40 A Clinician's Understanding of Dissociation: Fragments of an Acquaintance

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Mariska Kurtz (a pseudonym chosen by the patient) was an advanced postdoctoral fellow at a prestigious university in another major city along the Boston-Washington corridor when she called to request evaluation and consultation. Thirty-six years of age, divorced, fluent in several languages, and already well-published in her demanding scientific discipline, she told me that she would only see someone a good distance from where she worked and studied due to concerns about confidentiality. Initially she had seen a prestigious psychologist and a highly regarded psychopharmacologist at her own university, but she had misgivings about the correctness of their diagnoses and treatment recommendations. We scheduled double-length consultation sessions on two successive days some weeks in the future.

Mariska's evaluation and the early course of her treatment will be our texts for an exploration of dissociative symptoms and functioning from both her perspective and my own. Although I will convey some background material to orient the reader, for the most part I will try to demonstrate, with clinical vignettes, my own interventions and thinking, and Mariska's own words (from verbatim notes and journal entries) what it is like to have, to observe, and to intervene with dissociative processes and structures.

Mariska proved to be a striking dark-haired woman, tall, athletic, ready to smile, confident, and with a strong, firm handshake. She made good eye contact, and surveyed both me and my office with evident interest and curiosity. She spoke with a minimal accent I could not place. Once she had settled down on my couch, she continued much the same, but from time to time she appeared to feel brief waves of fright, and took furtive glances both at the door and toward the lower half of my body.

I asked Mariska to review what she hoped we could accomplish in our meetings together. She told me that she had sought treatment a few months previously for depression, panic attacks, increased anxiety, disrupted sleep, and nightmares about sexual violence directed at her or some unknown female. Anticipating my question, she told me that she had never experienced any mistreatment of this sort. Her psychologist had given her the diagnoses of major depression and generalized anxiety disorder. When she did not respond to initial interventions for depression and anxiety by the psychopharmacologist, she was rediagnosed as having bipolar II disorder, ruled out borderline personality disorder, and placed on mood stabilizers. When she complained as well of migraine headaches, difficulty concentrating, a sense that some things seemed unreal to her, and occasional lapses of memory, she was sent to a neurologist who ordered additional studies and started her on an anticonvulsant for suspected partial complex seizures.

She didn't feel helped, and ruminated on what impact her condition might have on her scientific career and personal life. With frightening efficiency she had reviewed the facts in her case and searched the medical literature and the Internet. She concluded that she was not sure she had what she was said to have, but, to her irritation and dismay, was becoming increasingly concerned that she might have a condition she was sure she could not have—a dissociative disorder. Her research had made her aware of my work. She laughed as she told me, "You are miles and miles away from my life." Inwardly, I translated, "Dissociated from my real world."

Mariska offered a complicated but essentially benign account of her past. Her parents were very affluent, from successful European manufacturing and banking families, and more played than worked at their occupations. They were more invested in their frenetic social lives and avocations. She and her younger sister were raised as much by a series of *au pair* girls and nannies as by their own parents, but she always felt loved by her mother and father. In her late teens and early twenties she became caught up with what she called "jet-set trash." She said,

"And I probably was as bad as the rest of them for a while; partying, and too much wine, drugs, and sex." Although her university grades were always excellent, she frequently discontinued her coursework or transferred universities to pursue various diversions or relationships until she decided she wanted to do something with her life.

Once she became determined, she focused on cutting-edge hard science, completed her degree, and won her doctorate rapidly. She had married a fellow graduate student, a German, only to find that he was more interested in her affluence than in creating a loving marriage. They divorced after 3 years, about the same time that she completed her doctorate. Much of the most creative research in her area was being done in the United States. Wanting a fresh start, she decided to take a research position in the United States.

She had made a wonderful initial adjustment, only to find herself becoming symptomatic, upset, and in need of help. When I tried to explore what was happening in her life immediately before and during the onset of her symptoms, she said she had no idea. As she did so, she looked downward, smiled, and shook her head. I remarked that it seemed that something had occurred to her, but she assured me that her mind was blank, and appeared puzzled by my line of inquiry.

Up to this point Mariska had pretty much directed the interview, presenting her story and concerns in a controlled and rational manner. I had already seen more than enough to suspect the possibility of a dissociative disorder, and now I felt ready to become more active in my inquiries. Although I conducted a full psychiatric evaluation, I will only discuss findings relevant to dissociation.

Dissociative identity disorder (DID) and allied forms of dissociative disorder not otherwise specified (DDNOS) are psychopathologies of hiddenness (Gutheil, quoted in Kluft, 1985). DID patients average 6.8 years in the mental health care delivery system before receiving an accurate diagnosis (Putnam et al., 1986). My own studies on the natural history of DID indicate only 20% of DID patients have an overt DID adaptation on a chronic basis, and 14% of them deliberately disguise their manifestations of DID. Only 6% make their DID obvious on an ongoing basis. Eighty percent have windows of diagnosability when stressed or when triggered by some significant event, interaction, situation, or date. Therefore, 94% of DID patients show only mild or suggestive evidence of their conditions most of the time. Yet DID patients often will acknowledge that their personality systems are actively switching and/or far more active than it would appear on the surface (Loewenstein et al., 1987).

What we usually see is the "dissociative surface" (Kluft, 2005), which takes effort to appreciate and decode. Alters need not assume executive control to influence the course of events. The dissociative surface reflects covert efforts of alters "behind the scenes" to influence behaviors, attitudes, feelings, and perceptions, or demonstrate the unintended leakage of other alters' feelings, issues, or intentions into others. Such intrusions are often subjectively experienced by the alter apparently in control as "made" passive-influence phenomena, like many Schneiderian first-rank symptoms of schizophrenia (Kluft, 1987; Ross & Joshi, 1992). Potential contributions/contributors to what is seen at the dissociative surface are listed in Table 40.1, and characteristic observations creating an index of suspicion for the activities in Table 40.1 are found in Table 40.2.

What had I noticed as I listened to Mariska? There were no admissions of severe memory problems, no unexplained out-of-character behaviors or possessions, and no history of overwhelming childhood events. Yet this brilliant woman, who had listed only minor derealization and some forgetfulness as possible indices of

TABLE 40.1
The Dissociative Surface

The host, or, the "usual patient"
The semblance of the host or "usual patient"
1. Passing for the host
2. Isomorphism
3. Tag-teaming

Copresence combinations
1. Mixed presentations
   a. Cooperations
   b. Clashes
   c. Vectors
   d. Temporary blendings
2. Fluctuating presentations
3. One-plus presentations
4. Shifting one-plus presentations

Instructed behavior

Intrusions
1. Simple
2. "Up the food chain"
3. From the "third reality"

Imposed or "made" behavior
1. Simple
2. "Up the food chain"

Switching, rapid switching, and shifting

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TABLE 40.2
Typical Manifestations of Dissociative Surface Processes at Work

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

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dissociation, had come to me because she suspected she might have a dissociative disorder. Two mutually incongruous realities were at play, with no apparent awareness of their incompatibilities. In the first, she had some mild to moderate symptoms and a benign background. In the second, she acknowledged sufficient distress to research her situation, suspected she had a dissociative disorder, sought out a specialist in dissociation and trauma, and made a number of nonverbal communications to indicate fright and apprehension of harm. I assumed that Mariska, as she gave her initial history, was in a state of mind reluctant to share, and/or may even have dissociated awareness of most of the symptoms that had prompted her concerns. That notwithstanding, here is a list of the phenomena to which I was reacting:

1. Strong suggestions of endorsing alternative realities, as noted previously. She has come for an evaluation for a condition she has researched and states she knows she could not have. A scientist of her caliber can be expected to have done an adequate literature search. It suggests that she both knows and cannot allow herself to know about a wider range of dissociative phenomena that she has both experienced and found in the literature; and that the knowledge may be in one or more alters able to handle the knowledge, while it is possible that the apparently well-functioning alter in apparent executive control thus far is unable and/or unwilling and/or not allowed to retain it. The hints of two alternate realities may also reflect trance logic, the tolerance and endorsement of mutually incongruous percepts by a highly hypnotizable subject. At this point I do not know about Mariska's hypnotizability, but I do know that patients with DID are highly hypnotizable (Frischholz et al., 1992), and that indicators of high hypnotizability constitute one of the six symptom-cluster areas in Loewenstein's (1991) special mental status examination for chronic complex dissociative disorders such as DID.
2. Brief waves of fright, with glances toward the door or toward the lower half of my body. These suggest the possible impact of apprehensive personalities' concerns that they are in a dangerous place with a potentially dangerous person whom they are checking for indices of sexual arousal.
3. She appears to be unaware that she, by smiling, looking down, and shaking her head and then denying there were any thoughts in her awareness about the onset of her symptoms, is demonstrating a possible brief amnestic moment and/or an intrusion or transient switch, a prevarication, or a deliberate withholding, or is indicating she is at least somewhat ashamed of something and planning not to speak of it (Kluft, 2006b; Nathanson, 1992).
4. She has a constellation of symptoms that are not uncommon in the aftermath of trauma, yet no trauma history has been given. Often trauma returns to awareness in a piecemeal fashion, with the recovery of narrative memory as a relatively late event.
5. She has not responded to medications appropriate to the conditions she was thought to have. This suggests that she may have a different condition. This is one of the classic suggestive diagnostic cues to DID (Kluft, 1987, 1991, 2005).
6. I take note of Mariska's major lifestyle changes and many relocations. At this point they may

be related to completely different factors. Such transitions are not infrequent in DID, and will be kept in mind.

No one of these findings is pathognomonic for DID, and numerous alternative explanations are possible for every one. Taken together, however, they offer food for thought and possible entryways into considering a dissociative disorder. I chose to return to point 3 to begin my inquiry.

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

Mariska: OK.

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

Mariska: Do I really have to say everything?

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

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

Dr. K: It sure is.

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

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

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

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

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

Dr. K: The dreams?

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

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

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

In fact, this was an inaccurate memory, but I did not appreciate that it was erroneous until the treatment was in its follow-up stage. Part of the backstory for Hargitay's character is that she was conceived when her mother was raped, not that she was raped herself. I now think that my patient's attraction to the name "Mariska" refers to her seeing her dissociated selves as the product of rapes.

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

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

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

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

To clarify the reader's concern about the connection of a pseudonym to an actual person, there were a series of serendipitous events that caused the actual patient under discussion to identify with the actress Mariska Hargitay and to request that she be called "Mariska" when her material was used in publications. Hence, the identification is true to the dynamics of the case, but the way Mariska came to this identification has been altered in the interests of confidentiality.

In introducing Mariska to the power of shame to both mimic and reinforce dissociation (Kluft, 2006b; Nathanson, 1992), and to be a major determinant of withholding important information, I had offered Mariska a way to understand her conscious wish to withhold material that caused her discomfort and to take a new perspective on what was withheld from her own awareness as well. She "took the ball and ran with it"; that is, she began to appreciate the importance of sharing what she had planned to hold back. Furthermore, my observations appeared to have stirred the interest of other aspects of Mariska, one of which may have intruded to make a remark of its own ("and learn"). It no longer seemed to me or to Mariska that her symptoms had developed without any appreciable antecedent. Before the session had ended, Mariska was beginning to question whether her symptoms had been triggered by exposure to events on "Law and Order SVU" that bore some resemblance to events out of her awareness. Her initially benign view of her past was being augmented by a glimpse of darker possibilities.

I chose not to react to the apparent brief intrusion or switch ("and learn") for fear of overwhelming Mariska by prematurely confronting her about having alters, and out of concern that my being that intrusive that quickly might telegraph the message, "act out having alters—that's what he's really interested in." I did not want to risk destabilizing Mariska or confusing the situation, and did want to help her attain the goals of her visits to me. Therefore, I spent some time exploring areas remote from dissociation before I returned to begin some of the more structured and dissociation-focused aspects of her evaluation.

When I returned to the assessment of possible dissociative phenomena, I asked Mariska about the experiences of autohypnosis and spontaneous trance in Loewenstein's (1991) special mental status examination for dissociative disorder patients. Among other positive findings, I learned that she easily became absorbed in a good book, a movie, or music to the point that she either failed to respond to someone calling her name, or was actually startled when her focus of attention was disrupted. DID patients are characterized as a group by high hypnotizability (Frischholz et al., 1992). Bliss (1986) believed that DID was created and maintained by the involuntary abuse of autohypnosis.

There are many good reasons not to move directly to a standard test of hypnotizability. Under some circumstances and in some jurisdictions if a person has been hypnotized they are considered tainted, or even disqualified as witnesses to their own life experiences (ASCH Committee on Hypnosis and Memory, 1995; Brown, Scheflin, & Hammond, 1998). This is because hypnosis is held to have the potential to yield inaccurate information, and because it is thought that what emerges from work with hypnosis may be "concretized"; that is, believed in with such tenacity as to make cross-examination, a crucial aspect of the American legal system, unworkable (ASCH Committee on Hypnosis and Memory, 1995; Brown et al., 1998). I had no idea whether these concerns would prove relevant, so I did not do a formal test that would involve induction into trance.

However, it is feasible to test a phenomenon that co-occurs with high hypnotizability without inducing hypnosis. The eye roll sign, part of the Hypnotic Induction Profile (Spiegel & Spiegel, most recent edition 2004), co-occurs with high hypnotizability and can be tested without inducing hypnosis. The eye roll is scored from 0 to 4 based on how much of the iris, the colored part of the eye, is visible when a patient, having looked up as if looking through the top of his or her head, is asked to let his or her eyelids flutter down and close. For a score of 0, the iris is completely visible; for a score of 4, only sclera, the white part of the eye, is visible. If half the iris is visible, and half obscured, the score is 2, etc. If a person under evaluation for these types of dissociative disorder does not have indicators of high hypnotizability, it is probable that the condition is malingered (Kluft, 1987b).

Mariska scored the maximum 4, and remarked that doing the eye roll made her feel weird. Friends had noticed her rolling her eyes, usually when she was becoming upset. "That test—It gives me shivers. Shivers I have felt many times."

Dr. K: Can you say some more about the shivers?
Mariska: No. Just shivers.
Dr. K: Under what circumstances do you get the shivers?
Mariska: Stress.
Dr. K: Stress?
Mariska: I know I am being vague. I don't know. [*sighs, then in a flatter voice*] When sh- … when I feel disliked, scared, rejected. And …

Dr. K: It sounds like it costs you a lot of effort to answer, and that you might be reluctant to share part of the answer.

Mariska: I don't want to say this. Freud again?

Dr. K: Yeah. Talking about this stuff can be an exercise in titrated mortification.

Mariska: Well, I can answer if I tell myself I'll never have to see you again. [*silence, then a deep sigh*] Sex.

Dr. K: Is sex connected with feeling disliked, scared, or rejected?

Mariska: I don't think so, but it's funny.

Dr. K: Funny?

Mariska: Well, I like sex. I'm uninhibited. But … I guess I get a little scared before I get into it, and when I get into it, I am so into it I never even remember it afterwards. So [*blushes*] what I said first is what men tell me.

Dr. K: Again, so difficult to talk about. Feel free to disregard my next question. Is there anything else your lovers have said that you found funny, interesting, or surprising?

Mariska: [*laughing, making bold eye contact, and tossing her hair*] I definitely will never come back here again. They say I tell them to call me Helga.

Dr. K: Helga?

Mariska: What?

Dr. K: You had just mentioned the name, Helga.

Mariska: [*confused*] Helga? In Berlin I had a nanny named Helga. [*fearful*] Was I talking about her?

In discussing Mariska's reaction to the eye roll we unexpectedly found several intriguing phenomena: (1) doing the eye roll unsettles her; (2) the eye roll, which can be used as part of an hypnotic induction (Spiegel & Spiegel, current edition, 2004), creates sensations she associated with psychosocial stress; (3) Mariska starts by claiming to like sex, reveals she is fearful as sex nears or begins, and then states she is amnestic for uninhibited sexual encounters; (4) Mariska lapses into talking about herself in the third person, a suggestive sign of DID (Kluft, 2005), but rapidly corrects herself, suggesting that a covert switch may have occurred to an alter who experiences Mariska as object rather than as subject, and that alter is trying to conceal its emergence; (5) there are suggestions that a number of alters are listening in and reacting, including an alter whose voice and demeanor is more saucy than subdued, perhaps the mysterious Helga; (6) we may have witnessed what is called a microamnestic event (Kluft, 1985), in which Mariska does not know what has just transpired, and is upset; (7) we put aside for future reference, making sure we do not use it in a manner that suggests a line of thought for the patient, that while in Berlin, in the care of Helga, she may have witnessed and/or experienced events that bear on her pattern of response to sexual matters.

After this conversation, I diverted Mariska from topics I thought might escalate her anxiety. Then I asked Mariska to fill out a Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986). The DES is the instrument that is most widely utilized to screen patients for dissociative difficulties. It is not a diagnostic test, but is useful for identifying which patients should be considered likely to have a dissociative disorder. It consists of 28 questions, and is self-administered. The person taking the test is asked to make a vertical slash along a 100 mm horizontal line to indicate "the percentage of the time" that each experience applies to that individual. In other words, each mm is interpreted as 1% of the time. Although the DES is vulnerable to both malingering and dissimulation, it is nonetheless useful for making an initial inquiry about an individual's experiences of dissociative phenomena. The DES is scored by averaging all 28 items. It is typical for persons with dissociative identity disorder and allied forms of dissociative disorder not otherwise specified to endorse all items to some extent, and to have average scores of 30 or more across all items. In clinical practice, the score of 20 is often used to trigger further evaluation for a dissociative disorder.

I do not use the currently more popular DES-II because its form (circling numbers indicating 0%, 10%, in deciles up to 100% for an 11-point Likert scale) makes it hard for patients to admit a phenomenon is present without committing themselves to 10% at a minimum. There are also other considerations, noted in passing in a following discussion.

I was shocked to find that Mariska had a score of 15, which normally would not trigger further assessment for a dissociative disorder. Then I scrutinized the test more carefully, and noticed that every single question that would trigger suspicion of DID was rated as zero, or even had a slash mark to the left of zero. Furthermore, all eight questions that constitute the taxon for pathological dissociation (Waller, Putnam, & Carlson, 1996) were "zero or less."

Finally, I appreciated what was transpiring. Looking up from the DES sheets, I saw that Mariska was scrutinizing my face intently. We were involved in an intellectual chess match. I could expect Mariska to have done her research. She told me she did not want to have a

dissociative disorder. On the DES she had disavowed the very sort of behavior she had just shown me.

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

Mariska was more than my intellectual equal. I could assume she had digested several articles on the DES and some of my articles on diagnosis, and would be prepared to rebut any observations I might make to the effect that she might have a dissociative disorder.

Mariska: You sure studied those papers a long time. What do they tell you about me and my problems?

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

Mariska: That's good then?

Dr. K: I'm not sure. Let's come back to it when we complete the evaluation and can understand it in the context of everything else we find. (This was wishful thinking on my part.)

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

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

Mariska: Invalid? What do you mean?

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

Mariska: So?

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

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

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

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

In the conversation that followed, I was able to convince Mariska that she should allow a full and candid exploration of her situation with a Structured Clinical Interview for the *Diagnosis of DSM-IV Dissociative Disorders – Revised* (SCID-D-R) (Steinberg, 1994). Then she could make a more reasonable decision about whether to address her problems or leave them untreated.

The SCID-D-R is considered 90% to 95% sensitive to populations of patients with dissociative disorders, and recent research allows for its use in the identification of malingerers. False positives are rare. The SCID-D-R obtains some background information and studies five core dissociative features: amnesia, depersonalization, derealization, identity confusion, and identity alteration, each of which is scored from 1 to 4, from absent to strongly present. The possible score range is thus 5 to 20. Five would indicate no dissociative phenomena whatsoever; 8 or less is characteristic of normal populations; 12 to 13 is found in mixed groups of psychiatric patients; 16 and above are characteristic of a severe and chronic or recurrent dissociative disorder; 20 would indicate maximal scores in all five core features. The SCID-D-R also elicits phenomena associated with DID and allied forms of DDNOS. Furthermore, the format of the SCID-D-R forces the closer observation of two of nine areas of inquiry in greater depth. The interviewer selects those two areas based on which of nine particular areas of inquiry have elicited answers that are most suggestive of the presence of alter personalities. The SCID-D-R also allows for the description of the clinician's observations of dissociative phenomena, and the tentative diagnosis of a dissociative disorder.

Mariska received maximal scores in all five symptom areas, for a total score of 20, acknowledged experiencing most of the associated symptoms. She also manifested several signs of dissociative processes. Typical examples

of her responses were: (1) for amnesia, she had lost blocks of time since childhood, and could not remember most of her eighth and ninth years of life, and she had been told of angry outbursts she did not recall; (2) for depersonalization, she often saw herself going through life as if she were watching a movie of herself; (3) for derealization, she often was unsure if certain people and places were real; (4) for identity confusion, she had often been conflicted as to who she really was; (5) for identity alteration, she revealed that often, in private, she found herself acting as if she were a child. Under associated features, she often was aware of inner dialogues, and sometimes found herself enacting these dialogues out loud or having written both sides of a dialogue in her journal, in different handwritings. These dialogues sometimes involved her interacting with another aspect of herself, but usually involved her overhearing conversations between or among alters. Rarely, she overheard two conversations at once. What impressed her most during the SCID-D-R was that the answers to many questions came to her from voices within her head, and that these answers indicated that her dissociative symptoms were frequent and long-standing. She was both terrified and amused by answers, which indicated that being addressed by other names had been a recurrent feature of her life, but that all such incidents other than the "Helga" episodes were completely strange and unfamiliar to her. When I compiled all the names mentioned in either the SCID-D-R or the psychiatric interview, there were nine clearly-named and one unnamed but well-characterized potential alter in addition to Mariska.

The SCID-D-R diagnosis of DID was clear. I had not needed the SCID-D-R to make the diagnosis, but making the diagnosis with a reliable and valid instrument has many clinical, scientific, and self-protective virtues. In a litigious era during which the DID diagnosis has been challenged retroactively in lawsuits, along with accusations of iatrogenesis, there is much to be said for using a state-of-the-art instrument that is widely used and widely cited in the literature.

As a clinician, however, the wealth of information about the patient's subjective experience of his or her dissociation acquired during the administration of the SCID-D-R facilitates my understanding and my capacity to empathize with the patient in those crucial early sessions during which establishing a therapeutic alliance is a paramount goal. I have been impressed over and over again that the SCID-D-R interview pulls forth information that otherwise might not emerge until much later in the treatment.

Mariska and I discussed the SCID-D-R findings in depth. She acknowledged that, because she was forthright in answering its questions, she had to accept its conclusions, however reluctantly. We reviewed issues of diagnosis and treatment. Mariska both accepted and denied the diagnosis of DID. With perfect trance logic (characteristic of the highly hypnotizable), she entertained both alternatives despite their incompatibility. Such stances are far from unusual in treating DID patients, and may persist for an extended period of time, and even be renewed after a successful integration. We reviewed the treatment resources available to her in the city where she lived. Despite the presence of several exceptional DID therapists in her locale, she requested that I take her into treatment, and made no objection to the lengthy commute.

Mariska said she preferred to see me because of confidentiality concerns. She did not want to risk encountering her therapist outside of the office, or take the chance of being seen by those she knew entering the office of someone known to have special interest in trauma or dissociative disorders. She liked the fact that my office was one of the few medical offices in my building. I thought that while this might be true, we had both felt comfortable with one another and responded well to one another's sense of humor. She knew from her reading that I had reported the successful treatment of a large series of DID patients (Kluft, 1984, 1986, 1993a) and, scientist to the core, she would follow the evidence in the literature. Years later, I would learn that she had posed as a psychologist needing to find a therapist for a patient relocating to the Philadelphia area, and had read some of my forensic testimony on cases involving therapists' sexual exploitation via Internet searches.

Mariska and I discussed the treatment ahead. We agreed to meet for a double session once weekly, aware that we might have to change that arrangement, depending on what emerged in treatment. The first therapy session was scheduled 2 weeks in the future.

This evaluation of Mariska allows us to step back and list some of the phenomena that fall under the rubric of dissociation in Table 40.3. Some items on this list were appreciated only later in the course of treatment; those already apparent are asterisked. Many items are overlapping and redundant; some that appear under different headings reflect different approaches to conceptualizing and grouping dissociative phenomena. Most of them will be discussed in other chapters of this book. At this point we need note only that the phenomena alluded to in the *DSM-IV-TR* (2000) diagnostic criteria embrace only a small fraction of the manifestations of dissociation in DID (Dell, 2006; Kluft, 1985; Loewenstein, 1991), and attention to the wider range of these manifestations facilitates the more efficacious diagnosis and treatment of this disorder.

TABLE 40.3
Categories of Dissociative Phenomena Noted in Mariska

1. Alters, also known as personalities, identities, personality states, etc.*
2. Identity confusion*
3. Amnesia*
4. Compartmentalization/modularity phenomena
   a) Alters, as above*
   b) Segregation of some subsets of information from other subsets of information in a relatively rule-bound manner (Spiegel, 1986)
   c) BASK (Braun, 1988) dimensions (ablative expressions)
5. Detachment (as in depersonalization and derealization in the perception of self and/or others* and also in concerns over whether memories are real or unreal; also seen in alters' lacking senses of ownership or responsibility for the actions of other alters)
6. Absorption*
7. Altered states of consciousness (e.g., hypnotic/autohypnotic/spontaneous trance phenomena*)
8. Failures of compartmentalization* such as intrusion phenomena, including both alters, memories, and BASK (Braun, 1988) dimensions (intrusive expressions)
9. Simultaneous operation of separate self-aware processes or states of mind,* including parallel distributed processing, elsewhere thought known phenomena (Kluft, 1995), unconscious thought (Dijksterhuis et al., 2006), inner world activities, and creativity by alters not in apparent executive control
10. Simultaneous executive activity by separate self-aware processes or states of mind (copresence phenomena [Kluft, 1984])
11. Inner world and third reality phenomena (events within that inner world that are accorded historical reality) which sometimes intrude into ongoing experiences, and/or impact ongoing experiences from behind the scenes (Kluft, 1998)
12. Switching* and shifting*
13. Multiple reality disorder (Kluft, 1991), for which dissociative identity disorder, formerly called multiple personality disorder, is the delivery and maintenance system*

*Indicates phenomena already noted and observed during the evaluation period, before the psychotherapy actually got under way.

Mariska's journal entry the evening after our consultation meetings offered her own perspective. Several handwritings were evident. Some excerpts are:

> Before I began to write tonight I looked over the last several pages. I thought that I was writing my own journal, but for the first time I see I was not alone. Why couldn't I see all those other entries? Why can I see them now? Who made them? What does it all mean?
>
> I am amazed that I agreed to see that man! I'm not sure this is a good idea. I'm not sure I like him. What did I do? I didn't! I watched myself explain why I needed to see someone far away from my university, far away from where I live. What does that mean? Did some other part of me drag me into therapy, afraid that, left to myself, I'd just push the consultation out of my mind and limp along?
>
> You all will have to speak English, or let someone else tell your story for you. I know that this is offensive to me, and to many of you. He is intelligent, but he is a typical American. When I spoke to him in French he answered quickly, but with an accent that hurts my ears. He cannot communicate as a cultured European would. If you can forgive him this, you will find that he can speak to us about emotions, about feelings—the languages which all of us have failed to master.
>
> Every time he spoke I wanted to check my buttons, to cover myself because I felt completely naked. When he explained what he thought, I felt penetrated, painfully penetrated. Yes, he knows a lot, and that's supposed to be good, but I don't like it. Knowing that much gives him power. I don't want anyone to know me that well, to have that much power over me.
>
> I only wanted the best for you. I never hurt you. Those were just dreams. Bad dreams. Don't let him convince you that I did something to you that I did not.
>
> You never listen to us. You hear our screams and you try to block us out. If you won't let us talk to him, we'll scream louder.
>
> You are not to tell him about the forbidden things. Any transgressions will be punished severely.

Mariska's journal testifies to the complexity of her moment-to-moment experience of dissociation, and demonstrates many of the phenomena I listed. However, appreciating these phenomena in terms of the confusion, helplessness, terror, and conflict that they cause Mariska

helps us to understand how difficult and potentially painful it is for the dissociative patient to commit herself to treatment. Mariska did experience a degree of relief and optimism because she felt I understood her and might be able to help her. But she was too sophisticated and knowledgeable to push aside her apprehensions for long. She leapt ahead to the consequences of being understood, and did not relish confronting painful material, accepting and addressing the existence and activities of alters who might prove very different from herself, grieving her previous more benevolent view of her past and of important people in her life, inner conflicts among the alters, and dealing with a man whose ability to understand her might be used to control and exploit her.

Mariska decided, with much misgiving, to share her journal entries with me. I was glad that she did so. I did not understand this gesture as an expression of trust or motivation, although I appreciated that those dimensions might play a role. Instead, I felt that at times her journal was written in a way that allowed her to probe and anticipate my reactions to feelings and experiences that she needed to talk about, but was apprehensive about addressing directly. She put subjects forward, and then waited, scrutinizing my reactions and remarks, to see if she could take the risk of discussing certain concerns, or whether it was too dangerous to do so.

As we began, I welcomed the full discussion and exploration of every topic, every misgiving, and every apprehension. Early work in building the therapeutic alliance with a DID patient involves, among many other things, a socialization to what the treatment will be like, and attention to issues of informed consent.

We went through the journal entry and discussed every concern that had been raised, even those that Mariska could not relate to herself. As we explored each area, I invited any other parts of the mind that might have concerns or reactions to share their remarks with Mariska so she could share them with me. Later in treatment I would ask them to either pass their remarks along or to speak to me directly, but at this early stage I thought Mariska might feel either very uncomfortable or treated dismissively if I did so.

This was Mariska's first experience with my working with both the whole patient and the alter system. Encouraging all of the alters to become involved in the treatment is a way of diminishing dissociative barriers, promoting a free flow of associations and information across alters, and diminishing the alters' "not me" (Chefetz, 2006; Kluft, 1995) attitudes toward one another. It involves a number of considerations. I welcome all of the alters to participate when their participation is neither problematic nor disruptive: the principle of invitational inclusionism. Elsewhere (Kluft, 2006a), I have discussed the many rationales for engaging the alters directly. In issuing this invitation, I insist on the alters' considerateness for one another, advocating for a "golden rule" mentality. I try to undermine pressures for irresponsible autonomy, insisting that "you are all in this together" and that "everybody wins, or everybody loses." I appreciate that in treating at once the whole person and the separate alters I often am doing double bookkeeping and making double appeals. Acknowledging and working within the alters' and the patient's subjective realities allows me to help them test and correct their misperceptions and misattributions. I move quickly to address issues of shame, narcissism, and masochism, which often govern alters' understandings of their situations and roles.

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

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

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

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

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

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

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

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

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

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

Dr. K: I will not hit you.

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

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

Dr. K [silently to himself]: I won't ask who, if anyone, has hurt her down there. The priority is to provide a safe environment for the therapy. If I ask her prematurely, she may start to relive a trauma or to experience a body memory. I will be seen by that part or by a protector part as having needlessly inflicted pain, fulfilling the fear that I will hurt her. Furthermore, she may hear me as encouraging her to speculate, or demanding that she offer an account of an event and identify her assailant. There would be a legitimate concern that an inaccurate account might be generated to please me and/or propitiate me.

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

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

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

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

Mariska: The short version is "Fuck you!"

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

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

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

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

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

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

Dr. K: Embarrassing?

Mariska: Very. I can't. I just can't. [*becomes very distressed*]

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

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

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

Mariska: That's for sure.

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

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

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

Mariska: What do you mean?

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

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

In this instance of invitational inclusionism, I am making an outreach to a number of alters and they are responding, beginning to build a relationship with me. I am impressed that the voices have responded as they have, bringing their dynamics with them. My experience is that the alters and their interactions with one another and with me express and/or enact crucial dynamics and subjectively experienced historical material, and I am allowing myself to hope that Mariska's personality system and, therefore, she, will be more readily accessible than in most DID patients.

Another example regards dreams. Mariska reported this dream in an early session:

> I am taking a walk with Helga. We meet Herr G, who was my father's business partner. They step away and begin an animated discussion. I am bored and walk toward a puppy someone has on a leash. There is a sudden noise and a tornado catches me up and whirls me around. Things from our house are whirling around me. I feel so bad that all my parents have is being destroyed. I feel dizzy and sick and I hurt all over. Then the wind

begins to die down and I see I'm going to hit the ground. I can't look down. I wake up screaming, with one of my roommates telling me loudly to wake up.

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

Dr. K: OK, Mariska has shared her reactions to the dream. Are there other thoughts or points of view?
Mariska: It's very faint, but a little voice says, "He's a bad man."
Dr. K: Would that voice like to say anything more?
Mariska: I feel her fear, and I hear a man's voice, "She can't say any more. The little bitch has said too much already."
Dr. K: I want to remind that second voice that we have agreed that there are to be no reprisals for what is said in therapy.
Mariska: He says his usual, "Fuck you!"
Dr. K: Anything further?
Mariska: Someone is saying that that is no dream. The first part is a memory, and the tornado part says how bad it was.
Dr. K: How bad it was?
Mariska: It says, "The part no one is allowed to remember."
Dr. K: Anything further?
Mariska: And now Helga says, "It's true that Herr G usually had nothing to say to those below him. But I was below him so many times that we developed quite a relationship." No! Doctor, Herr G was my father's business partner, his best friend. He trusted him completely. In fact, when my parents went on long overseas trips, Herr G would visit the house every day to be sure that everything was being done correctly, and to be sure that we were alright. [*suddenly looks shocked*] Helga was in charge when my parents went abroad. Oh! I'm going to be sick. [*wretches, grabs a waste basket, bends over it, wretches repeatedly for about a minute; then voice and facial expressions change*] Doctor, she cannot be allowed to know about Herr G. She idolized him. She dreamed she'd grow up to marry him or someone just like him. This would kill her.
Dr. K: Can you say some more?
Mariska: [*switches back*] What are you talking about?
Dr. K: I think you may have lost a moment there.
Mariska: Helga is saying Herr G was a pig. I don't, I can't believe that. Helga says the day residue you were looking for was another episode of *Law and Order SVU*. I'd forgotten that. I can't remember the plot now. Just that it really upset me.

By inviting contributions from many parts, the exploration of the dream is enriched and deepened. Without making intrusive inquiries, the simultaneously active and engaged parts, some of which were restricted from knowing about any trauma, and some of which were not, have given ample food for thought. I could put aside for future consideration the possibility that Herr G had taken advantage of Mariska's parents' trust in him to debauch Mariska's nanny Helga, and expose Mariska to inappropriate activities, whether vicariously or directly experienced. I would not assume this represented historical accuracy, but I would regard it as a hypothesis to explore and reassess.

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

The major tasks of *Establishing the Psychotherapy* are listed in Table 40.4. Mariska is an ambivalently voluntary participant, and I am pleased to be working with her. Her affluence and flexible schedule and my availability mean that there will be no impediment to beginning and sustaining the treatment. Mariska comes to her appointments and talks about relevant concerns in treatment. That is as good as it gets in the treatment of patients whose capacity to trust has either not developed adequately, or has been shattered by betrayal.

Safety considerations apply to patient and therapist alike. I found no evidence that Mariska was suicidal or

TABLE 40.4
Establishing the Psychotherapy (Kluft, 1993a)

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

self-injurious, but I remained concerned that her self-destructiveness might take the form of sexual misadventures. She had already demonstrated that she felt safe enough to try to work with me, but brought with her preformed traumatic transferences that meant that parts of her mind had to struggle with fears that I might prove to be harmful. The material about Herr G alerted me to the possibilities that she would be scanning me carefully for signs I was transforming into a predator; that she was likely to try to block out signs I was bad in order to protect the relationship; and that she was at risk for developing a false positive submissive transference (Kluft, 2000), replaying a relationship with an abuser who insisted on being treated as if he were deeply loved.

For myself, I did not think Mariska was likely to endanger me, physically or psychologically. The first expressions of sexuality and seduction as defenses had been addressed adequately, and it appeared that Helga and I had formed the beginning of an alliance based on my recognition that she was far more a protector than a sexually driven identity.

We worked to clarify the treatment frame. We agreed that in the unlikely event that I had to communicate with some third party about her, Mariska would have the opportunity to review and suggest appropriate changes in any document I might send. We agreed that unless some issue made it relevant, she would not have access to my therapy notes.

Developing the therapeutic alliance was a major objective during the early sessions. Mariska and I were both confident that we could work well together, but it rapidly emerged that each of us entertained a very different notion about what was meant by "work well together." Mariska did comply with every reasonable expectation; in addition, she shared an ongoing series of "observations" about our work that at once praised me to the skies and deprecated my perception, intelligence, empathy, commitment to Mariska and her treatment, and my choice of interventions. When I asked her to consider the implications of what she was saying, she professed to be puzzled by my concern and occasional consternation, and distressed that I was unable to hear her remarks as objective observations that reflected both her dedication to her treatment and her intellectual curiosity as a hard science researcher who was bringing her observational skills to bear on a healing art derived from the softest of sciences. Much as I had to teach her, Mariska argued that she might have a great deal to teach me.

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

Fortunately, even while I was distressed and somewhat distracted by Mariska's incessant disingenuous attacks, I was asking myself what projective identifications had slipped past my attention, what enactments might be in the process of becoming, and what unrecognized transference paradigms I might be responding to. Therefore, after my initial efforts to bring Mariska's behavior to her attention "went down in flames," I empathized with her frustrations with me. These efforts enraged Mariska: "You are not empathic in the slightest. Your remarks are condescending and supercilious." Mariska wondered if she had overestimated my intelligence, sensitivity, integrity, and investment in helping her.

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

I took some verbatim notes from the times Mariska was critical of me, and studied them with Luborsky's (Luborsky & Crits-Cristoph, 1998) *Core Conflictual Relationship Theme* (CCRT) methodology. Oversimplified episodes of interaction are studied to find the components for the model, "X wants Y from Z, but X's

failings and shortcomings (or strengths), and/or Z's failings and shortcomings (or strengths) prevent X from succeeding (or allow X to succeed) in getting Y from Z."

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

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

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

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

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

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

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

Dr. K: We have a problem. You all are behaving in ways and promoting ways of thinking that are likely to sidetrack or even undermine our work together. For reasons that I am sure are powerful and reasonable because of experiences we have yet to talk about, you all are reacting to me as if I may prove either unable or unwilling to help you, or as if you are certain I will come after you. That makes this office a difficult place to be in. I have no problem with your entertaining such notions about me as long as they are understood to be grist for the mill of therapy, but I am getting the impression that some parts of the mind feel, even if they know they don't rationally think so, that I will do you no good, and may do you harm. We should be in a position to discuss your misgivings and understand where they come from. And try to keep this in mind: once many things were too much for you and

apparently there was no help to be had. Now you may remember your helplessness then not as part of your traumatic memories, but as an accurate appraisal of your vulnerability in the here and now. Addressing myself to the part or parts that have the misgivings: without getting feedback from any others, what year do you think this is?

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

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

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

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

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

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

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

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

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

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

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

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

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

In our exchange, Mariska and I are working on working together. Many components of what I recommend in building the alliance are demonstrated. Mariska comes expecting to be an active participant in the therapy. If she were

taking a passive stance, I would have focused, with both dynamic and psychoeducational interventions, on making her a more proactive participant. The journaling was assigned. Assignments and patients' reaction to them and management of them often are instructive about the patient's degree of identification with the therapeutic process.

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

I am teaching Mariska how I expect her to behave in therapy, to explore rather than to avoid, to communicate rather than to act out, and initiating her into an early understanding of transference and enactment and their importance in our work. This is part of socializing the patient to psychotherapy. I am giving her some ground rules.

In this segment I am not dealing with informed consent, or giving her a map of what we may encounter (anticipatory socialization). There are some psychoeducational aspects to some of my remarks, but Mariska's aggressive literature searches preempted any deliberate psychoeducational efforts on my part. When she had asked for recommended reading, I had referred her to Jon Allen's (current edition, 2005) *Coping with Trauma* and Donald Nathanson's (1992) *Shame and Pride*. She had breezed through Allen's book, but bogged down in Nathanson's in a way that told me that she was so shame-bound that she was afraid of her own shame. Shame is a great instigator, maintainer, and enhancer of dissociation (Kluft, 2006b), and I correctly predicted it would be a central issue in her treatment.

Part of my effort to establish the therapeutic alliance is to address relational and intersubjective concerns. The previous dialogue was preceded by my sharing a reaction of my own. At this early point in the treatment, I felt it was premature to share my stronger reactions, lest they be disruptive and seen as criticism. Mariska and I had discussed how we would handle emerging questions about me and my reactions, and she had, for the moment, accepted my stance that while at times answering her questions might be helpful, at others it could be detrimental, so that if I had any concerns, I would share my misgivings about sharing particular information and, employing my own clinical judgment, reserve the right to withhold it if I had concerns.

Empathic observations were major interventions as we got underway, and Mariska seemed to find my empathy accurate most of the time, with some exceptions illustrated previously. It is important to help a patient deal with the DID diagnosis, and Mariska and I went back and forth over her simultaneously accepting and denying the diagnosis. As long as she was working on relevant topics, there was no need to debate the diagnostic issue.

Dealing with and helping the DID patient deal with concerned others is often a central concern, but I was not made aware of any such issues with Mariska. She had minimal but cordial relationships with her parents, whom she saw less than once a year, was not involved in any significant relationships, and was very absorbed in her work. She socialized primarily with colleagues in enjoyable but not very close relationships.

I find it important to demonstrate some degree of expertise in order to help the patient appreciate that therapy can "do something." At the outset of treatment of DID the achievement of major therapeutic goals is often well beyond any horizon the DID patient can envision. Demonstration of expertise here refers not to the therapist's wizardly skills, but to the therapist's skill in imparting useful strengths and coping strategies to the patient.

For example, as painful material began to emerge, and the foundations of Mariska's original understanding of her life and family began to erode, she had more and more moments of severe distress and somatoform symptoms which, by their nature, seemed likely to be body memories—that is, flashbacks or reenactments of the physical discomforts associated with traumatic experiences, the narratives of which remained cloaked from the awareness of Mariska and most of the alters. I taught Mariska autohypnosis, and two autohypnotic techniques in particular. The first was safe place imagery, and the second was glove anesthesia and its elaborations, which I use for trance ratification and to enhance mastery.

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

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

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

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

Dr. K: OK, great! If you are alone, you can use the Spiegel eye roll induction you've learned …

Mariska: Great? I'll look like a fool, rolling my eyes up and looking like a fool.

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

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

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

Mariska: That will work. I'll just "remind" my colleagues about my migraines! Another iatrogenic artifact from the laboratories of that twisted charlatan, Dr. K!

I also taught Mariska to create numbness in either hand, and used (with her permission) a sterile pin to test the numbness. When she opened her eyes and saw a pin she had not felt stuck upright in her skin, she was impressed. Such demonstrations lead to trance ratification, the patient's conviction that he or she really is in trance, making the often vague and nebulous concept of hypnosis convincingly tangible.

Next, I taught Mariska to transfer the numbness to other parts of her body by rubbing the numb hand on those parts. Since that method has limited application in public settings, and since there may be drawbacks to its use in sexually traumatized areas, I also taught her to let the numbness travel through her bloodstream to the afflicted areas. A few sessions later, Mariska remarked on her use of these techniques:

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

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

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

With these skills acquired, Mariska became more confident in herself, our relationship, and the treatment process. She was eager to learn still more.

As Mariska and I moved beyond evaluation and the tentative first sessions into the flow and process of the therapy, dissociation was no longer a set of phenomena to be noted, elicited, and understood, nor a series of abstract definitions. Instead, it was lived between us and within Mariska, infiltrating our relatedness and our experiences of ourselves and one another, becoming a new lens through which Mariska was becoming more able to unravel and comprehend the knotted skein of her life and her psyche.

We moved smoothly into the phase of preliminary interventions (Table 40.5). As more and more material emerged or was contributed by alters, Mariska was becoming more symptomatic. We were both aware that

TABLE 40.5
Preliminary Interventions

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

Source: From The initial stages of psychotherapy in the treatment of multiple personality disorder by R.P. Kluft, 1993, *Dissociation, 6*, pp. 145–161. Copyright 1993 International Society for the Study of Dissociation. Reprinted with permission.

the symptoms of the moment were the tips of what might prove to be far more menacing icebergs.

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

I did not want to see this pattern played out among Mariska's alters. As we discussed how we would proceed, I invited comments from all parts of the mind. Predictably, some comments passed on from within: (1) insisted nothing bad had ever befallen her; (2) told me Mariska had been a liar since she was a little girl; (3) warned "They know what will happen to them if they talk"; (4) told me to "Leave her alone! She belongs to me!"; and (5) insisted "Those people would never, never, never do anything to hurt you." In addition, Mariska heard crying and screaming in the background.

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

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

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

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

Mariska: Just curses and laughter.

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

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

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

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

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

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

Dr. K: Hey, for you, nothing but the best!

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

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

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

Mariska and I spent about 4 months primarily dealing with alters' misgivings and clarifying the role of shame in keeping information out of awareness. Mariska was reluctant to acknowledge or reveal awareness of alters who expressed anger or performed sexual functions. We discussed the pivotal role of shame in the trauma response, and the role shame plays in instigating, maintaining, and reinforcing dissociative adaptations.

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

Dr. K: What's your understanding of those behaviors?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mariska: Many of us.

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

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

The previously narrated interventions give some indication of how I approached the matter of contracts. I was fortunate that Mariska was not inclined to hurt her body or attempt suicide, and further fortunate that she had eliminated substance abuse from her life prior to my work with her. However, we had to work very hard to contain Mariska's use of sexual encounters for tension release, self-punishment, and self-degradation.

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

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

Dr. K: To what are you referring?

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. K: So Herr G and others are wanting to show how grand and phallic they can be, and promoting these encounters to do so.

Mariska: [*as Helga*] I'm getting tired of this. I try to protect the little ones by stepping in for them, but I don't want to do this any more.

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

My efforts to bring Mariska symptomatic relief included numerous medication trials, none of which were

satisfactory to either one of us. The personalities based on Mariska's mother resisted efforts to simplify Mariska's life by removing stressors and unnecessary burdens. My efforts were unavailing, but the majority of the alters confronted her and restricted her activities until she could be worked with therapeutically. Her various symptoms were explored by making inquiries, usually without hypnosis.

Mariska began to report severe headaches when she found herself to be the only woman in a group of men. As one of the few women in her field, such situations were commonplace.

Mariska: I have to do something about these headaches.
Dr. K: You have described the headaches very well, but for the sake of completeness, I want you to tell me about anything else you experience along with the headaches—ideas, images, feelings, sensations …
Mariska: [*interrupting*] No!
Dr. K: Well …
Mariska: [*interrupting*] No! Why don't you leave my headaches to the neurologist? Such questions you ask! No!
Dr. K: It seems from what you are saying that the headaches reflect both the intrusion of some uncomfortable material and your attempts to push that material away. Elements of the material succeed in pushing through as physical orphan symptoms, unconnected to the context in which they occurred.
Mariska: I'd rather have the headache. I'm not ready for this.
Dr. K: Well, that's a problem. Often I can get a symptom to subside, but that's usually associated with promising whatever parts are behind the symptom a chance to be heard.
Mariska: I really can't go there now. I have too much on my plate and a grant application that is due in 2 days.
Dr. K: OK, will you allow yourself to go to sleep while I talk with the others?
Mariska: I don't like this, but OK.
Dr. K: [*induces hypnosis, conducts all personalities other than those behind the headache to a safe place, suggests sleep*] It seems that there is something really important that you need today.
Mariska: Yes. But *she* needs to hear it. Not you.
Dr. K: You may be right, but let's start with me.
Mariska: Her mother sent her an e-mail.
Dr. K: An important e-mail?
Mariska: A terrible e-mail. Herr G is coming to the United States on business, and her mother gave him her e-mail and real address, and told her she had assured him that Mariska would be glad to put him up for a few days. Mariska is trying to push it out of her mind, and Helga says she is not going to take care of things. We have to do something. And we don't think we can say "No!" [*switch to Helga*] It's about time they stood up instead of saying "Helga! Helga! It's time to spread your legs." No more! No more!
Dr. K: Thanks. You can step back. Mariska, everybody, please listen. There is real danger here, and pushing it aside will put you all at risk. Mariska, this time I think you all need to listen.
Mariska: I hear it. I remember. What can I do? My parents don't know about Herr G. They will think I am horrible. [*switch*] We would like to see Herr G. [*switch*] Do you see why we tried to push through?
Dr. K: Mariska, is it true that your parents don't know about Herr G?
Mariska: [*cries*] I told my father over and over again, but he didn't believe me. My mother knows—she was in bed with Herr G and me. Why don't I just kill myself?
Dr. K: I think that when it seems easier to consider killing yourself than saying "No!" we have a lot to talk about.
Mariska: [*smiling weakly through her tears*] You think I have a problem? You think I need something like psychotherapy?
Dr. K: The thought had crossed my mind.

The crisis of Herr G's visit was averted. Mariska worked out a clever arrangement that allowed her both to decline Herr G access to her home, restricting her exposure to him, and hold a party in his honor at a restaurant. In this manner we approached and negotiated our way through myriad symptoms, which seemed to occur mostly when self-protective needs were in conflict with attachment needs. Mariska quickly mastered how to initiate inner dialogues in order to explore symptoms and how to get the alters involved to step back, and bring their issues to the next session. Often these alters left gargantuan telephone messages to assure themselves that I would be aware of their issues in case other alters "forgot" them, lest they not be addressed.

Mariska developed her own way of controlling spontaneous abreactions and flashbacks, based on techniques I had used in session. She relied on the basic psychodynamic question: "Why is this happening now?" Pursuing this through her inner world, she would find the alter or alters who had become upset, or whose issues were triggered, speak to them empathically, and persuade them to use a technique I had taught Mariska, hypnotically putting the upset alters to sleep between sessions, promising to call them and their issues to my attention. I rapidly found that I had to question Mariska about whether she had shut down anything to which we had to return, because she often "accidentally on purpose" gave herself what amounted to permissive amnesia instructions.

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

With a reasonably good therapeutic alliance that engaged almost all of the known alters (excepting parts based on Mariska's mother) and that had proven itself robust in handling a series of crises and difficult situations, it seemed safe to proceed to history-gathering and mapping. For reasons of confidentiality not much more of Mariska's history will be shared.

The history-gathering was done by asking each alter to tell its story, and then pursuing gaps and apparent and real discrepancies. If an alter became too emotional or disruptive, another alter that had witnessed the events in question, but was less prone to be upset, was asked to tell the story.

Only one additional piece of historical information will be shared. Near the end of the history-gathering a child alter said it missed "Heinrich." Another alter harshly told her to be quiet. Not a single alter could or would explain Heinrich. Thinking Mariska had given me honest answers, I wondered if Heinrich was an alter largely unknown to the others, and told Mariska I would try to see if there was an alter named Heinrich. Mariska gave no indication of distress.

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

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

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

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

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

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

Dr. K: I'm sorry.

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

I was completely blindsided by these revelations. Mariska both took pleasure in how well she had hidden her secret and was ashamed that it had finally been revealed. Her understanding of "Why is this happening now?" was that, in spite of her conscious plan never to speak of her brother, at a deeper level her mind knew it had to reveal this material if she were ever to recover. In reflecting on this newly revealed brother, I was also shocked to realize that although I knew Mariska had a younger sister, she had never been mentioned after the initial sessions.

For mapping, I used Fine's technique (Fine, 1991, 1993). Mariska was asked to write her name in the center of a piece of paper, and all alters were invited to place their names or to instruct Mariska where to place their names, placing their names closest to those to whom they felt most close. I also ask those who have no name or who are not ready to share their names to make a mark,

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

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

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

At this point, Mariska's treatment was well underway. From my perspective, and from hers as well, the early stages that form the foundation of the treatment had come to satisfactory conclusions. Mariska was well-equipped to explore and work through her experiences in relative safety and she had good prospects of preserving her functioning as she did.

We had become a team, both identified with the goals of the treatment and able to retain our connection with one another despite the vicissitudes of transference and countertransference. We were mutually accepting of the inevitability that intrusions from the past might become manifest in the present in myriad ways, and that they might test and try, but would not break, our alliance.

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

As we continued, it became apparent that dissociation not only characterized Mariska's diagnosis, but that it also was a major determinant of the interpersonal field and the relational processes in which we were engaged. Dissociation was understood to underlie and play a role in determining how and who and what she was in relationship to me and among her many selves. As early interventions clarified and contained aspects of Mariska's dissociative disorder, it became possible to decode Mariska's dissociative phenomena and dissociative way

of being and to make therapeutic interventions. Working with dissociation to cure dissociation became a characteristic aspect of the therapeutic process.

Mariska was able to build on the foundation we created together during these early stages of treatment. Although there would be many difficult moments in coming to grips with her mother's role in her traumatization, in dealing with those parts identified with mother, in learning about her sister's role in her life, and in addressing her brother's betrayal and mistreatment of her, she addressed and worked through her experiences and issues. After five additional (and seven and a half total) years of treatment, her psychotherapy was tapered gradually, and transitioned into periodic follow-up visits. During this period of follow-up visits, Mariska presented a paper at a symposium abroad, involving a number of colleagues whom she had never met before. One of these was a gentleman who responded as warmly to Mariska as she responded to him. A year and a half later Mariska and he married, and both relocated to share a life together. They were able to beat the biological clock and begin a family. Mariska is sufficiently prominent in her field that she is invited to speak in the United States quite frequently, and usually can squeeze in a follow-up session or two. Her life is good.

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