Deconstructing DID

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The author contends that a psychoanalytically informed approach to the patient with dissociative identity disorder (DID) can be very useful. However, there are difficulties in conceptualizing this condition without extending existing theory or applying in new ways what is already known. It is also difficult to put DID in a proper context relative to all the other disorders known to occur in the human mind. Depending on one's clinical experience, level of skepticism, and appreciation of history, DID may be seen as either: a) the psychological "missing link" that realizes Freud's goal of uniting the psychology of dreams with psychopathology, or b) a fraudulent condition that is wittingly or unwittingly manufactured in the therapist's office or c) a population of disturbed and disturbing patients, once the subject of great scientific interest, which, exiled like a "Lost Tribe," is now back in the fold of legitimacy. The author has had extensive clinical experience with psychic trauma, and bases his own views of DID on three assumptions: 1. that dissociation may be seen as a complex defense; 2. that DID may be thought of as a "lower level dissociative character"; and 3. that there is a unique psychic structure, the "dissociative self" whose function is to create "alter personalities" out of disowned affects, memories, fantasies, and drives. This "dissociative self" must be dissolved in order for integration of "alter personalities" to occur. A clinical vignette is offered to illustrate how he addresses some of the challenges of developing a therapeutic alliance at this end of the dissociative-character-pathology continuum, and how he grapples with the difficulty of integrating clinical phenomena, such as the appearance of "alters," with the psychoanalytic model of the mind.

INTRODUCTION

For the past two decades, I have been involved in the psychoanalytic study of the effects of massive psychic trauma on mental functioning. My work started with adult survivors of the Holocaust and the transmission of their trauma to their children, i.e., the second generation. My research then extended into the realm of child survivors, as I participated in an international interviewing project, collecting data on the longitudinal effects of profound early trauma on development (1). During this time I fortuitously met Richard P. Kluft, M.D., at the Institute of Pennsylvania Hospital,

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whose historic work (which is reviewed on pp. 289–319 in this volume) with dissociative disorders had already come into prominence (2). His patients had also reported severe early trauma, but more often it was associated with domestic physical and sexual abuse, not the deprivation and atrocities associated with genocidal persecution. Furthermore, their seemingly bizarre altered states, different selves, amnesia, and suicidal aggression presented a different set of challenges to the treating clinician.

Adding to the complexity of these patients, many of whom seemed somewhere between borderline personality and schizophrenia, while also suffering from substance abuse or anorexia, was the fact that they were being treated by a different approach. This was a cognitively and psychodynamically informed hypnotherapy, which used a different language to describe the structure and function of the mind. Since a number of Dr. Kluft's patients were admitted to my inpatient unit before he started his Dissociative Disorders Unit (DDU), it was not only an extraordinary opportunity but also an administrative necessity to try to understand what was going on with their care. It was bewildering and overwhelming at first, since I did not understand the paradigm being used and could not readily apply my psychoanalytic model of the mind to this psychopathology.

My background in Holocaust research taught me to tolerate my own pain while listening openly to horrendous stories of unspeakable atrocities, and to become aware that human beings are indeed capable of inhumane sadistic behavior. With this "preparation," my exposure to a large number of suspected cases of Multiple Personality Disorder (MPD) in the inpatient setting enabled me to eventually see that one of the most enigmatic patients in my own practice back then was also a "multiple." Since I was not looking for it, since the patient was very secretive about it, and since my patient had not read about it, had no contact with such patients, nor had been treated by any "recovered memory" therapists, I had no choice but to become a "believer" in the legitimacy of the diagnosis. Afterward, I devoted considerable energy trying to understand it and had the opportunity to work on the DDU—until the hospital became a casualty of the cutbacks due to managed care. My experience grew exponentially and over the years, I have had clinical contact with hundreds of such patients, ranging from administrative management, consultation, supervision, and inpatient treatment to long-term, five-time-a-week analytic therapy.

Toward an Analytic Understanding of DID

The essence of my approach to DID is based on three assumptions:

1. that dissociation is multiply determined and may be utilized as a

defense against anxiety in the here-and-now through the reactivation of altered states associated with earlier trauma: It should be seen as

> a defensive altered state of consciousness due to autohypnosis, augmenting repression or splitting. It develops as a primitive, adaptive response of the ego to the overstimulation and pain of external trauma, which depending on its degree of integration, may result in a broad range of disturbances of alertness, awareness, memory, and identity. Dissociation apparently may change in its function and may be employed later on as a defense against the perceived internal danger of intolerable affects and instinctual strivings (3) p. 841;

2. that DID, contrary to the prevailing view, may be understood as being at the severe end of a continuum of character pathology, i.e. a "lower level dissociative character" (4,5) whose predominant defense is dissociation; and

3. that there is a pathognomonic psychic structure at the core of DID, whose function is to not only to disown intolerable memories, affects, and drives (6), but to personify these conflicts through the creation of so-called "alter personalities." This structure therefore transcends and fuels these "alter personalities" or to use Fairbairn's term, the personifications (7), and is referred to as the Dissociative, or the "It's Not Me!" self. It is an unconscious construct that essentially creates the alters, while tricking the patient into believing that they are not part of her/him, much the way "the man behind the curtain" wanted to be ignored while he created the illusion of the Wizard of Oz. It is elusive and evades engagement in the therapeutic alliance, as it is the core of the dissociative defensive armamentarium. This "dissociative self" needs to be dissolved in order for integration to occur, and has at its disposal several organizing influences which help in the creation and maintenance of the conviction of separateness (6). Freud's view that different identifications might take over consciousness at different times (8) is necessary but not sufficient to explain the unique and at times bizarre quality of the alters. The elucidation of these organizing influences therefore may further our understanding of this phenomenon.

The influences which have come to light so far through analytic exploration are: a) the fragmenting effects of internalized aggression on mental states; b) perverse sexuality, i.e. different personifications encapsulating different traumatic memories, aggression and anxiety by traversing various sexual developmental pathways, such as sadomasochistic heterosexuality, homosexuality; and transsexualism; c) intergenerational transmission of trauma, i.e. the abuser's own trauma history becoming incorporated into the biography of certain alters; d) near-death experiences in childhood, i.e., out-of-body, telepathic-like phenomena; and e) the ego functioning seen in

the dream state. It appears that the mind's capacity to anthropomorphize altered states of consciousness, such as in hypnogogic and hypnopompic states, also may occur during traumatic autohypnotic states. Recurrent dreams of such experiences may then help to reinforce and solidify a sense of separateness. The common origin to both dreams and alters may be seen in such patients who report dreams of witnessing unknown children endure the identical experiences that their "alters" report first hand in the awake dissociated states. A reciprocal amnesia is often present in that the patient, when reporting the dream, has no memory of the dissociated state, and while in the dissociated state has no memory of the reported dream (4-6). Because this particular manifestation of the dream ego is a relatively unfamiliar one, the similarities between the dream state and the altered state in DID may be recognized, but not fully appreciated.

Most analysts would agree that it would surely be a sign of progress if patients started to remember their dreams and report them in the treatment setting. It would be seen as even further progress if those patients associated to them and made connections to their past and to how their minds work. This attitude is based on a century (9) of study and observation of this "royal road" to the unconscious. Indeed, Freud's recognition of the importance of dreams led him to hope one day to unite the psychology of dreams with psychopathology. Is DID that "missing link"? (5)

But, imagine for a moment what it would be like for patients to report their dreams to a therapist who doubted the dreams' existence and who had no understanding of their role in the patients' own inner lives! In such a situation, the patients' expanding dream life might be misdiagnosed as a serious regression, of psychotic proportion.

To complicate matters further, suppose there are others who believe that dreams are a dangerous by-product of the therapeutic interaction. So, instead of just confusing dreams for psychotic discompensation, the additional error would be to blame the clinician for iatrogenically inducing dreams to develop! Could an analogy then be drawn to the misunderstandings and confusion about the dissociative disorders, especially DID? While it certainly may be that exploitation of patients may occasionally occur for perverse reasons or secondary gain by deviant therapists, there is not one documented case of iatrogenic DID to my knowledge.

Extreme anxiety about the reality of severe trauma or skepticism about the legitimacy of the condition predisposes one to embrace iatrogenic theories of causation and air-tight circular reasoning that may then result in premature closure on thinking any deeper about the subject. Indeed, it is a double irony that the now legendary case of Anna O., Josef Breuer's patient

who was treated by the "talking cure" which inspired psychoanalysis, was not only considered a case of "double personality," one of the many archaic terms for DID (10, 11), but has also been more recently decried as a massive case of fraud (12). It is for these reasons and more that I have found it imperative to explore in depth how the various personifications, the hallmark of this condition (13), are created and what function they serve in the psyche. In so doing, I have been able to develop a basis of understanding, which seems to have predictive value for what may emerge in the therapeutic situation. The nature of this clinical interaction, however, depends on the goals of treatment that may range from palliative, supportive care to vigorous intensive efforts to achieve a "cure." Crucial factors include not only the theoretical approach employed, but also the therapist's ability to tolerate, contain, and empathize with the patient's subjective internal experience and behavior. From a broader perspective, what may therefore be judged as decompensation or iatrogenic causation when, for example, new "alter personalities" emerge, may become more comprehensible with a better understanding of the psychic structure and the impact of therapeutic relationship, which provides the opportunity to articulate that which has not been symbolized or verbalized before (14).

A Historical Note

Although there are many excellent reviews describing the history of the condition (15-18), the contributions of Sandor Ferenczi, the Hungarian psychoanalytic pioneer, are generally minimized or overlooked. A disagreement over his emphasis on the magnitude of the problem of sexual abuse may have contributed to Ferenczi's break with Freud and the other members of the "inner circle" at the end of his career. Like a parent's attempt to squash the child's revelations of incest, Ferenczi had been discouraged from presenting his landmark "Confusion of Tongues" (19) paper to the International Psychoanalytic Congress in Wiesbaden in 1932 because it was seen as a heretical step backwards by reviving the seduction theory of neurosis. Freud dismissed it as "harmless and dumb," but the furor it stirred up enabled Ernest Jones, Ferenczi's long-time rival for Freud's affection, to block its publication in English until 1949 (20). It was not even available in his native Hungarian until 1971 (21)!

Ferenczi, who was dying of pernicious anemia, was discredited as being psychotic because of a deteriorating brain (21), but a modern rereading of this remarkable essay shows not only great clarity, but it "presaged a widened interest in the analyst's analyzing functions, unconscious communication, countertransference, and the interplay of reality and fantasy inside

and outside the analytic situation" (20, p. 871). Regarding his insights into sexual abuse, Ferenczi described the importance of 1. domination by the adult perpetrator, resulting in emotional surrender and robotlike obedience, i.e. becoming an automaton; 2. the correlation between defenses like dissociation to cope with severe early trauma and later characterological problems; 3. the child's renouncing his/her own reality testing in order to conform to the needs of the parent; 4. the presence of pervasive confusion as an overriding state resulting in the belief that the abuse is an act of love rather than exploitation for the adult's own sexual gratification; and 5. identification with the aggressor resulting in the shared pseudo-delusion that they are in a mutually tender and beneficial relationship (21).

Sounding rather contemporary in his attempt to reconcile Janet and Freud, Ferenczi observed,

> If the shocks increase in number during the development of the child, the number and the various kinds of splits in the personality increase too, and soon it becomes extremely difficult to maintain contact without confusion with all the fragments, each of which behaves as a separate personality yet does not know of even the existence of the others.... I hope even here to be able to find threads that can link up the various parts (19).

It may be that the suppression of Ferenczi's work was a factor in the "dark ages" before the renaissance of analytic interest in DID in the late 70's and early 80's (22-24). In other words, the "lost tribe" of these disturbed and disturbing patients, may be seen as returning to the fold, but they remain rather enigmatic.

Nearly seventy years later, despite all the advances in theory, technique, and pharmacology, DID remains the most controversial psychiatric entity and perhaps still one of the most challenging to treat. In the following case study I will describe some of these difficulties in the early phase of treatment of a catastrophically ill patient, who would be considered a low-functioning DID patient, according to Kluft's classification (25). I will focus on the therapeutic relationship and the emergence of her personifications. I will then discuss how my theoretical viewpoint helped in my approach to the patient. For the sake of confidentiality, the case is disguised as per Clifft's guidelines (26).

CASE STUDY

Initial History and Presentation

Andrea was referred to me following one of many hospitalizations intended to stave off her mental deterioration over the preceding five years. A married mother of two in her mid-thirties, she had had a legal career before

a medical condition requiring a series of operations precipitated a depression associated with suicidality and extensive memory loss. Prior to her regression, she avoided mental health professionals until just before the surgery, at which point her long-standing eating disorder, characterized by huge weight fluctuations, had gotten out of control. She consulted the Yellow Pages and went to the nearest counselor advertising treatment, thus beginning her odyssey through the mental health industry. This experience included not only psychologists, social workers, and psychiatrists of limited credentials, but also some of the most prestigious institutions in the nation. Andrea was convinced that her condition had deteriorated at an accelerated rate as soon as she began to explore her never-forgotten memories of childhood sexual abuse by an uncle and being gang-raped in college where she was all but left for dead.

The older daughter of three, born to an egocentric, troubled, and unavailable woman whose military husband was away for long periods of time, Andrea grew up feeling very much alone. Her uncle spent much time with her and not all of her sexual experiences with him were forced and painful, leaving her with profound guilt and confusion. A review of the records described intermittent agitated outbursts and periods of time curled up in closets sucking her thumb. In each situation, she seemed disoriented, and psychologically unreachable by staff. In the former state of mind, she appeared terrified and screamed "get away from me!" whereas in the latter state, she was either mute or cried like a little girl. Andrea had amnesia for these episodes and absolutely refused to talk about them in her usual state of mind where she was sullen, sad, secretive, and generally silent. Interestingly, not only was the diagnosis of multiple personality or DID not considered, but even the use of the term "dissociated states" was used only in the most tentative terms.

Coupled with her conviction that talking only made her worse and the growing spectre of the medico-legal backlash resulting in huge claims for allegedly implanting "false memories," Andrea had nothing more to say and no more faith in doctors. So to her, I had nothing new to offer except perhaps, continuity of care. I sensed her utter hopelessness over being deemed a treatment failure, and had my own doubts about what anyone could do for her. So, I proceeded slowly and with great caution in what appeared to be a "heroic" (4) therapeutic endeavor. Also, because she had made several serious suicide attempts prior to being under my care and did not feel she deserved to live, I made it clear to her and her family at the outset that whatever we were dealing with was a potentially lethal condition. I could make no promises that I could help her but would be willing to

work with her if we could agree on some basic ground rules: 1. making every effort to stay alive from one session to the next; 2. meeting 4-5 times per week outpatient or inpatient; 3. saying what comes to mind; and 4. deciding on a mutually acceptable fee. My instructions about the "fundamental rule" for such a patient include reporting whatever sensory input she became aware of, including what she felt in her body, what she saw, heard, smelled, or tasted.

The Therapy

Andrea worked hard to get me to give up on her, sabotaging treatment by not talking, being evasive, and at times, by frank lying. She insisted she was untreatable as her frailty due to starvation made her extremely sensitive to the hypotensive effects of virtually every class of psychoactive drug; besides, nothing really helped her except for benzodiazepines. Furthermore, she insisted that it was necessary to have the safety valve of being able to purge because any effort to stop it would only result in more serious self-destructive behavior. Cutting and burning herself with her ever-present cigarettes (smoking was her only acknowledged passion in life), left her already disfigured body even more scarred. She flatly stated that she was determined to make her body look as disgusting on the outside as she felt on the inside, and was equally determined to prove to me that there was no such thing as a "talking cure." In her fractured mind, she was a contaminated, disgusting whore, who, because she was unable to fight off her assailants, would have been better off left for dead. Her fantasy life was consumed by trying to plan the punishment that fit her "crimes"—ranging from burning and cutting to amputation of her limbs or any other body part that had failed to protect her or was involved in the sexual activity.

A typical session in the first months of treatment was characterized by anxious silences, absence of curiosity, evasiveness, and intentional deceptiveness. Her sense of morality generally did not permit her to lie outright, so if I asked, the "right" question, I would get an honest answer. Andrea would spontaneously drift into quiet reveries and at times, even when I redirected her with conversation, she would lapse into a state where her eyes would glaze over and she would become totally mute and unresponsive. These stuporous states would continue well beyond the session and when she appeared to be alert again, she would have no recollection of her altered state of consciousness. On one occaslon, I shared my observations with her, but she conveyed total disinterest ("la belle indifference") and did not want to talk about it. Regarding my effort at developing a therapeutic alliance, I felt as though I was groping for a foothold on a slippery mountain, because

what little rapport we could establish during her usual state of alertness completely evaporated during her absences. I observed but did not comment on certain subtle behavioral differences in her alert state, such as insisting on sitting on the floor and wearing a special hat on some days, while being almost garrulous and jocular, sitting in a chair, and wearing another distinctive article of the clothing on other days. Throughout this phase of treatment, I assured her that my interest in her day-to-day safety took precedence over hearing about whatever horrible experiences she may have had. I tried to focus on her here-and-now functioning, essentially offering to be an auxiliary ego. I also told her that it seemed that she had very little sense of continuity from one session to the next, utilizing my own countertransference feelings and subjectivity from day to day. In an unusual moment of candor, she reluctantly agreed.

Several months into treatment, there was an opening in her defensive armor at the end of the fifth session of the week, when she welled up with tears and admitted just how scared, confused, and out of control she felt. Given the fragmentation of her previous care, with a non-M.D. primary outpatient therapist, an outpatient psychiatrist, a family therapist, an inpatient primary therapist, and an inpatient psychiatrist, I wondered how the chaos in her mind might have been replicated externally by her cadre of professionals who did not talk to each other, and left her feeling that nobody was in charge. As if their internal worlds mirror their early relationships, such patients often report a family life of isolation, secrecy, indifference to suffering, and incongruous use of language that becomes a template for their alter personalities or personifications who "behave" similarly.

Fairbairn, a very important object relations theorist in the British Middle School, had an interest in "multiple personality" also, and he favored the term personification instead. He believed that fusion and layering of introjects helped explain this phenomenon (7). The renewed appreciation of Sullivan's interpersonal theory merits further mention here also. He, too, used the term "personification" although he did not specifically refer to DID. Nevertheless, it is relevant to note that his emphasis was on both the internalization of people and to their interpersonal relationships (27). Furthermore, he formulated the "not-me" as dissociated mental contents, which could also be applied to DID, although his original notion of the personification of the "not-me" was intended to explain paranoid states, i.e., "outside people." In DID, however, the patient employs a pseudo-externalized displacement, so that what is disowned or "not-me" is

attributed to her "inside people" instead. I attribute this function to the dissociative self (6).

I suspected that Andrea was either close to inflicting a major self-injury or was already secretly hurting herself again, but also on the verge to take me into her confidence. I told the patient that unlike her previous situation, as promised, I would be her doctor in the hospital or out. Though she seemed visibly relieved to be reminded of our arrangement, she dreaded rehospitalization and my concern for her safety prompted a discussion of involuntary admission. The prospect of my being induced into forcing her to do something against her will had the quality of a sadomasochistic enactment, which I tried to convey to her. While I doubted she really understood the significance of my interpretation, she did sign into the hospital voluntarily, where a medical work-up revealed significant electrolyte imbalance, hypoglycemia, weight loss, and numerous fresh burns on her emaciated chest and pelvic area.

While restabilizing medically, Andrea continued to manifest her altered states, and remained unreachable. She made an abortive attempt to express herself artistically with a collage depicting blood, violence, sin, and punishment, but abruptly stopped the activity and withdrew once again. At this point, however, she made an important disclosure—that she was not *being* allowed to continue! A feeling of being controlled by an inner power dominated her, dictated her actions, and did not allow her to talk about either the content of the collage or the force that was censoring her. As if being held hostage, I asked if she could at least write me a note about it. Reluctantly, Andrea scribbled a line saying that " the unknown one" would not let her tell me any more. Sensing that the patient disowned her mental content relating to will, action, and responsibility to an unknown inner force, literally known as "the unknown one," it was still unclear to what extent it was personified. Trying not to reify "the unknown one" anymore than Andrea had, I used only her words and tried to empathize with her subjective experience of it all. While I thought it a bit ironic to be concerned that a patient as obstinate, withholding, and negative as she might be unduly susceptible to suggestion, much of her rebelliousness may have been a characterological defense against her vulnerability to being hypnotically dominated. Janet described this paradox as follows: "Suggestibility with them should not in fact be considered a simple exaggeration of docility and normal belief. Such persons are often neither docile nor believing. They have an unsteady, undisciplined disposition; they themselves recognize that they do not succeed in believing" (25). What I did come to understand later was that while it was indeed almost impossible for

her to say "no" to her uncle, her harshly unforgiving inner world, i.e., her superego, remained remarkably refractory to outside ameliorating influences. At this point, however, the patient had little to no observing ego and no understanding whatsoever about how her mind worked. All she knew was that she was "bad," that she was like a marionette, and that she did not want to know anything else. I told her that in my experience it was necessary for me to learn how to communicate with her in all states of mind, even those which she had no knowledge, reminding her of the clinical observations that others had made about her over the years. I used the metaphor of building a bridge, which required solld foundations on each river bank. She looked bewildered, but I informed her that an attitude of openness was more important than specific knowledge on her part. Furthermore, I told her that it was important to recognize that however strange and frightening things felt inside her mind, that it all had meaning and was there for very important reasons. As a result, it was potentially understandable and needed to be respected, even if we could not decipher it yet. Essentially, I was speaking to her "dissociative self" or what DID therapists might call "the total human being." I was not talking just to Andrea, a construction perhaps related to Winnicott's false self (26) who might be referred to as "the host personality," the mediator to the outside world. Andrea was the social facade, as it were, who could not do her job if she were constantly overwhelmed with bad memories and the associated affects.

The patient's behind-the-scenes "dissociative self" tried to ward off anxiety by wanting to believe that whatever it was, maybe it didn't really happen; or if it did, it must have happened to somebody else. And indeed, this doubt and disowning were the predominant defenses expressed by Andrea, who tried to keep everything under control through the most stringently obsessive dietary restrictions. She would calculate the caloric content of every morsel of food, setting ever-lower daily goals of intake in order to discipline herself. When she failed, she would be overwhelmed by disgust and feel forced to purge, which then increased her self-loathing and required more punishment of herself. Her idiosyncratic inner world of restrictions, rewards, and punishments was tinged with deep religious convictions, and totally consumed her attention, as she desperately tried to buffer herself from any other influences through this near-delusional preoccupation. Unfortunately, "the unknown one" part of her who demanded to remain unknown was full of rage, had remembered what had happened, and was unable to keep it all completely encapsulated. Essentially, her unmetabolized and unarticulated traumas threatened her with

annihilation anxiety, and when this material broke through, Andrea hurt herself as a punishment and to toughen herself up in preparation for "the next time" something might happen.

The situation was complicated by confusion over the passage of time and the distinction between past and present, which was not amenable to any intervention at this time. So, Andrea's own strategy for coping was quite simple: "Don't talk, don't think, don't feel, and don't remember. Let what is 'unknown' remain unknown." I told her that from her perspective, this philosophy made perfect sense and had helped her over the years, as it was the mind's natural way of coping with overwhelming situations. Furthermore, I empathized with her strong belief that talking about it was completely counterintuitive to her. Unfortunately, the efforts to suppress what had already been coming forth over the last several years was not working anymore and it appeared that, like Humpty Dumpty, she perhaps was not able to put all the pieces back the way they had been. Consequently, the only way I knew how to potentially help was for her to go forward and learn new ways to deal with her anxieties. Once again, the patient looked bewildered and doubtful, but I continued as I sensed that conveying a feeling of hope was more crucial at this time than the actual content of my words.

The patient's impulse control stabilized enough for her to be discharged from the hospital, but she was not able to stay safe for much more than a month and was repeatedly hospitalized. This continued pattern raised the perennial question about her treatability, and her insurance company contemplated curtailing reimbursement for acute care, pushing for a transfer to a state facility; she stated she would kill herself if she were sent there. More than just a manipulative threat. Andrea's vulnerability to retraumatization was so great that being in such an environment with so many disturbed people would likely have felt like another gang-rape situation to her. But, I told the patient that there was only so much I could do, and by acknowledging my realistic limitations, I tried to convey that I could not miraculously save her if there was no cooperation from "the other river bank," as it were.

A Crisis

The situation continued relatively unchanged, with the patient's enormous resistances, self-mutilation, and fears of engagement persisting into the second year of treatment when a shocking incident in the office brought me face to face, as it were, with "the unknown one." As the session proceeded, Andrea revealed that once again her impulse control was waning and that

she felt "the unknown one" to be very nearby. I asked if there was anything I could do in order to help her stay safe and an instant later, she reached in her pocket, pulled out a razor, and with a crazed look, started screaming that she had to toughen up Andrea, as she made a series of deep incisions along her forearm. I was literally stunned, as I sat there momentarily frozen, staring at the dripping blood, and the exposed tendons which resembled dissection from medical school. The patient raged on triumphantly as I, feeling helpless and transfixed, watched her butcher herself. She refused to relinquish the blade which I feared might be used on me if I tried to wrestle it from her. When I regained a modicum of composure, which seemed like hours (although was probably less than a minute), I realized that "the unknown one's" dramatic and bloody introduction signaled a new phase of treatment and left no doubt in my mind about the diagnosis. At that point, I asked Andrea to come back immediately, but the blood-letting continued, so I asked if there was someone else inside who could come and help. This was the first time I tried to "access an alter" in this patient; within moments after my distress call, the patient's facial expression, body language, agitation and rage subsided, and "the other Andrea" emerged, quietly and innocently asking me what I wanted, and requesting that I whisper so as not to wake up Andrea! I explained that there was a major problem with the left arm and that I needed her assistance immediately. She looked at it in surprise, said she felt no pain, dutifully handing me the blade while I found some paper towels. Getting her permission to apply direct pressure to her incision, I slowed down the bleeding. While I was ministering to her wound and trying to think of the next step, "the other Andrea" told me that the Andrea I knew would have been too upset to come back, and so she had to come out to help instead. She could not tell me how such a decision was made but I agreed that as long as she could cooperatively handle the situation, it was fine with me. Arrangements were made for her to be taken to the nearest emergency room, after which time she was rehospitalized, where I got to know "the unknown one" a little better under safer conditions.

Over time, other distinctly defined personifications identified themselves, such as the little girl who sucked her thumb in the closet, and several other androgenous selves who were much more forthcoming and at times actually seemed to enjoy the sessions. It seemed evident that the "others" felt and expressed what Andrea could not, be it impotent rage and internalized aggression, a wish to be understood and cared about in the transference, or vivid, unchanging details of her repeated abuse by her uncle, as well as gang-rape she had suffered in college. In addition,

their diverse opinions expressed her intrapsychic conflict as a pseudo-externalized interpersonal conflict, as well as being different manifestations of her "mosaic" transference (6). For example, there was enormous conflict over the female anatomy, and "the unknown one" hated me for having a man's body. Convinced that it was a mistake of nature "he" wanted a sex change in order to make things right. This dissociated transsexualism (4), a major organizing influence in the development of her separate selves, emerged as a central conflict throughout the treatment. Furthermore, the patient was haunted by recurrent dreams of watching somebody get defiled, and these nightmares corresponded to the first-hand account that "the unknown one" had raged about in the sessions. In these situations, there was reciprocal amnesia, and Andrea would either wake up from the dream, or "come back" after "the unknown one" was out, gagging from a gustatory hallucination of having feces in her mouth.

The neutralization of her aggression, the softening of her savage superego, and the development of her observing ego were the next steps in the long-term treatment of this patient.

DISCUSSION AND CONCLUDING THOUGHTS

It was initially unclear just how personified the patient's dissociative pathology was, although it was evident that I was about to offer a "heroic" treatment for a catastrophic illness. Without the advantages of a suitable, local specialized inpatient program due to the revolution in health care, I realized it would put a greater burden on our outpatient work. Short-term crisis management in an acute care facility and residential care were used instead. From a DSM-IV perspective, her symptoms at this point were most consistent with Dissociative Disorder, N.O.S., which would roughly correspond to an intermediate-level dissociative character along my continuum. The level of integration of her self and object representations was questionable, but in the absence of clearly delineated "alter personalities" who were ignorant of or disowned "the others," I was reluctant to jump to diagnostic conclusions. Because I conceptualize DID on a continuum of character pathology that employs dissociation as its predominant defensive operation, I did not feel urgency to make a diagnosis, since my overall approach would not have changed substantially. My main concern was her safety and day-to-day functioning. Therefore, I did not want to reify her tendency to disown her mental contents, and consequently I was careful not to suggest the presence of any "inside people," I preferred that "whoever" was there would emerge naturally in the course of therapy. At the time, my focus simply was to maintain contact with her in her different states. However,

the dramatic and shocking emergence of "the unknown one" left little doubt about a full-blown DID. It is possible that other therapists may have acted earlier on my ever-growing index of suspicion by trying to access "alters" sooner, but I chose not to for the reasons mentioned above until the crisis, when she slashed her arm. My reaction to that act went beyond my being surprised (30), an affect well described in analytic literature associated with an unexpected discovery, because I was not surprised by her diagnosis.

However, I was a bit traumatized, as I developed a transient PTSD, with recurrent, intrusive images and anxiety. I thus found myself wanting to set up a whole new system of rules and regulations governing our relationship so *I would be more prepared next time*. At this point, I realized that Andrea, through projective identification, had given me a miniature first-hand experience of what it must be like to be her (31). Traumatized since early childhood and living in fear of the next unexpected assault, she developed an elaborate inner world where she was in total control. Her extensive system of rules and regulations about her eating dovetailed with the emotional shock absorbers of her autohypnotic, dissociative states (14), in her effort to be "prepared for the next time" by freeing her mind from her body. Her goal was to literally starve herself into oblivion, to make her female body disappear, and become impervious to future attacks. In the meantime, she would "leave" her body and psychologically anesthetize herself from pain, which furthered the illusion of separate selves sharing the body. I felt it was crucial to disclose to her, as empathically as possible, that her behavior had an impact upon me, and to verbalize my own traumatic symptoms. In so doing, we started a dialogue about the psychological effects of overwhelming life experiences, which could result in defensive altered states. In this way, the therapeutic relationship became essential to helping her find a voice for her unspoken terror as she, for the first time, found someone to listen and participate in an interactional forum to reflect upon "the stuff" of her nightmares. To an outsider, since this conversation often occurred while she was in her altered states, it could be described as my talking to her "alter personalities." Given her mutism in her usual state of mind, it was a necessary step in treatment, indeed an advance, not a fragmenting regression. The shift between processing what her alters were communicating versus a more traditional mode of analytically oriented therapy required a certain flexibility of technique (32) and attunement to the various manifestations of her "dissociative self."

Over time, it became clearer that she would "switch" spontaneously as a result of anxiety in the sessions. This observation supported my contention

that dissociation could change in its function from a response to external trauma to a defensive operation in response to anxiety from intrapsychic conflict. With this paradigm in mind, I was then able to appreciate the dual nature of dissociation, so that when anxiety from the here-and-now mobilized her dissociative defenses, we could address either her intolerance of benign relationships or begin to reconstruct her past from the material "known" by her alters. Her need to disown the atrocities in her life was the domain of her "dissociative self," which through the maintenance of her system of alters convinced herself that if indeed anything really did happen, it must have happened to someone else, "the unknown one." Premature challenges to this defensive armor would have been overwhelming, as she was nowhere near ready at this point to consider that it was "all her." As a result, her "dissociative self" could not be confronted without first neutralizing her aggression and ameliorating her profound guilt. Complicated by her severe eating disorder, there was a need for a larger holding environment during major regressions in order for this long-term treatment to be carried out. In so doing, this external structure enabled an analytically informed therapeutic alliance to develop where the patient's profound psychopathology could emerge with a minimum of artifact and a maximum of opportunity for contact with those heretofore inaccessible reaches of her shattered psyche.

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