading gave me a growing confidence to stand by my opinion on what was, I soon realized, an extremely contentious issue.

Partly as a result of the milieu/training context in which therapy began, the patient's experiences of others' attitudes and behaviour were, as indicated above, expressed and explored in therapy from time to time. The advantage of considering these factors was that it allowed us to be realistic and open about her concerns regarding treatment, including my role in that treatment. I affirmed the legitimacy of her treatment concerns in an environment where she appeared to be the first person to have received an acknowledged DID diagnosis, and this in turn seemed to increase her confidence in her own ability to "read" and attach meaning to situations which might otherwise have been simply demoralizing. Given this underlying issue in the therapy, I made the decision to be open about the fact that I was engaged in a simultaneous process of reading and learning. Indeed, I am not sure how under the circumstances, I could have kept this hidden from her. In any case, as a result, I could communicate to the patient with a believable conviction that her diagnosis was not unique, and was both understandable and treatable. All these factors, I believe, also paved the way for my eventually obtaining permission from the patient to use her case as a subject of research without significantly damaging trust or altering the course of the therapy.

The therapeutic process described in this case study took place over a period of fourteen months. A total of approximately four months of breaks in treatment reduced the period of actual treatment to about ten months. Frequency of sessions varied from a minimum of once per week as an outpatient to a maximum of three times per week as an inpatient. Inpatient sessions took place in four different wards of two separate hospital systems over the fourteen-month period. Concurrent interventions ranged from intensive milieu therapy to ongoing pharmacotherapy. Therapy was allowed to extend beyond the usual twelve-month internship period with the permission of those in charge of the internship program and as a result of the nature of the research. The patient chose to terminate therapy following an opportunity to relocate far from the city. It is important to note here that, in accordance with ethical guidelines, any names associated with either the patient or treatment venues have been changed or left out.

Supervision took place once per week over the course of the therapy. My supervisor readily acknowledged a lack of experience in this specific area but offered extremely valuable overall therapeutic experience as well as consistent support and a helpful and knowledgeable approach towards the inevitable practical difficulties encountered whenever the patient was in crisis and needed attention within an overtaxed hospital system. This supervisor was also one of the staff in charge of the ward in which I first encountered the patient. He therefore had had many opportunities to observe the patient and the diagnosis of DID was made in consultation with him and other health professionals.

CHAPTER FOUR

HISTORY AND FORMULATION

HISTORY

Lisa was eighteen years old, single, and had just finished matric when she was admitted to the psychodynamically-oriented psychiatric inpatient ward where I first met her. Lisa presented as a tall and sturdily built adolescent, casually dressed, and wearing bangles and brightly coloured nail polish. She had a somewhat anxious yet open, friendly manner which in larger social contexts could range from relatively calm to loud and highly animated, with dramatic flourishes.

Lisa's case, initially discussed for possible admission to the ward's eight-week intensive programme, was presented as a difficult and complex one. She had been referred by a psychologist from her place of residence out of town, and she reported experiencing distressing flashbacks and nightmares, and depressed mood, as well as episodes of time for which she was amnesic and which she called "time out". Behavioural changes during these episodes had been reported to her by others, and on occasion she apparently had identified herself by other names. Two very recent incidents had distressed her. Firstly, Lisa reported that friends had arrived at her house saying that she had invited them for a party and was later informed that she had had sexual relations with several of the boys throughout the night but retained no memory of it. The second instance consisted of a chance encounter with a former family lodger whom she reported had sexually abused her over a period of about six months when she was twelve years old. Feeling in his control and unable to protect herself, she reported getting into his car, and being driven to a secluded place and severely beaten with a belt for allegedly not keeping their secret. She said she could not remember getting into the car. At the time of her presentation on the ward she further reported that flashbacks and nightmares had increased to a point where she felt she could not cope. Lisa felt scared most of the time and kept very busy particularly in the evening in an effort to control fear and thoughts of "bad people". She would regularly use alcohol, and occasionally

dagga to facilitate this. Poor relations with her mother were also highlighted, as well as a lack of significant support structures.

Lisa was, moreover, known to the hospital system as a result of an inpatient admission the year before, following an anxiety attack at school. Her previous diagnoses on Axes I - III, made by clinicians both in the hospital system and elsewhere were as follows:

Axis I: Major Depressive Disorder, Anxiety Disorder,

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Dissociative Disorder NOS

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but over the course of a few sessions her story began to take shape. She was the second eldest of four children, the two youngest of whom were half-siblings by two different fathers. Lisa's own father, a civil servant and police reservist, died in a car accident when she was five years old. She described her father as an excessively neat, religious man who was an elder in his church and who was at the same time violent in the home, for example ripping the heads off Lisa's dolls when angered. Lisa reported being severely and sadistically abused by him, emotionally, physically, and sexually. She described such abuses as his locking her in a cupboard for hours without food and punishing her afterward for soiling herself, injecting her with substances and inserting objects into her vagina also as punishment for being "naughty", and alternately hanging herself and her brother in a cloth bag on a tree branch and beating them. Lisa remembered he would sometimes swim with her held underwater in their pool until she lost consciousness and she alleged he once aimed his gun at her and fired a blank. Lisa said that occasionally he would inform her that he would punish her when he came home from work, at which point he might or might not carry out his threat. Lisa recalled in one such instance quietly begging her doll to save her from her father's punishment. When he returned home that day and did not abuse her, she attributed her temporary reprieve to the doll's magical ability to protect her.

These traumatic memories were all at least partially available to Lisa, but the recollection of them induced tremendous affect and she would often dissociate at some point while moving through them. Other, further abuses, including Satanist abuse, were wholly unavailable to her conscious mind and could only be accessed through dissociation into several child alters and an alter with a Satanist identity who had largely adopted the belief system of the cult. While the alter with the Satanist identity could relate past events from memory, child alters' memories were relived in fragments rather than related as history. These relived memories included being driven to a forest-like setting at night where "bad" men and women were present and forced her to participate in activities such as the sacrifice of animals and babies and the drinking of their blood. Her horror of these activities sometimes drove her to try and escape, at which point she would experience being punished by adults who would collectively strike her with objects or place her in a hole containing spiders. She experienced these people as often chanting and calling her a child of Satan. In one instance Lisa had two memories to

explain a scar on her thumb. Without dissociating she recalled cutting it on a broken window, while, in a dissociated state, the alter with the Satanist identity linked the scar to her ritual initiation into the Satanic cult. Also in a dissociated state, a child alter reported that, following her father's death, people were occasionally still coming for her at night and taking her to forest settings, but this appeared eventually to have stopped.

Some time after her father's death, Lisa's mother removed the family to another town and subsequently remarried. Both the mother's second and third husbands were physically, emotionally and verbally abusive towards all members of the family. Lisa linked her need to eat food only from a bowl to the first step-father's habit of taking her food away from her and her resultant anxiety that this would reoccur in any setting. Lisa also often found herself in the position of taking care of her younger brother and later her younger sister, in the absence of any other reliable caregiver. She reported having felt great ambivalence towards her infant brother, sometimes cutting him slightly and desiring to kill him. Both Lisa's mother and the second stepfather abused alcohol.

When Lisa was twelve years old the family took in the lodger to whom she had referred on presentation. She recalled that over this six-month period the lodger sadistically and sexually abused Lisa with her parents' knowledge, until he left. Lisa referred to him as a Satanist, saying that he wore a pentagram around his neck and that he referred to the abuse as her "training". Much later in therapy, in an adolescent dissociated state, she said that the incidents of abuse "always ended in blood". Lisa described her behaviour during her early teens as rebellious and sexually promiscuous, with some attempt at getting "close to God" and increasing substance abuse. Where previously she had cut and "operated on" her teddy, now she began occasionally self-mutilating, usually making fine cuts in her forearms with a razor to draw blood while in a semi-trance state. When her mother and step-father moved to another city, Lisa boarded with several families, but could not cope with their routines, such as family dinners eaten around a table, and had no tolerance for any suggestion of harshness on the part of the fathers. As a result, she felt she was perceived as difficult and ungrateful, and would leave the family at this point, eventually ending up as a boarder at her high school. In spite of recurrent behaviour problems and nightmares, Lisa maintained functioning through high school, involving herself in sports and drama, receiving her matric with exemption, as well as solidifying at least one friendship which has survived

to the present. At the school's request, Lisa had an intellectual assessment and was found to be functioning in the superior range.

FORMULATION

In order to formulate an understanding of Lisa's internal dynamics it is necessary to take into account the nature and extent of the trauma which she suffered throughout childhood and part of adolescence. Born into a severely dysfunctional family, her earliest experiences are likely to have consisted of extremes of feeling uncontained as well as uncontrollable. Often, experiences would have been so destructive both physically and psychically, that the only protective device which could have facilitated survival would have been that of a divided consciousness.

The young child's experience of adults' power is absolute in both its reality and its implications. When that experience becomes intolerable the only escape is through the mind itself. As a small child in terrifying situations, therefore, Lisa developed an ability to experience herself as other than herself. The child experiencing physical pain and terror was not Lisa but another child. This would have been, moreover, made certain and indisputable to her immature understanding by the fact that she had given this other child a different name. As abuse continued it is likely to have become familiar, though no more tolerable, and the process of dissociation, as a form of autohypnosis, would likewise have become a predictable response. Dissociation would not only have aided Lisa in getting through these experiences, but would also have made possible a protective amnesia between experiences to allow her to fulfill basic functions when not being abused. The context of secrecy within which the abuse and other criminal acts such as Satanic abuse occurred would in turn have reinforced Lisa's developing divided consciousness as those around her such as her father would have been perceived to be leading a double life (as alternately "bad" and "good") in their day-to-day functioning.

What Lisa experienced then, during the formative years of early childhood, was a world of multiple realities. This experience was continually confirmed both within and beyond her psyche by her own ability to carry on functioning and by the perceived ability of others to do the same. As the abuse continued and became more varied and

severe, however, the multiplicity required to protect Lisa had likewise to become more complex. More child alters were created to face the abuse, and several child alters may have become associated with specific abuse practices, creating in turn a protective network in which each alter often knew when to stand in for another. While this may have generated a degree of cooperation among alters, the nature of each alter's traumatic experience, so completely overwhelming in itself, may have created such a degree of fear and suspicion that no alter felt safe, and resentment against each other for not taking all the abuse may also have developed. The overall example of the family environment, in which fear and the abuse of power appeared to characterize relationships, is likely also to have shaped Lisa's developing sense of self as well as exacerbating internal dysfunction and conflict.

In addition to creating child alters to contain the pain and fear associated with abuse, Lisa's psyche began at some point to create alters such as the alter with the Satanist identity in order to accommodate the anger associated with intolerable feelings of badness and loss of control. Identifying with the perpetrators of the abuse, these alters would have made possible a projection of the bad self away from the child alters who experienced themselves as victims of abuse. While relieving the child alters of some of the burden of badness and anger, as well as generating some sense of internal control, the persecutory alters helped to create an intrapsychic world of continual infliction of pain, most tellingly reenacted in Lisa's repeated acts of self-mutilation. This ongoing relationship between internal and external infliction of pain on the self may have become exacerbated through the experience of actual abuse rituals in which blood was drawn at the end, thereby signifying a return to a measure of safety associated with an accordant measure of relief. As each act of self-mutilation has brought immediate and palpable relief and yet failed to resolve the core issues of Lisa's rage and deeply rooted sense of badness, she has been compelled to repeat these acts in a context of continuous and overwhelming pain.

Because dissociation is fundamentally an adaptive response to abuse which becomes unhelpful in the long-term, Lisa is currently experiencing the negative effects of what were experienced previously as at least partially helpful skills. In adulthood, the switching of alters generally occurs in response to high levels of anxiety, triggered by a perceived threat, but instead of diminishing affect it causes a disruption of memory and

contributes to further anxiety associated with a loss of agency. After a lifetime of disrupted consciousness, overwhelming affect, and compulsive acting out, Lisa exists in a perpetual state of internal chaos in which many events might or might not have happened and she must bear the consequences of actions of which she often has no conscious recollection. Exacerbated by early exposure to a cult belief system, this, in turn, has led to a high degree of fatalistic thinking and a diminished overall sense of responsibility.

The maladaptive aspect of Lisa's dissociation is also evident in her experience of repeated nightmares and flashbacks which maintain her paralyzing fear and make it difficult for her to adjust to a single reality in which events from the past are truly finished. Notably, while some maladaptive behaviour such as the disruptive switching of alters may be experienced by Lisa as distressful, other behaviour such as the abuse of drugs and alcohol may facilitate briefly comforting altered states experienced in a manner more tolerated by society than multiple identities can ever be. Relinquishing these behaviour patterns would therefore be especially difficult. Ongoing dysfunctional relationships such as that with her mother appear to further undermine Lisa's attempts to function in a more adaptive fashion. In light of this, the purpose of therapy is to aid the development of adaptive skills in a context of greater self-understanding and awareness on the part of the patient. To help Lisa to move towards a state of undisrupted consciousness, which allowed for continuity of memory and was associated with greater stability of emotion and improved functioning, was therefore the goal of this therapy from the time that the diagnosis of DID was made.

The course of therapy varied in frequency and setting, and was characterized by multiple interruptions and crises. During her initial admission Lisa attended twelve therapy sessions, once per week over twelve weeks. These became 1 and ½ hours long each, and were supplemented with separate weekly half hour sessions part way through the admission. The longer sessions focused primarily on traumatic material, often spontaneously abreacted in a dissociated state, while the shorter sessions were used for working through day to day problems. Before she was discharged, she accepted my offer to continue to see her as an outpatient. A break of approximately five weeks followed, during which time Lisa was out of town. She returned for outpatient therapy

twice per week, and had a total of four sessions before a crisis prompted her admission to a different ward within the hospital system. During these four sessions alters clearly emerged and the diagnosis of DID was made. Lisa remained an inpatient for five weeks and had ten therapy sessions during this time, twice per week. Feeling angry due to the circumstances of her discharge, Lisa terminated therapy with me when she left the hospital.

One month later Lisa requested a single session in which she informed me of how she was coping generally. Approximately two months after her most recent discharge Lisa contacted me again and requested to see me. I saw her and we set up a following appointment but prior to this she attempted suicide by taking a drug overdose and was admitted to a hospital within another system, as she now resided in their area. I saw her upon discharge and we resumed therapy sessions, once per week and 1 and ½ hours in length. Therapy continued over another five month period which included a five week break over the summer vacation. Therapy focused on managing crises and relationship difficulties, as well as dealing with emerging traumatic material and increasing communication and interaction among alters. During these five months Lisa was admitted another four times, twice to the hospital system in which I worked, and twice to the other hospital system. The second admission to the other hospital system was approximately one month in length. At this time it was agreed by staff in both hospital systems that future admissions would occur within the system in which I happened to work, to avoid confusion. During this one-month admission I contracted with Lisa, and obtained permission from staff, to see her three times per week for sessions 1 and ½ hours in length. By the end of her admission at there, Lisa had decided to relocate to a remote place outside the city. As a result, discharge and termination of the therapy occurred simultaneously.

CHAPTER FIVE

CASE STUDY AND DISCUSSION

CASE STUDY

I was assigned as Lisa's intern therapist during her stay on a psychodynamically-oriented inpatient ward, and I accordingly met her shortly after her arrival. Knowing I was her therapist, she expressed to me her sense of urgency regarding treatment and requested that I see her every day, which I had to explain could not be accommodated on the ward.

Lisa arrived at our first session with a collection of diaries, a little black book, and a doll whom she called Martha. Her sense of urgency was even more apparent; it was as if, in her desperation to be helped, she wanted to communicate her whole being to me in our one hour together. As she spoke, I was struck by the extent of chaos and pain that appeared to constitute her life, and I struggled to make even chronological sense of it. She did not show me the diaries, but chose instead the black book, which she said contained drawings she'd recently made following flashbacks she'd experienced at night. As I opened the book, she became visibly more anxious and said in a forced casual way "I'm just a normal teenager; I don't know what this is about!" The book consisted of a series of eight light pencil sketches mostly depicting what appeared to be Satanist rituals of sacrifice, torture and murder in which a number of people were present. Each picture also contained an identically drawn little girl as seen from the back, observing, and in one picture the little girl appeared to have been drawn twice, both observing and tied to a table as the central focus of the ritual scene. Looking at these drawings with me increased Lisa's anxiety even more, causing her to dissociate into a trance-like state in which her eyes closed and she became somewhat limp. Feeling inwardly panicky myself at this point, I actively responded by repeatedly telling her who and where she was. She then came out of her trance and we discussed what had happened. Lisa described feeling drowsy as well as a sensation of pins and needles prior to dissociating. In this session, Lisa also spoke in a somewhat embarrassed and dismissive way about having briefly gone to a psychologist who told her she had

dissociated into a little girl who liked Smarties and who demanded that the psychologist sing a song for her. She could not remember this, but had been informed of it by the psychologist. She said, however, that though she disliked Smarties, if she felt unhappy she had to eat them.

Lisa clearly raised the issue of multiple personality in my first meeting with her. Her dismissive attitude towards it was confusing to me, though in retrospect this attitude was completely understandable in view of her fear of exposing herself to a possible negative response, as well as her own resistance to contemplating the reality of what she was suggesting. My own inexperience both generally as a clinician and in the areas of Satanist abuse and dissociation made it difficult for me at this point to see any treatment path apart from one of letting things unfold in their own way and time. In further discussion of Lisa's case at ward round it was agreed generally that dissociation on the ward and in the therapy room should be discouraged if possible, in order to allow her to engage directly with anxious feelings and work through them. I found this pragmatic and personally containing on the one hand, as I had felt unsettled by this first session, but I also realized that I needed to keep a completely open mind if I were going to be of any therapeutic help to my client.

Over the next few sessions it became increasingly evident not only that Lisa had suffered severe and chronic trauma from a very early age, but also that any work with this traumatic material was going to have to allow for dissociation in the therapy sessions. I based this understanding upon the unusual process of memory recall which began to define her sessions. Lisa would begin with the verbal recall of some image or event in her past, or verbalize her awareness of some uncomfortable physical sensation such as pressure on her chest, causing her affect to increase. As she experienced increasing terror, words failed her and she would resort to actions, pointing repeatedly to a part of her body where an assault had occurred, or making motions to ward off more hurt as distinctions between past and present seemed to blur. Then there would be a shift in which past became fully present. I could not clarify for myself the moment of dissociation, but defined what was happening as dissociation by observing in her an experience of a shift into a reliving of past trauma, primarily Satanist abuse, through words, actions and extreme affect. Her voice, language and body movements also

changed, becoming more childlike, and she would sometimes speak Afrikaans through an episode.

My response to her dissociation was to move my chair closer to hers, repeatedly telling her that I was there, and that she was safe. At one point I told her she was Lisa and she was in the hospital, to help ground her, at which she turned and looked at me with an expression of hurt and anger and said, in Afrikaans, "no I'm not, I'm Martha!" Following this I deliberately restricted myself to two or three phrases which I felt would not insensitively dismiss the reality of her experience in the room, and yet might perhaps penetrate and somehow diminish her terror as well as lessening my feelings of helplessness and panic in the face of hers. My own feelings in these beginning sessions were very powerful. I felt I was a voyeur to Lisa's torture and abuse, the more so since she began repeatedly to call to me to help her. Often she experienced being surrounded by people who were hurting her and she would appeal to me as the "mooi tannie" to rescue her and take her to her mother. I began to feel that our sessions had become torture, and my office the torture chamber. To help counter this, and to address recurring problems in day-to-day functioning, I began to see Lisa for an extra half hour session during which we discussed current difficulties. I did this after consulting with my supervisors, who also gave me full support for allowing Lisa to dissociate freely in sessions.

Lisa would typically move through her reliving of the most profound abuse, into a state of complete physical and emotional exhaustion on the floor. After a few moments of stillness, she would "wake up" with no memory of what had happened beyond powerful physical sensations of aching, fatigue and an overwhelming sense of emotional unease and hopelessness. Under these circumstances, and given the fact that we had inevitably gone over the limit of our planned hour session (soon changed to an hour and a half), it was difficult to even begin to process the traumatic material of the session. As a consequence, over time, I found myself holding more and more of these unprocessed traumatic memories, their sheer quantity as well as quality making them extremely difficult to begin to address. To help Lisa feel more of an active partner in therapy, which I felt was in danger of exacerbating her feelings of helplessness and lack of control, I encouraged her to look for any changes, particularly in the flashbacks and nightmares which seemed to be connected with the material being abreacted in the

sessions. She did not perceive any changes, however, and at the end of her time on the ward Lisa informed me that she was still extremely disturbed by flashbacks and that her anxiety and "time out" periods were still not under control. She had also self-mutilated twice while on weekends away from the ward.

Towards the end of Lisa's inpatient admission I was able to offer her the option of continuing therapy as an outpatient. She accepted this and, after a break of five weeks during which she was out of the city, we resumed therapy twice a week. Lisa arrived for the second session looking very distressed. Her eyes were glazed, her face puffy, and she was shuffling rather than walking, all of which I had observed at times while she was an inpatient. Lisa told me that she was hearing children's voices and was disturbed by them because they would tell her to do things such as buy toys, which she couldn't afford. She was holding a small stuffed pony which she had had to buy. Lisa said the voices wanted to be heard because they had protected Lisa and now she wasn't helping them. They were especially angry that she had never let them speak on the ward. She said she hadn't let them speak because she thought no one would believe them. I said I was prepared to listen to them and believe them, at which point Lisa became visibly more agitated, looked around the room fearfully, then let her head fall forward while her fingers played idly with the little pony in her lap.

I waited and a few seconds later Lisa looked up at me with an expression I'd never encountered in her before. Her face seemed frozen, her eyes had become slits, peering at me with profound suspicion. She said defiantly, "I'm Jenny". I introduced myself and said I was there to listen to her. She then became frightened, looked around, and said her father would punish her if she talked. I said she was safe here. She said I'd tell her father, and I said I wouldn't. She asked me to promise, which I did. Then she brightened up, became more childlike, and said that next year she would go to primary school and she would tell the teacher what her father did and the teacher would protect her. At this point her fear began to rise again as she appeared to remember a particular event. She moved through the memory of abuse, speaking until it became too much, and then she seemed to freeze, her mood suddenly changed and she became more childlike again and defiant. She said "I'm Martha", in Afrikaans. Again, I introduced myself, and there was the same vacillation between childlike preoccupations and rising fear. Aware of the time, I eventually asked to speak to Lisa, and Martha said she was tired. She said "mooi

tannie”, dropped her head while reaching in a childlike way for my hand, and appeared to fall asleep. After a few seconds Lisa raised her head looking somewhat disoriented, as if she had just woken up. I explained briefly what had just happened. Lisa could not remember anything and expressed feelings of being uncomfortable with but resigned to what had occurred.

Over the following two sessions I met three more alters (an eighteen year old male named Neil, a twelve year old girl named Emma, and one child), with Martha appearing twice. I always introduced myself and explained what I was there for. I learned their names and heard something of their particular trauma. Lisa also began to talk more about her inner experience, saying that most of her life she had seen a row of people. In the middle was a man in a black hood, on one side were the “good people”, sitting, and on the other side were the “bad people”, out of control. I asked if they could talk to me and she replied that they didn’t trust me yet and that she feared for me, though not physically. Speaking of the alters generally, Lisa said they made her life miserable but she couldn’t see how she could live without them because they protected her.

Lisa did not, in fact, come to one of these sessions as herself. The alter who came to therapy introduced herself as Emma and said that she had had to come out because Lisa was so depressed over a job rejection that she had wanted to kill herself. Emma said she hadn’t been out since Std four and that she was the one who was good at maths, not Lisa. Emma then showed me a few recent photographs taken while on the ward, which she said Lisa had wanted to show me. When I pointed out Lisa in one of them, Emma tensed visibly and said that she didn’t like looking at her. Emma described herself as dressing differently and having hair of a different colour and texture to Lisa’s. Emma’s trauma centered on the extensive sexual and sadistic abuse perpetrated by the lodger when Lisa was twelve, of which she spoke at some length and with a high degree of affect. While speaking of Lisa’s mother, whom she did not acknowledge as her own, she exhibited an angry affect, markedly different in intensity from that of Lisa. I found this session very unsettling, not least because it was clear that there was a rivalrous relationship between Emma and Lisa, with Emma’s attitude being very dismissive of Lisa as someone who simply couldn’t cope. Having no idea how well this alter could function in daily life as a traumatized twelve year old, or what Lisa’s mental condition truly was (she was described by Emma as lying at home in bed), I gave her my

telephone number. Two days later Lisa called, after having cut herself while still dissociated as Emma, (she had a vague memory of the cutting), and was hospitalized, where I continued to see her twice weekly.

Over the next ten sessions while Lisa was an inpatient, the therapy with the alters as well as with Lisa as host personality developed significantly. In consultation with my supervisors we had made a definitive diagnosis of Dissociative Identity Disorder and I began reading in this area to understand better the dynamics of the condition. I was keenly aware that I had simultaneously to preserve two contradictory concepts in my mind, namely that Lisa was a single being, and that her mind was made up of parts which had formed themselves into highly individualized identities. Both realities needed acknowledgement, and I accordingly made conscious attempts to develop therapeutic alliances with each alter, as well as addressing Lisa's need to be heard and responded to as a single self. Lisa was informed of her diagnosis, which she acknowledged as fitting her experience, and I emphasized that dissociation had been an adaptive and protective response on her part as a child to overwhelming abuse. During this period we continued reflecting on her feelings, which were of depression, hopelessness and fear, as well as talking about the difficult nature of the therapeutic process itself. Lisa said she didn't want to know about the alters. It "freaked" her out and she just wanted to get on with her life. She felt frustrated about being in hospital and wondered how long this process would have to continue before she was well and could live "a normal life". Often she would express a wish not to know about what had happened while she had dissociated. Though unsure, I respected this and continued to hold more and more memories of the most brutal and inhumane acts. At other times, however, she showed a single-minded determination to face horrific material and try to incorporate it into her understanding of her life without letting it annihilate her will to live.

Over these ten inpatient sessions I also met five more alters, four of them young female children approximately four to five years old, as well as a very vulnerable young adolescent female alter who felt the physical pain of Lisa's self-mutilation. The work with the child alters tended to develop a common pattern. Emerging in the now familiar way, in response to some intrusive feeling, thought, or bodily sensation experienced by Lisa, they presented themselves as embodiments of distress: crying, shouting, or cringing silently. Invariably, their first need was to be contained enough to speak or

even just look up. I did this by acknowledging their feelings and their courage, as well as repeatedly stating who I was and that they were in a safe place. I now brought kokis and paints to the sessions, and this drew their interest, particularly since each held secrets with powerful injunctions not to speak, making drawing a safer alternative. In the process of drawing Satanist experiences, one child alter suddenly needed to see blood and switched from kokis to red paint, teetering precariously between the need to be sure that it was blood and the fear that it might be blood. Another child could not tolerate the thought of painting for fear of the consequences of making a mess, but could make a primitive drawing of her family, her house, and the cupboard in which she experienced being repeatedly confined. Apart from one brief attempt at green grass, the child alters invariably chose to use only red and black. Across all alters, the image of the male perpetrator(hooded)/father(bareheaded) was essentially the same with grossly oversized hands, indicating their power and the source of Lisa's physical pain. When the child alters had finished drawing or painting they almost invariably felt exhausted, lay down on the floor, and fell asleep, sometimes sucking on a baby's bottle which Lisa brought to sessions, at which point Lisa would emerge.

It was also during this period that I met a new and fundamentally different alter. In one session towards the end of Lisa's admission, Jenny came out and chose finger paints, feeling unsure of the paintbrush. After moving through Satanist material she began absentmindedly swirling her finger around in a circle on the page. Suddenly she stiffened and an adult voice said very aggressively, "what am I doing?" I explained about the paints and the alter responded "I'm not a child, I'm a man!" Before I could say anything, Lisa's mood and posture changed subtly and she said in a smooth and grandiose voice, "I am a goddess". She said she had been watching me from the beginning, told me her name and said, "that is the name they gave me". Though often verbally aggressive and belittling towards me, she used the session to communicate a wealth of material and feeling, alternating between anger and resignation. She told me about being "created" and her Satanic purpose, namely to fulfill Lisa's destiny, which was to make babies to be sacrificed, following which, Lisa would be sacrificed. While she spoke, she painted over in red one of the paintings which Jenny had done. Then she became less vague and decided to both draw and tell me the history of Lisa's involvement in Satanist abuse, beginning with her initiation as a young child into the

cult. Drawing sketchily but deliberately, the Satanist alter gave pictorial representation to the whole of Lisa's personality system as she knew it, distinctly separating child alters from adolescent alters. Her primary focus, again, however, was the nature of Lisa's purpose and destiny according to the cult. With some hesitation she solemnly revealed that this destiny could only be altered in one way: through the direct influence of Christianity.

When she was done the Satanist alter informed me that it was time for her to go back inside and then lowered her head. Lisa's body was still for a few seconds, sitting on the floor, and then she suddenly shot backwards and lay on the floor. Lisa was now conscious but said her body felt lame and then, clutching at her neck in a state of extreme terror, just managed to indicate that she was suffocating from the presence of an "evil man" who was sitting on top of her. Over a period of many minutes she seemed to be caught in a profound and seemingly deadly struggle between an internalized personification of evil and whatever forces she could muster to fight it off. I found witnessing this experience particularly disturbing because of my own feelings of helplessness and ignorance. I had to question what might be the effects of probing Lisa's mind and blindly tampering with its internal structure in therapy. To make matters worse, Lisa went home for the weekend and cut a pentagram shape into her forearm while in a more deeply dissociated state than she usually experienced during cutting. Although this increased my unease, the same alter chose to emerge again in the next session, explaining aspects of Satanist symbols and her experiences, and at the same time revealing not only her anger but also hints of a deeper, pervasive anxiety and the possibility of some therapeutic alliance between us. To my great relief, her second emergence did not have the same devastating consequences as the first.

While it appeared that the alter with the Satanist identity could now emerge without immediate adverse consequences, it was clear that these new developments in the therapy had caused Lisa's overall anxiety to increase significantly. She began to act out on the ward, openly smoking dagga and encouraging other patients to join her, as well as giggling and joking inappropriately with other patients during group therapy. In addition, a problematic sexual relationship with a man outside the hospital had triggered cutting on her thighs, and during a session, while dissociated as Emma and in a state of distress, she had suddenly run out of the building and cut her forearm. Following her out

of the building but unable to prevent her from hurting herself, I witnessed the palpable relief which came with the sight of her own blood. As a result of her smoking dagga, Lisa was required to forfeit a two-week extension of her admission and our inpatient sessions were abruptly ended. She responded by angrily rejecting all intervention, including outpatient therapy, feeling that she never wanted to see a health professional again. Her changes in behaviour led me to suspect that an alter was in executive control for at least part of the time during these last few days. Judging by her expression and body posture during a final ward round I guessed it to be Emma, and realized that she must be in control much more often than she had at first indicated.

Although we had, over time, repeatedly addressed Lisa's range of feelings towards therapy, our actual termination of therapy was abrupt, and I heard no more from Lisa apart from a request for a session a month later, in which she informed me that she had accommodation, a job as a waitress, and that things were going well. Two months following our termination Lisa phoned to say she would like to see me. In the session she said that she was not doing well, in spite of giving an appearance of being okay. As she spoke, I began to have the sense that I was with Emma. I told her this and there was a falling away of Lisa's mannerisms and Emma said yes, it was she. She said she just acted like Lisa and nobody knew the difference. I was now much more aware of the significance of this, knowing that Emma, while protecting Lisa and other alters from direct experience of difficult or abusive situations, would emerge in a crisis and resort to cutting or other harmful acting out in a desperate attempt to try to resolve it.

Emma then spoke about why she had come out. Two weeks previously, Lisa had been in a bar where she'd started drinking with five men and during this Emma had felt she had to come out to protect Lisa, who was feeling increasingly anxious. Her account became very vague but I gathered that since then she had been meeting these men singly at night and engaging with them in something that she would only describe as "hurting" and "bad". She said that she was doing this because she knew she mustn't cut herself and this made her feel "better" but at the same time she became very despondent and said she wanted to die. I asked where Lisa was and she said Lisa didn't want to come out. We contracted to resume therapy once weekly, but two days later Lisa was hospitalized briefly following an overdose on Panados and her anti-depressant

medication, which had been dispensed to her by a clinician on the same day on which I had seen her in a critically distressed state.

When we met again the destructive nature of the rivalry between Lisa and Emma, was most apparent. Lisa came to the session with no recollection of the past few days apart from understanding that she had attempted suicide and been hospitalized. She didn't know that I had seen her and that we had agreed to resume therapy. At this point she began to move in and out of consciousness, unable, though seemingly wanting, to remain wholly with me in the room. After a few seconds, Emma emerged, expressing distress and resignation about what was occurring at night. She also gave me a short letter she'd written to me, asking me to be her friend. I assured her that I was there to listen to her and to help her. As the session progressed, Emma became extremely reluctant to give Lisa any space to come out again, while I felt it was crucial that Lisa understand what was happening to her in order to be able to begin to protect herself. Addressing Emma's sense of rejection in relation to going in again, I explained that she wasn't being sent away by going "inside", but stressed the need to share time, after which she eventually agreed to let Lisa come out for a little, and lowered her head slightly. Lisa came out, looking dazed and overwhelmed. When I relayed back to Lisa what appeared to be occurring at night, she was enraged that her body could be so used yet was, like Emma, essentially fatalistic about the situation and refused to explore safety options, saying instead, rather ominously, that she'd "take care of it". The session ended with a feeling on my part of a stalemate within Lisa. The most I could ascertain was that, though perhaps inadvertently fulfilling the function of furthering the Satanist alter's perception of Lisa's destiny, these men seemed not to be connected with actual Satanist activities.

Over the next two and a half months, as a result of Lisa's primary need to function adequately as an outpatient, the therapy shifted from an emphasis on working with traumatic material to managing current crises, the most pressing of which was her continuing experience of going out at night. Other issues which Lisa raised were her often problematic relationship with a fundamentalist Church group and ongoing friendship difficulties. In addition, because of what was happening at night, Lisa was experiencing increased pain and fatigue, which was impacting in turn on her ability to work and exacerbating her sense of hopelessness. In an effort to address the confusion

and safety issues, and having a better sense of Lisa's internal dynamics, I asked, over several sessions, who could help, appealing to any alters with a possible protective function. In response, the alter with the Satanic identity and Neil, the eighteen year old male alter emerged, yet neither of them would or could take any responsibility for what was happening, both referring vaguely instead to some other, perceived outside force which was dictating Emma's actions.

Shortly after this the combination of Emma's distress, her rising need to harm herself, and Lisa's overall decrease in functioning led Lisa to make the request that she be hospitalized for two nights in an emergency inpatient unit. While she was there I saw her for two hours one evening in which we agreed we would try to establish from where this outside force which was compelling Emma might be originating. During the session an alter, who refused to divulge her or his name, emerged and demanded to be released from the hospital. Again, however, there seemed to be little sense of agency attached to this demand. The alter appeared overwhelmed by fear and suspicion associated with Satanist abuse experiences and triggered presumably by the nighttime context of the therapy session. One of her first actions was to draw the blinds. After much intense threatening on her part and explaining on mine, another child alter emerged in a state of extreme head pain associated with a red light. Both the pain and the light appeared to constitute a reliving of an experience of being programmed for secrecy, again associated with Satanist abuse. The experience of this severe head pain, which continued unabated after the child had withdrawn and Lisa had emerged, left Lisa feeling physically and emotionally devastated. She received medication on the ward and was helped to her bed where she had a restless and disturbing but relatively uneventful night.

Attempting to work in this more collaborative way of encouraging alters to consider and talk about a shared situation, though unsuccessful in terms of our immediate goal of altering her nighttime behaviour, was having an effect on Lisa. In addition to known alters, two more new female child alters, aged four and seven, emerged with traumatic material, and Lisa spoke of the voices in her head as becoming louder and more numerous. As a result, she was experiencing increased confusion and dissociation. Not all of this was related to trauma; for example, Lisa described walking past a street sign and hearing a child's voice in her head trying to read it. Although we did not work with paints at this point, I brought kokis and paper to every session and encouraged Lisa to

keep workbooks available for drawing or writing. At this time she established a workbook "for everyone" in which alters, mostly children but also Emma and Neil and others, either drew or wrote. Most of the subject matter dealt with past and present trauma, but on one page, three child alters drew themselves in a small group to indicate feelings of closeness. I continually encouraged Lisa to look for meaning in her overall sense of chaos, and we spent some time looking at alters' work and relating it to past and present experience.

In early December, about three weeks before our planned Christmas break, Lisa went out alone late one evening and was abducted from her neighbourhood and raped. She reported the incident to the police and managed to keep functioning until she left Cape Town for the Christmas holiday, following which she experienced a breakdown with panic attacks and increasing social phobia. She was admitted to hospital and, on the basis of her being in a more contained environment, I contracted to see her three times a week during her stay there. Lisa expressed strong suicidal feelings when we again met and was having difficulty keeping alters from emerging on the ward, where her diagnosis was not acknowledged. Seeing me again prompted an increased pressure on her to allow alters to emerge and express themselves. In our first session she was distressed by a continual internal crying which it appeared no alters could resolve as the crying came from a small child alter caught in the trauma of being locked in the cupboard while the key was 'buried' with her father. After exploring this internal stalemate, I suggested that I could speak to the child alter myself. Lisa lowered her head and a moment later her cowering and a soft whimpering indicated that this child alter had emerged. After saying who I was and acknowledging her terror, I began to encourage her to look up and see that she was no longer in the cupboard. As she said she could see nothing and her eyes burned, she instead felt her way around the objects near her to prove to herself that she was now free. I explained where she was in simplified terms and asked her if she knew of other child alters. She seemed to know of nothing but the cupboard. As I was by now aware that several of the child alters formed small subgroups of two or three and were able to provide company and comfort for each other, I felt that contact with these child alters could possibly facilitate this alter's fuller integration into Lisa's personality system. When it was clear that this alter was feeling somewhat calmer, I suggested that she go back inside and meet these other child alters.

She was willing to do this, and Lisa again emerged expressing a great deal of relief at the reduced distress.

During this inpatient period contact with alters was developed further and again, while attempts to encourage collaboration between alters ostensibly failed, there was clearly increased communication between all parts of Lisa's personality system. This naturally increased Lisa's experience of self-awareness, which was accompanied by a range of emotions as she still struggled with suicidal feelings. Lisa spoke in one session of being troubled by nightmares in which a voice threatened to kill her, and, buoyed up by what had apparently been a successful intervention with the child alter who had been in the cupboard, as well as wanting in principle to engage with as many significant alters as possible, I said I could speak with any part of her who wanted to talk about the nighttime. Lisa became very anxious but allowed herself to dissociate and after hearing noises which I later realized was the sound of someone in a profound sleep, the alter who was out 'woke up' and in a remote and threatening manner revealed to me that she was "fear itself". She told me she slept during the day and was awake at night for the sole purpose of terrorizing the other alters, which she enjoyed. I attempted to engage her by appealing to her grandiosity and sense of power while gently challenging her to try something different, with mixed success. Within a day of my encounter with this persecutory alter Lisa had self-mutilated more severely than ever before, requiring stitches in her leg. And yet, in discussing what had happened, we seemed to have begun to demystify an internal reenactment of abuse and Lisa reported in a following session that her nightmares had changed content and were marginally less traumatizing.

Although, with the help of drawings and writing, Lisa and I would explore her feelings as expressed through her alters, we did not during this period ever focus on traumatic material apart from the recent rape which appeared to have affected all alters who had experienced abuse in Lisa's past. Alters not acknowledging negative effects of the rape experience were those who fulfilled a persecutory role, and the eighteen-year old male alter, Neil. He claimed never to have been abused, and that he was strong and would protect the others if given the chance. He seemed to embody a significant portion of Lisa's anger and though wanting to protect, had little tolerance for other alters' distress and could become punitive. He said that he had created an internal "blanket room" for the children to play in but then removed it because they would not clear up

their toys. Interestingly, in the session following Lisa's severe cutting of her leg, he chose to come out in response to my having said earlier to Lisa that I was interested in communicating with all alters. He showed me a list of 21 alters' names which Lisa had brought to the session, having written it according to his instructions. Neil and I then arranged the names in groups according to age and the subgroups which they had formed, and Neil told me a little about each one. I added the alter who described herself as "fear" and Neil emphasized that it was "not one of us". Nine alters were children between the ages of approximately three and six, who had clearly been created as a response to the Satanist abuse and the abuse perpetrated by Lisa's father. There was one infantile alter, whom I had encountered briefly during one of Lisa's short hospitalizations. Another six alters, five female and one male, were between the ages of seven and ten. I had not met them and I was told they were very quiet, keeping mostly to their own little group. Neil also spoke of being close to Emma and, with the alter who experienced the pain of cutting, the three of them made up the group of adolescents. Lisa's name was also on the page, placed separately from the others. Finally, Neil spoke of the alter who held the Satanist memories as being very quiet at present. These were all the alters of whom we were aware, though there had been indications during the course of the therapy that there were more.

Lisa's therapy was terminated at her request three weeks after this session and has not been resumed since. Several factors appeared to have influenced her decision. Foremost was an unexpected offer for her to relocate temporarily to a remote place outside the city, an offer which attracted her because of its potential for providing her with the safe place she was continually seeking. She also saw it as a place where she could allow alters to emerge and express themselves somewhat more freely, an experience which she hoped would diminish the increasing split she had felt in the hospital environment between what was acknowledged in therapy and what could be acknowledged on the ward. Her decision to move was also a conscious and determined attempt to create for herself an identity other than the "crazy" hospital inpatient, which was constantly threatening to overwhelm her fragile sense of self. It was a difficult decision, but she managed to enforce it by steadfastly refusing to dissociate in any of the final sessions, despite acknowledged internal pressure, only handing me some alters' written goodbyes when she left.

Although the therapy in treatment terms was far from complete, it was clear that Lisa was determined to make this move, and I therefore supported her decision as a relatively constructive expression of her need to take control of her life. Therapy had been an extremely difficult, occasionally perhaps retraumatizing, experience for her, but at the same time, it was clear that Lisa was beginning to accept not only what was happening in her internal world, but also some of the traumatic material associated with those internal states. Reflecting on the therapeutic process in a final session, she spoke of feeling somewhat less confused, more aware, and, in rare optimistic moments, more confident that her life, past and present, could acquire some continuity of structure and meaning. For my part, I hoped that the therapy, in spite of its being hard, had helped to foster enough optimism not only to sustain her at the very least through the short-term, but also possibly to encourage her to seek out professional help again at some point in the future.

DISCUSSION

The aim of this case study has been to provide a window onto the observable symptoms and expressed internal dynamics of an individual diagnosed with DID. By tracing the therapeutic process from initial contact through to termination, the way in which symptoms were expressed, the effects of these expressions on the patient both internally and externally, and the overall progression of the patient's treatment and condition could be meaningfully related. The term "symptoms" has been understood to refer primarily to the emergence of alters (an essential feature in terms of the DSM IV criteria), but also includes other characteristic features of the condition as stated in the literature, such as self-mutilation, suicide attempts, and symptoms associated with Posttraumatic Stress Disorder, which were relevant to an understanding of this case.

As previously discussed, part of the value of a study such as this is its generalizability to certain theoretical propositions. Of these, perhaps the most fundamental is the concept that consciousness can become divided or dissociated in a child in response to severe and chronic trauma. The complex psychobiological process by which this is achieved, while not the focus of this case study, is glimpsed at

retrospectively through the observation of Lisa's process of dissociation as it manifested during sessions. Triggers such as traumatic memory, physical sensation, or environment repeatedly brought about a process of altering consciousness with the invariable outcome of the emergence of an alter. Given the scepticism with which the proposition that alters can be present in an individual is viewed, it was essential that this most fundamental of processes be elucidated if only superficially, in order to lend overall credibility to the case itself. A fundamental feature of this case study, then is the method of simply relating in some detail what happened and what could be observed in certain sessions in order to render as comprehensible -and undeniable- as possible what is typically viewed as a bizarre and controversial phenomenon.

A question raised in the chapter on methodology which is not resolved in the case study is that of the limits to objectivity created by the role of the therapist as researcher. All the material reported on in this study has of necessity been filtered through myself, an intern therapist relatively inexperienced in all aspects of the therapy. While not exploring this issue per se, I have been keenly aware of the lack of objectivity inherent in my interpretation of material and its selection for this dissertation. Ultimately, however, I have taken the viewpoint of Alderfer (1984), referred to above, and consider the advantages of the single-case study method to outweigh its very valid weaknesses in this instance. Advantages include the accessibility of a first-hand account as well as the subtext of my own experience, to which others may relate, of being confronted with and needing to make sense of an often bewildering and disturbing condition.

The issues on which I have focused in this case study have been raised in the literature on the subject of DID and its treatment. In my choice of focus I have also attempted to underline the direct relationship between selected issues as presented in the literature and those dealt with in the case study. Accordingly, the complex and at first confusing way in which symptoms presented themselves in the therapeutic context may be directly and usefully related to the wide range of symptomatology described in association with DID in the literature. Significantly, as mentioned above, throughout the course of the therapy Lisa presented with symptoms suggestive of other disorders, particularly Borderline Personality Disorder and the Anxiety Disorders. Without some understanding of the complexity of DID symptomatology as well as its dynamic function within the individual, certain symptoms would have seemed incomprehensible

or at least at odds with other aspects of her behaviour and various states of mind. For example, Lisa's marked lack of progress on the ward at the beginning of the therapy was in distinct contrast to the degree to which she applied herself to the programme. Only when viewed retrospectively, and with a knowledge of Lisa's extensive personality system, could this impasse, which was complicated by behaviour such as self-mutilation, begin to be understood and addressed. Similarly, it was notable that while Lisa presented in our session prior to her suicide attempt in a way which alerted me to her distressed state of mind (Emma), she was seen on the same day by a clinician who gave her a sizeable supply of antidepressant medication after what he later described to me as a brief but entirely satisfactory conversation with her. Clearly, knowing the diagnosis was not enough; without an understanding of the dynamics of the condition, and in particular the ways and circumstances in which different alters assumed control, no tangible help could be offered to Lisa.

While the literature on symptomatology could provide a helpful knowledge base, it is the literature concerned with treatment issues which I experienced as being linked most inextricably to those issues which I faced as a therapist throughout the course of the therapy. Once therapy ended, in reflecting on this case, I found that my thoughts gravitated toward two central questions relating to treatment. Firstly, was therapy helpful for this patient, and if so, what aspects were most helpful? The second question focused on the larger context of treatment, namely, what is going to happen to this patient in the future? In other words, if she returns to the hospital system, what types of psychotherapeutic treatment interventions will staff decide to make, and upon what will they base their decisions?

To begin to answer the first question I have had to assess what happened in therapy in terms of the kinds of treatment approaches described in the literature review. Clearly, it did not conform to the stage-oriented structure, where stabilisation, reduction of acting out and contact with alters to establish a firm therapeutic alliance characterise the earliest phases of therapy. The therapy resembled perhaps the more purely psychodynamic mode of intervention, but in fact, as a result of my reading, this shifted towards the end of the therapy to an attempt at a more structured approach. In the last few weeks of sessions, I made conscious and expressed attempts to communicate with all alters in Lisa's personality system. This was done with the understanding that there

were alters who had emerged either only briefly or not at all, and that some of these might be exerting powerful negative influences upon the personality system in a way that was detrimental to and could quite possibly sabotage the therapeutic process. Such an understanding was supported in particular by literature dealing with treatment for survivors of Satanist abuse. One of the questions uppermost in my mind, therefore, when we terminated was to what extent these unconscious processes had influenced Lisa's decision to leave and what that meant in terms of the internal battles she would continue to wage? Conversely, had the emergence for the first time of one of these alters not long before therapy was terminated not simply increased Lisa's anxiety to the point where the safest option appeared to be a flight into health? Given the negative impact of these dynamics on Lisa's functioning, the use of hypnosis, as described in the literature, could possibly have been of benefit in this situation, but I did not have the necessary skills.

Speculating upon what might have happened had I been able to access further –and safely– those aspects of Lisa's personality system which had remained powerful unacknowledged forces necessarily led me to consider my strengths and weaknesses as a therapist. My weaknesses were largely related to my lack of experience in an area which is demanding both emotionally and intellectually even to those familiar with dissociative pathology. An example of this may have been my inadvertent facilitation of abreactions during the initial phase of therapy, an experience which had no clearly helpful consequences and could have been retraumatizing. At the same time, Ross and Gahan (1988) point out that DID patients will often abreact regardless of the particular wishes or orientation of the therapist, and that initially in therapy, "spontaneous abreactions by child alters may be a key diagnostic clue in undiagnosed cases" (p. 43).

Experiencing my own limitations as a therapist, I also often felt that I could not adequately hold the two apparently contradictory concepts of multiplicity and unity in my mind in a way sufficient for the patient's optimal benefit. I found myself often feeling inadvertently relieved when Lisa, as host personality, reemerged and I struggled to make inclusive interpretations pertaining to all disparate parts of her self, most of whom I knew were present at every session regardless of whether or not they emerged. In that way, my struggle with multiplicity mirrored Lisa's own. Maintaining the delicate balance, therefore, between according alters their rightful place in the therapeutic

process and upholding my own and Lisa's sense of her ultimate unity of self was one of the most challenging aspects of the therapy. Over the fourteen months, however, I could observe, in both Lisa and myself, significant shifts in our perceptions of her multiplicity and her unity. I believe that acknowledgement of her multiplicity and everything which that implied was the fundamental issue of the therapy. Had the therapy progressed to a more mature stage, we might have reached a place where the issue of multiplicity, having been fully acknowledged and explored, could have increasingly given way to the issue of unity and a growing experience for Lisa of a single, more inclusive self.

The fact that Lisa terminated her therapy prematurely raises important questions about the nature and effects of her treatment. What, for example, did this therapy mean to Lisa? More particularly, what was the price exacted by the therapeutic process of acknowledging memories of extreme trauma? In contemplating an answer, I am reminded of the fact that, whether in therapy or not, Lisa was continuously assaulted by memories either consciously or in the form of nightmares, flashbacks, bodily symptoms and self-destructive behaviour. What made a profound impression upon me as a therapist was the degree to which Lisa felt she had no option but to be in therapy in an attempt to make her life a little more bearable. The hope that this could be achieved motivated her, but this hope often failed her as well, especially when positive results failed to appear quickly enough. She had created a complex defense system the extent of which neither of us was completely able to fathom, and therapy, which challenged those defenses, was therefore often experienced as a terrifying descent into unmitigated chaos. The extent of her trauma was such that even when not directly dealing with it, she was faced with its implications in all aspects of her thought, action, and being. Leaving therapy, therefore, while a statement at many levels, was to some degree an attempt at a new beginning, in part a resurrection of the defenses, but with aspirations of maintaining a minimum level of healthy functioning.

While termination was abrupt and premature, it occurred within a context of contained and positive emotions. This was in contrast to the feelings and behaviour associated with Lisa's temporary decision to leave therapy a few months before. In view of both this and the fundamental development of the therapy, I believe some progress was made in Lisa's overall condition as a result of treatment. Although when therapy ended we were still in a precariously difficult stage of exploring Lisa's personality

system without having adequately addressed risk-taking and self-harming behaviour, we could both perceive significant and positive changes. Lisa was beginning to understand within a psychological context what she was experiencing internally, and with that came some increase in acceptance as well as less confusion, though no significant relief from overwhelming affect or disruptive dissociation. What made beneficial change possible was, I believe, the deceptively simple context of a therapeutic alliance which was based on the fundamentals of non-judgemental respect, trust, and some degree of therapeutic understanding. In her final session, Lisa's most heartfelt and moving communication was her gratitude for my simply believing her.

While I endeavoured to establish and maintain an environment in the therapy room in which Lisa felt safe to express herself without great restriction, this was not always possible in the larger context of the hospitals where she received treatment. As outlined above, the reasons for this were several, ranging from overburdened facilities to typically wary attitudes towards DID. Moreover, Lisa's often impulsive, as well as specifically suicidal and self-mutilating behaviour, commonly understood as features of Borderline Personality Disorder may also have shaped the attitudes of staff which in turn impacted on her inpatient treatment. The abrupt termination, in one instance, of Lisa's inpatient treatment as a result of behaviour associated with Emma being in executive control, and the internal crisis which this implied, is perhaps the best example of a situation in which a lack of experience with DID among staff, including myself, had a detrimental effect. In another instance, as the therapy progressed and both Lisa and I became more aware and accepting of her whole personality system, the increasing divergence between our attitudes and those of staff around us was beginning to create an "us-and-them" scenario intolerable to Lisa. Ironically, the dynamic of secrecy, so embedded in Lisa's abuse experiences and one of the cornerstones of her world of multiple realities, occasionally also appeared to form a destructive subtext to our therapeutic work.

Although I can only speculate on what the future holds for Lisa, the experience of treating her in a hospital environment and the lack of specialized understanding which could inform treatment not only for her but also presumably for others with the same condition, was a major motivation for the writing of this dissertation. Most profoundly, the experience of providing therapeutic treatment to a person struggling with multiple

identities in the context of a past characterised by extreme trauma challenged my concepts of what it is to be human. In confronting the issues of Lisa's multiplicity and unity I also had to confront my own. Empathising with someone who had multiple, distinct, and often conflicting responses to every detail of her own experiences elicited questions about the nature of experience, memory and consciousness. To gain understanding seemed to me to be paramount, but I have also recognised that my understanding is limited by the paradigms within which I frame my knowledge and experience of self. Collective psychiatric thinking appears to be similarly constrained. Whether that thinking can break free of the mould or whether it continues to repudiate or ignore what it seemingly cannot accommodate, will help to determine the future course of mental health practice.

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CHAPTER SIX

CONCLUSION

This dissertation has employed the single-case study method with the aim of describing selected symptoms and dynamics of Dissociative Identity Disorder in the context of an individual, long-term psychotherapeutic treatment process. The single-case study as a research method is considered to be an accessible and meaningful way in which to approach and present the relevant material.

The experience of the individual who lives with multiple internal identities can appear disturbingly incomprehensible to anyone setting arbitrary limits upon the possible range of presentations of the self. The correspondingly diverse range of issues dealt with in the literature on the subject of DID is testimony both to the questions which this condition raises and the efforts made to understand it. The focus on severe child abuse, emphasized in the literature as being aetiologically linked to dissociative pathology, points to its importance as one of the foundations upon which an understanding of DID rests. This case study has likewise attempted to make the link between episodes of severe abuse and the particular pathology, including alters or groups of alters associated with them. The sheer extent and severity of the abuse to which Lisa was exposed is accordingly reflected in the complexity as well as the structure of her personality system.

When the clinician is confronted with an individual struggling with DID, the issue of effective psychotherapeutic treatment becomes paramount. Those clinicians working in the field generally recommend an overall approach which draws on certain techniques and key elements from several treatment modalities in order to address more effectively the unique and various needs of the particular patient throughout the course of the therapy. This case study has, by means of chronologically following the course of a single therapy, endeavoured to illustrate how the changing needs of the patient prompted adjustments in approach within the limited capabilities of the intern therapist.

Responding appropriately to the DID patient for that patient's benefit presupposes the establishment of an atmosphere safe enough for the patient to feel able to begin to

reveal aspects of his or her inner world, in other words, to exhibit the essential symptomatology associated with DID. Without this precondition, symptoms of DID may become, or remain, suppressed and even disguised but do not actually disappear. It has therefore been one of the aims of this dissertation to communicate the overall therapeutic context as well as the different circumstances within which alters emerged.

This point has particular relevance in South Africa where the disorder appears largely to be viewed with varying degrees of scepticism. Regardless of the argument that aggressive soliciting of symptoms may result in false positives, if the potential for the disorder to exist is not fully admitted then it follows that there would be little possibility for symptoms to be properly recognised, let alone considered, even when they do appear. This was amply demonstrated in Lisa's case, where only after weeks of presentation of DID symptoms in the context of a previous DID diagnosis, was a conclusive diagnosis of DID finally made.

With the high incidence of severe childhood abuse in South Africa, therefore, it would make sense to investigate patients alleging such abuse for a history of amnesia and for clinicians to be attuned to the possible signs and symptoms of dissociative pathology while abstaining from a so-called encouragement of symptoms. Including DID in the differential diagnosis of patients with symptoms such as persistent severe acting out, combined with some degree of amnesia and prominent anxiety or affective symptoms might be an important first step. In addition, a survey directed at clinicians and which attempted to determine the incidence of the DID diagnosis in South Africa's clinical population might be of great value in moving towards a more realistic view of the disorder's overall prevalence.

Correct diagnosis is an essential first step towards effective treatment. An understanding of the implications of the DID diagnosis, namely that it is an often severely debilitating and yet treatable condition, is, however, equally vital. In South Africa, where resources are limited, particularly in hospitals, it is perhaps helpful to focus on the important role which psychotherapy plays in treatment. Whether in inpatient or outpatient settings, the fundamental consistency inherent in supportive psychotherapy carried out in the medium- to long-term, can greatly aid in the alleviation of distress experienced by individuals diagnosed with DID. And for such individuals, the simple knowledge that there is a possibility of appropriate and potentially effective

treatment for DID can go a long way to fostering the optimism so critical for a positive treatment outcome.

It is in light of these ongoing issues and with a view to contributing to the development of an understanding of DID in South Africa that this dissertation was conceived of and written. Concurrent with this, however, was my own crucial internal process of learning. Perhaps my inexperience was advantageous to the patient in that I had not developed fixed attitudes towards symptomatology and its relationship to diagnostic categories. Perhaps also, my status as an intern allowed me to engage with the patient and the system with a vigour that might not have been possible under different circumstances. Here however, the possible advantages of my inexperience ended, and I accordingly launched myself on a path of learning which has led me to a greater understanding not only of one particular patient's condition, but also of the more general dynamics of the human psyche. To that end, the dissociation paradigm has proved to be a valuable tool.

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