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A case study investigation of the development and treatment of alter personalities in dissociative identity disorder

Ian Brown
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**A CASE STUDY INVESTIGATION OF THE DEVELOPMENT
AND TREATMENT OF ALTER PERSONALITIES IN
DISSOCIATIVE IDENTITY DISORDER**

By

Ian Brown

Being a report of an investigation submitted in 2006 as a partial requirement for the degree of Doctor of Philosophy (Psychotherapy) in the Faculty of Community Services, Education and Social Sciences at Edith Cowan University.

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

STATEMENT OF CONFIDENTIAL INFORMATION

The participant on whom this study is based gave permission that therapeutic material gained during the course of therapy could be used as data within the study. She also gave permission that written and drawn material could be incorporated into the thesis where it was relevant to the issues being discussed. In return, it was stipulated that where possible her identity would be disguised and that material should not be taken from the thesis without first obtaining permission from the author.

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ABSTRACT

Progress in the study and treatment of Dissociative Identity Disorder (DID) has been hampered by ideological debate regarding its validity. This is particularly the case when patient's suffering from DID also report ritualistic abuse. Part of the difficulty has been that past studies have not established independent checks to assess whether alters are artefacts introduced by therapeutic bias. This study addressed this issue by using independent judges to test the validity of a patient being treated for DID who claimed ritualistic abuse. The judges were 16 clinicians with an average of 21 years experience in their respective disciplines. The study also examined the development and treatment of alter personalities through a detailed examination of case material. The patient had been in continuous therapy with the author and treatment had been conducted using the self psychology model. The study involved three phases.

In the first phase inter-rater reliability between the judges was assessed. Each judge received a written transcript and tape of a particular session, which they were asked to assess on two Likert-type questionnaires. One questionnaire assessed therapeutic bias and the other alter validation. The criterion for inter-rater reliability was met and the study proceeded to phase two.

In phase two the hypothesis that the DID manifested in this patient was the result of iatrogenic biasing was empirically tested. Each judge rated two tapes, one tape in which an alter appeared for the first time and a second tape in which there was evidence of switching and dissociation. Each judge received different tapes. An appropriate design methodology was used and it was concluded that the DID evident in this patient was not the result of therapeutic bias and that the presentation of alter personalities could be validated by independent judges.

In the third phase the traumatic events described by the patient and their relationship to the development of her alter system are detailed. The material is examined from the perspective of theories that consider DID to be a development response to trauma and those that consider it to be the result of iatrogenic bias. Questions regarding the development of the alter system over the patient's life span are investigated as is the development of specific types of alters and their function within the patient's life.

The process of treatment and integration is described and evaluated against the existing literature. Self-harm and attempted suicides by the patient are examined in the context of treatment. Two main alter sub-groups, home and cult alters, were identified and the difficulty involved in integration between these two sub-systems is discussed. The importance of attachment to the main abuser who in this case was the father and the impact this had on her development is considered.

The study concludes with a discussion of the reasons for the continued development of some alters as opposed to others. Some consideration is given to the difficulties presented for the treatment of this patient in a public setting and the influence the debate regarding iatrogenic biasing has upon this.

DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

- (i) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;*
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CHAPTER ONE

1.0 INTRODUCTION

Overview

Dissociative Identity Disorder (DID) is a controversial condition that centres on the presence of alter personalities. Sceptics say that the alter personalities, which are the hallmark of DID, result from therapist iatrogenic bias and/or from patients who are malingering or responding to reinforcement. Non-sceptics say that alter personalities are a defensive reaction to unmanageable trauma.

Past studies are defective because there have been no checks for reliability or validity that the alters are present and that they can be identified as present by independent judges. Nor have there been checks to see if the alters are an artefact introduced or encouraged by the therapist. Therefore, the information that they offer is not seen as credible.

This study examines the presence and operation of alter personalities through a detailed case study of a person with an independent psychiatric diagnosis of DID. It differs from other studies by firstly attending to past criticisms and presenting independent external confirmation that the alters are present, can be recognized, and are not a result of therapist induction. It also attends to another criticism of past studies by using a therapeutic model consistently during treatment and describing it in detail. Secondly, it proceeds by examination of transcripts of this case to determine what factors contribute to the development of alter personalities and what indications for the process of therapeutic integration present themselves in the course

of treatment. The study then proceeds to consider some of the implications regarding the development of DID and its treatment that can be drawn from the data.

Background to the Study

During the 1990s, few clinical psychiatric diagnostic groups experienced the level of controversy engendered by the dissociative disorders (Klein & Doane, 1994). The controversy has continued into the present decade (Schefflin, 2000) with most of the scepticism focused upon one form of dissociative disorder, namely, Multiple Personality Disorder (Dell, 1988). Multiple Personality Disorder, now known as Dissociative Identity Disorder (DID), is a complex and chronic disorder that is characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual's behaviour. This is accompanied by an inability to recall important information that is too extensive to be explained by ordinary forgetfulness. Such disturbances are not due to direct physiological effects (DSM-IV, American Psychiatric Association, 1994; Kluft, 1996a).

Despite the controversy surrounding DID, the history of this condition is extensive and parallels the development of modern psychiatry (Putnam, 1989a). Indeed, in the late nineteenth century an understanding of dissociative phenomena was central to theories of psychopathology and valued as a way of understanding mental processes. William James and Morton Prince, for example, theorized about the organization of mental processes based on their personal experience with patients suffering from DID (Ellenberger, 1970).

Pierre Janet (1859-1947) is widely acknowledged as an important pioneer in the study of dissociation (Brown, Macmillan, Meares, & van der Hart, 1996). His studies of patients suffering from amnesia, fugues, “successive existences” (his description of DID), and somatic dissociation led him to postulate that these symptoms were attributable to the existence of “split-off” parts of the personality capable of independent life and development. He argued that the dissociative

elements (splitting of mental functions) that gave rise to patients' symptoms or behaviours frequently originated in traumatic experiences (Pitman, 1989).

Freud, in his early writings, considered the core of psychopathology to be the internal impression of a traumatic experience that, because of its unbearable nature, was sealed off from the rest of the personality (van der Kolk, Weisaeth, & van der Hart, 1996). In Aetiology of Hysteria (1896), Freud argued that the ultimate cause of hysteria was the sexual seduction of a child by an adult. He later abandoned this "seduction theory" in favour of the notion that what hysterics repressed from consciousness was not sexual trauma itself, but a childhood sexual wish. This shift in attention from the study of the effects of actual traumatic experience to the psychology of repressed wishes and instincts marked the shift away from a trauma dissociation model of psychopathology to a repressive one. This polarization is still evident in the current literature on repressed memory (van der Kolk et al., 1996).

The acceptance of psychoanalytic theory resulted in an absence of research on the effects of real traumatic events on children's lives. This led to a gross underestimation of the frequency of sexual abuse (Steinberg, 1995). Henderson (1975), for example, reported in the widely read professional text Comprehensive Textbook of Psychiatry, that the proportion of incest victims was about 1.1 to 1.9 per million. Since this publication, however, a plethora of epidemiological, clinical, and developmental studies leave no reasonable doubt that many more children are victimized and abused physically and sexually than was previously understood (Knutson, 1995). Russell (1986) reported that 16% of women in the North American population are abused by a relative and 31% are sexually abused by a non-family member before their 18th birthday. In terms of the hospitalized population, 50-75% of general psychiatric patients reported histories of childhood trauma. Myers (1991) considered that such findings lend support to the hypothesis that the profound and deleterious effect of childhood abuse continues throughout the individual's life.

Paralleling the recognition of the widespread incidence of actual childhood trauma there was a resurgence of interest in its sequelae in adulthood. DID and the

dissociative processes again became central features in models and theories of the organization of mental processes in adults (Fischer & Pipp, 1984; Hilgard, 1977). As with childhood trauma, the number of reported cases of DID have increased in the last decade. The actual prevalence of DID is unknown. However, it is conservatively estimated to occur in 1% of the general population (Ross, 1997), in 3-6% of psychiatric inpatients and, in 5-18% of patients in substance abuse treatment settings (Kluft & Foote, 1999). Some researchers argue that the condition has frequently been confused with schizophrenia, borderline disorders, and hysterical neuroses (Bliss, 1986). It is a chronic disorder, and Kluft (1985) observed that without proper treatment it appears to be a life long disorder though it may manifest itself differently over the lifetime of an individual.

Since the 1980s there has been a significant increase in the number of DID cases reported in the literature. Kluft (1987) proposed several factors to account for this:

1. More widely disseminated information about DID.
2. Narrowing of the definitions of other conditions such as schizophrenia, with which DID may be confused.
3. Greater scrutiny of cases where there is failure to respond to appropriate treatment for some other condition.
4. Increased awareness of the hitherto unacknowledged high prevalence of child abuse and incest.

Piper (1994) finds it implausible that these factors alone could account for the increase. Instead, he believed that vague and over-inclusive diagnostic criteria accompanied by mutual shaping between patient and therapist account for much of the increase. He also noted that many of the techniques used to diagnose and treat the condition reinforced its symptoms. Furthermore, as Kihlstrom (1995, p. 950) recently observed, “even though hundreds if not thousands of MPD cases have been reported since 1974, fewer than two dozen have been subjected to any kind of experimental investigation.” Whilst Kihlstrom’s assertion regarding the number of

experimental studies is debatable, there is a paucity of experimental studies of DID and this has contributed to criticisms regarding its validity.

Many contemporary clinicians working with DID cases have noted, as did Janet decades before them, that some adult patients increasingly remember their abusive experiences during the process of their lives and in psychotherapy. Such findings have led some researchers such as Loftus and Ketcham (1994) and Ofshe and Watters (1994) to claim vigorously that such “memories” are frequently not the product of historical and real traumas, but “pseudo memories”. It is claimed that these memories are iatrogenically implanted by well meaning therapists who create vivid “recollections” by procedures like hypnosis, abreaction, and other psychotherapeutic techniques. Individuals with DID tend to be highly hypnotizable (Bliss, 1986) and vulnerable to suggestive influences (Bowers, 1991). This, along with the complex and unusual nature of the disorder, has led some clinicians and researchers to question not only the validity of earlier memories of trauma, but also the diagnosis of DID itself. Instead, they argue that DID is an iatrogenic phenomenon created by demand characteristics on the part of the therapist.

Complex arguments about the authenticity, aetiology and nosologic status of DID, however, cannot be resolved without adequate information describing and delineating the disorder through systematic investigation (North, Ryall, Ricci, & Wetzel, 1993). The aim of the present study is to investigate whether the manifestation of alter personalities in a DID case can be identified by clinically trained observers, and whether iatrogenic bias can be detected before this emergence. If alter personalities can be identified, and if observers judge that these have arisen spontaneously, then alternative hypotheses about their emergence will be proposed.

Treatment of DID is a complex undertaking (Mollon, 1996). The process of integration proposes that the separate identity states “fuse” together and that this process continues until complete integration is achieved (if ever) (Putnam, 1989a; Ross, 1997). The exact nature of this “fusion” is not completely understood. Reported treatment of individuals with DID have identified two principal strategies:

stabilizing the most functional or competent personality (Oltmans, Neale, & Davidson 1985), or integrating the disparate personalities into one, of course the latter strategy necessarily involves stabilization (e.g., Putnam; Ross). Few accounts describe the way the stabilizing or integrating was attempted and there are no between-methods comparative studies. Greaves (1993) suggests that current DID research has suffered from the absence of theories of the self such as that of Kohut (1971, 1977, 1984). He argues that self psychology would make a significant contribution to research because of its elucidation of external events as determining factors in the development of an individual. There are also possible advantages with self psychology as a treatment model. Its emphasis is on listening from an empathic vantage point and tracking emotion shifts rather than interpreting and thus could be expected to minimize iatrogenic bias. It also has a clear methodology that can be described and carefully adhered to throughout each therapy session. For these reasons the therapeutic method of self psychology has been used consistently in this study.

1.1 Dissociation and the Development of Dissociative Disorders

Overview

Lynn and Rhue (1994) consider that the topics of dissociation and the dissociative disorders provoke fascination and consternation in roughly equal measure. In part this is due to the purported link between child abuse and pathological dissociation such as DID. This is partially exemplified by the recent surge of interest in whether delayed recall of memories of sexual abuse is fact or fiction (e.g., Loftus, 1993; Lynn & Nash, 1994; Piper, 1997). Proponents of DID regard dissociation as a mechanism by which traumatic experiences such as child abuse are processed, and by which painful memories are kept sealed from consciousness (e.g., Kluft, 1999a; Putnam, 1997). Conversely, antagonists of DID (e.g., Merskey, 1995a; Piper), whilst not denying the concept of dissociation, do refute that it is a central factor in the development of DID.

Before examining these differing views further, issues regarding the development, classification, and function of dissociation will be considered.

Development of Dissociation

Ray (1996) considered dissociation to be a normal developmental process and that all individuals are born in a dissociative state. This, Ray proposed, may result from either the immaturity of the infant's nervous system or from a break in the physiological entrainment process between the mother and infant at birth. Ray further proposed that before birth the infant's developing nervous system is organized around that of the mother. This entrainment process is broken with birth and the various aspects of the child's nervous systems initially function in an unintegrated manner. Following birth, the development and integration of physiological, emotional, cognitive and motor responses continue until a unified sense of "self" develops. Ray considered that traumatic events occurring during this phase of development interrupt the normal development of a coherent sense of self and can lead to the fragmentation of self evident in severe psychopathology including DID. From this perspective, dissociation is conceived to be a function of normal developmental processes but susceptible, under certain conditions, to pathological processes.

Putnam (1994) identified dissociative amnesia as a principal feature that distinguishes normal and relatively adaptive forms of dissociation from pathological symptoms. Sufferers from dissociative disorders also differ along a range of psychophysiological variables (Putnam, 1989a; Ross, 1997). Spiegel (1984) suggested that individuals subjected to recurring trauma early in life (5 or 6 years) are more prone to the spatial fragmentation of the personality that is typical of DID. Those who have passed through the major developmental stages before being subjected to trauma experience temporal fragmentation or other more circumscribed dissociative symptoms. In this respect DID is not qualitatively different from any other kind of character pathology such as narcissistic or obsessive personalities (McWilliams, 1994).

Classification of Dissociation

There are two major models of dissociative phenomena (Putnam, 1997). The most prevalent of these is the concept of a dissociation continuum ranging from normal dissociative processes such as daydreaming, through dissociative episodes and disorders, to the major pathological forms such as fugue states and DID (Bernstein & Putnam, 1986; Braun, 1993; Putnam, 1989a). From this perspective dissociative tendencies such as absentmindedness or “spacing out” seen in the normal population lie at the basis of the more pathological forms seen in patient populations (Ray, 1996). The second model is a typological one where pathological dissociation and normal dissociation are viewed as representing different and distinct types of dissociation. This model is associated with Janet’s work and his belief that pathological dissociation is the consequence of a combination of constitutional vulnerability, suggestibility, and powerful emotional events (Putnam, 1997).

Current research into the classification of dissociation has been assisted by the development of measurement tools such as the Dissociative Experiences Scales (DES), (Bernstein & Putnam, 1986; Carlson & Putnam, 1993). Waller, Putnam and Carlson (1996), for example, reanalysed DES data gathered from seven clinical sites and concluded that a typological model was a better fit of the data for clinical samples than a continuum model. Putnam (1997) believes that the data thus far support both models: The continuum model needs to be invoked to account for some findings, and the typological model invoked to account for other results. Whilst this is an area requiring further research, Putnam's observations are consistent with Cardeña’s (1994) proposal that dissociative episodes can be best understood within a multidimensional model. Cardeña suggested that dissociative episodes be classified as to whether they are considered pathological or normal, and whether their cause is assumed primarily neurological or psychological. Thus, as presented in Figure 1 (adapted from Cardeña, 1994), dissociative disorders are classified as pathological and of psychological origin. Dissociative episodes considered pathological but the cause of which is thought to be primarily neurological are considered to be of a different type.

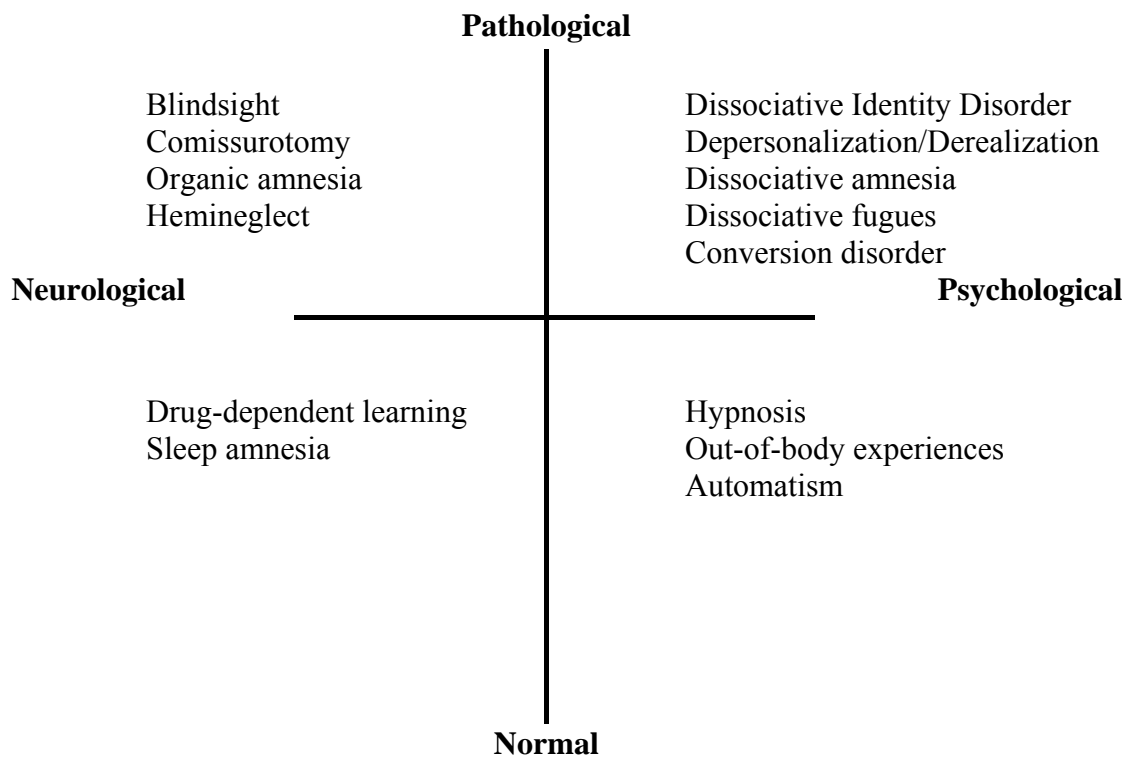


Figure 1. Dissociative phenomena (Cardeña 1994)

A model that preceded some of these principles is the BASK (Behaviour, Affect, Sensation, Knowledge) model of dissociation proposed by Braun (1988a, 1988b). In his scheme, dissociation can occur in various permutations and combinations of four continua: Behaviour, Affect, Sensation, and Knowledge. The model subsumes many processes that often occur together but have not always been seen as related. According to Braun, one can dissociate from the *Behaviour*, as in motor conversion disorder, or dissociate from the *Affectual* memory, as in painful feelings and emotions or from the *Sensation* as in conversion anaesthesia and “body memories” of abuse, and *Knowledge* as in fugue states and amnesia. The BASK model regards repression as a subsidiary of dissociation and puts a number of phenomena that have previously been regarded as hysterical into the dissociative domain. It also links to historical trauma many issues that have tended to be seen as solely expressing intrapsychic conflict.

Definition of the Dissociative Disorders

The Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV, American Psychiatric Association, 1994, p. 477) defines the essential feature of the Dissociative Disorders as “a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic”. The DSM-IV (1994, p. 477) classifies five dissociative disorders.

1. Dissociative Amnesia is characterized by an inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.
2. Dissociative Fugue is characterized by sudden, unexpected travel away from home or one’s customary place of work, accompanied by an inability to recall one’s past and confusion about personal identity or the assumption of a new identity.
3. Dissociative Identity Disorder is characterized by the presence of two or more distinct identities or personality states that recurrently take control of the individual’s behaviour accompanied by an inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.
4. Depersonalization Disorder is characterized by a persistent or recurrent feeling of being detached from one’s mental processes or body that is accompanied by intact reality testing.
5. Dissociative Disorder Not Otherwise Specified is included for coding disorders in which the predominant feature is a dissociative symptom, but that do not meet the criteria for any specific Dissociative Disorder.

The DSM-IV (1994) definition of the dissociative disorders is reflected in Cardeña’s (1994) psychological/pathological content distinction. Dissociative symptoms are also included in the DSM-IV in the criteria sets for Acute Stress Disorder, Posttraumatic Stress Disorder, and Somatization Disorder.

Function of Dissociation

An understanding of the dissociative disorders is still at an early stage (Putnam, 1997) and within the literature the function of dissociation has been defined in different ways. Cardeña (1994), for example, identified three distinct ways in which the concept of dissociation is used. First, the concept is used to describe mental processes that are not consciously accessible, and that can function independently of an individual's stream of consciousness. This is the broadest sense in which the concept of dissociation is used and ranges from behaviour peripheral to the individual's awareness such as driving and changing gear whilst talking, to behaviours seemingly outside of the individual's awareness such as sleep walking. Such descriptions of dissociation refer to non-pathological states and are considered parts of an individual's normal functioning. Second, dissociation is used to describe a fundamental alteration in consciousness, which can involve a disconnection or disengagement between the individual and some aspect of his or her self or the environment, as is apparent in the clinical syndromes of depersonalization and derealization. Third, the concept of dissociation is used as a defence mechanism that accounts for disparate phenomena such as non-organic amnesia and the warding off of physical and emotional pain. It has been proposed, that the dissociative warding off of physical and emotional pain serves as a mechanism for the development of severe and chronic conditions such as DID (Kluft, 1999a).

Dissociation as a Defensive Response to Overwhelming Trauma

The concept of dissociation as a defensive response to overwhelming trauma is central to current thinking regarding the development of severe and pathological dissociative disorders such as DID (Kluft, 1999b; Putnam, 1998; Ross, 1997). Janet is not only acknowledged as a pioneer of theoretical discussion of dissociation but is also credited with the first systematic study (Ellenberger, 1970; van der Kolk & van der Hart, 1989). His theory of dissociation developed from his work with patients suffering from hysteria, together with his interest in hypnosis and the psychological effects of trauma (Atchison & McFarlane, 1994). He proposed that dissociation might occur when a person experiences "vehement" emotions, including terror,

which narrow attention and disorganize the ordinary integrative functions of consciousness. These experiences and related memories, Janet maintained, are not integrated into the person's identity and long-term memory but become, instead, simple "fixed ideas" or complex alter identities that continue to have separate mental existence. These sometimes continue to affect the person in insidious ways such as in DID (Putnam, 1989b; van der Hart & Horst, 1989).

While a "defence mechanism" is ordinarily assumed an individual's way of warding off anxiety or pain, Ludwig (1983) has proposed an explanation based on evolution theory. He proposed that dissociation serves adaptive and defensive purposes including automatization of behaviours, efficiency and economy of effort, resolution of irreconcilable conflicts, escape from the constraints of reality, isolation of catastrophic experiences, cathartic discharge of feelings, and enhancement of herd sense. Further, he states that the sham death reflex among slow animals may be analogous to dissociation. In a similar vein, Ironsides (1980) concluded that alterations in consciousness and behaviours (e.g., "being in a daze," passivity) that some humans exhibit after a catastrophe is a biological response of conservation/withdrawal to save physical and psychological resources when dealing with inescapable trauma.

Recently, Putnam (1997) arranged the defensive functions of dissociation identified by Ludwig into three categories. These he identified as (a) automatism of behaviour, (b) compartmentalization of information and affect, and (c) alteration of identity and estrangement from self. These functions, Putnam affirmed, reflect the multi-dimensional defensive nature of dissociation and can operate independently or in concert. In an acute traumatic situation, however, they function together to reduce extreme psychological and physical pain.

Automatism of behaviour is divided into "normal" and "dissociative". Putnam (1997, p. 68) maintained that one of the "benefits of 'normal' dissociation is the capacity of the mind to divide attention into two or more streams of consciousness; this allows an individual to perform more than one mental task at a

time.” In contrast, dissociative automatic behaviours are not controlled by conscious thought and may have survival value in times of severe and repeated trauma. Putnam, for example, considered that automatic dissociation may provide the psychological means for an abused child to comply with the demands of the perpetrator without having to be fully aware of what is happening and of how he or she is responding.

Putnam (1997) defined compartmentalization as the failure to integrate experience and knowledge. Defensively, compartmentalization permits the isolation of overwhelming affects and memories thus providing an individual with a mechanism to store and recall emotionally laden information separately from other information. This is particularly the case where intense psychological dissonance might result if conflicting sets of information should become associated. Putnam reasoned that by compartmentalizing overwhelming experiences and feelings, a child can both “know” that he or she is being terribly maltreated by a parent and can simultaneously idealize that parent. Compartmentalization assists the child to avoid painful cognitive dissonance and irreconcilable conflicts in situations in which there can be little control. Such painful experiences, however, remain dissociated and are not psychologically transformed over time in the manner that other memories have been. Instead they remain largely out of consciousness and continue to influence and shape the individual’s behaviour (Putnam; van der Kolk, 1996a; van der Kolk & Kadish, 1987).

Putnam (1997) identified alterations of self and identity as constituting a core symptom of pathological dissociation. He suggested that, whilst they may take a variety of forms, the defensive dynamic behind these alterations is to protect the individual, if only transiently, from psychologically unacceptable experience. In time-limited disorders such as dissociative amnesia or dissociative fugue, alterations of identity are selective and time-limited and may only disturb those aspects of identity associated with a specific event; full awareness of primary identity returns relatively spontaneously. In more chronic identity disorders such as depersonalization disorder and DID, the defensive aspects typically become more and more elaborated with the passage of time. In DID, for example, the emergence

of the first alter personality state is frequently reported to have arisen in the context of an overwhelming traumatic event and to have had an immediate protective survival value. The persistence of such defensive mechanisms, however, frequently leads to the development of internal persecutory alters whose function is apparently at odds with their initial adaptive purpose (Putnam, 1989a). The development of such psychological processes warrants further study. This is particularly the case when the problematic and long-term maladaptive function of these elaborations is considered (Putnam, 1997).

Summary

1. Dissociation is considered part of a normal developmental process and contributes to the development of “self”. The development of “self” is, however, susceptible to fragmentation and under certain conditions dissociation can lead to severe pathology including DID.
2. Two major classification models of dissociation have been described. Currently, both models account for some, but not all, of the data. The typological model, however, appears to be a better fit for clinical samples than a continuum model.
3. The DSM-IV (1994) endorses and classifies five dissociative disorders.
4. Dissociative disorders can be understood as adaptive responses to overwhelming trauma. In time limited disorders, alterations of identity are selective and limited whereas, in more chronic conditions such as DID the adaptive and defensive aspects become elaborated with time. This frequently leads to the development of internal persecutory alters whose function is apparently maladaptive and in contradiction with their initial adaptive purpose and their functioning within the alter system requires further investigation.

It is now necessary to examine the particular manifestation of dissociation pertinent to this study.

1.2 Dissociative Identity Disorder

Overview

This chapter has so far has been concerned with the dissociative disorders in general of which DID is one manifestation from the psychological/pathological quadrant (Cardena, 1994). In this section DID, as a discrete entity of the dissociative disorders, and its treatment are considered. DID is described by researchers as incorporating all of the dissociative experiences described within the pathological/psychological quadrant defined by the DSM-IV (American Psychiatric Association, 1994) definition of the dissociative disorders (North et al., 1993; Putnam, 1989a). In this section the DSM-IV diagnostic criteria for DID are given along with a brief review of the history of DID. Consideration of the relationship between DID, trauma, ritualistic abuse, the impact of trauma on memory functioning, and the aetiology of DID are discussed.

Diagnostic Criteria for Dissociative Identity Disorder

The DSM-IV (1994) definition of DID used in this study is as follows:

- A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving relating to, and thinking about, the environment and self).
- B. At least two of these identities or personality states recurrently take control of the person's behaviour.
- C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

- D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behaviour during alcohol intoxication, or complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

A Brief History of Dissociative Identity Disorder

As previously observed DID is not a new development; evidence of DID is said to exist in the images of shamans changed into animal forms or embodying spirits in Palaeolithic cave paintings (Putnam, 1989a; Ross, 1997). Throughout recorded history cases of demonic possession have been reported that many experts now believe are cases of DID (Golub, 1995; Putnam). Detailed accounts of DID being a mental condition began appearing in the 18th century (Ellenberger, 1970). Although there are reports of an earlier account by Paracelsus who wrote in 1646 of a woman who had amnesia about an alter personality who stole her money (Bliss, 1980), Eberhardt Gmelin is usually credited as being the first to report a case of DID (Ellenberger; Greaves, 1993). Whether it was the first written report or not, Gmelin's 1791 account of "exchanged personality" is the first known detailed account of DID (Greaves).

During the late 19th century and early 20th century reports of DID became more frequent and its symptoms increasingly elaborated (Ross, 1997). Pierre Janet, for example, described a number of cases of multiple personality including the cases of Leonie, Lucie, Rose, Marie, and Marceline (Merskey, 1995b; Putnam, 1989a). Leonie appeared to have three or more personality states including a child alter named Nichette, a childhood name. In the case of Lucie, who also reputedly had three personality states, there was an alter personality named Adrienne who seemed to experience flashbacks of a traumatic childhood event. In the case of Rose, she suffered from a variety of somnambulistic states. In some, she was paralysed and in others she was able to walk.

According to Greaves (1993), the published case literature on DID during the 19th century and the early part of the 20th century would occupy several volumes. In 1944 Taylor and Martin published a paper that surveyed all the cases of DID known to its authors and “was the most quoted reference in the history of the illness” for the next 30 years (Greaves, 1993, p. 361). Thereafter few accounts of DID were published in the English speaking world until Thigpen and Cleckley’s (1954) paper, “A case of multiple personality”. Their book based on this case The Three Faces of Eve was published in 1957. Despite Taylor and Martin’s (1944) paper and the work of Thigpen and Cleckley (1954; 1957), little new work on DID was reported during the period 1910 to 1980 (Ross, 1997). Fine (1988), however, reported on several cases previously unknown to most students of the condition that had been reported during this period in the French and the European literature (Kluft, 1994a).

The decline of interest in the dissociative disorders was paralleled by the rise of Freudian concepts, with Bleuler declaring DID a form of schizophrenia, and with the predominance of behaviourism in academic psychology (Kluft, 1994a). Thigpen and Cleckley’s (1954, 1957) work renewed interest in the study of DID. However, this was in part offset by their assertion that the disorder was extremely rare, by the patient’s minimal responsiveness to treatment, and by the absence of clarity regarding issues of aetiology and treatment (Greaves, 1993). Thigpen and Cleckley (1984) continued to view DID as extremely rare and stated that they had only seen one additional genuine case. Greaves considered that the absence of a clear aetiology and treatment approach contributed to the decline of interest in the study of DID. It was not until the publication of the book Sybil by Schreiber (1973) that the relationship between childhood abuse and DID begin to gain wider recognition. Schreiber’s book was based on Cornelia Wilbur’s treatment of Sybil. Greaves (p. 364) considered this case to be “the most important clinical case of multiple personality in the twentieth century”.

Greaves (1993) proposed that the case of Sybil is significant in several respects. Firstly, Wilbur went to great lengths to validate the accounts of abuse including interviews with Sybil's parents, a visit with Sybil to her childhood home and discussion with Sybil's doctor including a review of his records. Secondly, the

case firmly linked DID with child abuse. Thirdly, graphic description of the amnesia, fugue episodes, and conflicts among alters in Schreiber's book "served as a template against which other patients could be compared and understood" (Putnam, 1989a, p. 35). Wilbur's therapy included hypnosis and other therapeutic interventions and produced a successful resolution which "served as an example for many multiples and their therapists" (Putnam, p. 35).

As the 1970s continued, case reports of DID became more frequent. However, many of the articles and reports on DID over the next two decades focused on proving that DID existed rather than on contributing new clinical knowledge. Putnam (1989a) considers that the "critical and conservative tone" that had been adopted in the review articles of Taylor and Martin (1944), and Sutcliffe and Jones (1962) contributed to this. In a discussion of these reviews, Putnam (p. 32) observes that "although both concluded that multiple personality was a real clinical entity that could not be discounted as fad or fraud, they set a stance of defensive scepticism that later authors were forced to adopt for purposes of credibility."

Ross (1997) identified the year 1980 as a landmark in the history of DID because the dissociative disorders were given official diagnostic status in the Diagnostic and Statistical Manual of Mental Disorders-3rd ed. (DSM-III) (American Psychiatric Association, 1980). Putnam (1989a, p. 35) considered that this "conferred a legitimacy upon DID that no other form of 'proof of existence' could". The DSM-III discussion was important in several ways. First, it differentiated DID from other disorders such as schizophrenia. The finding that DID patients are often misdiagnosed as suffering from schizophrenia has been confirmed several times since (Bliss, 1980; Bliss & Jeppsen, 1985; Putnam, Guroff, Silberman, Barban, & Post 1986). Second, the DSM-III also assisted in the establishment of specific criteria for DID which provided many clinicians with their first exposure to the disorder. Third, the recognition of DID by the DSM-III also stimulated renewed interest in the disorder and encouraged many clinicians who were treating DID cases to share their knowledge more openly (Putnam, 1989a).

Ross (1997) considered that the modern scientific study of DID commenced in 1984. He attributed this to the formation of the International Society of the Study of Multiple Personality and Dissociation (ISSMP&D) renamed the International Society for the Study of Dissociation (ISSD) in 1994. The ISSMP&D was the first major conference on DID. It was held in Chicago in 1984 and brought together many leading figures in the field. The conference became an annual event and assisted in promoting research into DID and its publication in the scientific literature.

An increase in reported cases such as the series of 50 patients reported by Coons, Bowman and Milstein (1988) led to the removal “rare” designation from the description of DID in DSM-III-R (American Psychiatric Association, 1987). More recently additional large series of cases have been reported by Boon & Draijer, (1993), Middleton and Butler (1998), Ross, Miller, Reagor, Bjornson, Fraser and Anderson (1990), Ross, Norton and Wozney (1989b), and Schultz, Braun and Kluft (1989). In the most recent edition of the DSM-IV (1994), the text on the dissociative disorders and DID has been expanded and the diagnostic criteria for DID improved by the addition of amnesia criterion. The addition of the amnesia criteria is empirically supported in the literature and its inclusion further assists in differentiating DID from Borderline Personality Disorder (Gleaves & May, 2001). The increased understanding of the link between trauma and DID has led to an increased level of research (Kluft, 1994b).

Despite this activity and the long history of the DID the dissociative disorders are still marginalized within psychiatry and psychology and considerable scepticism of DID remains. Despite tremendous North American interest, British and Australian publications “carry few articles on dissociative disorders: they tend to be sceptical of MPD [DID], viewing it as more a figment of American mental health professionals minds than psychiatric illness” (Atchison & McFarlane, 1994, p. 593).

Dissociation Identity Disorder and Trauma

Many clinicians and researchers in the field of dissociative disorder argue that DID is amongst the most severe psychological responses to repeated childhood sexual trauma (Kluft, 1999a; Putnam, 1997) and that it is accompanied by pervasive changes in neurological functioning (Streeck-Fischer & van der Kolk, 2000). Bowlby (1988) defined trauma as any perceived threat to the self. He noted its pervasive effects on the developmental well being of the individual. From this perspective the experience of trauma is a function of the interaction between the event itself and the perception of the individual experiencing it (Bowlby). Van der Kolk and Saporta (1991) proposed that trauma is qualitatively different from routine stress and that intense experience of trauma results in lasting biological changes to the central nervous system. Yehuda and Harvey (1997) recently refuted a putative linear relationship between routine stress and a number of psychobiological variables, in particular, serum cortisol. Biological differences were also found between acute stress and chronic posttraumatic stress disorders. Further, Yehuda (2000) reported that the biology of traumatic stress seems to be different than biological alterations observed in other psychiatric disorders such as depression.

A number of studies support the relationship between childhood trauma and DID. Coons and Milstein (1986) reported that 85% of a series of 20 patients with DID had documented histories of childhood abuse, while Frischholz (1985) and Putnam et al. (1986) reported rates of severe childhood abuse in more than 90% of their patients. Coons (1994a) also established confirmation for 18 out of 19 cases of adolescent DID and Dissociative Disorder Not Otherwise Specified (DDNOS). Similarly, Hornstein and Putnam (1992) documented abuse in 61 out of 66 children and adolescents suffering from DID or DDNOS. Kluft (1999c) similarly established validation that abuse had taken place in 19 of 34 DID adult patients whom he had treated. Furthermore, of these 19, 10 had always recalled the abuse and 13 of the 19 were able to obtain documentation of events that had been retrieved during their treatment. Ross (1997) reviewed the epidemiological literature on DID and reported that at least 88% of DID patients report either sexual or physical childhood abuse during their first assessment. Ross also discovered that these patients had continuous memory before treatment for some of the abuse and that they recalled further details

during the course of therapy. The sex incidence is about 85% female (Coons, 1980). This increased incidence of DID in women may occur because sexual abuse and incest, which are strongly associated with DID, occur predominantly in female children and adolescents. Putnam (1989a, p. 49) stated that the type of abuse suffered by DID patients tends to have been significantly more “sadistic and bizarre than that suffered by most victims of child abuse”. The degree of incapacity may vary from mild to severe. Subsequent adult impairment may result not from the trauma alone, but from the destructive context in which it is embedded (Tillman, Nash, & Lerner, 1994). Spiegel (1988) concurred. He argued further that although dissociation remained the central consequence of trauma it needed to be examined within the broader context of disturbed cognitive development and identity formation. In a similar vein, Terr (1991, 1994) postulated that the type of trauma experienced in childhood could be divided into two basic types. Traumatic events that are singular and unanticipated lead to “Type I” trauma. Full detailed memories “omens” and misperceptions characterize this type of trauma. Whereas, longstanding repeated exposure to extreme traumatic events leads to “Type II” disorders. Denial and psychic numbing, self-hypnosis, rage, and dissociation characterize these. Terr proposed that the repeated use of dissociation as defence against overwhelming trauma is the progenitor of dissociative disorders in adulthood.

Dissociative Identity Disorder and Ritualistic Abuse

Since the middle of the 1980s there has been an increase of DID patients recalling extreme sexual and physical maltreatment occurring as part of a ritualistic abuse practice (Kluft, 1997). These patients frequently allege that family members had participated in the ritualized abuse experiences (Kluft). Ritualistic abuse is at the extreme end of trauma and one of the most severe forms of abuse reported by people suffering from DID (Coons, 1997). Young and Young (1997), for example, reported that DID patients who report ritualistic abuse manifest the most complex dissociative and posttraumatic features of the severe abuse syndromes. The case for ritualistic abuse is, however, hampered by a lack of confirming evidence and despite extensive legal investigation there has so far been no external verification (Coons 1994b; Lanning, 1992).

Fraser (1997a, 1997b) reported that there has been little formal research into the ritualistic abuse phenomenon. Coons (1997) concurred and observed that despite the fervour of disputant beliefs regarding ritualistic abuse research into it has only just begun. Greaves (1992) distinguished four approaches frequently adopted by professionals interested in the ritualistic abuse area: (1) nihilism, (2) apologist, (3) heuristic, and (4) methodologist. Nihilists, he argued, seem to explain away presentations of ritualistic abuse because they can conceive alternative explanations and that therefore allegations of ritualistic abuse cannot be true. Greaves divided apologists into two categories: (a) those who conceive their task as explaining why ritualistic abuse productions must be true, and (b) those who argue that many of the ritualistic abuse claims could be true. Heuristics, Greaves stated, are clinicians who are mainly uncommitted to any objective conclusions about the whole matter, but who have found that treating their ritually abused patients' reports in a confirming manner has resulted in favourable treatment outcomes. Methodologists, Greaves proffered, have the least developed perspective in the ritualistic abuse field. Greaves maintains that in any scientific investigation, observation always precedes method and that from a psychiatric perspective there has been insufficient systematic investigation for a clear methodology to evolve. He states that there is disagreement on such fundamentals as what data should be observed and that researchers are frequently working from different data bases which results in a failure to make key discriminations between issues. Greaves (p. 48) concluded that the confusion regarding such issues has allowed researchers "to engage each other in endless 'straw man' arguments".

Fraser (1997b) stated that the term ritual abuse was probably first used in the book Michelle Remembers (Smith & Pazder, 1980). Other more recent terms are sadistic abuse, sadistic ritual abuse and satanic ritual abuse. Fraser (1997a, p. xii) summarized the major features that are alleged in reports of ritualistic abuse as including some or all of the following:

- Perverted physical, psychological, and sexual abuse of children and adults is reported in groups frequently claiming or pretending to worship Satan.

- Mind coercion techniques, including terror and isolation, are reputedly used to obtain compliance, discourage defection, and ensure future obedience, allegiance, and secrecy.
- Enforced membership lasts for many years and ideally for life.
- Members may believe themselves wedded or committed to Satan and unable to escape his ever-watchful eye.
- There is obedience to a hierarchy of leadership. Leaders are often called priests or priestesses.
- Ceremonies are said to include the ingestion of blood and urine obtained from humans or animals.
- Human sacrifices allegedly occur, and human body parts may be disposed of in ritualized cannibalistic ceremonies.
- Inbreeding and the subsequent desecration of the foetus or newborn are reported. In other cases, some infants are supposedly groomed as future leaders or recruiters.
- Members may come from all strata of society. Multigenerational familial participation is said to be common.
- Sexual orgies, including paedophilia, promiscuity, and bestiality, reputedly take place. Frequently these acts are done under the influence of mind-altering chemicals. These acts may be filmed for future sale in the pornographic market.
- Ceremonies supposedly occur on major Christian feast days or on days relating to natural planetary phases such as the summer solstice or the cycles of the moon.

Van der Hart, Boon and Jansen (1997) observed that most DID patients alleging ritual abuse present a consistent and persistent set of severe symptoms. These include severe posttraumatic stress symptoms, somatoform symptoms, extreme and unusual fears and phobias. They also experience repeated dissociative states in which behaviours associated with ritualized abuse are exhibited and reported. There is frequent substance abuse, recurrent self-mutilation such as cutting and burning, repeated attempted suicide or feelings that one has to die, extreme

feelings of guilt and shame, and indoctrinated belief systems. Typically, these patients have a long history of medical and psychiatric care, and many of the symptoms and behaviours outlined above were present before specific DID treatments were started. Ross (1995) observed that ritual abuse patients talk about, and are more preoccupied with, calendar dates than DID patients with no claims of ritual abuse.

Coons (1997) estimated that of those patients reporting ritualistic abuse only a minority is suffering from psychoses or a factitious disorder which leaves the question of how to treat those who report ritualistic abuse and are not psychotic or factitious. Many, as previously noted, have severe dissociative symptoms. For therapists, the treatment of patients who report having been involved in ritual abuse is “experienced as significantly more complex, more difficult, more challenging and more professionally ‘draining’ than clinical work with other client groups” (Youngson, 1994, p. 296). Kluft (1997) reported that length of treatment for DID patients alleging ritual abuse is nearly doubled compared with the treatment of DID patients not alleging ritual abuse. Further, DID patients alleging ritual abuse are likely to experience significantly more crises, regressions, hospitalizations, and episodes of self-injury during treatment than DID patients not alleging ritualistic abuse. Kluft concluded that it was not clear whether the increased pathology and length of treatment was due to the severity of the trauma and abuse, whether it was due to iatrogenic bias during treatment, or whether it was due to factors applicable to these patients.

Coons (1997) reported that patients who report ritualistic abuse and do not have evidence of either factitious disorder or psychosis sincerely believe that they were victims of ritual abuse and express emotions associated with such traumatic events that must be respected. Similarly, Kluft (1997) considered that if the patient continues to produce ritualistic abuse material then it would have to be addressed during treatment despite any uncertainty about its historical reality. Sakheim and Devine (1992 p. xiii) affirmed that in order to understand allegations of ritual abuse we must maintain scientific scepticism and clinical empathy and that we “need to

avoid the hysteria of overreaction and the denial mechanisms triggered when one is confronted with horrible material”. Sakheim and Devine (p. xiii) observed that:

Despite our psychological understanding of post-traumatic stress reactions, we tend to disbelieve most victims. We preferred not to believe the reports of incest and other forms of child abuse for years. In general, we demand tremendous amounts of proof before we are willing to believe that people can be horrible to one another. Although we know that this has occurred throughout history, each time such practices come to light we try to avoid the pain of knowledge.

In a similar vein, Mollon (1996, p. 184) considered that “Accounts of ritual abuse suggest profoundly perverse activity. The question of the existence of cults that abuse children is controversial. What is less in doubt is the existence of pornography depicting deeply perverse abuse of children, including murder”. In treating these patients Mollon (1994) stressed the need for the therapist to maintain an “open mind” regarding such material and to be ready to revise tentative hypotheses as further data emerge.

Trauma and Memory

Williams and Banyard (1999) believed that the contentious nature of the debate about the accuracy of memories of childhood trauma recalled in adulthood may, in part, be the result of the different strategies used for clinical and laboratory research. The study methods for traumatic memory in normal humans may not be applicable to victims of extreme trauma, such as childhood abuse. Much of the research on adults forgetting trauma that occurred in childhood is based on studies of clinical samples of adults in treatment for the consequences of such trauma (e.g., war veterans, survivors of childhood sexual abuse). Such studies often necessarily have to rely on uncorroborated trauma histories and retrospective reconstruction of memory states. Conversely, the research focusing on “recovered memories” of fictitious events has occurred in laboratory controlled studies (e.g., Loftus 1993; Loftus, Donders, Hoffman & Schooler, 1989; Loftus & Hoffman, 1989) that maximize specificity but draw criticism in regard to ecological validity (van der Kolk, 1996b; van der Kolk & Fisler, 1995).

In response to this debate Williams and Banyard (1999) propose that it may be more appropriate to consider research that investigates the effects of extreme stress on memory function (Bremner, Krystal, Charney & Southwick, 1996; Bremner, Krystal, Southwick & Charney, 1995, 1996a, 1996b). Current research generally supports the view that memory organization is a dynamic process that changes over time and that can be affected by the intrusion of new events and by the act of retrieval itself (Bremner, 1999; Loftus & Hoffman, 1989; Yapko 1994; Zola, 1997). Conversely, there are also carefully controlled laboratory studies showing that information that was initially processed consciously and stored, but later forgotten, can be brought back, a phenomenon called hypermnesia (Erdelyi, 1984, 1996). Current research indicates that the brain is made up of anatomically distinct regions that constitute a cohesive and integrated system organized in a way that is not completely understood (Greenfield, 2000/1998). Similarly, current research also indicates that there is more than one kind of memory with different kinds of memory dependent on different brain systems (LeDoux, 1996; Squire, 1992; Zola & Squire, 1986). The different memory systems are linked by the medial temporal lobe (Alvarez & Squire, 1994). This region of the brain encompasses several areas, including the hippocampal region and the entorhinal, perirhinal, and parahippocampal cortices (Zola & Squire, 1993). The medial temporal lobe region binds the disparate aspect of a memory from the separate specialized regions distributed in the cortex and helps make them into a cohesive whole again at the time of recollection. Zola (1997) reasoned that if there is more than one kind of memory then memory is not a unitary entity and that it is, therefore, necessary to qualify statements about memory in any discussion of “recovered memory”.

That there are different kinds of memory dependent on different brain systems has generated considerable research on the distinction between explicit and implicit memory (Bremner, 1999; Parkin, 1999; Zola, 1997). Explicit, conscious or declarative memory is mediated by the hippocampus and related cortical areas, whereas implicit or unconscious forms of memory are mediated by different systems (Bremner, 1999). One implicit memory system is an emotional (fear) memory system involving the amygdala and related areas (Davis, 1997; Davis & Whalen, 2001; Schacter, 1996). In traumatic situations, implicit and explicit memory systems

function in parallel (LeDoux, 1996). Subsequently, stimuli similar to those experienced in the original trauma can activate both the explicit memories of the event and the implicit emotions associated with them. LeDoux (p. 202) described the process thus:

Later, if you are exposed to stimuli that were present during the trauma, both systems will most likely be reactivated. Through the hippocampal system you will remember whom you were with and what you were doing during the trauma, and will also remember, as a cold fact, that the situation was awful. Through the amygdala system the stimuli will cause your muscles to tense up, your blood pressure and heart rate to change, and hormones to be released, among other bodily and brain responses.

Bremner (1999) submitted that current research supports the proposition that traumatic life events can alter the human hippocampus and its memory functions (Jacobs & Nadel, 1985) and can impair explicit conscious memory functions (Bremner et al., 1993; McEwen & Sapolsky, 1995). Bremner (1999) also proposed that these differences might be invoked to provide a rationale for delayed recall of childhood abuse. Because the hippocampus is thought to be involved in memory recall and the placing of memories in space and time, it has been hypothesized that hippocampal dysfunction is involved in memory fragmentation and delayed or impaired recall evident in post traumatic stress disorder (PTSD) patients (van der Kolk, 1996b). Nijenhuis, Spinhoven, Vanderlinden, Dyck and van der Hart (1998) argued that since DID may be regarded as a complex form of PTSD (Herman, 1992; Spiegel, 1984; van der Kolk, Herron & Hostetler, 1994), explanatory models of PTSD also could be applicable to DID. Recent studies, for example, have shown that in survivors of trauma, such as victims of repeated childhood abuse or Vietnam veterans with PTSD, the hippocampus is shrunken (Bremner et al., 1995; McEwen, 1992). These same persons exhibit significant deficits in memory ability, without any loss in IQ or other cognitive functions. It is generally accepted that adrenal steroids, released by the amygdala in response to stress, account for these physical changes in the hippocampus and in the memory problems that result (Diamond & Rose, 1994; LeDoux, 1996; McEwen & Sapolsky, 1995).

The research outlined above indicates that the hippocampus plays an important role in the formation and later recall of traumatic memory. LeDoux (1996) proposed that if the hippocampus were completely overwhelmed by stress at the time of the trauma then it would have no capacity to form an explicit memory of the event. It would therefore be impossible to “recover” a conscious memory of the event since no such memory would have been formed. If, however, the hippocampus was only partially affected by the trauma it is likely that the formation of memory will be weak and fragmented, such that there would be deficits in retrieval and delayed recall (Bremner, 1999; Bremner et al., 1995). In such a situation, it may be possible to reconstruct aspects of the experience mentally, however, the accuracy of the memory will depend on “how much filling in was done and how critical the filled-in parts were to the essence of the memory” (LeDoux, p. 244).

The reverse appears to be the case for implicit memory since stress does not seem to interfere with the performance of the amygdala (Bremner, 1999; Zola, 1997) and may even enhance its functioning (Christianson & Loftus, 1987, 1991). LeDoux (1996) hypothesized that victims of trauma might have no explicit recall of a traumatic event, but at the same time form very powerful implicit, unconscious emotional memories through amygdala mediated fear conditioning that potentially can become a source of intense anxiety. Due to the conditioned fear effect, later exposure to cues related to the original traumatic event in the relatively “safe” environment of the therapeutic process might later facilitate retrieval of the traumatic event (Bremner, 1999; Bremner et al., 1995).

Van der Kolk (1996b) suggested that what might most complicate the capacity to communicate about traumatic experiences is that memories of trauma may have no verbal (explicit memory) component. Instead, he proposed traumatic memories might have been organized on an implicit or perceptual level, without any accompanying narrative about what happened. Rauch et al. (1996) found some support for this proposition. During the provocation of traumatic memories in PTSD patients, Rauch et al. found there was a decrease in activation of Broca’s area, the part of the brain most centrally involved in the transformation of subjective experience into speech. Simultaneously, the areas in the right hemisphere (including

the amygdala) that are thought to process intense emotions and visual images showed significantly increased activation. That is, traumatic material appeared to be organized on a perceptual (implicit) level rather than on a narrative (explicit) level (Terr, 1994; van der Kolk, 1996b; van der Kolk & van der Hart, 1991).

Van der Kolk (1996b) proposed that strong emotional arousal experienced in trauma interferes with hippocampal functioning and therefore explicit memory. He suggested that sensory input from the thalamus is initially processed by the amygdala (LeDoux, 2002) then the hippocampus and then the prefrontal cortex where integration and planning occurs. In traumatic situations, however, extreme arousal disrupts hippocampal functioning and its capacity for the consolidation of memories (Greenfield, 2000/1998), leaving the memories to be stored as affective states in the amygdala or in sensorimotor modalities, as somatic sensations and visual images (van der Kolk, 1996c). These amygdala-mediated emotional memories (implicit memories) are thought to be relatively indelible, but their expression can be modified by feedback from the prefrontal cortex (van der Kolk, 1996b, 1996c).

Aetiology of Dissociative Identity Disorder

Whilst trauma has been identified by many researchers as the main progenitor of DID it is also acknowledged that DID can develop from other pathways. Ross (1997), for example, proposed that DID can develop from one of four pathways. He identified these pathways as (1) childhood abuse, (2) childhood neglect, (3) factitious disorder, and (4) iatrogenic bias. He considered that each pathway has a unique pattern that differentiates it from the other three. Childhood abuse, as a pathway to DID has already been discussed; its main features being that DID is understood as a defensive adaptation to severe, chronic childhood trauma. In these circumstances Ross considered that the manifestation of DID will be apparent before the age of 10 years, and that the child will exhibit symptoms of complex dissociation on a chronic basis.

Ross (1997) described childhood neglect DID pathway patients as having developed from the emotional unavailability or absence of one or both parents. The parents themselves are often suffering from DID or from such disorders as depression, alcoholism, and psychosis. Childhood neglect may involve such incidents as being locked in cupboards and basements or left in a cradle alone for prolonged periods. Ross described the pervasive trauma experienced by neglected and emotionally deprived children as the absence of a secure attachment figure (Bowlby, 1988). In the absence of a secure attachment figure these children retreat into an internal fantasy world which they populate with imaginary identities with whom they can form attachments.

Ross (1997) proposed that once such an elaborated inner world has been created the neglect pathway patients apparently develop in one of three sub-pathways. In some cases the person activates inner personalities who take executive control in dealing with the outside world prior to therapy. In these patients Ross considers that diagnostic representation is predominately one of DDNOS (Dissociative Disorder Not Otherwise Specified) with some pre-existing “relatively simple” DID. On the second sub-pathway the DDNOS is elaborated iatrogenically by therapist error into a speciously created DID. On the third pathway the patient is DDNOS at the beginning of therapy and DID does not develop. Childhood neglect patients are usually very responsive to hypnosis, but not to the same extreme level as patients with DID childhood abuse pathways. He considered that childhood neglect patients typically present as dependent personalities and that the preferred treatment modality is a modified DID/trauma model in which the therapist treats the patient as a whole entity rather than working with each individual alter personality, as in childhood abuse DID patients.

For both childhood abuse and childhood neglect patients, Ross (1997) identified attachment to the perpetrator as the fundamental developmental problem to which the child has to respond. For the child the biological imperative is the need for an attachment figure (Bowlby, 1991/1971, 1991/1973, 1991/1980), but frequently the only figure available is that of the perpetrator. Ross stated that in such circumstances the child is caught between the need for attachment and the need to detach from a

destructive environment. Such circumstances create confusion for the child, “The environment, through the abuse, signals the child to shut down her attachment systems, but her genes override this environmental imperative. The two realities do not fit together, and the world does not make sense” (Ross, p. 65).

As discussed in the previous section on dissociation, DID is generally understood as an adaptive response to overwhelming trauma. The adaptive and defensive aspects of severe dissociation become elaborated with time and leads to the development of alter personalities (Putnam, 1997). Ross (1997) extended this model suggesting that the biological need for attachment may be the mechanism that enables the child to form a relationship with the perpetrator. Ross considered that the child must dissociate in order to retain his or her psychobiological integrity; the dissociation allows attachment responses to develop. However, in such circumstances the need for attachment becomes “personified as separate identities that idealize the parents, and are amnesiac for most or all of the abuse. The amnesia barriers need not be absolute, as long as they downregulate [modulate] the traumatic psychophysiology sufficiently to permit attachment.” This allows for the creation of stable alter personalities that are “always available for attachment, safety, security, and nurturing” (Ross p. 65).

Factitious Disorder patients presenting as DID are on the third pathway. Factitious Disorder is characterized by physical or psychological symptoms that are intentionally produced or feigned and motivated by a psychological need to assume the sick role (DSM-IV, 1994). These patients do not have a history of dissociative symptoms before therapy, but they do usually have an elaborate medical-surgical history and often have an extensive knowledge of medical terminology and hospital routines. Ross (1997) reported that they are not as receptive to hypnosis as childhood abuse and childhood neglect patients but, because they are seeking to deceive, may report extreme high scores on measures of dissociation such as the Dissociative Experiences Scale. Confronting these patients with evidence that their symptoms of DID are factitious usually leads either to relatively rapid remission of the DID, or their departure to seek treatment in another facility where they again present with factitious DID.

The iatrogenic pathway differs from Factitious Disorder where there is a deliberate attempt by the patient to feign DID symptoms. In iatrogenic cases Ross (1997) considered DID to be caused by poor therapy techniques. In the predominately iatrogenic case, there is no history of chronic, severe dissociative symptoms before therapy, although some fantasy proneness and hypnotic ability is required to create iatrogenic DID. Similarly, like the patients from the neglect and factitious pathways, iatrogenic patients do not seem to have the extreme trance proneness that is evident in childhood abuse DID patients. During the iatrogenic DID phase, iatrogenic patients present like factitious disorder patients with high scores on measures of dissociation such as the DES, however, their scores return to normal once they receive appropriate treatment.

Ross regarded pure iatrogenic cases as developing from one of three premorbid conditions. One group of patients has bipolar mood disorder (Merskey, 1995a), which is interpreted by the therapist as switching of alter personalities. The second group of patients has complex symptoms of anxiety, mood disorder, eating disorder, personality disorder, and dissociation, but no diagnosable dissociative disorder. The third group of patients has posttraumatic stress disorder but no DDNOS or DID before contact with the therapist. Ross (1997, p. 71) reported that, of the pure iatrogenic cases he has examined, the amount of control and influence by the therapist has “been extreme and has involved inpatient admissions for as long as two years or 10 to 15 hours of outpatient contact per week for years”.

Kluft (1984a) proposed a four factor theory for the aetiology of DID and severe dissociation. His four factors relate to the childhood abuse pathway elaborated by Ross (1997). Kluft proposed that these four factors are necessary for DID to occur. Simply expressed the four factors are:

1. That the child possesses a high capacity for dissociation.
2. That the child has experienced severe and chronic trauma that overwhelms the normal adaptive function of dissociation.

3. Dissociative responses are shaped by particular childhood influences and to some extent rewarded by the family. The form and organization of DID depend on the child's temperament and other non-traumatic experiences.
4. The abuse is persistent with inadequate soothing or comfort during and after traumatic episodes. There is also a systemic family collusion to deny feeling, to forget pain, and to act as if the abuse was imaginary and did not occur.

Ross's (1997) four pathways to DID proposed that DID cases can be created as in iatrogenic cases where there is extreme and prolonged therapeutic error. DID cases can also be created when factious disorders are not properly diagnosed and, in childhood neglect cases, where DDNOS or relatively simple forms of DID are exacerbated. Kluft (1999a) concurred that iatrogenic factors can further complicate and cause deterioration in the condition, but is not convinced that the "full" DID condition can be iatrogenically created. The "full" DID condition is described in the childhood abuse pathway (Ross, 1999). Kluft's (1984a) four-factor theory describes this pathway. The DSM-IV (1994) is a phenomenological diagnostic system. Its criteria for DID (as presented earlier) describe the childhood abuse pathway and distinguish the other factors detailed by Ross when differential diagnosis criteria are applied to a diagnosis of DID. The DID criteria specified by the DSM-IV (1994) are applied in this study though consideration is given to the other pathways discussed by Ross.

Summary

1. The diagnostic criteria for DID are as presented in the DSM-IV.
2. DID has a long and well documented history, with modern studies dating from Janet's work. Despite this the study of DID is still marginalized within psychiatry and psychology (Ross, 1997).
3. Many researchers have detailed the lasting impact of trauma on the central nervous system. Exposure to extreme and repeated traumatic events is understood as the progenitor of DID in adulthood (Streeck-Fischer & van der Kolk, 2000).

4. Since the middle of the 1980s there has been an increase of patients who report ritualistic abuse. Whilst there has been little formal research into the topic, patients alleging such abuse tend to present with the most complex dissociative and posttraumatic features of the severe abuse syndromes (Fraser, 1997b; Greaves, 1992).
5. Recent research has confirmed that there are different kinds of memory each dependent on different regions of the brain. Such findings have led some researchers to suggest that traumatic memories are organized and processed differently from “normal” memory and that this impacts on the later recall of traumatic memories (LeDoux, 1996; van der Kolk, 1996b; Williams & Banyard, 1999).
6. Whilst trauma is identified as the main progenitor of DID other pathways such as factitious disorder, and iatrogenic bias are acknowledged (Ross, 1997).

In this chapter some of the issues requiring further study were discussed along with an overview of the literature on dissociation and dissociative identity disorder. In the following chapter issues pertinent to this study are considered.

CHAPTER TWO

2.0 ISSUES PERTINENT TO THIS STUDY

Overview

Discussion has so far focused on the broad issues relevant to a diagnosis of DID and the dissociative disorders. Issues regarding DID that are applicable to the present study will be considered in this section. Three areas of research are discussed: (1) DID and iatrogenic bias, considered under the headings of (a) therapist bias (b) malingering, and (c) single case studies; (2) alternative personalities and their function in the presentation of DID; and (3) the treatment of DID.

2.1 Dissociative Identity Disorder and Iatrogenic Bias

Therapist Bias

Whether DID is a naturally occurring disorder or the result of therapeutic bias and/or malingering is one of the most enduring debates regarding DID. Sceptics of the disorder consider that all alter personalities and the full DID condition itself are the result of therapeutic bias and/or cultural influence (e.g., Ofshe & Watters, 1994; Piper, 1997; Simpson, 1995). Simpson (p. 100) for example, considered that therapists exert strong pressure “to get the patient to accept the diagnosis of MPD” and that such therapists commonly use “leading and repeated questions” to shape and “coach” patient responses. As previously discussed, Ross (1997) agreed that iatrogenic bias can influence the development and symptoms of DID. However, as Ross noted, to induce pure iatrogenic bias requires considerable effort and persistence on the part of the therapist. Kluft (1999a) acknowledged that iatrogenic factors can further complicate the condition, but noted that such bias is not

representative of the full DID condition and that the full manifestation of DID cannot be created iatrogenically by error on the part of an inexperienced therapist.

Concern that therapeutic intervention might exacerbate the condition is evident in the literature and is of particular importance to therapists working in the area of DID. Putnam (1989a) identified possible iatrogenesis and exacerbation of symptoms as the most common fears of therapists beginning to work with DID. Not surprisingly, the therapist's attitude about iatrogenesis can play a significant role in both the under and over-diagnosis of DID (Braun, 1989). Putnam (p. 132) argued that:

The most convincing evidence that alters are not being iatrogenically induced comes with time. Although new personalities may be created in therapy, the vast majority of alters in any given multiple's system will have a history that predates the diagnosis and therapy by many years.

Kluft (1999a) noted that it has long been clear that many of the symptoms of DID can be created by suggestion or experimental manipulation and that, with minimal suggestion, individuals can be induced to enact several DID behaviours. Spanos (1996), for example, considered that DID is a social construct that exists within a particular cultural and historical framework. He suggested that some therapists routinely encourage their patients to construe themselves as possessing multiple personalities. From this perspective, patients "learn to reorganize and elaborate on their personal biography so as to make it congruent with their understanding of what it means to be a multiple" (Spanos p. 3). Spanos (p. 3) maintained that therapists play a particularly important part in the generation and maintenance of DID providing "official legitimization for the different identities that their patients enact". Some of the research on which these observations are based come from studies in which actors are taught to simulate DID. However, conclusions from experiments on normal individuals such as college students or actors cannot be generalized to authentic patients suffering from DID and are not proof that DID does not exist outside of iatrogenic biasing (Putnam, 1989a; Ross, 1997). Likewise, the enactment of behaviours associated with a mental disorder does not constitute proof that one has the mental disorder or provide evidence that the disorder does not exist (Spitzer,

1976). Kluft (1999a) submitted that even if some symptoms can be induced by hypnosis or suggestion in normal individuals or even in some patients, this does not explain all DID cases, such as those never exposed to hypnosis or overt suggestion (Spiegel, 1988).

Similarly, with cultural influence, expectations may exert a significant impact upon the presentation of DID, but it does not necessarily make the condition invalid. Tutkun, Sar, Yargiue, Ozpulat, Yanik and Kiziltan, (1998), for example, found that the percentage of DID and dissociative disorders in Turkey was similar to those reported in North American studies. Moreover, their study reported that patients presented with the same clinical issues as those reported in North American studies, yet DID phenomena are not part of the popular Turkish culture and patients had not been exposed to antecedent suggestive influences (Tutkun et al.). In a similar vein, Somer and Weiner (1996) studied the diaries of a small group of patients diagnosed with DID and found evidence of early dissociation years before they had sought treatment and long before discussion of DID had become popular in the media.

Ross, Norton and Fraser (1989) hypothesized that, if DID is due to iatrogenic bias, then specialists ought to exert this influence more strongly than do general psychiatrists. They collected data from 236 cases of DID reported by 203 general psychiatrists. Additional data were gathered on 45 cases seen by two psychiatrists who were specialists in the area of DID. Ross et al. found no differences between these groups, either on the diagnostic criteria for DID or the number of personalities identified. Specialists in DID, they argued, were not influencing their patients to create an increased number of personalities, nor to meet more diagnostic criteria. The authors concluded that their data provide evidence against the contention of iatrogenesis in DID and compelling evidence supporting DID as a genuine disorder with a consistent set of core features.

Proponents of DID also point to documented physiological differences between personality states in DID as further evidence of its diagnostic validity. These conditions cannot be fully replicated by normal or professional actors

simulating different personality states (Ross, 1997). The physiological documentation cited includes findings of distinctive patterns among the various alternate personalities in studies of positron emission tomography (PET) scans, evoked potential (Larmore, Ludwig, & Gain, 1977; Putnam, Loewenstein, Silberman & Post, 1984), voice prints (Putnam, 1984), visual acuity, eye muscle balance, visual field size (Miller, 1989), galvanic skin response (Bahnson & Smith, 1975; Brende, 1984; Putnam, 1984), electroencephalographic patterns (Coons, Milstein, & Marley, 1982), electromyography (Larmore, Ludwig & Gain, 1977), and cerebral blood flow (Matthew, Jack, & West, 1985). Moreover, physiological findings specific to particular ages of the alternate personalities being tested have been reported (North et al., 1993).

Ludolph (1985) questioned the wisdom of using hypnosis in the treatment of DID, given the evidence that DID-like manifestations can be hypnotically induced. While hypnosis is advocated as a valuable tool in the treatment of DID (Maldonado & Spiegel, 1995; Spiegel, 1989), experts (Bowers, 1991; Herzog, 1984; Kluft, 1989) also caution that only therapists highly skilled in its use should apply hypnosis to the treatment of DID. They argued that hypnosis could potentially inadvertently foster further dissociation and create new alternative personalities when ineptly handled. Kluft (1982) reported an example of a patient who developed 18 iatrogenically created “alter personalities” due to mishandling by an inexperienced therapist who had not been trained in the use of hypnosis and had not previously used it. Braun (1984a), however, wrote that while it is possible that personality fragments can appear under hypnosis, there is no evidence that personalities with separate histories and a full range of affect can be created with hypnosis. Putnam et al. (1986) also detected no differences in clinical presentations, symptoms, or history between patients who had been hypnotized and those who had not. Similarly, Ross et al. (1989b) found that only a third of the 236 patients they studied had been hypnotized before receiving the diagnosis of DID. Bliss (1988) and Braun (1984b) argued that the alternative personalities routinely begin in childhood, long before individuals are ever introduced to hypnosis. The mean time of first splitting is typically reported to have been between the ages of 4 and 8 years (Coons, Bowman & Milstein, 1988; Fagan & McMahon, 1984; Putnam et al.) and usually before age 12 (Putnam et al.).

However, younger patients may remember further back than adults can and in one study, eight of 11 adolescent patients retrospectively reported alternates beginning by age 3 years (Dell & Eisenhower, 1990). Kluft considered that the available information strongly indicates that DID occurs naturalistically, but that the condition can be responsive to suggestive influences. However, he also noted “if it were completely responsive to suggestion, it would be easy to treat!” (Kluft, 1999a, p. 7).

Kluft (1995) considered the allegation that DID develops from therapeutic bias is easy to make but difficult to sustain, and suggested that allegations of iatrogenic bias need to demonstrate:

1. That neither DID nor DDNOS were present before the questioned therapeutic interventions.
2. That DID can be created by the interventions that are alleged to have created it.
3. That the interventions that are alleged to have created the DID have occurred.
4. That efforts to prevent such an outcome were not made, or were insufficient.
5. The absence of alternative credible explanations for the presence of DID.
6. That if iatrogenic factors necessary to cause DID are present, they were the definitive causative agent rather than a minor contributing factor.

Kluft (1995, p.358) observed, that nowhere in the literature is “there a demonstration rather than an allegation of the iatrogenesis of the full and sustained picture of DID/MPD”. Equally, however, according to North et al. (1993), studies “proving’ that DID exists outside of iatrogenic biasing are also not forthcoming.

Malingering

Kluft (1995) considered that DID patients, along with most of those abused as children, become skilled at anticipating and responding to the needs of others. In response to stressful situations DID patients are capable of manipulation in order to achieve at least an illusion of safety or control. Kluft suggested that those sceptical

of the disorder may perceive the capacity to dissociate as evidence of iatrogenesis and confuse such symptoms with Factitious Disorder/Malingering patients who feign or produce physical or psychological symptoms in order to achieve and maintain the patient role. The ability of DID patients to form new alters in response to their external circumstances, Kluft maintained, should not be construed as evidence for iatrogenesis by those who do not appreciate the adaptive value of such a capacity. Given such concerns, it is not surprising that DID has received considerable attention in forensic settings and as Kluft (1987) observed, many experienced forensic experts are inclined to see individuals with DID as “fakers”, “liars”, and “malingerers”. He compiled a list of behaviours characteristic of malingering and considered whether similar behaviours occurred in DID patients who were not facing any charges and who were under no pressure to prove they had DID. Kluft found that all of the indicators of lying and malingering were also found to occur among genuine DID patients. There were, however, important differences. No malingerer was able to consistently present with an assumed personality’s voice, movement characteristics, or memory, except in situations related to criminal allegations. In malingerers, emotional responses to affectively charged issues unrelated to alleged offences often ceased. They were renewed in interviews known to be for the purpose of forensic evaluation, and when they were under observation by individuals whose reports might influence their assessment. True DID patients were much more consistent, and these differences were significantly maintained regardless of the topic of conversation or with whom the individual was speaking. Furthermore, no malingerer endorsed more than two front rank symptoms of schizophrenia (Schneider, 1959), symptoms which have been shown to be prevalent in DID (Kluft, 1985a, 1987). No malingerer had an extensive prior history of unsuccessful medical treatment or psychotherapy, again indicators of DID (North et al., 1993). In forensic examination malingerers invariably maintained the focus on their legal situation, whereas DID individuals, usually talked about other areas of concern and often had difficulty keeping the forensic purpose of the study in mind.

Coons’ (1989) review of the literature lent further support to these findings. He warned that treatment may obscure the diagnostic presentation of DID, in particular the distinction between personalities. He also found, that in some cases,

behaviours such as absence of appropriate affect, were discriminating and only obvious to trained clinicians. Coons concluded that the most difficult symptoms to fake accurately are the switching phenomena, and consistent reproductions of alter personalities over time.

Kluft's (1995) observation that DID patients can form new alters in response to external circumstances is not surprising given that alters are thought by many clinicians and researchers to be formed in response to overwhelming traumatic influences and have adaptive value. Equally, however, it is difficult to distinguish between characteristics of malingering and those of a DID disorder. Coons (1989) found that behaviours that assisted discrimination between malingering and DID were appropriate affect and the switching phenomena along with consistent reproduction of alter personalities over time. These issues will be considered in the present study.

Single Case Studies

The present study employs a single case methodology. It is therefore important to consider other single case studies where iatrogenic bias has been reported. Information on the outcome of treatment of DID have been obtained from meta analyses (Ross, 1997). These pool and analyse outcome data from numerous small studies. Comparative treatment outcome studies can explore the efficacy of specific treatments, but are of limited value in testing therapeutic constructs (Jones, 1993). To examine dissociative processes, such as emergence of alters and switching between alter personalities in the therapy session, research must employ a case study methodology. Hilliard (1993), in supporting the use of single-case designs for testing clinically important hypotheses about patient change, noted that such studies are frequently merely descriptive, lacking formal hypotheses and neglecting validity issues.

Despite the intensity of debate on DID, few detailed case studies have been reported. Even fewer attempts have been made to institute external validity checks

on events occurring within the treatment session. This is true also of those studies that adopt a sceptical stance. While many have advocated iatrogenesis as the cause for DID, most have failed to apply validity checks when conducting their own research. The following brief review necessarily includes single case studies that are methodologically unsound, and case studies that are sceptical of the disorder.

Cutler and Reed (1975) reported a case in which the development of DID was attributed to social reinforcement. They documented a history of DID-associated phenomena extending back to the childhood of the patient. They argued that the patient was suffering from psychogenic fugue, albeit rare, that she entered when under stress. In it she adopted alternate personalities drawn from past experiences of actual people. These dissociative phenomena, they believed, were then subject to reinforcement from others. Treatment combined recurrent hospitalization with monthly outpatient supportive therapy for three years. Five years later there was a further period of supportive therapy and medication during a period of marital stress. At 15-year follow-up the authors found that the patient had not sought additional psychiatric care. They also reported that the patient's appraisal "of her illness, and particularly of her episodes of multiple personality, is that it is a mechanism for avoiding trouble" (p. 23). Cutler and Reed explained their patient's symptoms within a social learning paradigm but did not provide independent validation of their findings, and gave insufficient data to judge whether, or for what reasons, the symptoms remitted. Possible factors explaining the diminishing treatment contact, and implied remission include a possible minimalist therapeutic approach, patient suggestibility (Kluft, 1987), and dissimulation to "please" the therapist. Cutler and Reed (1975, p. 23) wrote "the gradual remission of symptoms has been most helped by accepting the personality changes and thus being less worried by them". No consideration appears to have been given to behavioural alternatives. Their study failed to meet the basic criteria for good single-case research set out by Hilliard (1993) and its findings are therefore of limited value.

Freeland, Manchand, Chiu, Sharma and Merskey (1993, p. 246) reviewed four cases diagnosed as DID. In one case the patient commented to her treating doctor that, "I was also treated by a psychiatrist who discovered under hypnosis that I

had four different personalities”. The treating doctor replied, “I don't altogether buy the idea of MPD”, to which she responded, “nor do I.” The authors regarded this comment as “proof” that the earlier diagnosis was erroneous. They did not consider the possibility of iatrogenic biasing by the treating doctor against the earlier diagnosis.

A second case, in which one of the differential diagnoses was DID, but which was treated for bipolar affective disorder, is described. After one month of treatment with lithium, the patient reported feeling the best in 10 years. The authors reported that the patient no longer “believes she has a multiple personality disorder, but has mentioned that she knew the existence of a personality named Shelley who liked to swear, deceive and lie” (p. 246). This, they concluded, is evidence of deception, and that the disorder is not one of DID. The authors argued that publicity given to DID has biased its diagnosis because “it cannot be assumed that anyone with the ‘condition’ will have developed it without prior preparation or suggestion, whether from the media or from health care professionals”(p. 247). Whilst the popular press has promulgated the symptoms of DID, the same is true for any psychiatric disorder that has been reported or discussed in the media. Media exposure does not invalidate diagnostic conditions. In a study aimed at identifying experimenter bias, the authors completely ignored the possibility that their own comments regarding DID could have biased their patients’ descriptions of their symptoms, and influenced their treatment.

Seltzer (1994) argued that the apparent development of DID was mediated by patient dependency. He reviewed five cases previously diagnosed with DID by a colleague and failed to find evidence of the disorder in five putative cases. Seltzer, however, did not attempt to validate his proposition. Unfortunately, insufficient clinical data were provided to either establish or exclude any DSM-IV diagnosis. He wrote of case five, “She has improved on clomipramine 200 mg at bedtime but continues to hear the voice of one former alter with some insight into its implantation by the therapist” (p. 444). He discounted the possibility of DID and concluded that the cases “voices” were the result of biasing by his colleague. Without an appropriate validation process, however, they could equally be an indication of DID.

In a recent review of the literature, Sarbin (1997) cited Seltzer as supporting the notion that DID is caused by iatrogenic influences. However, he did not consider the methodological shortcomings of the paper, and did not cite any other study purporting to support the iatrogenic argument. Coons and Grier (1990) recommended the same objective approach to the diagnosis of DID as with any psychiatric disorder. They suggested that this include a careful history taken over several days, careful clinical observation, and collection of collateral information and, where appropriate, psychological testing. They presented a case in which careful observation failed to provide confirmatory evidence of DID and instead, factitious disorder was diagnosed.

The case study has a pre-eminent position in the study of psychology and psychiatry and most researchers and clinicians acknowledge the importance to research and theory development of clinical observations gained from case studies (Schwartz, 1992). The case studies discussed here purport to support the hypothesis that the aetiology of DID is iatrogenic bias. These studies, however, have been poorly designed and fail to meet the basic criteria for good single-case research (Hilliard, 1993), the conclusions that can be drawn from them contribute little to our understanding of this disorder and their findings are therefore of limited value. It may be that DID is iatrogenically generated, but these studies have failed to test this hypothesis. Kihlstrom's (1995) assertion applies here: Though many case studies of DID have been reported, few have been subjected to any kind of experimental investigation. To advance our understanding of this disorder and the issue of iatrogenic bias what is required are well constructed case studies that apply accepted levels of design methodology. It is the intention of this study to test the hypothesis of iatrogenic bias in a case study where an appropriate design methodology has been applied.

2.2 Development of alter personalities

One of the most striking features of DID is the alter personalities that recurrently take control of the body (Pica, 1999). Putnam (1997, p. 175) suggested that alter

personalities arise in the context of severe trauma and “reflect the creation of a set of complex, enduring, identity-based, discrete dissociative states that evolve during childhood and adolescence”. Putnam proposed that severe trauma creates a state of dissociative consciousness and that when traumatic events are chronic and repetitive an alter personality system develops with each alter becoming increasingly differentiated. The repetitious nature of specific traumatic events contributes to alter differentiation with each alter taking on specific functions and characteristics. Therefore, memory for particular traumatic events becomes dependent on that particular alter personality and such events are not readily retrievable from other alters which have been created to cope with other specific traumatic events. Putnam considered that this leads to the fragmentation of identity that is the hallmark of DID. According to Putnam (p. 176), fragmentation is not the

‘Shattering’ of a previously intact identity, but rather a developmental failure of consolidation and integration of discrete states of consciousness. In particular, it is a profound developmental failure to coherently bind together the state-dependent aspects of self experienced by all young children that leads to the [DID] patient’s experience of multiple ‘selves’.

Alter personalities do not exist as separate entities or individuals but as discrete dissociative states of consciousness (Kluft, 1999a; Putnam, 1997; Ross, 1997) and it is “Only when taken together can all of the personality states be considered a whole personality” (Coons, 1984, p. 53). Kluft, (1998, 1999b) considered that an individual’s particular alter systems reflect an underlying adaptive strategy that has allowed him or her to respond to circumstances that are frequently irreconcilable, such as a father who is abusive in one situation but caring in another. Such responses become incorporated into a child’s autobiographical memories through fantasy and cognitive restructuring and result in the development of alternative realities that are modified and endorsed as actual (Kluft, 1999b).

Pica (1999) stated that though several theories have been proposed to explain the manifestation of alter personality states in DID, the majority have failed to explain how alters develop over the life span and why the disorder becomes more

complex after childhood. Pica hypothesized a three-stage model of alter personality formation in which alters evolve out of childhood imaginary companions and merge with dissociative states of consciousness in response to childhood traumatic events before individuating into distinct personality states during adolescence. Pica believed that many questions regarding the development and function of alter personalities (such as whether alter personalities are formed by a gradual process of increasing differentiation or appear as fully differentiated separate identities) remain unanswered and require further research.

Structure of alter systems

Although cases with dozens or scores of alter personalities have been reported the mode is three and the median typically eight to ten (Kluft, 1991; Putnam, et al., 1986; Ross, Norton & Wozney, 1989b). The differences in alter personalities can be striking, but authorities consistently stress that these are more apparent than real (Putnam, 1989a; Kluft, 1991). A study by Ross et al. (1989b) found that mental health professionals consistently reported the same basic structure in the alter personality systems of their DID patients. The respondents reported the presence of three basic types of alter personalities: a child alter personality, a persecutor alter personality, and a protector alter personality. These findings replicate those reported by Putnam et al. .

Ross (1995) reported that child alter personalities usually hold the traumatic memories though not all hold the feeling of being bad and some alters may be quite content and well adjusted despite the abuse they have experienced. There may be child alter personalities of different ages and there may be a different child alter for each episode or variety of abuse (Mollon, 1996). The cognition of being bad is held by the persecutor alter personalities which routinely believe that the child alters caused the abuse and deserve to be punished. These are often based upon identification with the original abuser/s (Mollon). The persecutor alters may be extremely dangerous and may act out this cognition on the host personality through such self-injurious behaviour as cutting or burning, and frequently urging other alters

towards suicide. The natural tendency of the organism to protect itself then gives rise to protector alter personalities (Ross).

Kluft (1984b) identified two other types of alter personalities: the host and the original personality. Kluft, (p.23) defined the host personality as “the one who has executive control of the body the greatest percentage of time during a given time”. It is often the host personality that first presents for treatment and the one who becomes identified as the “patient” prior to the diagnosis of DID (Putnam, 1989a). The host is typically described as depressed, anxious, and as suffering from a variety of somatic symptoms, particularly headaches and usually is unaware about the existence of other alter personalities (Putnam et al., 1986). Kluft (p. 23) defined the original personality as the “identity which developed just after birth and split off the first new personality in order to help the body survive a severe stress”. Putnam stated that the original personality is typically not active and is often described by other alters as having been “put to sleep” or otherwise incapacitated at an earlier point because he or she was not able to cope with the trauma. The original personality usually only emerges during the later stages of therapy when much of the traumatic material has been processed by other alters. In most patients the host personality is not the original personality.

Kluft (1998) emphasized that it is important to recognize that when alter personality systems are relatively small they may all share similar beliefs regarding the inner and external world. When the trauma has been severe and chronic, however, the alter system is more complex and layered. Kluft (1991) proposes, that in those patients with a large number of alter personalities, the alters constitute a cognitive system in which most alters relate to each other as if they were actual people. Consequently, constellations of alters frequently develop secondary autonomous inner worlds and develop a life of their own in which they may have inner relationships, alliances, and discord and experience themselves as constituting an inner family or society with its own rules and mores (Kluft, 1991). Mollon (1996) noted that whilst some alters may not be cognizant of the existence of any others, it is more common for alters to have some knowledge of each other, though some have a more complex awareness of the dissociative system than do others.

Structure of alter systems in ritual abuse

Mollon (1996) reported that the system of alter personalities in patients who report a background of ritual abuse is more complex than in other DID patients; they are also likely to have a greater number of alters and the most virulent persecutor alters. Van der Hart et al. (1997) considered that systems of alter personalities for these patients are usually layered with different sub-systems of alter personalities. Within these sub-systems four different types of abuse are commonly reported: (1) abuse taking place in the home, (2) ritual abuse associated with satanic worship, (3) pornography and prostitution, and (4) some form of mind control.

1. *Abuse taking place in the home.* Van der Hart et al. suggested that abuse taking place in the home usually involves one or both parents, often along with other perpetrators. The nature of the abuse can be sexual, physical, and/or emotional. The basic sub-system consists of alter personalities that are involved in the patient's daily life and that keep memories of home abuse. Most of these alter personalities are unaware of ritualistic abuse experiences and express disbelief when confronted with reports or allegations from other alters of ritualistic abuse. These alters apparently belong to different subsystems of personalities. They usually present narrative fragments of ritualistic abuse during the course of therapy. There exists one-way amnesia between these different subsystems, with the "daily" alter personalities absent when alters with ritualistic abuse experiences take over executive control, and not the other way round.
2. *Ritual abuse associated with satanic worship.* All patients report participation in rituals that include chants and symbols. Common elements include witnessing or participating in torturing and killing of animals, children, or adults; physical abuse; forced impregnation and sacrifice of one's own child (or foetus); forced cannibalism; forced drug usage; and being buried alive in coffins. While reporting such extreme experiences, alter personalities are usually extremely anxious and hardly able to relate such material without starting to re-experience them.

Sometimes they relate material in their drawings. All patients refer to extreme intimidation and threats to keep silent.

3. *Pornography and prostitution.* Most patients (i.e., specific alters in these patients) report being both victim and perpetrator in the production of pornography, or being exploited as prostitutes, apparently for the financial benefit of a perpetrator organization.
4. *Mind control.* All patients who report alleged ritualistic abuse report some form of mind control, to ensure their loyalty to the perpetrator group or organization (Van der Hart et al., 1997). Some patients, in particular those with multi-layered subsystems of alter personalities, appear to have been subjected to extremely sophisticated mind control techniques, including a combination of drugs and hypnosis, pain, terror electric shocks, isolation, and sensory deprivation or sensory over-stimulation (Gould & Cozolino, 1992; Shaffer & Cozolino, 1992; Young, 1992; Young, Sachs, Braun, Bennett, & Watkins 1991). Patients allegedly subjected to these mind control programs display subsystems of alter personalities that are highly indoctrinated, and some seem narcissistically involved in serving the goals of the perpetrator organization. They seem to have been exploited for criminal purposes.

Ross (1995, p.112) responding to the investigation into ritual abuse wrote that:

It is curious that there is so much disagreement about the existence of something that is described in such sketchy fashion in the professional literature, by believers and skeptics alike. Except for single-case studies written for general readership, detailed description of the phenomenology of these cases is lacking, even in the peer-reviewed literature.

Notwithstanding the current lack of knowledge of this important area, Mollon (1996, p. 129) concluded, "Such patients pose the greatest difficulties and challenges in

treatment.” Pica (1999) believed that many questions regarding the development and function of alter personalities (such as whether alter personalities are formed by a gradual process of increasing differentiation or appear as fully differentiated separate identities) remain unanswered and require further research. Putnam (1997, p. 90), reviewing the literature on alter systems, reported that though various typologies of alter personalities have been offered, there are little systematic data but “Types of DID alters, such as childlike personality states, angry alters, protectors, and persecutors, are found often enough to warrant further investigation”. The development and structure of alternative personalities is a hallmark of DID this study provides an opportunity to contribute to this important area of investigation. Moreover, this study also provides an opportunity to contribute to research of alter systems in DID patients reporting ritualistic abuse, an area of research in which a “detailed description of the phenomenology...is lacking” (Ross 1997, p. 112).

2.3 Diagnosis and Treatment

Diagnosis

When DID patients are correctly identified and receive appropriate treatment they have a better prognosis (Coons, 1986). Putnam et al. (1986), however, drew attention to the lack of diagnostic precision with DID. Their study of 100 DID patients revealed that on average they received 3.6 different psychiatric diagnoses (range = 0-11) and spent 6.8 years (range = 0-23 years) in therapy before accurate diagnoses were made. Steinberg (1995) emphasized the burden placed by misdiagnosis on the individual, and economically on the health system, when cases of DID potentially treatable in an outpatient setting end in unnecessary hospitalization. In a study of 33 patients who ultimately received treatment for DID, Kluft (1984a) found that 47% were hospitalized before receiving the correct diagnosis compared with 19% who were hospitalized subsequent to accurate diagnosis. Undiagnosed DID patients received incorrect diagnoses of schizophrenia in 25% and 40% of cases respectively in two studies (Putnam, 1989a; Ross et al., 1989b), while 12% and 16% had received electroconvulsive therapy. More than half

of 102 DID patients in a third study had been treated with antipsychotics (Ross et al., 1990). Data such as these support the contention that undiagnosed DID patients are perceived as suffering from other severe mental illnesses.

In seeking the causes of misdiagnosis it has been suggested that symptoms of DID may not be volunteered because patients are unaware that they have the disorder (Loewenstein, 1989). In Kluft's (1984a) study, 40% of DID individuals gave only subtle hints of DID and 40% showed no overt signs at all. Not surprisingly, the diagnosis was inversely related to the degree of clarity of the symptom presentation. Patients who sought psychiatric help with self-diagnosed DID were less likely to be believed by their psychiatrists, and those without clear signs of DID were discovered only by systematic enquires.

Another factor in misdiagnosis is the tendency of DID patients to dissimulate. Kluft (1986) found that 50% of DID patients withheld evidence of DID at first assessment. Ninety percent said they had at some time tried to hide the manifestations of DID for fear of meeting with scepticism and rejection or of being regarded as crazy. Patients frequently encounter therapists who are sceptical of the diagnosis and who do not respond to complaints of symptoms related to DID (Dell, 1988; Spiegel, 1988). According to Wilbur (1984, p. 27), some, "test the doctor to find out if he or she approves of some or any of their behaviour" before being open about their symptoms. Such findings indicate that the controversy surrounding a diagnosis of DID combined with lack of understanding about dissociative disorders, significantly contributes to the suffering of individuals seeking treatment.

A study by Dunn, Paolo, Ryan and Van Fleet (1994) suggested that an understanding of trauma and its clinical presentation are important factors for therapists in the diagnosis of DID. They found, that from a total of 1,120 psychologists and psychiatrists who responded to a questionnaire surveying their beliefs regarding the diagnosis of DID, more than 97% indicated a belief in dissociative disorders in general and 80% reported a belief in the diagnosis of DID. A significant aspect of this study was that the participants were employed in

Veterans Affairs Medical Centres and were therefore more likely to be familiar with posttraumatic dissociation in returned soldiers (van der Kolk, 1996a).

The return of soldiers from Vietnam was accompanied by the description of posttraumatic stress disorder (PTSD). This diagnosis has several dissociative features (Spiegel, Hunt, & Dondershine, 1988), and many authors have noted similarities between PTSD and the dissociative disorders. Such similarities have encouraged a cross-fertilization of diagnostic and treatment approaches to the spectrum of posttraumatic disorders.

The findings discussed in this section indicate that the formation of an appropriate therapeutic alliance is an important precursor for the diagnosis and treatment of both PTSD and the dissociative disorders. Furthermore, such findings indicate that models of treatment incorporating such an approach are likely to be more successful in their outcomes than those that do not.

Treatment

As previously acknowledged, several researchers have concluded that DID and therefore alter personalities are artefacts of therapist bias rather than an intrinsic aspect of the patient's condition. Simpson (1989, p. 565), for example, writes:

Spontaneous remission is probably the norm, unless the patient becomes engaged with a clinician already primed and interested in the condition. It seems to be one of the few conditions which almost invariably get worse in therapy. ... Where the health care system or health insurance does not subsidize this indulgence, the condition simply does not occur.

Despite such assertions, however, the weight of clinical experience emphasizes that it is important to address the DID and to work with the alter system (Kluft, 1999a, 1999b). Kluft (1999a, p. 16), for example, wrote that "Every published series of DID patients who have made progress or achieved integration has involved treatment by therapists who worked with alters; the most successful therapists in the field work

vigorously with alters”. Kluft (1985) reported that his data indicate that only 2%-3% of DID patients could achieve integration without specific treatments that dealt with the alters and that therefore, unless there are specific contraindications, it is appropriate to work with and to elicit alter personalities. Such observations regarding the diagnosis and treatment of DID, however, are essentially based on clinical experience rather than experimental evidence (Putnam, 1989a; Ross, 1997). Maldonado, Butler and Spiegel (1998) concurred with Putnam’s and Ross’s assessment of the literature and reported that only three authors have published treatment outcome data on DID patients (Coons, 1986; Kluft, 1984c, 1986, 1994; Ross, 1997), and that none of these studies employed control groups.

Kluft (1999a) described three general types of DID patients with different characteristics and treatment prognoses. The first are relatively high-functioning individuals with many assets and psychological strengths. They usually integrate and complete treatment in two to seven years. The second group has fewer psychological resources and presents with more borderline features than the first group. There is usually considerable co-morbidity and interpersonal relationships are often difficult with marked dependency issues frequently evident. Their treatment course is more difficult than for the first group and though some may reach integration most remain unstable for long periods and require ongoing supportive help. The third group’s pathology is the most severe of the three and they exhibit increased difficulties with affect modulation and may manifest psychotic symptoms. Kluft advised that this group must be treated in a supportive manner for long periods and that only a minority ultimately progresses to integration or satisfactory resolutions.

Kluft (1996b) recommended that psychotherapy be orchestrated in stages. Briefly expressed, the initial stage is concerned with the establishment of psychotherapy. During this stage preliminary interventions, history gathering and mapping of alter systems are undertaken. During the second stage the trauma material is addressed and processed, the therapeutic impetus is towards integration and resolution of the material. The final stage involves the learning of new coping skills, solidification of gains and follow-up to assist in the working through process.

Kluft (1999a) noted that the majority of experienced clinicians have found that two or more sessions a week are necessary to treat DID patients successfully. Putnam (1989a) also recommended treatment sessions of 90 minutes duration as necessary to process the dissociative material.

Personality integration, whilst not marking the end of treatment, is a central focus of therapy with DID patients (Kluft, 1997; Putnam, 1989a; Ross, 1997). Kluft (1984a) has provided the following operational definition of integration, namely three stable months of: (1) continuity of contemporary memory; (2) absence of overt behavioural signs of multiplicity; (3) subjective sense of unity; (4) absence of alter personalities on hypnotic re-exploration; and (5) clinical evidence that the unified patient's self-representation includes acknowledgement of attitudes and awareness previously segregated in separate personalities. Kluft based his criteria on the outcome data from 171 cases seen over a 10 year period. Of these, 83 cases (67.5%) achieved stable therapeutic integration. Based on these data, Kluft estimated that two thirds of patients entering treatment should be able to reach stable integration. However, even Kluft (1988, p. 578), who has reported the best results in treatment outcomes described in the literature (Maldonado et al., 1998), warns, "the treatment of [DID] can be arduous, painful and prolonged. ... The achievement of integration is usually considered desirable, but in some cases a reasonable degree of conflict-free collaboration among the personalities is all that can be achieved." Given the significance of integration in the treatment of DID, it is important that clinicians are alert to both positive and negative indicators. Greaves (1989), drawing on the literature as well as his own work, proposed "marker events" which reflect the processes of integration. Such markers indicate whether treatment is on course. They can also be used to facilitate therapy (a summary of Greaves' markers of integration is presented in Appendix D). Greaves' "markers" will be considered in this study when issues of treatment and integration are discussed.

Treatment of ritualistic abuse

Van der Hart et al. (1997) considered that the treatment of adult DID patients reporting ritualistic abuse should be the same as for the treatment of DID and other trauma induced disorders. Van der Hart et al. endorsed the stages of therapy proposed by Kluft (1996b) and suggested that treatment of ritualistically abused DID patients be concerned with (1) stabilization and symptom reduction, (2) treatment of traumatic memories, and (3) integration and rehabilitation. Further, Coons (1997) considered that adults describing ritualistic abuse usually have severe dissociative disorders. Such observations, along with clinical experience has led van der Hart et al. to observe that the initial optimism regarding the treatment of DID has changed to a realization that complete personality integration, including the treatment of traumatic memories, is not always feasible. Many DID patients reporting ritualistic abuse seem to belong to this category. Kluft (1994a, p. 67) reported that patients with a background of ritual abuse appear to progress “quite unevenly and unpredictably over the short run and about half as rapidly as patients who have never made such allegations.” Van der Hart et al. similarly reported that treatment of such patients is arduous and protracted, and complicated by issues of safety and complexity of the DID.

Concerning safety Van der Hart et al. (1997) reported that most of the adult DID patients reporting ritualistic abuse in the course of their treatment appear to continue to be abused by perpetrator organizations. They consider that in such cases, the only focus of treatment should be to assist patients to remove themselves from the abusive situation. Unfortunately, when DID patients enter treatment it is not often clear whether abuse is still occurring; part of the reason for this may be that the presenting or host personality may be unaware of ongoing abuse. Van der Hart et al. recommended extreme caution in working with these patients with therapy focusing on symptom stabilization and crisis management rather than integration and treatment of traumatic memories (Horevitz & Loewenstein, 1994).

As previously discussed, DID patients reporting ritualistic abuse appear to have more complex systems and structured layers of alter personalities than other

DID patients. In part, this is due to the type of mind control techniques or conditioning applied by perpetrator organizations (Fraser, 1997b; Ross, 1995; Young & Young, 1997). Van der Hart et al. (1997, p. 155) reported that when these individuals are able to cease contact with perpetrators “and when their dissociative barriers are dissolving, they tend to have intense feelings of guilt, shame, and suicidality related to ‘perpetrator behaviors’ that they themselves have been forced to manifest. These issues are extremely hard to deal with in therapy.”

Young and Young (1997) suggested that when these patients begin to talk about ritualistic abuse in therapy, self-abusive, acting-out personality states usually appear to protest or stop the disclosures. These alters often function as, or are identified with, ritualistic beliefs though they have the same characteristics and defensive function as any other alter personality. The formation of ritual alter personalities may reflect the patient’s attempt to create internal identities that are as strong and powerful as his or her perpetrators, or an attempt to comply with the perpetrator in an effort to stop the abuse.

Kluft (1997) identified three presenting patterns for patients alleging ritualistic abuse. In the first pattern, the patient becomes deeply involved in treatment and issues regarding ritualistic abuse are heard with decreasing frequency. In this pattern the patient gradually recovers without the ritualistic material achieving prominence or requiring significant work. Kluft suggested that with this pattern the ritualistic material served as an allegory for the actual material.

In the second pattern the ritualistic material emerges later in therapy and after the patient has worked through material that is more mundane. In this pattern the patient improves as the ritualistic material is worked through. Kluft (1997) suggests that two inferences may be drawn: (1) the ritualistic material was deeply repressed or dissociated and/or (2) the patient is not yet ready to leave the therapist and is generating more material to prolong the therapist’s interest.

In the third pattern the ritualistic material assumes prominence early in therapy and attempts to put the material aside repeatedly fail. Kluft (1997) suggested three inferences can be drawn: (1) the intensity of the material is so pressing and overwhelming that it needs to be addressed, (2) the patient is still active in ritualistic abuse situations, and/or (3) it serves as a displacement for more mundane experiences and conflicts. Kluft considered that, regardless of the material's origin, because its psychological reality is so intense and compelling to the patient, there is no alternative to working through the material as it is presented. The treatment is usually prolonged and prognosis is guarded.

This study provides an opportunity to scrutinize the therapeutic progress of a patient diagnosed with DID and alleging ritualistic abuse whilst being treated consistently with a specific therapeutic model. Given the lack of objective data regarding this population, such considerations would make a significant contribution to the literature.

Summary

1. This review notes that despite its long history and endorsement in the DSM-III (1980) and DSM-IV (1994), the diagnosis of DID is a hotly debated issue.
2. An increase in the number of cases reported since the 1980's has led some writers to claim that it is more common than previously believed, and that it has frequently been confused with schizophrenia and the hysterical neuroses.
3. Sceptics argue that, in part, the increase is the result of iatrogenic biasing.
4. It may be that DID is iatrogenically generated, but studies have failed to test this hypothesis. There is a lack of design objectivity in most of the studies reviewed. The present study aims to address these weaknesses using a single-subject design.
5. The patient -therapist relationship, according to critics such as McHugh (1995), and Merskey (1995a) is where the aetiology of DID originates. A study of this

relationship using a case study approach will allow for an investigation of this hypothesis.

6. Greaves (1992) proposed that a self psychology perspective would be a fertile theoretical stance from which to explore DID. It would bring a comprehensive clinical model of the self to the understanding of DID. It would thus appear ideally suited to the study of an adult psychiatric disorder of self-functioning, which is regarded as being the outcome of abuse in childhood.
7. Despite the intensity of the debate on DID, particularly ritualistic abuse, Putnam (1997) notes that there are little systematic data on alter personalities, their development (Pica, 1999) or detailed descriptions of ritualistic abused patients (Ross, 1995). Systematic data on these issues would contribute to our understanding of alter personalities.
8. The treatment of DID patients is of fundamental importance in gaining an understanding of the nature of the disorder, this is particularly the case for patients alleging ritualistic abuse and what is required are more studies providing systematic and detailed objective data. It is hoped that this study will contribute to the provision of such data.

2.4 Aims of the study

It has been shown that there are serious deficiencies in the current knowledge of the development and treatment of Dissociative Identity Disorder. Using a focussed and in-depth single-case study of a person diagnosed with DID, this research will seek answers to the following questions:

1. Are the “alter personalities” which are the defining diagnostic component of the disorder recognizable only by the subjective judgement of the therapist or can external observers validate their presence?
2. Do the “alter personalities” appear as part of the patient’s response to trauma or are they the result of therapist induction in the treatment?

If the alter personalities can be established as a verifiable entity and are not due to therapist induction, transcripts of the case will be used to ask the following questions:

3. What factors in the patient's life experience contribute to the formation of alter personalities?
4. What indications are there in the treatment that would indicate personality integration or cure of the disorder?

In the following two chapters the methodology used to answer these questions is outlined.

CHAPTER THREE

3.0 PROCEDURE EMPLOYED IN THIS STUDY

Overview

Before a detailed discussion of the methodology, it is necessary to review the case study as a method of examination and self psychology as the consistent treatment modality. It is also necessary to review the patient herself as the focus of the research, initial development of the therapy leading to the diagnosis of DID, and the training/orientation of the therapist.

3.1 The Case Study as a Form of Investigation

Advantages of the case study

The Journal of Consulting and Clinical Psychology (1993) devoted a special issue to single-case studies. The Editorial reported increasing support in the psychotherapy research community for the “empirically based, context-sensitive, discovery-oriented single-case study” (Jones, 1993, p. 372). Yin (1994) noted that case studies are used extensively in social science research. This methodology is a frequent mode of thesis and dissertation research and is increasingly used as a research tool in evaluation research. Jones (1993) and Rice and Greenberg (1984) similarly drew attention to the renewed interest in psychotherapy research in the intensive study of the individual case. Jones (p. 371) attributed this to a recognition that controlled clinical trials had limitations in “informing us about how patients change through psychologically mediated interventions.” The author noted “that an understanding of the processes that promote therapeutic change requires a close analysis of the therapist patient interaction” (Jones, p. 371). Person (1991) argued

that whilst comparative treatment outcome studies can explore treatment efficacy, they could only provide indirect validation of underlying clinical constructs.

There is a further reason for the renewed interest in single-case design: the need to test clinical theoretical models. Jones (1993, p. 371), for example, argued that

Statements about psychotherapy that are derived from group data typically have little direct relevance for the clinical problems that are presented to the psychotherapist, so that much of the therapy research enterprise has remained peripheral to clinical practice and to the major theoretical and intellectual currents in the field.

Disadvantages of the case study

An important objection to single-case study is the possible limit to scientific generalization. However Yin (1994) pointed out that scientific findings are rarely based on single experiments. Instead they are usually founded on a multiple set of experiments, replicating the same phenomena under different conditions. Case studies and experiments are similar in purpose, both seeking to relate their findings to theoretical propositions. In both cases the sample under investigation is understood as a dynamic entity in the context of opposing theories. The single-case study, however, contributes by expanding and generalizing theories (analytical generalization), rather than by enumerating frequencies (statistical generalization) (Yin). Chassan (1979) argued that intensive study of the single participant, which is based on frequent observations of the individual over time, could provide more operationally meaningful information. He felt that this has more direct implications for psychotherapy than end-point observations extending over relatively large numbers of patients. Reliance on averages, Chassan argued, results in a lack of specificity, and vagueness about population characteristics and other important variables from which inferences should be drawn.

Hilliard (1993) proposed that single-case research be viewed as a sub-class of intra-participant research. Aggregation across cases is avoided and findings are generalized through replication on a case-by-case basis. Yin (1994) noted the neglect of intra-participant variation and of mediating process variables in traditional psychotherapy outcome research. He argued that a focus on variability within therapeutic dyads over time however is at the very heart of psychotherapy research (intra-participant variability). Hilliard noted that psychotherapy research has tended to ignore intra-participant variability or to assess it indirectly through cross-sectional group correlations. What is required, according to Greenberg (1986, p. 4), is research that focuses on “identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change over the entire course of therapy”.

Reasons for the case study in this investigation

The process/outcome distinction and its relation to methodological issues, is an important one for the proposed study. The central question in the iatrogenic debate is whether DID develops out of the interaction between therapist and patient and is thus an intra-participant question. Single-case methodology, it is argued, is the appropriate method to research this question. It addresses data that are not aggregated across participants, but which are analysed on a case-by-case basis. Hilliard (1993) suggested that premature aggregation across participants might be misleading, when the dimensions of the relation vary widely across participants. Averaging across participants distorts the form of a relation and obscures the very relationship factors that individual studies reveal. Single-case approaches are cautious when proposing that a group is truly homogenous unless this has been clearly shown. While the symptoms of DID are clearly delineated (e.g., DSM-IV), research is needed into how treatment responses vary according to the nature of previous life experiences. Differences in treatment responses may reflect the traumatic origin that many researchers have attributed to DID (Putnam, 1989a; Ross, 1997). It is essential to delineate specific aspects of a case before the process of replication is undertaken. It may be that the assumption of homogeneity has contributed to confusion regarding questions of iatrogenic bias. From this

perspective, a programme of research should begin with the study of single-cases, and then possibly move on to aggregation over groups that have been established as truly homogeneous (Hilliard).

Maldonado, Butler and Spiegel (1998) noted that no controlled treatment studies of DID have been reported. It is argued that an intensive individual study within a specific treatment approach would be a valuable contribution to the literature. Greaves (1992) proposed that a self psychology perspective would be a fertile theoretical stance from which to explore DID. It would bring a comprehensive clinical model of the self to the understanding of DID. Kohut (1971, 1977, 1984) developed much of the work underpinning this model. His observations of patients in treatment are remarkably homologous with findings from recent research on early childhood development (e.g., Stern, 1986). The self psychological model would thus appear ideally suited to the study of an adult psychiatric disorder of self-functioning, DID, which is regarded as being the outcome of abuse in childhood.

3.2 Treatment Modality: Self Psychology

Self psychology developed out of traditional analytical thinking, but diverges from it in its concept of the development of self. From a traditional analytic perspective, the self is formed out of the predominantly unconscious conflicts between instinctual, conscious, and external reality (i.e., id, superego, and ego). Of particular importance is the Oedipal phase of development. The unconscious strivings and fantasies of this period are seen to colour and affect the child's relationship with his parents. Such an approach is an intrapsychic one, in which external events play less of a role in determining the development of the individual than internal forces (Baker & Baker, 1987).

Self psychology also traces the origin of many disorders expressed in later years to childhood, but diverges from traditional analytic thinking in that the

disorders are seen as the result of “developmental arrests” rather than as the results of oedipal conflict. From this perspective, oedipal conflicts would have resolved without recourse to a neurotic defence had the child’s essential needs been met (Kohut & Wolf, 1978). Essential ingredients for healthy development are the child’s relationship with his parents and whether they are able to respond empathically to his or her developmental needs. The infant’s sense of self develops out of this relationship, rather than out of unconscious motivations and instinctual drives.

Self Object

Self psychology uses the term “selfobject” to denote the important others in the individual child’s developing self. The self emerges out of the interactions between the child and its selfobjects (Kohut, 1971, 1977). Early selfobjects are usually the parents. If the child is to emerge with a healthy sense of self-esteem and a cohesive nuclear self, its selfobjects need to engage and gratify three basic needs. These are the need for mirroring, the need for idealization, and the need for twinship experiences. From these experiences the nuclear self develops and a cohesive self forms (Lee & Martin, 1991). These experiences are essential to optimal development and continue to sustain a sense of vigour, well being, and nurturance throughout life. In mature relationships selfobjects are recognized as autonomous, rather than used as providers of service to inner needs.

Kohut (1971, 1977) proposed that when a child experiences adequate and appropriate mirroring and idealizing experiences with its selfobjects, it develops a cohesive sense of self and is able to tolerate and weather the vicissitudes of life, without experiencing them as a severe blow to self-esteem. In contrast when such needs have not been adequately responded to a developmental arrest occurs. The child develops a “false” or “cosmetic” self that may appear adequate but is not cohesive and is prone to fragmentation. The internal structures for regulating and channelling infantile narcissistic needs have not developed in an optimal way and the individual will remain vulnerable to narcissistic injury. As adults, such individuals are likely to suffer from a low self-esteem and an inability to respond empathically to

the needs of others. In therapy, with such individuals, transference is entered into where the basic but unmet mirroring and idealizing needs of the patient can be met as the therapist performs the function of the early selfobject.

Mirroring

The emergent self of the infant has two important narcissistic needs: those of exhibitionism and grandiosity. In the early stages of infancy selfobject needs are intense and absolute and primarily met by the mother (Kohut, 1971; Lee & Martin, 1991). If she is secure enough in her own self-esteem, she will be able to respond with pleasure and acceptance to the proud exhibitionistic displays of the infant (Goldberg, 1988). The mother's ability to participate and respond to the infant's grandiose and exhibitionistic displays confirms his or her emerging sense of well being and self-esteem. Even the most attentive of parents, however, will be unable to meet all the infant's needs without him or her experiencing some delays and frustrations. It is through such delays and frustrations that the infant learns to internalize the functions provided by the selfobject and to develop his or her own inner structure. The infant is then able to transform his or her grandiose demands into self-regulation and self-discipline.

When mirroring needs have not been adequately responded to, such individuals continue to seek confirmation of their self worth and value from others. However, responses that do not seem totally approving are likely to be experienced as an intolerable blow to their self-esteem (Baker & Baker, 1987).

Idealizing

In addition to the need for empathic mirroring, there is also a need for the infant to feel close or merge with someone who will meet his or her needs for safety, calmness and comfort. This function is referred to as the idealized parental imago. The parent is idealized as an omnipotent and powerful selfobject from whom the infant can draw support, protection and approval. The parental imago provides a

template that is internalized by the child. As with other selfobject needs there is a process of maturation, under optimal development the infant idealizes the father or another significant person and then through a succession of minor disappointments with him or her, experiences a slow diminution of the idealization. At the same time the infant begins to internalize the function that the idealized selfobject had previously fulfilled.

When idealizing needs have not been adequately responded to, the need to merge and draw comfort and support from a powerful selfobject remains as an archaic structure in the mature individual. Such individuals continue to seek approving relationships with omnipotent, powerful others with whom they can draw comfort and support (Siegel, 1996).

Twinship

Twinship needs refer to the need to feel a degree of similarity to idealized others. The small boy, for example, may identify with his father, his sense of belonging sustained by the presence of a selfobject that he is sufficiently like to understand and who in turn understands and accepts him (Siegel, 1996). These experiences lead to the feeling of being like others, that one belongs and is connected to the wider community. Initially, the infant seeks to merge with the twinship selfobject, but with maturation develops a tolerance for difference in self and others.

An individual who has not had such needs met will have difficulties in feeling accepted and belonging. This may be reflected in detached and aloof behaviour, or in an insistent need for others (Baker & Baker, 1987).

Constituents of Self

Self psychology conceives the self as consisting of three major constituents. These are referred to as poles: the pole of ambitions, the pole of ideals, and an

intermediate pole of talents and skills. The pole of ambitions develops as a result of accurate mirroring of the infant by the parents. This leads to the development of ambition and an enthusiasm for life. The pole of ideals emanates from the infant's ability to idealize his or her parents and to draw comfort and strength from this. From these experiences the infant develops a sense of self-direction and an ability to set realistic and challenging goals. The third pole develops from the twinship selfobject experience and connects the other two poles. The individual's particular talents and skills are activated by the tension that exists between ambition and ideals (Bash, 1988).

From this perspective, certain types of psychopathology develop from the faulty interactions between the infant and his or her selfobjects. The problems in these cases originate from inappropriate or faulty responding by significant selfobjects at important developmental stages. They do not develop an autonomous and cohesive self and they remain intimately connected to their archaic selfobjects (Lee & Martin, 1991). Instead of being able to draw upon their own inner resources for self-esteem, ideals and talents, they remain tied to others to meet such needs. Their sense of self remains vulnerable and responsive to "injury" by others, rather than being directed by recognition of their own innate needs and abilities.

Therapy

In therapy, the specific transference that the individual makes reflects the earlier deficits. The transferences are understood as the psyche's attempt to establish a more cohesive self than the enfeebled self who resulted from earlier selfobject failures. By working within the transference, the therapist performs the function of a selfobject. The therapy moves to the archaic arrest. In this process the therapist adopts an empathic stance, seeking to understand from the client's perspective and to assist the client experience and verbalize his or her emotions. As with the original selfobject, there will be misunderstandings and errors. It is through such "therapeutic errors" that change occurs. The minute and mutual empathic exploration of such errors enables the client to convert archaic grandiosity into

healthy self-esteem and to transmute external idealized omnipotent figures into a set of internal guiding values and ideals. The process of transmuting internalization allows change to occur at an internal structural level; the archaic self is gradually expanded and the individual is able to take up the thwarted developmental process and develop a cohesive sense of self.

Self psychology has much, it is argued, to contribute to an understanding of the developmental implications early trauma has on the structural integrity of the sense of self (Ulman & Brothers, 1988). The self psychology model of self functioning provides a unique perspective from which to consider the development of alters, the impact of selfobjects in their development and the impact this has on the maturation process. It brings a unique perspective to the transferences formed during therapy and a rationale for their origin. This study investigates the developmental implications of early trauma on the development of the self, using the self psychology model of self functioning.

The self psychological approach to treatment is used in this study for a number of reasons. Firstly, it is non-intrusive. Secondly, it adopts a “following” rather than an “interpretative” approach which would appear to make it eminently suitable to treating a disorder in which issues of therapeutic bias are of major concern. Thirdly, the concept of empathic attunement in the therapeutic relationship and how this is utilized in the restoration of a cohesive self (Baker & Baker, 1987) would make a significant contribution to DID research. Fourthly, the particular focus on self functioning would appear to make it ideally suited to investigating a disorder, DID, whose genesis is regarded as the outcome of trauma in childhood (Greaves, 1992).

3.3 The Participant of this Study

Overview

In this section a description of the therapeutic environment and a detailed description of the participant and her case history are given. Some consideration is also given to the orientation of the therapist.

Setting

During the period of her treatment this participant had been seen in two public mental health settings both administered by the Western Australian Health Department. The first setting was a community outpatient psychiatric clinic situated in Fremantle. The participant was seen at Fremantle Clinic from February 1993 until October 1994, for 182 sessions. The Clinic was later incorporated in a purpose built inpatient and outpatient psychiatric facility located in Fremantle Hospital where the participant continued to be seen. The distance between facilities was minimal and the pending move had been discussed with the participant to ensure minimal disruption to therapy.

Initial Presentation

The participant, referred to here as Ruth, was first seen in February 1993. She had not previously attended Fremantle Clinic. Rockingham Community Services (a community health service funded by the local council) referred her, she had been participating in an anxiety management group. Social workers conducting the group referred Ruth as her anxiety was not responding to their treatment and her level of functioning was deteriorating.

At the initial presentation she complained that she could not attend her local shopping centre without suffering from a panic attack. She described how

approximately 18 months earlier, whilst visiting the shopping centre, she had experienced a panic attack. Before this, she had been living in the country for eight years with her husband running various businesses. They had returned to the city as Ruth had difficulties working in isolated areas. She had been in the shopping centre (a large complex) when she experienced palpitations and a high level of anxiety. She had gone to a doctor in the centre who explained that she was experiencing a panic attack and that she was suffering from agoraphobia. She had not experienced such strong sensations before and thought that her difficulties were the result of stress. She described herself as having always been a tense person.

She felt that most of her difficulties dated from August 19, 1991 when she discovered that her childhood friend, Julie, had committed suicide by taking an overdose of tranquillizers. Her friend was being treated for Bipolar Disorder. Though she did not find out about her friend's death until August 1991, the actual suicide had occurred in December 1987. She described their friendship as a close one, though they had not seen each other for several years, nor had they kept in contact. She attributed this to the isolated nature of the businesses that she and her husband, John, ran which meant that they frequently had to move. She also felt extremely uncomfortable being with her friend once the illness was diagnosed. She was fearful that her friend's behaviour might be unpredictable, though there was no evidence of this. Nevertheless, her discomfort with her friend's illness contributed to the lack of contact.

She described herself as being anxious most of the time and that she would physically shake when meeting people she did not know or when facing new situations. She noted that at times of stress she bit her nails and cuticles and that she ate compulsively. Her biggest pleasure was in eating "junk food" and she had gained 5-10 kilograms during the past two years. For the previous 10 months she had been unable to work. She enjoyed reading and liked to "escape in books". She also felt that she was becoming unrealistic in the way she viewed her family and increasingly felt unhappy with life at home. Her husband drank four cans of beer a night, which she perceived as him being an alcoholic although his drinking had never troubled her in the past. She resented the decision that they had made to go into their last

business and felt that she was not listened to and that in her marriage she “just have to go along with things”. She also felt that her three children were all against her.

During the initial session she also alluded to issues that possibly indicated childhood sexual abuse. These are discussed in the section detailing her history. She also described how at times she gets very angry “and loses control” and feels as if “my whole body is rejecting me at the moment”. During the initial interview she discussed her fear that “I think I’ve got something very big boiled up in me”.

The therapist’s initial impression was of a 39-year-old woman of slightly shorter stature than average and slightly overweight (he later discovered that she was 157 cm and 60 kilograms) with short tightly curled brown hair. She was neatly dressed in casual clothes and expressed her concerns coherently and openly. She was having difficulty coming to terms with issues pertaining to her childhood, having trouble within the marriage, and coping with her children’s emotional needs. She was increasingly isolating herself and finding it difficult to contemplate making changes in her life or in confronting some of the issues that were of concern for her. Nevertheless, she was quite articulate, had obviously thought through some of the issues, and had discussed them with previous therapists before attending this Clinic. Though she was clearly experiencing a high level of anxiety, evident in the concerns that she raised, she presented with a blunted and constricted affect and impressed as having a dependent personality. At this stage the therapist agreed to see her for a few more sessions to explore further some of the difficulties she was experiencing and to see what options might be available in terms of treatment.

During the next six sessions, which were weekly, she told how she tried to present as a strong person by not discussing issues with her husband and by being secretive with everybody else. An example that she gave for this was that when her mother left home she told her school friends that her mother had died. She discussed her difficulty in going out especially on her own and how she used large quantities of tranquillizers to cope. She discussed symptoms of anxiety including stomachache, diarrhoea, sweating, light-headedness, breathing hard and fast, and a desire to

continually empty her bladder. She also identified problems with her vision, dizziness, sometimes getting migraines if highly stressed, and several bodily pains that appeared psychosomatic in origin. In sexual relationships she discussed how she tended to distance herself and that most of the time “I don't feel anything”. She reported difficulty in responding emotionally to her children when they were younger though she clearly cared for them.

She described herself as a compulsive type person who liked to keep things in order and that she did not like change. She liked to keep clean and washed two to three times a day. She always washed after sex and washed her genitals with lots of soap and hot water, perceiving herself to be dirty and “smelling” of sex. During subsequent sessions when discussing issues of concern she constantly flexed her legs and feet, contorting her arms and wringing her hands, pulling at her fingers till they were red from the pressure, and often twisted her bracelets round her wrist causing soreness. She discussed how she did not feel “connected and real” and that she tried to disconnect from her feelings to avoid crying, perceiving this as being “really messy”.

Previous Treatment History

Her first child was born in September 1974 just before Ruth's 20th birthday. Approximately nine months after the birth of her son she was admitted to a private hospital for three weeks with post-partum depression. She was suicidal and had thoughts of driving her car into oncoming traffic. She was treated by a psychiatrist at the hospital for three weeks and then continued to see him for approximately nine months at the outpatient facility of a public hospital. She reported a strong transference to him and that the consultations stopped when she “got attached to him and he stopped me coming”. The hospital's records indicate that she was a patient. With the participant's permission, the psychiatrist was contacted; he had retained her case notes and confirmed that he had seen her and his observations agreed with her perceptions. She recalled discussing with him her feelings towards her mother who had left the family when Ruth was 8 years of age. She also discussed her marriage

and her own adjustment to becoming a mother, but they did not discuss some of the earlier issues that were concerning her and since “he did not raise them” she did not discuss them.

Following this she had seen by several other health professionals during the intervening years. These had been on a brief basis. In December 1991 she attended a clinical psychologist in private practice for three sessions, but felt unable to cope when earlier memories of childhood trauma were discussed. She found these “extremely distressing, crying most of the time during the sessions” so she decided not to continue. She later attended a local GP approximately five times and found him supportive. However, she still felt that she needed to deal with issues that she perceived as emanating from her childhood. In response to this need she attended a “psychologist” in private practice. From the middle of 1992 she saw him weekly for 16 sessions. They explored issues regarding her relationship with her father and her sense of having been abused. She perceived him as being overly familiar and stopped seeing him. It later transpired that he was not a psychologist but a defrocked Anglican priest. He was later prosecuted for misrepresentation and his case was reported in *The West Australian* newspaper in January 1995 when other patients made complaints to the local authorities regarding his treatment of them. Ruth had not been aware until she read the newspaper article that he was not qualified and that her instincts regarding his treatment were accurate. She later attended Rockingham Community Services where she participated in three groups, one for women who had been sexual abused, another for anxiety management, and a group for assertion training. Since her condition appeared to be deteriorating and was not responding to treatment they referred her to Fremantle Clinic where she was seen by the author.

In terms of medication, she had been prescribed an anti-depressant, dothiepin hydrochloride though she had not taken any for the six months before presentation. She had also been prescribed the anti-anxiety agent’s oxazepam and diazepam, which she had been taking almost continually since 17 years of age. She reported that she had decreased her use of oxazepam to 15mg when needed though the accuracy of this could not be established. She discussed much later in therapy that she preferred oxazepam or diazepam because it “had a numbing effect”. Due to

complications with her menstrual cycle she had also been prescribed the anti-nauseant metoclopramide hydrochloride. Following the ninth session the therapist arranged for her medical needs to be reviewed by one of the consultant psychiatrists employed at Fremantle Clinic. Following the initial medical review it was agreed that she only obtain medical prescriptions from Fremantle Clinic and she was prescribed, dothiepin hydrochloride 25mg bd. and 100mg nocté and directed to continue using oxazepam on an occasional basis. Regular medical reviews were arranged. The medication that she was prescribed changed over the course of her treatment and will be referred to in the body of the thesis as appropriate.

By the seventh session the therapist referred her to a Coping with Depression Group conducted by a clinical psychologist at the Clinic. The group was based on a Cognitive Behavioural orientation to treatment and was largely educational in focus. The therapist was not part of the group. Later in her treatment, and whilst an inpatient, she attended various groups conducted by the inpatient facility. These were largely occupational or skilled based (e.g., relaxation techniques) in orientation or cognitively based assertion groups. She also attended the 10 sessions of an art therapy group that became available whilst she was an inpatient. The therapist did not participate in any of these groups though he did discuss any material emanating from her participation that she wished to raise. Therapeutic material raised by her involvement in these groups along with material produced by her during the course of therapy will be discussed further in the body of the thesis.

History of Participant

Ruth was born in January 1954 and is the eldest in a family of five children. She grew up in the Eastern States and moved with her family to Western Australia as a young child. She has two brothers who respectively are two years and four and a half years younger than her. She also has twin sisters with whom she has had little contact. They are eight years younger than Ruth. When the mother had given birth to the twins and returned home, she discharged a third child born dead. Ruth discovered her mother lying on the bed, having discharged the baby and in distress,

when she returned home from school. This was a traumatic event for Ruth and she ran out in to the street screaming. A neighbour comforted her and called an ambulance for Ruth's mother. The father was working away at the time.

During the course of therapy she discovered from a relative that her father had been previously married. He has two sons from his first marriage, but apparently has no contact with them. There is also an elder brother, given up by her parents for adoption, and with whom there has been no contact. Her mother later confirmed this. Ruth also discovered, much later in therapy, that she had a half-sister from her father and stepmother. Her sister had also been given up for adoption without Ruth or her siblings being aware of her birth. When she found out about her sister Ruth contacted her, but her half sister did not wish to maintain contact.

Her father is in his mid 80s and is the 11th child in a family of 14. There are three sisters. The family was based in an urban environment in the Eastern States. He came from a family that was relatively affluent until they lost most of their assets during the Depression of the 1930s. She knows little of his background other than he left home at 14 years of age and "disappeared" from the family for several years. He served in the army during the Second World War. Her mother is 10 years younger than Ruth's father and was raised in a farming community. She is the third eldest in a family of four daughters and three sons. She is the eldest daughter. Ruth knows little of her mother's early years.

Ruth's parents separated when she was eight years of age. Initially the mother left without any of the children, but later returned for the twins who were 18 months of age. Ruth recalled few memories of childhood apart from some vague memories around the age of three riding a tricycle. Those memories that she did recall of childhood were of it being "cold" and of her mother being pregnant. She also recalled that when the family sat down at the diner table the father would take off his belt with the threat of it being used if any of the children misbehaved. She did not recall, however, ever being hit, but remembered being very frightened. None of the children were allowed to speak at the table and when they went out together

“there was little gaiety in [their] lives”. When her mother left the father continued to look after the children, occasionally with the assistance of housekeepers. He worked as a cook and occasionally worked away from home for long periods. At the age of 11 years Ruth and her brothers were placed in a Salvation Army Home for 18 months as her father was working away from home. She recalled this as a relatively happy experience.

When she and her brothers returned from the Salvation Army Home they again lived with their father. He employed several housekeepers to care for them but they generally only stayed a short time. This was put down to the children’s misbehaviour. Eventually, they cared for themselves while their father was working. Later, when Ruth was 15 years of age her father remarried, though he and Ruth’s stepmother had been seeing each other for some time. She described her stepmother as the “saving grace” of the family. The stepmother has a son one-year-older than Ruth. They used to be close, but she has not seen him for a while and they have lost contact. She has little contact with the eldest brother and is closest to the youngest brother. Since the age of 27 her younger brother has had problems with his memory; this was caused by aneurysms resulting in brain damage for which he has had shunts.

When discussing her childhood, during the initial session, she spontaneously recalled how on one occasion she remembered touching her father’s genitals while sharing a bed with him, but then stated that she was uncertain as to whether this was “real or a dream”. She also recalled that whilst at the Salvation Army Home she was always attempting to gain attention from men. There was an army barracks at the end of the road and she would do everything “short of laying in front of the truck to get their attention”. She also recalled that whilst at the Home she took a younger boy to the toilet and remembers that she “tried to do something” but could not recall what this might have been. She did not recall any sexual intimacy until she met her husband at the age of 17. She described herself at school as being “available but only up to a point”.

She described herself as being an average student with few friends and as an afterthought added, "I still don't have any friends". In grade six she recalled "falling in love" with a male teacher. Her closest friend during these years was Julie. She lived in the house opposite Ruth's and she described them as being inseparable when younger. In later sessions the depth of Ruth's feelings for her friend and the important role Julie had in Ruth's childhood became apparent. As children they had an intimate relationship that continued into Ruth's early teens. She appears to have idealized Julie who was a few years older than she was. Her relationship with Julie appears to have been the closest and most intimate relationship that she had during childhood. She left school having completed her Junior High School Certificate and worked for a short time as a dental assistant but after six weeks left as she found the sound of the drill distressing. Her father obtained a clerical position for her in the company that employed him. She also met her future husband, John there. She fell pregnant to John and her father insisted that she have an abortion, which he arranged. He later stated that they either had to get married or they would have to stop seeing each other. They married when she was 17 years old and John 19 years of age.

They have three children. Daniel the eldest was born in September 1974, Denis the second eldest was born in July 1978, and Sandra the youngest was born in May 1981. After having given birth to Daniel she had three four-month-term miscarriages. In order to give birth to Denis she stated that she was advised to spend the nine months of her pregnancy in bed. Denis was delivered by caesarean section. In order to carry Sandra her cervix was stitched. Daniel and Sandra were both delivered by forceps. Daniel was born with jaundice and she was not able to hold him until he was two weeks old. Following his birth she had noticed an emission from her vagina but thought it was "normal" and felt too embarrassed and "ashamed" to mention it. It was not until 10 days after giving birth when the discharge had become more vigorous and pungent that she sought attention. Investigation revealed that a swab had been left in the vagina and was the cause of the discharge. Her first miscarriage was also particularly traumatic as it occurred on the steps of the maternity hospital that she was attending for assistance.

Before returning to Fremantle 18 months earlier, Ruth and John had owned various businesses in the North of WA in the previous eight years. Generally, they had been successful in their ventures but Ruth felt that their last business had been too isolated and was unable to continue working there. She had left her husband and had a brief affair with their business partner. She had not worked for approximately two years before attending Fremantle Clinic. She described the first 15 years of their marriage as successful but for the past 6 or so she was uncertain as to whether she loved him or not. She has engaged in other relationships but these have not brought her the reassurance that she thought they would.

Three years before attending the Clinic she saw her mother for the first time since she had left. Before this she had felt very angry towards her mother though this mellowed somewhat over the two days that they spent together. However, she has not kept in contact with her mother (who after leaving the family had moved to New Zealand) and still feels some anger towards her wondering why she had left the children and why she had not kept in contact with them. For the previous few months Ruth had the desire to contact her mother to ask her “what's gone on in my past?” and to explain to her how she now felt. She described her father as never saying he loved her. She felt uncomfortable if he was physically close to her or if he touched her. Though, somewhat in contradiction, she found it extremely distressing to be far from him.

In her relationship with her children she also felt somewhat emotionally cut off. When Daniel was a baby she did not know what to do when he cried. She was distressed with his crying and would walk away from him, often leaving him on his own. She thought his distress was a sign that he was going to die and she regularly took him to the children's hospital for check ups. She also found it difficult to cope with her daughter's desire for attention; it was easier to deal with the boys and tolerate their embraces. She had difficulty responding with emotional warmth to any of the children. She was not prepared to discuss her early experiences with her husband and was secretive towards him regarding her concerns. She would not contemplate attending a parenting course with him or attend the Clinic as a couple.

Although she had some doubts about their marriage she wondered how she would cope on her own.

In later sessions she discussed how as a child she suffered from respiratory illness. During her 11th hospital admission (her admissions are discussed in detail in subsequent chapters) she had difficulties walking even a short distance without becoming breathless. She was referred to a respiratory specialist who diagnosed asthma. He felt that she had probably been suffering from asthma since childhood but it had gone undetected. It was only in recent times when Ruth and John moved to a country region where there is a high pollen count that her condition became apparent. The respiratory specialist later revised this diagnosis and he identified her difficulties with breathlessness as related to either stress and/or angina. Angina had been diagnosed, whilst she was an inpatient, two years earlier. She also reported that around the age of seven she was functionally deaf for a short period. However, an examination at Princess Margaret Children's Hospital found no organic reason for her deafness and her hearing later returned. With Ruth's permission the hospital was contacted for further information. Medical records confirmed that Ruth attended the General Clinic of the Hospital on the 3rd of October 1960 and again on the 13th of April 1964. More importantly, for this study, they also confirmed that she had attended the Ear Nose and Throat Clinic during the period February to May of 1962. Clinical examination along with X-rays of her ears and audiology tests revealed no organic basis for her apparent "deafness". Her birthday falls late in January therefore she would have just turned eight when her hearing was investigated.

3.4 Initial Course of Therapy leading to DID Assessment

This section outlines the initial process of therapy. It illustrates how, in the course of its development, the symptoms of DID presented themselves thus informing this participant as valid for the case study. Several of the issues raised by the participant during the initial phase of treatment were returned to and expanded as the therapy progressed. The significance of these issues and the therapeutic response to them will be discussed later in the thesis. A detailed examination and analysis of

the course of therapy will make up the body of the thesis and is discussed in subsequent chapters.

From the onset of therapy Ruth introduced issues that were of concern to her in an oblique way. During the initial sessions she frequently alluded to material rather than expressing it directly, or she presented it in notes written between sessions, or in her discussion of dream material. Later, she produced drawings of material that was of concern to her. As therapy progressed she introduced and addressed material more directly. During the first few sessions of therapy she discussed concerns regarding her marriage and her role as a parent, but the main issue raised during these sessions related to Ruth's concern with whether she had been sexually abused as a child. During the second session she discussed how on bath night the children would take turns to bathe in the bath water. Being the eldest child she would be the first to bathe. In recalling this she described herself as "I've gone all weird". She shuddered, feeling that she was going to pass out but could not account why this should be the case. By the fourth session she had written a note regarding being in the bathroom and afraid. Her note is reproduced below:

As I was laying in bed thinking about a bath when I was a kid I see a man in the bath with his penis floating. I feel I'm huddled in the corner. I think it is my imagination.

As I'm writing this I'm also remembering getting into my step mother's bed with my brothers & step brother. I'm sure nothing but touching happened.

I feel very anxious writing this. I even find this very hard to write but I can remember what I did to the little boy at the home. It makes me feel so sick that I did this but here goes: I rubbed his penis up against me. He wasn't very old and I never have done anything else like this ever. Why would I have done this? It makes me sad to think that somebody would do that to a child.

I also remember when I was married a little while and I went to the Drs. and he had to give me an internal exam and he then asked me if I climaxed when having sex. I said I don't know and he then started doing things with his fingers and kept asking me if I was getting the same feeling as I would having sex. I went home to in-laws and told

my mother-in-law about if I thought it a strange thing to do but he was a doctor and I trusted him.

After I had [Daniel] I got very depressed and I had a lot of trouble with sex. I would just lay there. Sometimes I would cry. [John] used to like oral sex and I hate it. It used to make me feel sick and I would gag but I would let him do it. I very rarely ever participate now because I think [John] now understands that I don't like it. I don't like kissing much either.

I can remember going across the road and walking into their [Judith's] house and looking into their bedroom. They were naked and having sex [Judith's parents]. I looked, they saw us but did not stop. I was not shocked but a little surprised at what I saw. I was around 13 yrs.

In discussing the material related to the bathroom she stated that she was confused and wondered whether an actual event had occurred or she had imagined it. Apparently, several people that she had seen had told her that this was an indication that she has been sexually abused. However she did not know if this was the case or not. I did not of course offer an opinion but empathized with her uncertainty. She also went on to discuss her compulsion with personal cleanliness, often having three showers a day and staying under the water for a minimum of 20 minutes. She used copious amounts of soap particularly round the genital area and she used hot water within her vagina until it hurt. During later sessions she revealed that she inspected her genitals with a mirror to make sure that it was not "dirty". Increasingly, she presented as a chronically anxious individual suffering from panic attacks with obsessive and compulsive behaviour.

By the ninth session she stated that she had written to her mother asking, "what had happened" to her during childhood. She had not heard from her mother but did receive a phone call from her sister. Her sister reported that she was going through a similar situation and that she was undergoing counselling and looking at issues of sexual abuse. By the 10th session her mother had replied saying that she had left the father and children because she "couldn't stand being knocked around any more" and that she felt in fear of her life. Ruth wondered why she would leave her and the children with the father if that was the case. The mother was surprised that Ruth would still be experiencing difficulties with this as Ruth "had not been

knocked around any more than normal” also she had not realized that the violence and explosive environment would have caused distress. The mother also described how the harder she tried to make things “right for him, the worse us kids got it”.

Ruth had breast implants at 21 years of age and revealed with some embarrassment and shame that she also had two nipples on her left breast. She went on to discuss how she frequently felt pain in her stomach; this led her to associate to her memories of menstruation at the age of 10. Her first menstrual cycle had been whilst she was at school. She was sent home but nobody told her how to cope with it. Her father gave her some sanitary pads telling her she needed to use them but without any instruction. Not knowing how to use them she carried them around in her bag until her lack of hygiene was obvious to her male school teacher who told her how to use them.

She frequently cried during sessions. During the early sessions she would quickly suppress her tears, however, in later sessions her crying was more frequent and enduring so that at times it was difficult to hear what she saying. She also maintained little eye contact usually looked at the floor and only infrequently glanced in my direction. This continued to be the case until the latter stages of therapy.

Another issue of concern was that of her marriage. She stated that she had been married 22 years but he “does nothing for me other than look after me”. She discussed how she was used to being looked after and did not know what would happen to her if John were not there. Nevertheless she was not there emotionally for him. As with many issues in her life she was keen to keep her concerns concealed and not discuss them with her husband for fear that he and other people would judge her to be bad or wrong. She discussed how she responded immediately to people who “send out signals” that make her feel wanted. She continued to discuss how she did not like any form of physical contact except when she was feeling panicky and then she had to “hang on” to someone. She did not like to feel confined and had a “real fear” of losing control over her bodily functions and was afraid that this might happen during a panic attack. She discussed her fear of spiders and how she had the

same fear of humans that they will “wrap around me and I won’t get away”. Whilst at home she often distracted herself from her thoughts by humming or singing.

During the 13th session she discussed a re-occurring dream where a man in a green sweater was “slobbering all over her” and having sex with her. Whilst this dream and fear had never been so clear before she had always been concerned that someone was “out to get her”. She coped with her fear by saying “come and get me” telling herself that she would not worry about him and could “cut him off”. She discussed her sense that she was being “pushed into corner” and how this had been an ongoing fear for her. She also discussed how she had no sense of self and no recognition of “definitiveness” within her. She returned to the theme of sexual abuse fearing that something terrible had happened to her, though it was not clear that this was the case. She stated that as a child she was not allowed to cry in the home, but the emotions that she felt most now were sadness and anger. She discussed some of the feelings of anger that she had for her father clutching her stomach as she did so. She described herself as being petrified of him and that both her abortion and marriage were undertaken because of her father's insistence. She felt inadequate in dealing with her children’s needs and felt completely unassertive in her relationships. She perceived herself as having no power whatsoever and as having to do what other people including her children told her. Consequently she felt very resentful and discussed how she felt fearful and how “my head talks to me all the time, tells me I'm stupid”. Towards the end of one session she began to talk about internal “voices” that she heard, particularly an “abusive male voice”. She identified this as her “abuser” and the source of her “negative thoughts”. She perceived him as having a sickly smile and as taking pleasure in her “powerlessness” and “vulnerability”. At that stage I did not perceive these “voices” to be hallucinatory or dissociative in origin, but rather as reflecting negative thoughts and possibly indicative of earlier experiences. Later that day she phoned me to apologize for expressing anger during the session and explained that she did have real problems that she was concerned about and for which she wanted help.

During ongoing sessions she discussed her feelings of ambivalence towards her father. She was fearful of being physically or emotionally close to him yet

simultaneously professed great love for him. Though he is now old and physically frail she described her reaction to him being as if she was a young child who was fearful and very small. She had always felt this way towards him though she rarely admitted such feelings even to herself. Indeed when she and John first moved to the country Ruth was distressed at the prospect of being away from her father and it took her some time to adjust to this. Equally, she discussed how she perceived him as an aggressive and violent man and when she thought of this aspect of him it was as if she were an observer watching herself as a small child and seeing her father as he was then rather than how he is now. When discussing this, she thought of her father telling her “you talk about it, or let it out and you'll get it”. Frequently during sessions when discussing such material she would complain of feeling nauseous or sick, or felt that she was choking and unable to swallow as well as expressing continual feelings of fear, self-loathing and self-hatred.

On the 17th session she handed me written notes describing how there were “two sides” to her and how she tends to “switch off” when stressed. It reads as follows:

There is 2 of me Ian [therapist] sees the one that was raped bashed and hurt the one that is not worthy of being loved. The one that if she wants to be loved by her father will do what he wants to the best of her ability. The one who has no protection against him. The one who feels him touching her. Telling her it wont hurt.

Then the other one tells that it is wrong & wicked to think these things. You are only thinking those things because you felt that you were abandoned when young and it is brought about by anger.

The following was written on a separate page:

I am writing this because nobody cares I am really angry. Does everybody want me to tell them that I can remember this man lying on top of me panting sweating kissing me telling me to be quiet and he won't hurt me. Do you want to know that his breathe smells of alcohol and his penis is huge and I'm scared it will kill me but it doesn't because it goes on and on. Do you also want to know that I used to fight it but I would get a hit so I know that it's easier to do what he wants. I wear a nighty so its easier for him. There is no peace in this house because everyone is scared so one person can do

what he likes. It is easy to curl up into a little ball and believe this is not happening to you.

In discussing the content of her notes she recalled “images” of herself as a child being cuddled and tickled by her father and of herself as a child of six alone in her bedroom rocking herself for stimulation and comfort. Increasingly she reported feelings of depression and reoccurring nightmares of being attacked sometimes by spiders and snakes. Though she was not at this time suicidal she did discuss that she felt she was dead inside and that she deserved a lot of hurt.

During several sessions she discussed how she continually felt dirty and afraid and that she was having difficulties keeping her legs still particularly whilst trying to sleep. Similarly, when she discussed traumatic material during therapy sessions her legs were constantly moving. She attempted to control this by tensing the muscles in her legs though this appeared to cause her pain. By the 19th session she began to discuss issues of abuse more openly. Before the 20th session she had phoned her eldest brother. She discussed with him some of the issues she had been discussing in therapy and he revealed that their father had molested him although he had few memories and those he did have he “didn't want to know about or to remember”. Her husband later verified that her brother had stated similar sentiments to him. By the 21st session she returned to the issue of how frequently she washes herself particularly her genitals washing until she is “red-raw” and that she was showering at least twice a day frequently for 3/4 of an hour. In discussing this she associated to a “memory” of her returning home from school and seeing the housekeeper lying naked on the bed with Ruth’s cat licking the housekeeper’s vagina.

She also recalled that at 10 years of age she had been taken to hospital with stomach pains something from which she recalled she frequently suffered. Initially, it was thought that her appendix caused the pain but on examination the pain appeared stress related. The examining doctor apparently mentioned that her genitals were well developed. She felt ashamed of this and still feels revolted by her genitalia (the hospital that she attended was a private one that closed down several years

previously and the therapist was therefore unable to check whether they had records of her admission).

She said that as a child she was scared all the time and frequently cut her finger and sucked the blood in order to soothe herself. By the 26th session she brought in a letter that she had received from one of her sisters in New Zealand and asked me to read it. The letter was a long and frank one that discussed her sister's sexual adjustment and identity. She also wrote that the maternal grandfather had been sexually abusive to her when she was five. During this session Ruth returned to the sentiment that she could sense a presence around her all the time like a snake and how she has memories of a man running his hands all over her body. She recalled how, as a child, she was always feeling sick and full of aches and pains. She had also brought along a drawing which depicted a little girl performing fellatio on a man; she explained she had "no choice". She commented that she frequently cleans her teeth and that she always has to have something nice in her mouth. She discussed that there was no escape from the man because he had held her hair and that she would throw up everywhere. Now she would "rather die than vomit" having done so much of it as a child. The worst part for her was in being unable to get away from the memory. She always discussed such memories¹ with great difficulty accompanied by long pauses, attempts to suppress her feelings and a twisting and contortion of her body and limbs. She continued by stating that the angry part of her was shouting "Why can't she just bring it all out and tell him [the therapist] it all?" She felt that she deserved what was happening to her and that her parents had not wanted her. Sometimes she felt that if she said anything he would hit her, "he really stands over me a lot", and she had to keep herself in check. At this stage it was difficult to discriminate between whether she was discussing her "angry part" or her father, or if they were the same. She felt split as if part of her was saying, "I promise I won't tell anything." and feels that by this "he will not lash out" at her. She continued by asserting that her husband was a lot like her father; they do not look the same but she just has the feeling that they both have strong opinions and they both

¹ This thesis acknowledges that memory is a constructive process and that memories such as those stated by the participant are implied and are not necessarily factual unless veracity has been proven.

make her feel angry. She discussed how it makes her feel worse when she has no reason to feel angry.

By the 29th session she brought more writings discussing the issue of anger and that now I would know what it was like for her too. She discussed how inside of her several parts were fighting with each other. She saw them as children. She often saw a mental picture of what is happening but “gives over” her feelings to the children inside of her. One of the children was very angry another had tantrums and the other is a shrivelled up person that just takes the abuse that is occurring. Her writing, each paragraph written in different writing, is quoted in part below:

The little me – I picture me as a baby, in the fetal (sic) position. I think she knows what a doll feels like that has been pulled poked had arms & legs moved where they don't really want to go. Dressed undressed and thrown around.

The angry one is really scary because she is vicious. She yells at me a lot to listen to her. She is the eldest. Sometimes I find myself hitting myself. I find her hard to control especially when I'm talking to Ian [therapist]. All she wants me to do is hit myself.

There is another who I look gently at because she is 6 yrs old and has a wonderful face but when you look her in the eyes there is nothing there. She sits there rocking herself and sucking her thumb. I wish I could take away her pain.

I know there is one who feels the pain but I don't know how to or don't want to get in touch with her much at all because you then really feel overwhelmed by it all.

She talked about her fear of expressing anger and that she might “explode” with rage during a session. She was particularly apprehensive that she would act out in the same way as her father, or as she had done with other men when she felt grateful. I empathised with the dilemma that this presented her with but also discussed the nature of therapy and its boundaries. She discussed how the anger in her gets expressed in somatic concerns such as in neck aches, back aches, headaches, stomachs and diarrhoea. She described that when memories of abuse occurred she felt them with all her senses - sight, smell, sound, and taste. She described how as a

child she was able to dissociate and go to a place where there were lots of children to play with. She, along with the “children”, looked down on what was happening to her but did not feel anything. She wondered why she would have to go back into her body after the abuse and concluded that it was because she deserved to feel the pain but then wondered if she was going back so that she would remember and could extract some revenge. She discussed how increasingly she was using the therapist in her dreams to protect her and that she would occasionally think of him during the day when she was feeling distressed.

During the 13th session she continued to discuss her sense of worthlessness and how as a child there was little encouragement shown to her. She then appeared to regress asking me “do you want to know something else?” in a childlike voice. She said that when she and John had sex she watches herself and that up to a certain point she gains enjoyment but then at a precise time “I click off”. She stated that she would do “all the motions” but that she is not truly there. During the 31st session she returned to her “memories” of bath time as a child and of having to play a game of “horses” and “submarines” with her father in the bath and that she would have to grab the “reins” or “sink the periscope”. She stated that she felt a “change” when that memory occurred and that she tried “to cut off from it”. She went on to discuss how she did not want to remember about the angry part of her but the “angry child” told her that she did. She talked about the “noise” in her head that she could hear and that this came from all the different voices talking “there are many voices in my head that are talking to me all at once”. She commented on a pain that she felt on the left side of her temple when she thought about her father and that she was sure that he must have hit her a lot. In particular, when she thought about her father, she felt pain in her stomach.

She continued to discuss her experiences of the bath and how the angry part of her was more able to confront the father and that this made her feel good. However, she was frightened because there were other parts of her that were yet unrecognized, she felt that they were different parts raised at different ages. She continued discussing dreams whose content appeared related to her anxiety of being helpless and vulnerable. She also had a reoccurring dream of being unable to move

while a snake was crawling over her; she identified the snake with her father. She noted that when she talked about such dreams she feels as if she was being hit. She discussed how she tried to suppress her emotions and that she did not want to feel because she felt vulnerable when she did. At times she was confused by the intensity of her feelings. An example she gave was when giving birth to her eldest son she believed that she was screaming “the place down” but John told her that she did not make a sound.

At the next session she brought notes written in different handwriting that relayed some of her childhood experiences and how she now abused herself. She often hit herself particularly on the arms and hands with a rolling pin. She would also “punish” herself by taking various tablets and eating the wrong foods and not looking after herself. She later discussed that she would cut herself particularly on her stomach and genital areas. She would also “punish” herself by repeated use of a vibrator that she would use until she was sore. She denied any suicidal ideation just a desire not to exist. She ended the session by wondering whether she was lying when she said that her father had abused her and that perhaps, he really was a loving individual and it was “all her fault”.

In subsequent sessions she continued to recall memories of her childhood and her ambivalence with the thought that her father had abused her. An example of this was how she had recently seen her father at the shops and had been “super nice” to him and had kissed him as her way of denying what had “actually happened”. Despite such strategies her thoughts remained full of “terrible words” and she recalled that when she was 13 years of age, on weekends, she would phone people that she did not know “yelling ‘help, he’s got me. He’s raping me’”. She also discussed how on occasions she was looking at everything as if she were six years of age and wondered how she had got to be so big and that everything in the home appeared so large. A note that she had brought to the session echoed similar themes:

I had a picture in my mind on Thursday night. I think I’m six and the man is laying on my bed. His fingers are in me and his other hand is touching me. My legs are open and I feel him over me. As I think & see this picture I have no emotion. I can see that she is not aware of

what is happening. I have the absolute feeling that she is not really me. As I write this there are many voices in my head that are talking to me all at once.

She brought a soft toy to one session and held it in her lap and whilst discussing issues of abuse began to vigorously prod her fingers in what approximated the toy's genital and anal regions. She then spontaneously said that she did not know why she did not just say that her maternal grandfather, her stepfather, and father had all abused her as well as all the others that she had allowed to. During succeeding sessions she continued to recall memories of earlier abuse that occurred within the home and involved her father. She frequently returned to how she felt six years of age most of the time and could remember the fights between her parents. She discussed how her mother would be a "nervous wreck" before her father arriving home from work around 4 30pm. Now 4 30pm was also a particularly difficult time of the day for her, one where she experienced headaches and anxiety. She discussed that the "Angry One" was angrily "screaming" at her saying, "we did not ask to be born into this" and that she was angry with the mother because she "never did anything to stop it". During this session she frankly discussed the dichotomy she experienced between presenting as outwardly agreeable whilst brimming with rage. She discussed how the Angry One, which she viewed as an "evil" part screamed at her that the good part is like a needy "baby sparrow that has always got its mouth open to be fed. She's waiting for him, whatever he wants to do she does. He's wanting to put it in places it doesn't fit. She's like a piece of meat".

During subsequent sessions she continued to discuss the duality that she felt within her and the internal arguing between the different aspects, feeling as if she were a "vehicle for the different parts" and that they talked about her as if their existence was separate from hers. She perceived the "Angry One" as aged from eight to her present age, whereas the other parts remained as young children. Many of her notes were written in different handwritings, these writings she asserted were not her thoughts "they speak I just write". In one note she wrote:

It's like I'm in the desert or in the middle of the ocean. I'm lost and scared. Nobody can help me or save me. I'm drowning inside. But inside me a very little voice is telling me that I can go on. But I must tell you that I'm getting bloody tired. I think of [Judith] a lot and her

family. My girls are always with me now. I wish everyone could see them. THEY HURT. But I don't. Please help me.

It continued in different writing:

Today I feel sick again. My stomach aches. They are looking at me and asking me to do something. What can I do. I'm cold on the inside of me. I have this intense feeling of dread creeping through me. Today I can hardly remember anything that I've already said over the last few months. There is something horrible that I know but I just can't grasp it and tell.

In later sessions she discussed that as a child she was often sick with urinary and chest infections and that she frequently suffered from migraines on weekends. She remembered that she never went to the doctor without her father insisting on being present or with the doctor coming to the home. She frequently reported various pains and aches during and between sessions and at times was concerned that she might vomit during a session. During the 58th session she stated that she could see snakes everywhere even on my office floor. She also stated that she could see several children in my office: a baby of about 6 months in my bin, another child, a bit older, sitting on top of my cupboard, another child floating in the air, and another turning around on my office chair. She recognized that none of these "images" were real. Despite the rather bizarre nature of her material she did not impress as psychotic though her production did impress as regressed. During a later session she returned to the theme of being in the bath with her father. She wrote:

Well I finished off my picture of me in the bath playing horsey with Dad. It's alright. He puts his hands over mine and rubs them up and down and then he shakes a little and then all this stuff comes out and its yucky. But its alright. Then comes the bit I'm not sure if I like or not. He lays me back in the water and starts to wash me but when he reaches my wee wee he takes a long time and he puts his finger in a little bit. He loves me and tells me I'm Daddy's little girl. I hate this now this is why I feel so bad inside.

Throughout this phase of therapy she usually gazed at the floor rarely casting a glance in my direction. At times an entire session would consist of her crying or

sobbing whilst rocking herself; this became a more frequent occurrence as therapy progressed. She felt as if she was caught in an internal struggle between her desire to feel nothing and her desire to “discover what had happen to [her]”. During session 79 she said that the words “[she] was a child of the Devil” kept running through her mind. From this session on she introduced material with ritualistic overtones. She discussed how she was a child of the Devil and that the two nipples on her left breast were proof of this. She also discussed how purple was a significant colour for her and spoke about eating babies hearts and memories of being in a box with a dead person and another of being in a box with bugs crawling over her. The drawings that she now produced also depicted material of a ritualistic nature (some of Ruth's drawings are presented in Appendix F and will be referred to in subsequent chapters). In discussing such material she appeared to dissociate as indeed she did for any material of a traumatic nature. She discussed her self abuse more openly stating that she felt compelled to harm herself. She discussed how various calendar events such as Easter, Christmas and New Year were particularly difficult periods for her. As therapy proceeded her depression deepened as did her self-harm behaviour and by session 117 she was hospitalized for 10 days to allow for some respite. During session 136 she brought in a soft toy monkey as a transitional object. The “monkey” remained in my office and was used by her during subsequent sessions. Before this she had been using a large cushion from my office and she had held on to this when relaying or experiencing stressful material. For a long period she held on to both the cushion and the soft toy clutching them tightly against her chest and burying her face in them at times of distress.

When recalling traumatic events she initially experienced them in an emotionally detached way as if she “was an onlooker”. She described how “mental pictures” of traumatic events would be explained to her by an alter named the “Story Teller” so that Ruth could remain emotionally distant from the material and “we [therefore] have time to digest what she [the Story Teller] said”. While driving home from one session she said that a voice had come and said, “From Baby came Angel, from Angel came Chris and Carol”. Carol was the first alter to identify herself to me during the 125th session. She said that she was six years of age. By the 146th session the process of switching was more evident during sessions and on the 149th

session the alter named the Angry One spoke to me and then during the next session an alter named Mary spoke to me directly for the first time. Mary had first spoken to Ruth before this session. Ruth had been at home when a “voice” spoke saying, “Hi, I’m Mary” and that since then this alter had made more frequent appearances. She was concerned with what was happening and wrote the following:

I only want to be me not all these inside ones as well. I feel strange a lot of the time. I can see and hear what is being said but I don't feel like I'm part of what is being talked about. I am an observer of myself. When I am talking (even writing this) I can hear other conversations going on. This makes it difficult to follow other people when they are speaking to me.

Sometimes when I get in the car I need to shift the seat and adjust the mirror. When the girls write they use their left-hand – something that I can't do – and you can easily read what they write. I often have a sense of my head floating then my body. Sometimes my eyes flicker and makes things funny to look at. I often have a warm tingling sensation going through my body. I can sit wherever I like and see things but really I'm still sitting in the chair. I must say I often lie on the floor in Ian's office even though I can see that I am sitting in the chair —WEIRD.

She often declared that she did not “remember too much about the [previous] session”. She was concerned as to whether her memories were “real or not, or just pretend” and she experienced great difficulty accommodating the abusive memories that she expressed regarding her father with the love that she professed to hold for him.

The appearances of the alters led the therapist to the diagnosis of DID and treatment continued on this basis. The patient's symptoms were consistent with the criteria specified in the DSM-IV and consultant psychiatrists involved in her treatment later confirmed this diagnosis. Hence, it was not considered necessary or therapeutically appropriate to administer any other assessment tool such as the Dissociative Experiences Scale (Carlson, E. T., & Putnam, F. W. 1993). This patient is eminently suitable for the study: She meets the DSM-IV criteria for DID, three consultant psychiatrists independently confirm her diagnosis, and her presentation is consistent with DID literature. The participant's work with these issues along with

the emergence development and function of alters and their treatment occupies the main body of the thesis.

3.5 Therapist's Training and Orientation

Since many sceptics of DID (e.g., Loftus & Ketcham, 1994; Ofshe & Watters, 1994; Piper, 1997) deem therapist iatrogenic bias to be the genesis of DID the final section of this chapter briefly summarizes the therapist's training and orientation. He graduated from the University of Western Australia (UWA) as a Clinical Psychologist in 1984. The first three years of his career were with the Western Australian Prison Department. In part, because of this experience, he was relatively acquainted with the range of pathologies found in forensic environments and hence was familiar with issues of malingering and factitious disorder as well as issues of sexual abuse. Following this, the Western Australian Health Department employed him. His work in psychiatric clinics has been with both children and adults though since 1991 he has been employed only in adult psychiatric settings. He also maintains a part-time private practice.

Before treating this patient he had not previously knowingly seen or treated a patient suffering from DID, neither did he know of any colleague who had. He held the belief that this was a rare condition, had little understanding of it having only read fleetingly of its occurrence, and was initially unaware of the controversy surrounding it. He had heard of Thigpen and Cleckley's book The Three Faces of Eve (1957) and Schreiber's book Sybil (1973) though at that time he had not read either of them. He considered that the condition was unlikely to present in modern practice and hence this was his first encounter with the disorder. Whilst he had not suspected that this patient was suffering from DID he did maintain an open attitude as to her condition. His initial impression was of an extremely tense and anxious individual evidencing some dependent features and presenting as being overwhelmed by her present circumstances. He also held the possibility that some of her symptoms were indicative of childhood sexual abuse. Her difficulties appeared chronic and he believed it advisable, at least in the short term, to focus on the

presenting issue of panic attacks and assist her to contain her anxiety. Her previous therapeutic history alerted him to the importance of maintaining an open attitude and to allow her to express her narrative in her own time. He did not encourage her to state or resolve whether she had, or had not, been abused but instead encouraged her to develop her own narrative without preconceived notions. His response to any such material was one of empathic understanding in which he followed the participant's productions rather than led them.

The theoretical training for his clinical degree at UWA was based on a cognitive behavioural approach. He had also undertaken postgraduate training in hypnosis though he did not use hypnosis with the participant. Before treating the patient, he was enrolled as a part-time PhD. student in psychotherapy at Edith Cowan University where training in a self psychology approach was offered. Part of the requirement for this degree was individual supervision of cases. When Ruth first presented it was apparent that her issues were likely to be complex and he sought supervision after the 20th session. He remained in supervision regarding this client to the completion of her treatment. From early in therapy all sessions were taped with the patient's permission. These tapes along with other material produced by the patient were used in supervision. The diagnosis of DID was arrived at gradually as the diagnostic criteria unfolded. By session 150 the supervisor and he considered that there were sufficient diagnostic criteria present to warrant such a diagnosis. The patient was also independently diagnosed as suffering from DID by three different consultant psychiatrists also employed by the WA Health Department. Their diagnosis is documented in their case notes and discharge summaries.

Hence, the patient had been in continuous therapy with the author since February 1993. Treatment had been conducted using the self psychology model. The patient's symptoms meet the DSM-IV diagnostic criteria for DID. Over 1050 of the 1125 treatment sessions had been audio taped, and supplemented with cross-referenced case notes for all sessions. Furthermore, during the course of therapy, the participant had written extensive biographical notes, letters from different alters, and drawings that graphically portray this experience. She had been hospitalized 12 times during treatment, her average stay being 5 weeks. During each of these

periods she had been under the medical care of a consultant psychiatrist. In total, four consultant psychiatrists have treated her whilst she has been an inpatient. Three confirmed the diagnosis of DID on the discharge summary. The other consultant who treated her during her first hospitalization diagnosed posttraumatic stress disorder with borderline personality.

In the following chapter the method employed to investigate the research questions is presented.

CHAPTER FOUR

4.0 METHOD

Overview

In this chapter the method employed to investigate the research questions is presented. Issues pertaining to the validation of DID are considered under three headings. First, the development of the Questionnaires used in the study and the rationale for their use is discussed. Second, the research questions and the procedure used are described. Third, the study and the three phases into which it is divided are detailed. In the first phase, issues of diagnostic reliability and observer bias will be considered. In the second phase, iatrogenic bias will be specifically considered whilst in the third phase, the relationship between treatment and the development of DID will be investigated.

4.1 Validation of DID

Development of Questionnaires and Rationale for their Use

Procedural difficulties in detecting and validating the diagnosis of DID have arisen in the context of:

1. Controversy over the existence of the disorder.
2. Paucity of empirical studies.
3. Relative unavailability of practical diagnostic guidelines.

McHugh (1995) contested the claim that DID was validated. He argued that the point of contention is not whether patients exist with a set of complaints that are consistent with the DSM-IV criteria for DID, but rather, whether this collection of

complaints and behaviours represents a natural product of mental life or a socially constructed iatrogenic artefact generated in the interaction between patient and therapist. North et al. (1993) claimed that no other documented disorder had inspired comparable arguments about whether the disorder existed at all independent of iatrogenesis. In part the iatrogenesis debate continues for lack of research; in part the question of iatrogenesis remains open because of the absence of validity checks for possible therapist bias (Greaves, 1992; Yapko, 1994).

Greaves (1992) felt that diagnostic positions had been taken a priori, without consideration of the evidence. He argued that there had been little systematic analysis of the reliability and validity of the empirical evidence for the many competing hypotheses. In assessing validity, Greaves proposed that those educated in psychotherapy have been trained to evaluate the validity of patient productions from at least three concurrent perspectives. These he identified as:

1. Process checks of validity.
2. Internal checks of validity.
3. External checks of validity.

Each validity check contains several subcategories. The global assessment of these evaluations results in a determination of the kind of intervention the therapist makes.

In *process checks* of validity the therapist considers:

1. Cognitive processes - organized logical thinking versus tangential, associative thinking.
2. Affective process - the match between the patient's affect and the reported material.
3. Non-verbal behaviour – the fit between the patient's gestures and what is being said.
4. Congruency – the fit between the cognitive, affective, and behavioural components in combination and the content of the material.

5. Symptom complex - the adequacy of the manifest content of reports related by the patient as a reasonable explanation of the presenting symptoms, especially in reports of trauma.

In *internal checks* of validity the therapist, in part, considers the following questions:

- (i) Is the patient's story logically possible?
- (ii) Does the patient contradict him or herself?
- (iii) Does the account grow in consistent detail with the repeated telling?
- (iv) Does the material grow in consistency or become more and more disorganized?

External checks of validity are a combination of the therapist's knowledge base and his or her responses to the data that emerge during treatment:

- (i) What the patient reports.
- (ii) The therapist's ability to establish sufficient rapport.
- (iii) The therapist's knowledge of complex psychodynamics.
- (iv) The therapist's belief and knowledge about the nature of the external world.

Whilst checks of validity may be considered as a matter of course by the treating therapist, they have not, as noted by Greaves (1992), been undertaken by independent judges. It is proposed that such an undertaking would be of significance in understanding the productions of these patients and in considering issues of validity. Within the psychotherapy literature there is a large body of process research (e.g., Bergin & Garfield, 1994; Langs, 1982; Rice & Greenberg, 1984). Greaves' thinking on validity checks is drawn from this research. The use of such checks by independent judges in this study extends this body of work in DID research.

Putnam (1995, p. 961) suggested that the crucial question raised by this debate is “How should the validity of a psychiatric diagnosis be judged?”. In discussing the criteria of Robins and Guze (1970), Putnam noted that psychiatric diagnoses must satisfy three basic forms of validity: content validity, criterion-related validity, and construct validity. The latter is probably the most fundamental. It requires the therapist to give a specific and detailed clinical description of the disorder. In the proposed study the issues of validity raised by Greaves (1992) and Putnam are considered, so that an informed examination of the case material can be undertaken.

Given the concerns regarding iatrogenic diagnostic bias raised by McHugh (1995) and others, issues of therapeutic bias are paramount. Yapko (1994, p. 165) in a review of the literature on therapeutic bias concluded that good therapy, regardless of theoretical orientation, is conducted:

(1)...[on] the basis of a free narrative, (2) unprompted by leading or suggestive questions, (3) in an atmosphere free of coercion, (4) with a therapist who manifests a neutral position and (5) allowing both him or herself and the client the freedom to plead ignorance.

Observations such as these underline the importance of the clinician’s responses and the profound impact they may have on the patient’s presentation.

Greaves (1992) found no research studies on DID that focused on process validity using independent judges. He believed that without such checks the research is of little value. In this study the validity checks proposed by Greaves and the “good therapy” checks noted by Yapko (1994) as necessary to minimize iatrogenic bias are incorporated. Questionnaires were developed using the principles and criteria laid down for process checks of content validity by Greaves (1992), and Putnam (1995), and principles for good therapeutic practice that are necessary to avoid or minimize iatrogenic bias (Yapko).

Once issues of procedural validity have been considered, issues pertinent to treatment can be examined.

Relationship between Treatment and the Development of DID

Examination of the diagnostic validity of DID therefore equally involve consideration of the therapeutic process. Progress in the study of therapeutic integration in the field of dissociation has been hampered by ideological debate on iatrogenesis. Thus, despite its importance, integration has not been systematically described or delineated (Stern, 1984). Whilst a number of researchers (e.g., Kluft, 1988; Putnam, 1996; Ross, 1997) have contributed significantly to our thinking regarding integration, Ross (p. 378) argued that Kluft's 1988 paper on integration has not been "significantly extended by anyone in the field". It is proposed here, that the therapeutic process and the process of integration are necessarily intertwined and need to be investigated concurrently. Therefore, issues of therapeutic bias will be examined in the context of therapeutic integration. Whilst it is acknowledged that treatment of DID is likely to be most effective within an integrated model (e.g., Kluft, 1996a; Putnam; Ross), it is also argued that an examination of this process from a self psychology perspective will make a significant contribution to the field. Firstly, it provides an opportunity to explore issues pertaining to integration and treatment using a specified rather than an eclectic treatment model. Secondly, self psychology has much, it is argued, to contribute to an understanding of the developmental implications of early trauma for the structural integrity of the sense of self (Ulman & Brothers, 1988). Thirdly, an understanding of the material from a self psychology perspective would make significant contributions to the treatment of DID, emphasising the importance of empathic attunement in the therapeutic relationship and how this is utilized in the restoration of a cohesive self (Baker & Baker, 1987).

This study focused on the validity of DID as a naturally occurring mental process and on the nature of the experience. It sought to address criticisms levelled at previous research in the area. There were validity checks on what is claimed to have happened in the patient over the course of therapy. If these patient processes are observable to independent judges then the study will present a detailed clinical analysis of the behavioural manifestation of DID and the changes that occur during therapy. The case is documented in detail over a sustained period (9 years) and thus allows a critical analysis of an extensive body of data.

It is hoped that this study will provide insight into factors determining the development of DID, and extend clinical understanding of the nature of this disorder and of the process of its amelioration. The latter is of particular significance since there have yet to be controlled studies of the treatment of DID (Maldonado, Butler, & Spiegel, 1998).

Statement of the Problem

In order to move towards a greater understanding of the issues surrounding the existence of DID, it would seem prudent to consider basic issues of validation as proposed by Greaves (1992) and Putnam (1995). The problem is how to move beyond the polemic and iatrogenic debate and empirically validate DID and the process of therapeutic integration. This study proposed to achieve this using traditional approaches to procedural validity. Once these approaches have been completed it is then possible to consider issues relevant to treatment and aetiology. Evaluation of the iatrogenesis debate utilizing the traditional process of diagnostic validation will assist in determining whether the diagnosis of DID is supported by research evidence and will contribute to an informed debate regarding its aetiology and treatment (Greaves; Putnam; Robins & Guze, 1970).

Research Questions

1. Is the manifestation of Dissociative Identity Disorder evident in this specific patient the result of iatrogenic bias?
2. Can independent judges validate presence of the central diagnostic symptom, namely, the presentation of alter personalities?

If these research questions are judged in the affirmative, the following questions regarding the nature of DID and the therapeutic process will be examined.

3. What factors contributed to the development of alter personalities in this patient?

4. What are the indications for a process of therapeutic integration?

If the null hypothesis is found for the first two research questions then the remaining two research questions will be investigated in the light of those factors that have been found to contribute to the process of therapeutic bias.

4.2 Procedure

The study used a single case design divided into three principal phases. Reliability was considered in the first phase. Iatrogenic bias and alter validation were evaluated in the second phase, whilst in the third phase treatment and aetiology were examined.

Phase One: Reliability Study

The reliability of the instruments and evaluation of judges' ratings were considered in this phase of the study.

Participant

The participant of this study is as discussed in Chapter Three. To briefly reiterate, she has been in continuous therapy with the author since February 1993. Treatment has been conducted using the self psychology model. The participant's symptoms meet the DSM-IV diagnostic criteria for DID. Over 1050 of the 1125 treatment sessions had been audio taped, and supplemented with cross-referenced case notes for all sessions. Furthermore, during the course of therapy, the participant had written extensive biographical notes, letters from different alters, and drawings that graphically portrayed this experience.

She had been hospitalized 12 times during treatment, her average stay being 5 weeks. During each of the 12 periods she had been under the medical care of a

consultant psychiatrist. In total, four consultants had treated her when she had been an inpatient. Three confirmed the diagnosis of DID on the discharge summary. The fourth consultant (who treated her first hospitalization) diagnosed posttraumatic stress disorder with borderline personality.

Selection of Independent Judges

The independent judges had to meet the criteria of having at least 10 years experience in clinical psychology, psychiatry or social work and being familiar with the principles of psychodynamic therapy. Given the limited availability of suitably qualified judges in Western Australia who met the criteria, random selection was not possible. It was initially agreed that a minimum of 10 judges was required for the study. In consultation with the therapist's supervisor, 36 individuals were identified as meeting the selection criteria. A letter advising them of the study and seeking their participation was sent by the supervisor (Appendix A). Of the 36 individuals contacted, 16 agreed to participate. A further five individuals indicated that they were able to complete the initial stages but, due to other commitments, were not able to participate in the full study. These judges were used in the pilot study.

Materials: Questionnaires

Two questionnaires were employed, each with five items and a 7-point Likert-type scale.

Questionnaire One

The items in Questionnaire One were designed to evaluate iatrogenic bias. Incorporation of the qualities detailed below indicates good therapeutic practice regardless of theoretical orientation (Yapko, 1994).

1. The presence of a free narrative.
2. The absence of leading or suggestive questions.
3. The absence of coercion.
4. Therapeutic neutrality.

5. Allowed to plead ignorance².

A copy of Questionnaire One is shown in Appendix B.

Questionnaire Two

The items in Questionnaire Two conformed to Greaves' (1992) criteria for process checks of validity. The items in Questionnaire Two were designed to evaluate validity of alter presentation. Judgement in the affirmative to items one, two and three, indicated appropriate validity checks for the material, whereas, a negative judgement for item four and a consistency judgement for item five indicated appropriate validity checks. Incorporation of the qualities detailed below indicated good therapeutic practice regardless of theoretical orientation (e.g., Basch, 1988; Langs, 1982; Malan, 1995; Yapko, 1994).

1. Is the material presented in a coherent manner?
2. Does the patient's affect match the content of her reports?
3. Does the combination of presentation and affect fit the content of the material?
4. Is the patient's account contradictory?
5. Does the account grow in consistency or become more disorganised?

A copy of Questionnaire Two is shown in Appendix B.

Process

The process for phase one of the study was divided into two stages. First, clarity of the terms used in the questionnaires was assessed. Second, inter-rater reliability was evaluated.

² Allowed to plead ignorance refers to the therapist allowing the patient and/or himself to state that they are ignorant about what really happened, particularly when there is no reliable means available to determine whether an account is real or imagined.

Pilot study: Clarity of terms

The purpose of the pilot study was to ensure clarity of terms and to ensure that the questionnaires could be rated in a comparable method. To achieve this the selected five judges were provided with the two questionnaires and a definition for each of the 10 items. First, questionnaire items and their definitions were individually discussed with the judges. Second, any modifications necessary to improve definition clarity were made. Third, judges used the definitions of terms to rate the questionnaire items whilst/after listening to a taped therapeutic session. Each judge received the same tape along with a typed transcript. They were instructed to listen to the tape and to rate each item on the questionnaires. Clarity of understanding for the terms was achieved when there was a 75% agreement between the judges that each of the 10 questionnaire items could be defined and rated. It had been determined, before testing, that if a judge's ratings were consistently deviant that this rater would be excluded from the study. Inquiries regarding his/her perceptions would be noted. This, however, was not necessary and the determined level of item clarity was achieved.

Inter-rater reliability

Once rater clarity had been achieved, the second stage of phase one was commenced. The 16 judges who had agreed to participate were each sent an information package (Appendix B). Each judge received a package that contained: (1) a letter that outlined the nature of the study and an explanation of the task; (2) two questionnaires, as previously described; (3) a Definition of Terms document; (4) demographic details of judges questionnaire; (5) an audio tape of a therapy session and a typed transcript of it; and (6) DSM-IV criteria for DID. Each judge received the same information package. The audio tape was randomly selected from the total pool of tapes where switching or dissociation was judged, by the author, to have occurred.

The purpose of the second stage was to ensure consistency of rating between judges. Inter-rater reliability was assessed using one-way analysis of variance. ANOVAs were used in preference to correlational statistics as they conveniently and

reliably accommodate data where a large number of raters have been employed (Rosenthal & Rosnow, 1991). The judges separately rated the same tape and their responses were compared³. The ratings on both questionnaires were assessed using one-way analysis of variance.

Analysis

Judges' responses to Questionnaire One were compared to assess internal consistency. Items were analysed using repeated-measure analysis of variance using "items" as the independent variable. Mean square statistics from this analysis was used to estimate the reliability, R_{est} (see Rosenthal & Rosnow, 1991). The value for R_{est} is similar in magnitude to a mean intercorrelation and is therefore interpretable with reference to the usual standards for acceptable forms of reliability. A R_{est} of .75 or higher was anticipated.

Reliability (Random Error): Questionnaire One

		Items				
		1	2	3	4	5
Judges	1					
	2					
	3					
	.					
	.					
	.					
	↓					
	16					

³ It could be argued, that once reliability amongst judges is established, then one judge would suffice to rate the remaining tapes. The task of rating, however, is exacting and time consuming and best shared across a number of judges.

Questionnaire Two

The same procedures were used to determine internal consistency for Questionnaire Two.

Phase Two: Evaluation of Iatrogenic Bias and Alter Validation

In the second phase of the study, issues pertinent to iatrogenic bias and alter validation are considered. Phase two was commenced approximately 4 months after phase one.

Participant

As described in phase one.

Judges (15)

For this phase one of the 16 judges had to withdraw due to family commitments; it was not felt appropriate to attempt to recruit further participants and 15 judges were considered a sufficient number for the requirements of the study.

Materials: Questionnaires One and Two

As described in phase one.

Process

Judges rated two tapes, one tape in which an alter appeared for the first time and a second tape in which the therapist believed there was evidence of switching and dissociation. Fifteen tapes were selected in which an alter appeared, and 15 in which switching and dissociation was evident. Judges rated different tapes. Thirty taped sessions were selected from the total pool of tapes. For this stage of the study there was a pool of 700 tapes. The number of tapes selected was determined by the

availability of judges and the amount of material that they could reasonably have been expected to evaluate. Tapes were randomly selected from the early, middle, and late stages of therapy. The ratio of tapes selected to the total pool of tapes was 1:23. Tapes were selected in which (1) an alter appeared for the first time, (2) there was evidence of switching (more than one alter present during that session), and (3) dissociation occurred. From the pool of 700 tapes, there were 15 tapes in which an alter appeared for the first time. Judges were randomly assigned one of the tapes from this pool, at a ratio of 1:1. The pool of tapes in which switching and dissociation occurred was considerably larger, comprising approximately 500 tapes, at a ratio of 5:7. These were divided into the early phase of therapy (first 18 months), the middle phase of therapy (18-36 months), and the late phase of therapy (> 36 months). In total there were 80 tapes in the early phase of therapy, 268 in the middle phase, and 352 in the late phase. To ensure as representational sample as possible, tape selection was proportional: early phase 3, middle phase 5, late phase 7. These tapes were randomly assigned to the 15 judges, at a ratio of 1:33. Thus each judge received two tapes, along with typed transcripts: one tape in which switching and dissociation occurred, and another tape in which an alter appeared for the first time⁴. They were instructed to evaluate both tapes against the five items on each questionnaire (Appendix B).

It is argued that the items in the two questionnaires can be applied to the content of both tapes. The issues of iatrogenic bias and validation of alters can reasonably be expected to be evident across therapy sessions. They thus apply across tapes, regardless of whether an alter had appeared for the first time or whether it reappeared in subsequent tapes. Examination of the material in this manner allowed for the most economical use of data and judges.

Judge's responses to the pool of 30 tapes were applied to research questions one and two. To reiterate, research question one is the assessment of iatrogenic bias: *Is the manifestation of Dissociative Identity Disorder evident in this specific patient the result of iatrogenic bias?* Research question two is the assessment of alter

⁴ In these tapes there will, by definition, also be evidence of dissociation and switching.

validation: *Can independent judges validate the presentation of alter personalities?* Judges evaluated the tapes against the criteria developed by Yapko (1994), and the criteria argued for by Greaves (1992). Responses were analysed using the designs discussed below.

Analysis: Questionnaire One

An ideographic presentation of the 15 judges' mean ratings of Questionnaire One is displayed. The cut-off score is 4. Questions were rated from 1 to 7, with 7 indicating total absence of bias, and 1, total bias. In this study bias is considered to occur along a continuum (Putnam, 1989a). A rating of 4 or less will be considered to indicate the presence of iatrogenic bias⁵. In evaluating a mean rating of 4 or less, consideration needs to be given to the number of ratings necessary for a significant finding of iatrogenic bias. In this study iatrogenic bias will be judged to be significant when 15% or more of the mean ratings are 4 or less⁶.

Cut-off Score for Iatrogenic Bias

	1				
	2				
Mean	3				
Rating	4	Cut-off score			
	5				
	6				
	7				
		1	2	3	4
					5
		Items			

⁵ In the absence of a more objective statistical or mathematical procedure the author has been forced to make a subjective decision regarding a cut-off score (in the same way that $\alpha = .05$ stems from a subjective/arbitrary judgement).

⁶ In total there are 1050 possible ratings (e.g., rating [7] x items [10] x judges [15]). A percentage of 15% was selected to indicate bias, since its converse would indicate 85% or more of the judges are in agreement. Such an agreement could reasonably be accepted as significant for this study.

Analysis: Questionnaire Two

The procedure for analysis of the data is the same as for Questionnaire One.

Phase Three: Treatment/Aetiology

In the third phase of the study questions regarding the aetiology and treatment of DID were investigated. Yin (1994) proposed that single case studies could be used to pursue explanatory purposes. The objective is to explore competing explanations for the same set of events. This can be achieved by assessing each theory against the actual course of events and from the findings develop the best explanation for accommodating the data.

Participant

As described in Phase One:

Materials

Tapes previously evaluated by the judges and case material selected from the total pool of tapes. Biographical material, letters and drawings by alters will be included, when appropriate.

Research Question Three

What factors contributed to the development of alter personalities in this patient?

Process

Tapes were traced in which at least one of four specific alter personalities have emerged during the course of therapy. These were examined in the light of their developmental history, and consideration given to the function they have served

in the patient's life. Tapes were thus selected from therapeutic sessions in which at least one of the four alters either "appeared" or "disappeared" during the course of the session together with any other taped material from the total pool capable of casting additional light on alter development.

The data were assessed against the iatrogenic model (i.e., McHugh, 1995; Mersky, 1995a, 1995b), the DID model described by Kluft (1996a, 1984a), Putnam (1989a), and Ross (1997), and the trauma model described by van der Kolk (1996b). Material was presented qualitatively in text and, when appropriate, included the participant's biographical material, alters' letters and drawings.

Research Question Four

What are the indications for a process of therapeutic integration?

Process

Tapes from the total pool were selected in which there was evidence of integration or fusion. Emphasis is placed on the clinical material detailed in questions 3.

A minimum of four alter personalities were examined from the aspect of "markers of integration" proposed by Greaves (1989) (Appendix D). Particular consideration was given to the "disappearance" of any alter, the fusion of any alter with another, and developmental change in an alter. Treatment factors facilitating or impeding integration were examined.

Greaves' "markers of integration" were examined in terms of a self psychology treatment approach. The process of integration was considered in terms of treatment factors outlined by Kluft (1993), Putnam (1989a), and Ross (1997).

Material was presented qualitatively in text and, where appropriate, included the participant's biographical material, alters' letters and drawings.

In the following chapter the results from phase one and phase two of the study are discussed.

CHAPTER FIVE

5.0 RESULTS: PHASE ONE AND PHASE TWO

Overview

The results for phase one and phase two of the study are presented. In phase one issues of reliability were investigated whilst in phase two checks on iatrogenic bias and alter validation were examined. Results for phase three of the study are presented in subsequent chapters.

5.1 Phase One: Reliability Study

Experience and Specialty of Independent Judges

In Table I the experience and specialty of the independent judges are presented. Twelve of the judges were clinical psychologists, three were psychiatrists, and one a social worker. Clinical psychologists had a range of 10-23 years experience in their speciality. Psychiatrists had a range of 17-25 years experience and the social worker 28 years of experience, in their respective specialties. However, several judges had considerable clinical experience before gaining their current specialist title. One clinical psychologist, for example, had 20 years prior experience as a psychologist before undertaking specialist training in clinical psychology. The three psychiatrists held specialist qualifications in medicine and psychiatry, whilst the remaining judges all held post graduate degrees in their specialities at a Masters level. One clinical psychologist also held a PhD. Three of the clinical psychologists initial and specialist training was overseas: one trained in Poland, one in Switzerland and one in Belgium/France. All judges had trained in a psychodynamic model. Nine of the judges had training in self psychology and whilst

the remaining seven judges had not trained in this model they were familiar with self psychological principles. There was also a range of experience with all judges having worked for periods in both the public and private sectors. Several had lectured in prescribed psychodynamic courses and one had been employed as a senior university lecturer. Hence the judges represented an experienced group with considerable clinical experience both in their specialty and within psychodynamic theory.

Table I Independent Judges Specialty

Specialty	n	Mean years in Specialty	F	M
Clinical Psychology	12	17	9	3
Psychiatry	3	20	3	
Social Work	1	28		1
Total	16		12	4

Inter-rater reliability

The judges individually rated the same tape and their responses to Questionnaire One and Questionnaire Two were compared. The ratings for both questionnaires were assessed using repeated-measure analysis of variance with “items” the independent variable. Rosenthal and Rosnow (1991) proposed that when more than two judges are used for comparison an excellent approach to inter-rater reliability is one based on the analysis of variance. To assess the aggregate reliability of judges the effective reliability (R_{est}) is estimated using the Mean Squares column of the analysis of variance. The value for R_{est} is similar in magnitude to a mean intercorrelation and is therefore interpretable with reference to the usual standards for acceptable forms of reliability. A R_{est} of .75 or higher was anticipated. Effective reliability is estimated as follows:

$$R_{est} = \frac{MS \text{ judges} - MS \text{ residual}}{MS \text{ judges}}$$

Questionnaire One: Iatrogenic bias

The analysis of variance for judges' inter-rater reliability on Questionnaire One is reported in Table II. A R_{est} of .81 is reported. This meets the criterion and indicates consistency of rating between judges for Questionnaire One.

Table II Analysis of variance: Questionnaire One

Source	SS	df	MS	R_{est}
Judges	22.52	15	1.50	.81
Items	2.03	4	.51	
Residual	16.69	60	.28	

Questionnaire Two: Alter validation

The analysis of variance for judges' inter-rater reliability on Questionnaire Two is reported in Table III. A R_{est} of .81 is reported this meets the criterion of .75. Therefore it is concluded that the criteria for inter-rater reliability for Questionnaire One and Questionnaire Two have been met and the study can now proceed to the second phase.

Table III Analysis of variance: Questionnaire Two

Source	SS	df	MS	R_{est}
Judges	13.98	15	0.93	.81
Items	2.87	4	0.72	
Residual	10.65	60	0.18	

5.2 Phase Two: Evaluation of Iatrogenic Bias and Alter Validation

As discussed in the previous chapter one of the judges was unable to participate in this phase of the study. This judge's exclusion from phase 2 resulted in minimal changes to the figures reported in Table I. The mean of years in specialty

increased from 17 years to 18 years and the total mean years in specialty increased from 65 years to 66 years. It reduced the number of clinical psychologists from 12 to 11 and reduced the total number of female judges from 12 to 11.

Phase 2 required each of the 15 judges to respond to two tapes and to score their response on Questionnaire One and Questionnaire Two. Each of the 30 tapes was different.

Questionnaire One: Evaluation of iatrogenic bias

The judges' mean responses to tape one and tape two on Questionnaire One are reported in Figure 2. Questionnaire One required the judges to rate the tapes for iatrogenic bias against five items on a 7-point Likert-type scale. As reported in Figure 2 the mean response of judges across all items is greater than the criterion cut-off score of 4. Mean responses for tape one and tape two are 6 or greater. Therefore, the null hypothesis that the manifestation of DID evident in this specific patient is the result of iatrogenic bias is rejected and instead it is asserted that the manifestation of DID in this patient is due to other factors.

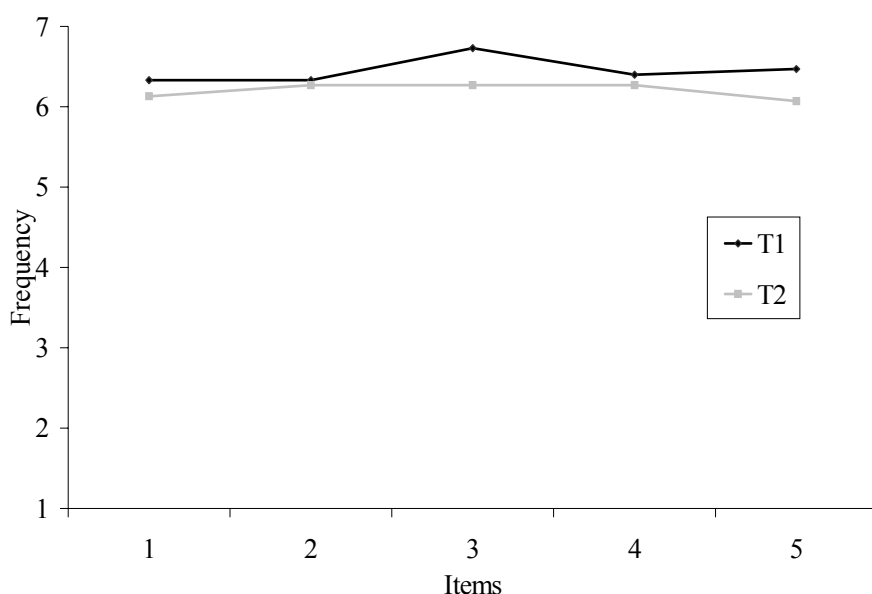


Figure 2. Iatrogenic bias: Judges' mean responses to tape one and tape two.

Table IV details the frequency of item selection by judges on Questionnaire One for both tape one and tape two. The item selected least is 5 with the most frequent selected item 6 or 7. This is the case for both tape one and tape two.

Table IV Frequency of item selection

Items	Questionnaire One					
	<u>Tape One Selection</u>			<u>Tape Two Selection</u>		
	5	6	7	5	6	7
1	1	8	6	4	5	6
2	1	8	6	2	7	6
3	0	4	11	2	7	6
4	1	7	7	2	7	6
5	2	4	9	4	6	5
Total	5 (7%)	31 (41%)	39 (52%)	14 (19%)	32 (43%)	29 (39%)

Questionnaire Two: Alter validation

The judges' mean responses to tape one and tape two on Questionnaire Two are reported in Figure 3. Questionnaire Two required the judges to rate the tapes for alter validation against five items on a 7-point Likert-type scale. The mean responses across the five items are consistently greater than the cut-off score of 4 for both tape one and tape two. Therefore the model hypothesis that independent judges can validate the presentation of alter personalities in this patient is accepted.

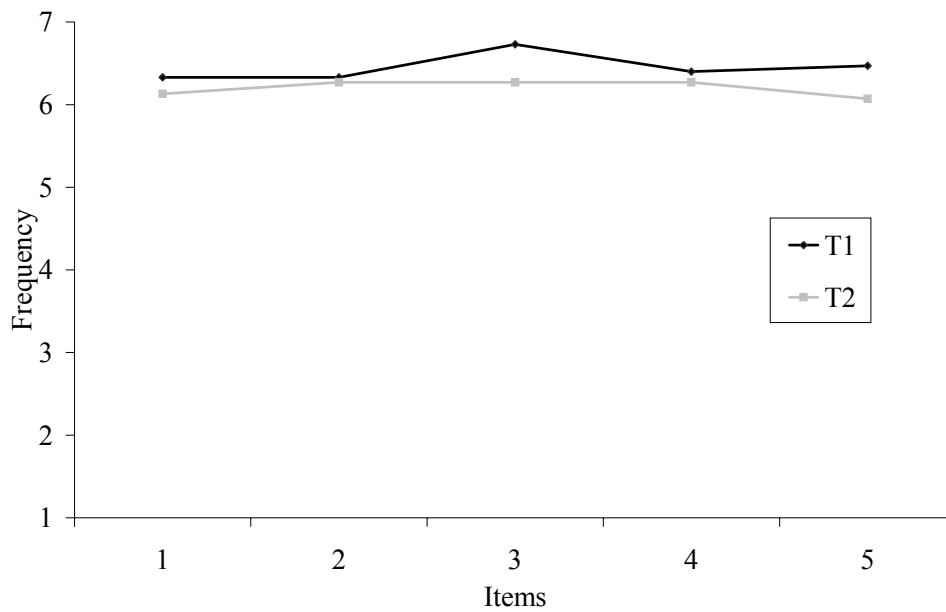


Figure 3. Alter validation: Judges' mean responses to tape one and tape two.

The frequency of item selection by judges on Questionnaire Two for both tape one and tape two is detailed in Table V. The item selected least is 5 with the most frequent selected item 6 or 7. This is the case for both tape one and tape two.

Table V Frequency of item selection

Items	Questionnaire Two					
	Tape One Selection			Tape Two Selection		
	5	6	7	5	6	7
1	1	6	8	5	2	8
2	1	9	5	2	7	6
3	1	4	10	0	9	6
4	1	6	8	0	7	8
5	0	7	8	2	7	6
Total	4 (5%)	32 (43%)	39 (52%)	9 (12%)	32 (43%)	34 (45%)

Summary

In phase 1 of this study consistency of rating between judges was considered. The criteria for inter-rater reliability were met and from these findings it was possible to proceed to phase 2. Phase 2 of the study used an appropriate design methodology and sought to empirically test the hypothesis that the DID manifested in this specific patient was the result of iatrogenic biasing. The null hypothesis was rejected and it was concluded that the DID manifested in this patient is not the result of therapeutic bias. It was also concluded that the presence of alter personalities in this patient could be validated by independent judges. Comments made by judges are included when relevant to the issues being discussed (Appendix E). Having addressed some of the reliability and validity issues raised by sceptics it is now appropriate to proceed to the third phase of the study. The research questions raised earlier are presented and discussed in the subsequent chapters

CHAPTER SIX

6.0 RESEARCH QUESTION THREE:

What Factors Contributed to the Development of Alter Personalities in this Patient?

Overview

In Chapter 6 factors pertinent to the development of alter personalities in this patient are discussed under three headings. First, the traumatic events that this patient described during the process of therapy are considered. Second, the alter system of this patient is presented. Third, the relationship between the traumatic events and the development of particular alters is discussed. Finally, the data are assessed against the iatrogenic model (i.e., McHugh, 1995; Mersky, 1995a), the DID model described by Kluft (1996a, 1984b), Putnam (1989a), and Ross (1997), and the trauma model described by Van der Kolk (1996a & 1996b).

6.1 Traumatic Events Described by this Patient

The patient's personal and medical history has been presented in Chapter 3. In this section the patient's account of traumatic events that occurred during childhood is summarized. The traumas are presented in their resolved detail. Many of the traumas were introduced and alluded to by different alters during the early phase of treatment and were enunciated more fully during the course of therapy. The means by which this material was processed is discussed further in Chapter 7, where issues relevant to treatment are considered. The traumatic events described here are a summation of her therapeutic process and the author has not attempted to include

all of the traumas that she endured and that she discussed. The purpose here is to convey an appreciation of the nature of the important traumatic events. The impact this had on the development of specific alters is discussed in Section 6.3 of the chapter. Early in therapy the patient described traumatic events of a ritualistic nature. She described her father as the leader of a cult in which her mother was also involved, though to an insignificant degree compared to that of the father. She continued to discuss memories of severe and overwhelming ritualistic abuse throughout the therapeutic process. This material and her processing of it are discussed in detail in subsequent sections of the thesis. Phrases taken from sessions are quoted as spoken by Ruth unless otherwise stated.

As has been previously stated the author does not propose that these events necessarily happened. There is no external validation, but for the purposes of the study the author will assume that they did and inspect whether the development of alters and their integration make sense within this possible scenario of events. Given this scenario, the author also examined whether it is possible to develop a theory about the development of these alters that is consistent with the literature. This chapter will be written as if the events took place and in subsequent chapters issues regarding their validity will be re-examined. Traumatic events described by the patient are considered under two headings: those that occurred within the home and those that occurred within the cult.

Traumatic Events within the Home

The patient's early home life can be divided into the period from birth to 8 years of age when the mother was part of the family and the years from age 8 onwards after the mother had left. The mother left with the twins who were then aged around 18 months, though she had left a few months earlier without taking any of the children. There appeared to have been some attempt at reconciliation before the mother leaving surreptitiously the second and final time. The mother was afraid of the father and moved to another country and made no contact with her children until fairly recently. She still lives overseas. The patient's family moved from the

Eastern States when she was around 3 years of age. They moved to Western Australia and into a street where the father seemed to have known some of the people. The family rented a property that was built on the back block of one of these friends. One of the earliest traumatic events that she recalled was that of being placed in a garage pit by male neighbours. She was put in the pit and boards were placed over the top of the pit. She was left there for some time before being released and told not to say anything about what had happened.

Within the home environment she recalled a persistent pattern of sexual and physical abuse from an early age. From 5 years onwards the patient recalled sexual abuse by her father and on one occasion by her mother and her maternal grandfather. There was a persistent pattern to the early abuse with the father. He constantly fondled her, encouraging her to sit on his lap whilst he fondled her and encouraged her to fondle him, telling her that she was special and that he loved her more than he did her mother. This sentiment was often repeated and alternated with cruelty, which is discussed during the course of the thesis. He would come to her bedroom and changing his voice tell her that he was the “Bogeyman” or that it was “Santa Claus” or some other mythical figure such as the “Tooth Fairy”, the “Easter Bunny”, “God” or “Satan”. Terrified she closed her eyes and turned her face to the wall attempting to “block” out the “monster” which would fondle and masturbate over her. Later, he made no attempt to conceal his identity and he would simply come into her bedroom and abuse her, usually without any words being spoken other than telling her to be quiet. Amongst the earliest issues of a traumatic nature recalled by the patient was that of her father abusing her in the garden shed when she was a young child of approximately 5 years of age. She was frightened not only by the traumatic event but also by the events surrounding it such as the musty smell of the shed and the fear of spiders biting her. He would frequently take her into the shed on the pretext of getting her to help him. Once there he would fondle her and lie on top of her on the earthen floor. At this time she also recalled the weekly bath she had with her father when she would have to “play” various games that involved her touching his penis with her hands and mouth. In the course of her performing these acts her head was held under the water making breathing difficult and she thought that she would

choke, the experience of choking was more traumatic than the sexual acts themselves.

Early in therapy she recalled that when she was around 5 or 6 her mother took her to the maternal grandparents' farm. The grandparents lived in a different Australian State and the journey by train would have taken two days. She recalled parts of the train journey, the sound of the wheels on the track and the gaps between the carriages and her fear of falling between them. She recalled how her grandfather took her outside to the woodpile where he undid his trousers and was attempting to get her to touch his penis. She had climbed up the woodpile to get away from him but was frightened as he told her that there were snakes in the woodpile. He had an axe and was threatening her when the grandmother arrived and took her back to the house telling the mother that she needed to keep an eye on her. She was as frightened of the grandmother as she was the grandfather and later recalled how "I can still see this huge woman stomping down; she pulls me down so hard and said 'Why do you make him do things like that you're so bad.'" The mother, much later, told Ruth's husband John, that her father had abused her and her sisters when they were children.

The next significant traumatic event that she recalled was when their mother took her and her two brothers to the meeting rooms of the Buffaloes (a male secret order pledged to brotherliness, mutual aid and charity works). The mother left with her youngest son, Bob, leaving Ruth and her eldest brother, Steve, with their father and his friends. The patient recalled being taken with her brother to an upstairs room where they were undressed, "inspected" and directed to engage in sexual exploration with each other.

She remembered one occasion when her mother, in what seemed like a fit of impotent rage towards the father, made Ruth have oral sex with her while the father was away from the home. The mother angrily told Ruth "You do it for your father, you can do it for me". This appeared to have been the only time that the mother actually sexually abused Ruth though there were several occasions of physical abuse

where the mother would hold Ruth's hand over a boiling pan of water or make her sit alone in a dark cupboard. Perhaps, not surprisingly, the father was abusive towards the mother and Ruth recalled several abusive incidents between them and of the father bringing other women into the home. As Ruth grew older her father became increasingly dominant in her life. Conversely, the mother increasingly rejected and emotionally distanced herself from her daughter and the father became Ruth's main source of "comfort and support".

The abuse continued unabated once the mother left and increased in intensity with Ruth taking on some of the duties of maintaining the home and increasingly those of a "wife". The father demanded that Ruth "love" only him. He killed her pet cat, which had been a soothing presence to her. She would dress it up and take it for rides in her dolly's pram. He picked the cat up by its neck holding it in front of Ruth saying "you love this cat, don't you Ruth" and threw the cat against the wall killing it. She had other cats but did not form the same comforting relationship with these.

After the mother left the family the father joined a single parents' association organized by a woman named Peggy. This does not appear to have been connected to the ritualistic abuse but child abuse did occur. This association appears to have been limited to a subset of the cult who had separate "parties" where children were sexually abused. A major traumatic event remembered by her was an abortion when she was aged 11 years of age. The abortion was performed at Peggy's home where many of the "parties" were held. Following the abortion the father left WA to work on an island offshore of Australia and Ruth and her brothers were placed in the care of the Salvation Army for approximately 18 months. There was still some contact with Peggy during this time but it became less frequent. The cult abuse ceased when she went to the Salvation Army Home and though the father continued to abuse her when she returned home the cult abuse did not recommence. When Ruth was aged 12 her father met his present wife. They did not live together, however, until Ruth was 15 years of age. The abuse within the home did continue after the stepmother moved in but at a greatly reduced rate. During the ages of 12 to 15 the father prostituted her taking her to men's homes to perform sexual acts. She was also taken to "parties", frequently held at Peggy's home, where children were sexually abused.

Though these events were traumatic they were not cult orientated and during this period alters that had a specific role within the cult played a lesser role in the patient's life and other alters became the dominant ones. This is discussed further in this and subsequent chapters.

Traumatic Events within the Cult

During the period that Ruth was abused by the cult her father appeared to have been its leader. He performed a central role in the cult's ceremonies and was its main spokesman in directing cult activities. Ruth's mother was present during these activities though her role appeared to have been a minor one and she remained in the background during the ceremonies until she left the family. The elder of Ruth's brothers was also involved in the ceremonies as were other children though Ruth appeared to have had a more central role, no doubt due to her father's prominent position within the cult. On occasions Ruth had to "instruct" and "punish" other children though she was generally kept separate from them. The main meetings of the cult, in which Ruth was involved, took place on a weekend in a National Park on the outskirts of Perth Western Australia during the late 1950s and the 1960s. The cult's activities often began as a picnic in which games and other family orientated activities of an innocent nature were played. This would change as the day progressed and towards evening the focus changed to cult activities. This was usually the case during public holidays and on special occasions such as Easter, and Christmas festivities. On other occasions, particularly during winter, the patient remembered being driven to the area during the early evening with the ceremonies beginning almost immediately and without the sense of a family group outing. The traumatic events that the patient recalled within the cult setting are described under two headings: ritual abuse associated with some form of mind control; and ritual abuse associated with satanic worship (van der Hart et al., 1997). The impact these traumatic events had on the development of specific alters will be considered in subsequent sections.

Mind Control and Ritual Abuse

A common experience for Ruth during cult activities was that of terror, degradation and humiliation, which served to emphasize feelings of helplessness, worthlessness and her dependency on the goodwill of the cult for her well-being. Abuse occurred within a group setting and all present frequently participated in and witnessed the degrading and humiliating events. She was routinely told that she was “a useless piece of shit”, a “cunt”, a “whore”, that she was to blame for the death of animals and babies killed during cult ceremonies. The father, who was in charge, dressed in a black cloak with his body painted in black and red paint, and his penis painted red (see drawings 1-3 Appendix F). Frequently, after the father had sexually abused her he held a mirror to her vagina, now red from the paint, and yelled at her that she was “a fucking useless cunt!” and that was what a cunt looked like. Such messages were repetitious and it was conveyed to her that she was powerless to resist or to have any sense of individuality. If she cried she was punished. She was usually given laxatives before ceremonies having previously been forbidden to defecate during the week. Her father would rub and press on her stomach till she would void. On occasions, using sticks, her father would rub it over her body and face causing her to vomit she was made to eat the vomit till she “learnt” not to be sick. Ceremonies frequently culminated with men masturbating and urinating over her face and body. Later, when she began menstruation she had to save her sanitary towels and the father would ceremoniously burn these in the bonfire. Many of the ceremonies involved the drinking of urine and blood mixed together or the eating of the flesh of animals and babies that had been sacrificed. She also recalled “needles” being put into her vagina to relax her muscles and on occasion’s mild electric shocks to her genitals. This frequently causing her to urinate, sometimes cult members greeted this with pleasure whereas at other times it led to further abuse. In addition to other abuse nearly all cult meetings involved Ruth in some form of oral and anal sex. On occasions this was with female as well as with male members of the cult and on occasions with other children. She recalled photographs being taken of her whilst they were engaged in some of these acts, which were later shown to her as proof of her “badness” and of her “enjoyment” in participating. The more complex ceremonies lasted longer and generally marked festival occasions such as Christmas and Easter, such ceremonies had overt satanic themes.

One of several methods the father had for frightening Ruth and ensuring her cooperation was the threat of spiders being put on her. One particularly traumatic method was to lie her naked in a box and empty a jar of spiders over her before closing the lid. She would lie still trying not to breathe, fearful that the spiders would bite her or crawl into her body. After a period the father would lift her out of the box and brush off the spiders, so that she was grateful to him for “rescuing” and “protecting” her. Such events were followed by sexual abuse. She was constantly threatened with violence and told that the father and Satan owned her and would know if she ever spoke about the cult and its activities. On other, but less frequent occasions she was told that she was very special because of the two nipples on her left breast and that this was a satanic sign that she was bad and also, somewhat contradictorily, chosen as special. The father told her that other people would not understand and that he would get into trouble but more frequently she was just intimidated to prevent her from talking.

A similar method of ensuring her cooperation occurred when she was placed in a “coffin” with a man made up to appear dead. Naked, she was placed on top of the “corpse” after a few moments the “corpse” rose up groaning, terrifying her before sexually abusing her. During a more prolonged ceremony she was made to lie on the ground naked the father telling her that she had to lie still “and don’t move because there was a snake there”. She did not see the snake till afterwards though “I could feel it going inside. ... I had to lie there very still and ... then, when they pulled it out there was only ... only half a snake there. ... The other ... other part of the snake stayed ... stayed inside, it broke off.” She believed that the snake had crawled into her vagina and entered her body. They put the snake into her vagina and then pulled it out but its head was gone and only the bottom half of the snake remained. She believed, as they told her, that the snake’s head was inside her growing and watching and that it would attack her if she disobeyed her father or if she ever told anyone about the cult.

Satanic Worship and Ritual Abuse

Regularly an animal usually a dog or cat was killed in a sacrificial manner. At one ceremony the father disembowelled a cat, Ruth having to sit on the ground whilst the cat's intestines spilt over her and the cat's carcass then placed round her neck (see drawing 4 Appendix F). One particularly traumatic event was a prolonged ceremony in which a dog was skinned alive in front of her. The dog had been encouraged to lick Ruth's vagina after some food had been placed there. The dog was then sexually stimulated by one of the men and encouraged to ejaculate over her. Ruth was told that this was her fault and that because of her badness in allowing the dog to have sex with her they had to punish the dog. The dog was tied up and skinned alive a small patch at a time. The patches of fur were placed on Ruth who was made to sit close to the dog from where she could vividly see the panic in its eyes. She heard the dog's cries even though it was tied and muzzled and was told that because this was her fault it was her decision whether they killed the dog or not. The dog was killed and further mutilated, its severed penis and tail was attached to Ruth whilst she had to behave as if she was a dog.

A particularly traumatic event was being "married" to her father when she was 8 years of age. She was dressed by her mother and wore a white dress and socks but with black shoes (see drawing 5 Appendix F). The mother gave her to the father in a cult ceremony that appears to have taken place at Easter. She remembered being undressed and her father telling her that she now belonged to him and to Satan. A prolonged ceremony followed in which the father sexually abused her and it culminated in the killing of a baby. The baby was stretched out on a tree stump its arms and legs held while the father ritualistically cut the baby's face and body so that its blood flowed. Ruth was instructed to cut the baby as the father had but she was too horrified to do so. She was made to take the knife but in frenzy she stabbed the baby but because she had not done it, as the father had wanted, she was punished.

Later, in other ceremonies she was made to participate in the ritualistic killing of two other babies, Ruth holding the knife whilst her father guided her hand. He then cut the bodies removing the genitals. The babies' bodies were thrown on the

bonfire their blood drunk and their flesh eaten. The skull was pulverized with cricket bats and what was left was thrown to the dogs. At other times foetus were used. Ruth was congratulated on her action and given a purple “cape” to wear sat next to her father whilst other cult members congratulated her. Blood from the babies was symbolically smeared on to Ruth and a few other cult members. One of the symbols she recalled as frequently being smeared in blood on her was the letters six and nine joined in a circle (see drawing 6 Appendix F). Later, in the evening, she would be abused for thinking that she was superior. These traumatic events and the killing of the dog where the most difficult for Ruth to process and will be discussed more fully in subsequent sections of this and later chapters.

6.2 The Alter System of this Patient

The alter system of the patient is described in this section. As in other studies the alter system can broadly be described as consisting of child alters, helping alters, and persecutory alters (e.g., Putnam, 1989a; Ross, 1997). Alters can further be divided into those involved in cult activities and those involved in the home. Some alters were involved in both cult and home activities. There were 31 alters, 4 of whom were “joint” or twin alters that identified themselves as connected and who always presented jointly. Sixteen alters were female, 4 were male, the gender of 10 unclear, and one was an animal alter, Serpent. The alter system can be further divided into those alters that were “central” to the functioning of this patient, and those alters that were “fragmented” and their role in the patient’s functioning peripheral. One alter, Louise, was iatrogenically created by the patient. These issues are discussed further in this and subsequent chapters.

Presentation of Alters

Table VI sets out the alters’ names, the sessions in which they first and finally presented, whether or not they were involved in cult activity, and gives an estimation of the frequency with which they presented during therapy. During the early stages of therapy in particular, the therapist was unfamiliar with the different alters and

whilst it was generally evident that a different alter had presented, discrimination between them was not always possible. If the therapist was uncertain as to which alter was present, the presentation was recorded as “unknown”. An alter was not recorded as present unless it was known to the therapist or in the case of new alters it had identified itself to the therapist. Hence, the data presented in Table VI underestimated frequency of presentation since it often took several sessions before some alters either introduced themselves or were identified by other alters. This is particularly the case early in therapy when the first alter to make herself known as a “separate” entity is recorded in session 146, as the Story Teller. Logically, the original personality and presenting personality, Me/Main One (Me/MO), had been apparent from the first session but this is not recorded in Table VI since she was unknown to the therapist. Similarly, alters such as Baby and Angel were spoken of by other alters but did not introduce themselves to the therapist. In retrospect, the alter Baby did present herself early in therapy through her behaviour, rocking, crying, burying her face in a cushion etc., however, the therapist had not at that stage made the diagnosis of DID and therefore frequency of presentation for this alter has not been recorded. Similarly, the alter Angel never spoke directly to the therapist but was frequently referred to by other alters during the early stages of therapy. The therapist was unknowing regarding these early presentations and it is only when an alter had introduced herself as a separate entity that this is recorded in Table VI. Also, the frequency of a particular alter’s presentation has only been recorded once during each session whereas, on occasions, some alters presented more frequently depending on the issues that the patient was discussing.

As therapy progressed, the therapist was able to identify alters with greater precision and did not rely on the patient to identify an alter unless it was one new to the therapist. Where the subsequent identity of an alter could be reliably identified, its presentation in earlier sessions has also been recorded. Identification of alters, however, was not a therapeutic issue at any stage during the patient’s therapy. There was no pressure for alters to “appear” or to identify themselves to the therapist and it was only when an alter spontaneously identified herself or when her identity was already clear to the therapist through her behaviour and her concerns that her presence was recorded. As the therapeutic process progressed, “central” alters (e.g.,

Me/MO, Chris/Carol, Amie, Marcie, The Whore (W), The Angry One (AO) and Mary) could be identified by the therapist with increased accuracy. Alters could usually be identified by their behaviour and the issues and concerns that they presented. AO, for example, presented in an “energetic” manner and the issues that were of concern to her were frequently, at least in the early stages of therapy, to do with her frustration at the slowness of the others and their timidity. Conversely, Mary was pre-occupied with order and safety and with AO’s “bad” language and her concerns that the other alters were lying whereas Chris/Carol was concerned with the issues of childhood and being hurt. Marcie was concerned with cult abuse. The alter Me/MO would present with doubts regarding the legitimacy of what other alters were reporting whilst at the same time readily acknowledging their presence. All alters central to the alter system had identified themselves during the first 200 sessions, though it took many more sessions to deal with the issues that they raised. During this period, 12 alters either presented or were discussed by other alters. Of these seven were central to the alter system and to the therapeutic process. There was then a gap of 167 sessions before the alter Boy presented in session 358, though he had been discussed prior to this. During the remaining 706 sessions, a further 19 alters presented of which three were imperative to the therapeutic process. Issues raised by the pattern of alter presentation will be discussed in detail further in the thesis.

Table VI. Name of Alter and Frequency of Presentation

Alter Name	Sessions Active in Therapy	Active in Home	Active in Cult	Frequency of Presentation
Baby	Early	Yes	No	Not recorded
Angel	Early	Yes	No	Not recorded
The Story Teller	146	No	No	1
The Angry One	147-875	Yes	Yes	422
Mary	150-621	Yes	No	64
The Body	152-352	Yes	Yes	12
Me/The Main One	155-1125	Yes	No	515

The Whore	156-815	Yes	Yes	169
Chris/Carol	162-499	Yes	Yes	31
Amie	168-379	Yes	Yes	8
Darryl	174-541	No	Yes	32
Marcie	191-1092	No	Yes	99
Boy	358	Yes	No	1
Voice	372-870	No	No	25
Shadow	473-474	No	Yes	3
Louise	537-577	Yes	No	8
Informer	561-673	No	Yes	16
Devilish Sue	545-563	No	Yes	4
Dizzy Lizzie	572	No	Yes	1
Les/Charlie	578/585-613/638	No	Yes	57
Younger Me	621-648	No	No	9
Beth	690-697	Yes	No	5
Scream	695-746	No	Yes	24
On and On	705	No	Yes	1
Daddy's Perfect Person	725	Yes	No	1
Death	860-877	No	Yes	12
Maggie/Mae	917-957	No	Yes	16
Young Bert	946-1028	No	Yes	9
Stuck	1013-1019	No	Yes	4
You Gin	1051-1054	No	Yes	3
Serpent	1064-1075	No	Yes	3

The Alters of this Patient

The alters that make up the patient's alter system are described in this section. The names of the alters were those by which they were introduced. However, some of the fragmented alters were not named and the therapist has named them here to assist in identification. The name chosen by the therapist in these cases is one that reflected the issue or function with which they were concerned. When it is the therapist who has named the alter, it is identified in the text. The alters are presented in two groups: central and fragmented. Of the alters, seven are defined here as central and 24 as fragmented. Issues pertinent to the definition of this patient's alters as central or fragmented are discussed further in Section 6.3.

Central Alters

Alters referred to as central alters are those considered vital to the functioning of the alter system. They were frequently referred to by other alters as being important and/or their presentations during therapy supported this; they also have a developmental line of connection to other alters (see Figure 4 Section 6.3). Where possible the alters are presented in the same order as in Table VI.

The Angry One

This alter was referred to as AO and was a central alter within the system. She was involved in both daily and cult activities. The other alters presented AO, at least initially, as a very powerful individual who was capable of expressing great rage and as an alter who was to be feared. She quickly committed to the process of therapy and frequently complained about the slowness of others in discussing their concerns. She was constantly angry with other alters whom she perceived as stopping her expressing her anger, particularly to the father. AO's function within the system appeared to be, as the name implies, to contain some of the rage and anger that could not be openly expressed towards the father, mother and others who had abused the patient. It was AO who could first express the injustice of the abuse and had sufficient grandiosity to be able to voice her desire for retribution though initially this was expressed against other alters within the system rather than

outwards to the external world. This alter held some of the archaic grandiosity that the patient had never been able to display within the home, a fact that other alters supported. She described herself as aged 9-15. She was an important alter in progressing treatment and her role in this will be discussed more fully in the following chapters. The patient wrote the following:

AO was really called the Angry One. She took over from Marcie but then she required the assistance of several others including Boy who could do some of the hard physical stuff. She also had Darryl who was a replica of the dad even though he really wasn't. She also made Les & Charlie to torment her so she would be able to continue doing hideous acts that dad wanted done.

The following three (fragmented) alters were created by AO to fulfil functions that she was unable to perform or that were incongruent with her “personality”.

Darryl

Darryl was one of the persecutory alters in this patient's alter system. He had a central role in “punishing” other alters for not obeying his interpretation of the father's wishes. He played a role in the celebration of killings within the cult and on such occasions would proudly “parade” wearing a purple cloak placed on him by his father in celebration of the “sacrifices”. He modelled himself on his father who was the leader of the group and described himself as doing his father's work. This alter did not emerge during the actual killing of animals or of babies but rather afterwards when the deed was being congratulated in the cult ceremony. Other alters depicted Darryl as being in their “heads” shouting his demands that they harm themselves. He emerged as a presence early in therapy and would threaten other alters because they were talking about the father's involvement in the cult. He gave alters (particularly the child alters Chris/Carol and Marcie) two options “to live and be punished forever, or to die” actively encouraging ways in which these aims could be achieved. He was described by other alters as having red marks on his face and in this respect was similar in appearance to the description that various alters had made of the father and other cult members. The patient made a clay model of this alter early in therapy

which she handed to the therapist in session 367. A photo of this is presented in Appendix F (item 7-8). Whilst Darryl was not central within the alter system, he did assist in maintaining the status quo of the system and his function will be discussed further in the thesis.

Boy

Boy was a young boy who did not appear to hold much of the horror but was able to do things “girls can’t do” such as climb trees touch lizards and spiders and take some of the physical pain that others “girls” could not. He was also able to climb over the wall of the Salvation Army Home. He occupied only a few sessions but was referred to by other alters and his role acknowledged by them. His role within the alter system, however, was relatively limited.

Les and Charlie

These alters were described by the patient as being “connected” to each other. They were only present during cult activity and their “dual” function appeared to have been to offer comfort and reassurance to each other. Charlie is the “bigger” brother of the two. They were persecutory and first appeared during the middle stages of therapy. Les presented first (session 578) then later Charlie (session 613) took over. They were important alters in progressing some of the cult material during therapy. Initially, they spoke of their role to punish other alters particularly Me/MO who was seen as responsible for the pain that they were having to contain. Both had been involved in the ceremonious sacrifices made by the cult. Charlie was described by both alters as the one who was in charge and he saw his role as to defend the father and cult’s secrets “I’m going to get Les to kill them. I think of myself like dad. He trusts me to carry out the job I have to do, frighten children. ... Most important job, frighten them, finish them off”.

Mary

Mary had a central role within the alter system and appeared early in therapy. Her initial role was to take care of the child alters and also to ensure the smooth running of the home when the mother left when the patient was 8 years of age. She took a more prominent role within the alter system at 12 years of age when the patient returned from the care of the Salvation Army Home. During therapy she would present as worried about the children and concerned that the patient's husband not be upset by the other alters and making sure that he was pleased. She had difficulty in accepting what the other alters were saying, and constantly felt that they were lying or confused, though she did not question their presence. Her role will be discussed in more detail in subsequent chapters. Of this alter the patient wrote:

Mary was born because we needed someone to be a perfectly normal teenage person who was able to function in a very dysfunctional family. She was great because she could cook, sew, wash and clean and this made dad very happy. Although he still came into her room at night she was able to forget and get on with ordinary things. She was a very good person.

Me/Main One

This is the original personality (Kluft, 1984; Putnam, 1989) and also the presenting or host personality though her form did change over the process of therapy and Me is the one from whom the other alters developed. The patient described the Main One as being the "outer" part of her, the part that interacted with the world whereas Me was the "internal whole" part of her. Me "created" the Main One to deal with the outside world. Both alters were described and discussed by other alters as being one and the same and were central alters within the system. This alter will be discussed in detail throughout the remaining chapters of the thesis. This alter dealt with everyday aspects of the patient's life and whilst acknowledging the presence of "others" was the most resistant to coming to terms with the traumatic events that the other alters discussed. This alter did not deny that there had been abuse but rather that:

I don't believe it. Like I had two dads and my dad didn't do it. I've made him into being good, loving, caring smiles at me. Really he's the scariest thing on earth. All my energy is spent turning this away.

The process of this will be discussed in detail in the remaining chapters.

The Whore

As the name implies, this alter performed most of the sexual activities both in the home and in the cult. She took her name from repeatedly being called a “whore” by those abusing her. She took this to be her name. The alter was quickly referred to as Miss W. The name, “The Whore”, was largely used by other alters, initially, in a disparaging manner. Miss W was described by other alters as being linked to the alter Amie. Amie was younger than W and had first appeared during the early stages of therapy and was one of the central alters within the system. It appears that Amie was the first alter to deal with sexual abuse from perpetrators other than the father. As the sexual abuse became more frequent and perverse, an older version of Amie, Miss W developed. This alter was also central to the patient's alter system and will be discussed more fully. Miss W was also closely aligned, though often with a different purpose, to AO. Though this alter was discussed relatively early in therapy, there was some delay before she was “allowed” to appear during a session. Some of the others, particularly Mary, were concerned that she would be so seductive during therapy that the therapist would be unable to resist her advances and that this would “ruin” therapy. AO and W were close to each other though not always in an agreeable way. They shared common traumatic events but would emerge in response to different circumstances of the trauma. The patient described W as the “one who tried so very hard to make him into a loving father”.

W who was originally called the whore was a very important part of living. She was used in such horrendous ways but always kept thinking that because her dad loved her he would stop doing things and just love her. All she craved for was heaps of love and she didn't understand the correct way of loving someone. She thought [that] by doing the things that he wanted she would receive love, how unfair for her. She also later in life got me into a fair amount of trouble & grief

because of the things she did. She was used for sex but was never really sexual in herself.

Chris/Carol

This alter was also a “twin”; the alter Chris was 4 years of age and Carol was around 6 years of age. They engaged in the early stages of therapy. These alters appeared to have developed early in the patient’s developmental history and were the first alters exposed to the sexual abuse of the father. Carol was the only one of them who could speak since Chris had been “struck” silent by the “horror” of the abuse that they had experienced. A pencil drawing of Chris/Carol appears in Appendix F (drawing 9). The patient explained the drawing as showing Chris with darkness around her eyes because of what she had seen and unable to speak for fear that she would be attacked by a monster. Carol talked about issues mainly related to sexual abuse within the home although she was also exposed to abuse within the cult. Of a night-time, the father would come into her bedroom pretending that he was a monster. Terrified, she would close her eyes trying to “shut” the monster out and to lie still. She also recalled being abused by the father in the garden shed and at bath time when she had to share the bathtub with her father.

The “duality” of this and other such alters appeared to reflect the sheer overwhelming nature of the abuse and the impossibility of one alter being able to contain it without support. Hence, one part of this alter (Chris) was apportioned the “unspeakable horror” whilst the other part of the alter (Carol) was apportioned a diluted portion that she was able to manage. An example of this is illustrated in the following.

Chris never really grew. She was the brunt of abuse and she never really talked much because it had to be hidden from Carol. How could Carol love her Dad & Mum if she knew the truth about her life.

These alters fused early during the middle phase of therapy. Prior to this, Chris did speak. During therapy, when distressed, this alter would “disappear” or

“cover” herself in a colour field of green. This appeared to have developed from her focus, when afraid, on the green pattern of her bed quilt. She had also ritualized her sleep pattern to cope with her fears by sucking her left thumb and brushing the corner of her bed sheet against her cheek for reassurance before falling asleep.

Amie

Amie was portrayed as having red hair and green eyes (the patient has brown hair and hazel coloured eyes). She was described as being around 8 years of age and appears to have developed in response to increasing sexual activity and abuse within the cult. She also appeared early in therapy and seems to have been “created” by Carol/Chris to cope with the increasing abuse. This is discussed further in the thesis. She told of the early parts of the abuse. Amie was also involved in the cult and was the main alter exposed to the early horrific aspects of the abuse.

Marcie

Marcie was a central alter within the system, one that eventually all the other alters needed to come to terms with and accept. She was present mainly in cult activity and occupied a central role with the patient’s alter system. Her function was to hold all the horror, pain and affect from the cult abuse. Other alters contained some aspects of this abuse but it was Marcie who held it all and was perceived both by herself and others as literally being covered in this abuse. Appendix F (drawing 10) depicts a drawing of her entitled *Marcie in Hell* and depicts this belief graphically. “She was made to do dreadful things, dreadful because she was so small”. She along with Me was the last to be fused prior to integration. Her age was depicted as being 8/9 years of age; unlike some of the alters whose age had a greater range, Marcie’s age remained constant. She, like Amie and AO, had red hair and green eyes. Her role and function within the alter system will be discussed fully in the following chapters.

Fragmented Alters

Kluft (1984b) described fragment personalities as an entity similar to the concept of personality but with a more limited range of function, emotion, or history, such as a specialist in protection, one limited to the expression of anger, or one which assumes control for a limited period of time or a special circumstance. The following are referred to as fragmented alters because they served a more limited function than those discussed above. They did, however, have an important role in progressing therapy that will be discussed in subsequent sections.

Baby

This was the youngest of the alters. She was referred to early in therapy by other alters and was the first alter to fuse. During session 253 the alter W announced that Baby had “joined” with her. Though this alter did not speak directly to the therapist, she was frequently referred to by other alters as being present during sessions and on occasions the patient did respond in a regressed manner crying but not talking. In retrospect this alter appears to have contained the trauma of the emotional and physical neglected of her early childhood whilst allowing other alters to develop a more “adult” role in response to the traumatic events that they were experiencing.

Angel

This alter was also one that did not speak to the therapist but was referred to on several occasions by other alters and described as 2 years of age. Angel's apparent purpose within the alter system was to hold onto a childhood fantasy of angelic goodness, the wish for a “safe” home, and also a reflection of the “spaced out” and the “floating” feeling of dissociation. Angel thus appeared in the patient's early childhood during moments of abuse and appeared to be both a representation of the feeling of dissociation and the wish for good world where “bad” things did not occur. Angel only made a few very brief appearances early in therapy identified by other alters. A drawing by the alter Chris/Carol depicting twin Angels in an idyllic childlike setting is included in Appendix F (drawing 11).

The Story Teller

Though the patient referred to the Story Teller early in therapy, it did not appear to be an alter in the fullest sense. Its function was to tell the story of what had happened but without affect, hence, the Story Teller would comment on what was happening in a dispassionate manner when a particular alter was too distressed to be able to continue his/her story. This alter disappeared early in therapy as other alters took a more central role within treatment. This alter was also responsible for some of the early written material. Whilst this alter only identified herself to the therapist on one occasion, it was probably present more frequently particularly when other alters were experiencing difficulty in processing traumatic material. This alter enabled the patient to distance herself emotionally from the material until she was able to engage with it more fully.

While I was telling Ian [therapist] this story, I was not emotional in any way. It wasn't until the next day that I found myself with the thought that it wasn't me telling the story but it was a person within me so I have named her the Story Teller. I remember now that this has happened on a few occasions. I feel that she handles the very difficult memories so that we have time to digest what she said.

The Body

This alter expressed the physical pain of the various traumas that the patient experienced. The Body appeared early in therapy and fused with AO by session 352. The alter's role in the system was as a container for some of the physical trauma that had been experienced. The Body would appear during a session and rock back and forth for comfort. After the alter fused with AO other alters complained that they were now experiencing the Body's feelings when discussing traumatic events. The Body was described as belonging "to everyone through the abuse and pain".

She is a very still quiet person who does not have a very high regard for herself. She is very depressed and we do worry about her. She is as old as the Main One but when she speaks to Ian [therapist], especially today, she was not very old. She is me I and we. She has been through everything but doesn't have the capacity to remember because she is only the body - nothing else, nothing less, and nothing more. Just a very tired body that does feel some pains but not much. We have protected her because it would be hard for her to last 40 yrs.

Voice

This alter appeared early in therapy and was described by the patient as just a voice therefore the therapist used the name Voice to discriminate this alter. The alter Voice persistently told Me/MO that she had to take notice of what they had experienced. Though this alter's function is similar to that of the Story Teller, it is different in that the Story Teller retold the story itself whereas the Voice described what problems or difficulties the particular alter being discussed was having.

Nobody likes to see themselves as something other than what they see themselves. Told her 'remember when you used to do all this?' but she can't look at this; at what he's done. I told her if she just looks at it her headache will go she doesn't have to take Panadol even her backache will go. How much she loves him. It's stronger than what she feels for John [husband]. She feels that the dad was there for her. Stupid, he got out when trouble. But she doesn't know about being pregnant. I'm normal one, can feel happy can feel peeved but every time I feel she shoves it down.

Shadow

This alter was named Shadow by the therapist. Shadow presented during a phase of therapy when the alter Me/MO was struggling with memories of a cult ceremony where the father had disembowelled a cat and spilt its intestines on to her before placing the cat's body across her throat. Whilst she was processing this material, she described other alters who were speaking to her. One, who was persecutory, said "He says, if I try really hard [I could] see it. Wouldn't I like to before I die? Wouldn't I like to have it right back on top of me?" The memory of this incident evoked the presentation of the alter, Shadow. This alter appeared to have contained transitory emotions associated with the anticipation of a traumatic event or the feelings of confusion and disorientation that followed. Hence, this alter contained momentary aspects of the trauma before the presentation of a more central alter that could contain the trauma's emotional consequences. The alter described herself being in a place that was full of "shadows in the darkness". Much of the cult activity took place in the evening with cult members appearing "shadowy" in the light of the bonfire.

Heat [I] can't feel, darkness make shadows move, well I can't see them, all I can see is their dark outline. Touch [and] feel something hairy. If you don't breathe much it doesn't hurt so much. ... I try to breathe so they think I'm dead ... [and] leave me alone. Why don't I have leg, arms so I can push them away. Even if I had legs push, but where too? How can I kill them to get out of this, I won't to go to sleep I don't want to feel this I don't want to be the cause of any embarrassment [soiling]. Darkness, [I] feel sick. ... [I] can feel him, hairy part that I feel, feels hairy. Why can't I have arms and legs? I'm not the only one like lots of shadows. I don't like this place".

Louise

This alter was created during the period when the patient was in therapy. The patient later wrote that Me/MO had created Louise in order to present a more sophisticated version of W. This alter and her creation will be discussed further in the following chapters.

Informer

The alter Informer was named by the therapist and had a particular connection to the alter Mary. Its function was to inform her of the cult activities that Mary denied. Informer was similar to several of these fragmented alters and its function appeared to be to process material that the central alters were having difficulty with. It contained feelings of anxiety and panic that it wanted other alters to experience so that it would not have to retain them.

I hate feeling all panicky. I hope I don't make them sick today. Some body has to let them know these things. I'm like the nervous one I think. He was a very violent man he made it very hard to stand perfectly still. I used to get frightened of the sight of him standing there with nothing on. Mary only one can't break through to.

Then later in discussing its role with the alter Mary.

I'll tell you what I sees ... what she sees. They cut fingers and toes off baby. And don't think I'm AO okay? You don't need to know who I am, cut off its testicles give to dogs cut all the fatty parts out of its check turn over bottom turn back over, cut straight down middle all yucky stuff. This got ... I call it worms but funny coloured. I don't

feel anything, I'm just telling you. Did you know that worms inside a baby very long? Have this flat thing; long looks like dark purple. Just they got all of the insides and just for some of the bits the dogs got most of it. I try to get Mary to see how she doesn't believe they used to take pictures. Important she believes, Mary; if you're going to die really should die knowing the truth.

Dizzy Lizzie

Dizzy Lizzie was an alter that had the fragmented function of containing the feeling of "dizziness". The patient described this alter as "a young girl that could enjoy fun times rolling down hills and feeling giddy and laughing". This alter enabled the patient to join in "play and ... helped to make life normal...and she would roll down hills and go dizzy". This alter presented briefly twice during therapy. She acted in a childish manner giggling and laughing without apparently being able to progress therapeutic material. It is likely that she was also present during cult activity and experienced some feelings of light headiness when given alcohol prior to cult abuse and hence her name.

Dancing round and round kept giggling, round and round thought that it was funny. I would think of nice things just that any time anything starts to hurt me I have to be happy.

Devilish Sue

This alter was similar to Dizzy Lizzie in her presentation though her function was different. She was close to W and her function was to assist when W was too traumatized to move during times of sexual abuse. She was also able to dissociate from the abuse both moving her bottom under the force of the father's abuse whilst "pretending" that she was somewhere else.

Guess what I was trying to say, he was having sex with her. Every time he moved she moved. Mary gets all embarrassed. There is no such word as no. Cause if I tell you to do something that's what you do. That's what he says – dad. No escape, but there is he doesn't know if [I] concentrate everything into head doesn't matter what he's doing to you, can have two parts of your head working at once. Have

to move bottom a bit but other part doing nice things climb tree [and] sit up with birds and he doesn't know that, you see.

This alter had given herself the name Devilish Sue. This apparently was in recognition of her courage and defiance of the father in keeping part of herself “separate” from him whilst “acting” without his knowledge, albeit surreptitiously.

Younger Me

A younger version of the alter Me/MO named by the patient. This alter retained memories of a “close” relationship with the father. It also reflected the ongoing desire/need for a close and loving relationship with the father that the alter Me/MO also aspired to.

I've got to get out of here, this body. I didn't care I didn't feel anything so it didn't hurt. I could say, “I love you dad”. Only with my dad just with dad [sex] ... but it's my dad I really love him. I don't know about others. I don't have to bother about them. Why I said got to get out of here, don't want to be part of them, told her [Me/MO] yesterday that I liked it. He loves me so much; other dad's don't love their children as much. Angry with Steve [eldest brother] never angry with me, cause I was a good girl.

Beth

This alter was named by the patient. Beth's main function was to be good. She went to Sunday School and was fearful of the stories of Hell and sinfulness that she heard there. She perceived AO as responsible for much of the “bad” behaviour and felt that she would have to atone for the sinfulness of AO. She took her name from a Sunday School story of a faithful daughter loved by her family and father. She wanted to be like her because “she was good and loved”.

Scream

This alter presented in the late stages of therapy and during a relatively brief period (51 sessions). She presented 24 times. This alter was named by the therapist and contained feelings of intense anxiety and the belief that her emotions were out of control.

You can't see what I'm really like, what I'm doing. I'm hysterical, best way of describing my screaming, some one needs to shake me, slap me, tell me to shake out of it. My dad did that, made me stop. Just went quiet and I was shaking. Sitting curled up and shaking like a puppy dog that's just been washed. Nobody knows how to explain me, who I am and how I am. That's my hurt. It hurts. My whole body hurts, it just hurts, and he doesn't care and he makes me angry. I'll break their [other alters] foot, arm every bone in their body, then he won't be able to hurt me any more.

Scream was concerned with the feelings of "being out of control" that had been disavowed by Me/MO. This alter also contained feelings of disappointment and disillusionment. "Think of little things at a gathering [cult] say 'come over here', go thinking I'm going to be cuddled and he spits on you. I don't want to be alive any more". In discussing her relationship with the alter, Me/MO, Scream stated:

I'm just her terrified side I hold all her shakiness. Think I've come to talk about all the things she can't is that so wrong? She made me over 4 years ago. She wants you to know what happen to her.

That this alter appeared to have been "created" by Me/MO during the course of therapy will be discussed in subsequent sections of the thesis.

On and On

An alter named by the therapist and who appeared during the middle phase of therapy. The name describes the alter's function as described by the patient, with the alter just going on and on repeating issues to Me/MO.

All I want to do is hurt [others] simply because she [Me] wasn't there, what she deserves to get. She wasn't there and says it's not true. I have a mission; better than saying have a job to do. I told her to bring a knife with her today cos I had plans for her. I've been listening to her. I don't know where I came from I can just remember Dad telling me if things got to be bad for him we'd got to help him out by punishing.

Daddy's Perfect Person

This alter appeared during the middle phase of therapy and was named by the therapist. This alter spoke to Me/MO at a stage in therapy where Me/MO was beginning to accept that her view of her life was not accurate. The alter's function was within the cult where her role was to be her father's helper and carry out his directives "perfectly" in order to please him.

I'm the one who sits inside her [Me/MO] and tells her things. She's telling you that she felt wonderful, perfect and I was in charge of giving them drinks, except it made you a bit wonky that's all. There was a big bowl of this drink. I think it had alcohol in it. Just thinking that when I was 16 I liked vodka and orange only cos you couldn't taste the vodka. Why do you think my eyes get so heavy? Frightens me, I'll close my eyes and say nothing. Think it's designed to stop me crying. When you're 7 you feel so important. I was the oldest girl there. Felt like I was in charge. I could run around saying get your clothes off fold them up neatly. There's a little bit of blockage between us, nobody wants to get close in case [they] feel the others' feeling. Makes me want to cry when I think they could do terrible things to a 7-year-old. They made us hurt ourselves through our lives.

Death

This alter was named by the patient. Death's function was mixed. Death perceived his role as preventing other alters speaking of cult activities, but this alter also contained anger towards AO for her role in the cult's sacrifices and also held some of the feelings of guilt for this. It also held memories of childhood not held by other alters. It presented during the latter phase of therapy and, as with several of the fragmented alters, was closely aligned to Me/MO. Death like Me/MO retained much of the feelings of longing for a "good father". I "don't want to betray him makes me

feel sick, angry, but truth. Dad, how he made me think he loved me”. The relationship between alters particularly that between Me/MO and fragmented alters such as Death is discussed further in subsequent sections of the thesis.

You don't realize that I have a position in my dad's plans. You see no one is suppose to survive this. Need to do things. Need to make sure she doesn't tell any more. My purpose is to hurt her, body to be hurt. I've got proof I saw it. I saw her thinking that she was some thing, really, really flash, stomping around doing things. Some things she wasn't asked to do. He did bad things, all fucking bad. He would want me to do. He used to say they ever talk about he'd be in big trouble. Who do you think been behind these attacks [self-harm] anybody feel guilty? I divide everything I can make odd things even. Take an odd one out middle got evenness either side of it. Do it when worried. I am so angry that they didn't run away. Some one has to pay for this they're the only one I can get at.

Maggie/Mae

This was also a “joint” alter, which appeared late in therapy. Maggie was the only one of the two alters to speak. She described Mae as being her “identical sister” and that they shared the “pleasure of knowing that we were his [father] best. I'm his best because Mae was there for me. She couldn't be the best cos I did more”. Maggie's name was short for maggot. The name appeared to have described how she felt “maggots crawl maybe I do. Feel like I have them crawling inside me, consider that after everything they have said [other alters during therapy] I must be the bad person”. These alters were initially persecutory and claimed to have enjoyed their involvement with the cult and perceived the father as good and important and that therefore they were important too. Their main function was to participate in the cult's ritualistic activities particularly those associated with ceremonial sacrifices. These alters also discussed another “joint” alter, Bub/Debbie. Bub a boy aged 7 and Debbie a girl also aged 7 years of age. Since it was only Maggie/Mae that mentioned these alters and they did not speak directly to the therapist they were not included in Table VI, though their function and that of Maggie/Mae within the alter system will be discussed in subsequent sections.

Young Bert

This alter appeared in the latter stages of therapy. He appeared as a younger version of the father and took on his name, Bert. In doing so his function was to regulate the system and threaten other alters, particularly Marcie, when they were perceived as undermining the father's authority within the alter system. The alter initially portrayed himself as extremely important and a "person" to be feared. Alters such as Young Bert ensured that the system remained in balance and they took on some of the grandiosity and authority exhibited by the father. He was not a central alter in the system.

In order to keep things being able to happen Marcie made Young Bert. He was there to totally threaten her. All Marcie wanted to do was to die and she made quite a few serious attempts. Young Bert talked to Ian [therapist] a lot and finally we changed his name to Gary. He was all hot air just trying to frighten Marcie.

Stuck

This alter described herself as stuck between the alters Marcie and Me/MO. She described the right side of her body as functioning differently from the left side, the right side being Marcie whilst the left side was Me/MO. This alter contained some of the memories associated with the abortion that she recalled at Peggy's home

I feel like I've got black eyes inside. I can sort of see it. ... Plate is white. I can see everything she can't 'cos it's too much for her. All she can see is the plate. I was 11 years he had spoons and this plate everything hurts. I knew he had a plate. Stomach still hurts had these spoons put this stuff on, put inside me, hurt.

You Gin

You Gin (U Gin) appeared towards the later stages of therapy. Gin being a derogatory term for a female Australian Aborigine, but one more commonly used in the 1950-1970s than in the present. This alter contained the specific function of being abused in the cult whilst having boot polish smeared over her body and a tea cosy placed on her head. She was taunted as "You Gin" and therefore thought that

this was her name. She was created by Chris/Carol to endure this particular cult activity which will be discussed later.

Serpent

This was the last new alter to present before integration. The alter took the form of a snake that the patient claimed watched her and threatened to strike her if she spoke about the father. It appeared quite childlike but real to the patient. The alter Serpent did “speak” to the therapist and appeared to have been an internalized form of the snake that the father claimed was inside her and would grow and strike her if she ever spoke and was another of the persecutory alters that threaten to harm the patient. This alter also contained some of the memories of self-harm. When the patient was a child the father had instructed the patient to cut the tips of her fingers with a razor blade as a means of controlling her emotions. Like some of the other alters, Serpent was angry with Me/MO, feeling that it was her fault that they had been created in the first place and this was part of the reason for wanting to harm her.

She’s a worthless piece of shit want to cut her throat so I can get out, away from her thoughts. Nothing going to be all right she belongs to him. I think I come from Marcie and its just not working. There’s nothing to be happy about. Why [should I] live a miserable life?

The relationship between traumatic events and the development of the alters discussed above is discussed in the following section.

6.3 Relationship between Traumatic Events and the Development of Specific Alters

In this section the relationship between traumatic events and the development of particular alters is considered. First, the alter system as a whole is reviewed and alters are examined in light of their developmental history; and consideration is given to the purpose that they have served in the patient’s life. Second, specific attention is given to several alters whose particular “creation” had been discussed by the patient and their development is examined in more depth.

Development of Alter System

Figure 4 presents an organizational chart of the “developmental history” of the patient’s alter system. The chart presents the alter system of this patient and the chronological relationship between alters, though there may have been alters (e.g., Bub/Debbie) that did not enter into the therapeutic process and that therefore have not been recorded here. The chart is, however, accurate in detailing the alters that the patient discussed and that were observed by the therapist during the course of the therapeutic process. The chart is divided into two groups, those in which the alter’s name is enclosed in a chart box and those labelled as “fragmented alters”. This latter group was directly linked to the alter Me/MO whereas fragmented alters “created” by other central alters are depicted in a chart box in hierarchical relationship to them. Hence, the fragmented alter “Informer”, which was created by Mary, is presented in hierarchical relationship to her. The fragmented alters directly linked to Me/MO are listed in the order that they presented during therapy. The process of alter “creation” will be discussed in detail in the remainder of the thesis. Those alters previously identified as central to the functioning of the alter system and that “created” other alters appear in the shaded boxes. These alters will be discussed in greater detail since they are understood as essential to the maintenance and functioning of this patient’s alter system and their attempts to cope with traumatic events as the impetus for the “creation” of subsequent alters.

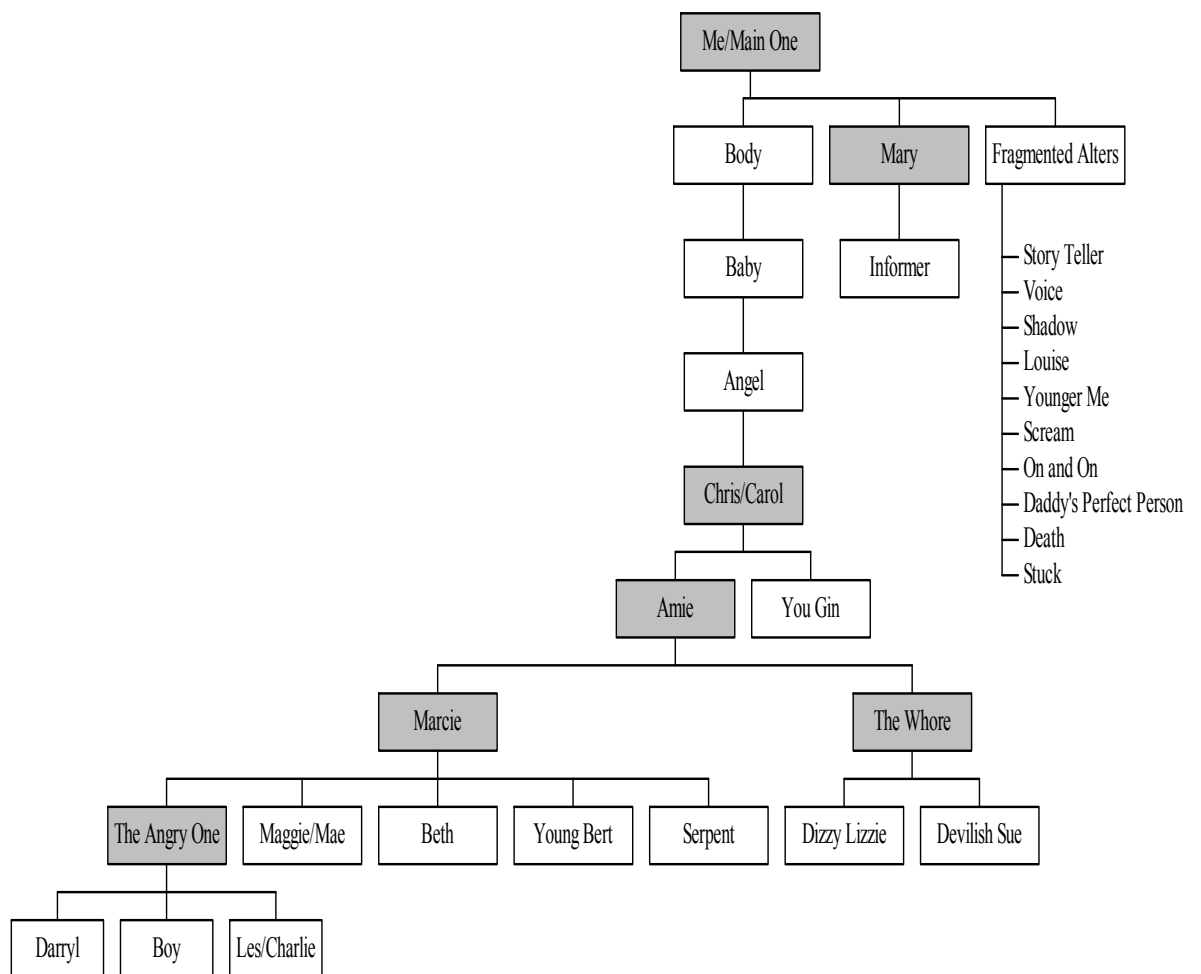


Figure 4. Organizational Chart of this Patient's Alter System and its Development

Figure 4 presents the sequential development of the alters though the time line is not explicit. The patient had created all of the alters by the age of 10 with the exception of the fragmented alter Louise. However, the time between the creation of specific alters is not known in all cases. In some, such as the alters Amie and Marcie, they appear to have been created in the course of one particular traumatic event. All alters from Chris/Carol onwards had some knowledge of the cult abuse. The alters Me/MO and Mary had no knowledge of cult abuse excluding the fragmented alters of Me/MO and the fragmented alter, Informer. The number of alters in this system and the complexity of their particular purpose is a reflection of the enduring nature and intensity of the traumatic events. The alter Me/MO has already been identified as the original personality. She was referred to as such by the other alters and it was also this alter along with the alter Marcie, the alter who most

personified the traumatic consequences of cult abuse, that were the last to fuse prior to integration. By that stage Me/MO had fused to become Me.

Function of the Alter System

The alter Me/MO appeared to represent both the outer (MO behaviour) and inner (Me emotional) aspects of this patient. They had dissociated early in the patient's development to deal better with the task of survival. The patient appeared to have created MO so that she could continue to respond to the daily tasks required of her but to separate this from emotional knowledge of the abuse. It was the Main One who was closely aligned with Mary and appeared to have been "created" to assist both the alters, Me and Mary.

The main person to help us live fairly normal was Mary. Even now I hope she knows how much I loved having her there. She did everything that was required. She led onto the Main One who with Mary brought up our children, looked after our husband took care of bills and most importantly at this stage was able to maintain a relationship with our dad & step mum. She took over Mary's job and did it well. She never knew what had happened to her until a long time in therapy.

What they dealt with was the day-to-day aspects of living. During childhood it was Me/MO that remained closely attached to the father, with assistance from the alter W. After returning from the Salvation Army Home, it was this alter, along with the alter Mary, that was able to function as the "loving" daughter with the "best dad in the world". Me/MO could not "bear" to be very far from the father and would regularly visit him. When she and her husband worked in distant locations, she telephoned him regularly and would seek his approval for decisions made by her and her husband, John. It was also this alter, along with the alter Mary, that was responsible for taking care of the home and her children, especially when the children were young. For the alter Me/MO, it was as if the abuse never happened or if it happened it was to the other alters because they were bad. Whereas, because Me/MO and Mary were good and loving towards the father they did not experience the abuse, they wanted nothing to do with the issues raised by other alters. It was not

that they denied the abuse, though some aspects of it they did, it was more that it did not happen to them therefore it was not their issue. They retained the idealized father as strong, powerful, and loving. By being “good” and “loving” to the father, they believed that they had earned his love and were distressed with the negative comments of other alters about the father. It was hard for them to tolerate such understandings since their existence had been built on not knowing and ascribing painful experiences to other alters.

[It] causes me a great deal of pain because of what she talks about to you. [I] Know she can sit here and tell you she knows about him [the father] being a bad person. I don't believe that, he was a good dad!

Sustaining the persona of the father as “a good dad” was central to the needs of the alter Me/MO, and subsequently to the maintenance of the alter system. In part, the creation of other alters by Me/MO was an attempt to dissociate from the realization that the father was abusive and as an attempt to retain an idealized imago of the “good father” in order to preserve a sense of internal stability. The problem of attachment to the perpetrator and the clinical working of this material is one of central importance to integration (Ross, 1997) and one that is discussed in Chapter 7.

Whilst the alter Me/MO is referred to as the original personality it is more correct to describe the alter Me as such and to describe the alter MO as the presenting and host personality (Kluft, 1984b), however, these alters became as one during the course of the patient's development. In discussing this difference (session 140⁷), the alter Me stated “I think I've been dead. Person who first came to see you is not really me. The main person [MO] is always going to have problems, [she is] 10 years behind [my] birth, born when [I was] 10 years of age and [she] stayed.” In the following session the alter Me stated “from 10 years of age the father goes fairly straight, safe to remain as me, took some of the others with me”. Me created MO to function within the home and to deal with the physical activities of life. This alter was the last of the central alters to be created. The alters Me and MO functioned jointly so that they needed each other in order to usefully function. The other alters

referred to the alters Me/MO as the original person and spoke of them as joint alters. Later, in the final stages of therapy Me/MO integrated leaving the alter Me. The fusing of these and other alters will be discussed in Chapter 7.

The alter Mary has been placed to one side in Figure 4 because she appeared to have been created by Me/MO to provide a separate purpose to the others; her role was in the home to look after the father and replace the role of the mother. She appeared to have been created around the age of 8 when the mother left and the patient took on the mother's "role" within the home. Hence, chronologically, this alter was the penultimate central alter to be created. Mary took on those functions related to the running and cleaning of the house though it is probable, as it is with all the alters, that Mary's role and her ability to respond to it became more complex with time. She also provided a "mothering" role to some of the younger alters such as Chris/Carol and to the patient's children. Her name appeared to have been taken from a Sunday School association with the Virgin Mary, mother of Jesus and therefore a source of infinite goodness who put the needs of others before her own, a quality of great importance to this alter. When she eventually fused it was with Me/MO, the alter with whom she was closest and most like. The majority of the child alters fused with Mary she being seen as the "mother" who could look after them. The following was taken from session 241 with Mary.

I can't afford to feel unhappy I'm suppose to accept things as they are. Just like I was suppose to go to school and be a good student be a good daughter and have everything done. Isn't it funny I think W and I born at the same time I had to do all the things for dad cooking, cleaning he'd leave instructions even when I was working. Steve [eldest brother] violent, not to me I wouldn't push him, AO would push him, I didn't listen. I did what I had to do. I didn't see him getting hurt by dad, and yet I did see him getting hurt [witnessed father sodomizing Steve]. I only got hit once, he had good reason I was grounded don't know what for. Did I ever tell you? I'd thought of being a nun you don't have to do anything for anyone just be quiet.

⁷ These comments are retrospectively attributed to the alter Me. When the patient made this statement the therapist had not made the diagnosis of DID.

When the patient was 12 years of age, she returned home after 18 months of relative stability in the Salvation Army Home. Though this period had not been without its difficulties in adjustment, it was at least a period free of abuse. During her time at the Home, she had had little contact with the father apart from an occasional postcard and an audio tape reminding her and her brothers to “be good”, a message which the patient took to mean “be silent”. The prospect of returning home was terrifying to those alters who were aware of the abuse and they had to adjust to the possibility of continuing cult abuse. The alter Mary could remain relatively optimistic at the prospect of returning to live with the father and present as an alter who was relatively untouched by the cult abuse. Moreover, the Home’s insistence on regular church attendance had augmented this alter’s perception of the Virgin Mary as the source of goodness without a bad thought towards others. Mary’s role within the system became more prominent from the age of 12 years on her return to the family home.

This alter along with Me/MO was one that frequently felt that the other alters were confused or telling lies and that these things “just didn’t happen” and that their father was a “good father”. Despite this Mary found no contradiction for the existence of other alters whose presences she did not doubt and in fact saw it as her role to care for the younger ones. She also continued to worry what effect alters such as AO were having on the patient’s marriage and worried about pleasing the husband, John, and ensuring that his needs were met by W and that the home ran smoothly. She was frequently concerned with issues of balance trying to keep things even and finding ways and means to achieve this. She would find ways of making odd numbers even, and line up the venetian blinds in my office with the rooftops by twisting her head or mentally counting external objects. The task of keeping things running smoothly required the “balancing” of factors that did not fit with a picture of a “happy home” such as ongoing parental sexual and physical abuse. It was also indicative of the various means by which the patient distracted herself from the internal emotional dissonance and upheaval that she experienced.

The alter Body was also referred to as an “original alter” one shared by the central alters of Chris/Carol and AO. These alters frequently depicted the Body as

responsible for the “shaking” and “trembling” apparent during many of the early sessions when they were discussing traumatic issues. It was the alter Body that “contained” physical pain. The Body was described as being “as old as Me” and appeared to represent an early attempt to regulate the emotion of physical pain and to relegate it to a separate alter. “She’s the original, [Me] saved her by just leaving the body”. This dissociative process enabled the patient, at an early age, to deal with the perceived traumatic impact of physical abuse by dissociation. This alter was created in an attempt to dissociate the physicality of trauma, as far as such is possible, from the emotional consequences of the abuse. It is also an example of the type of concrete cognition evident in early development; pain experienced in the body belongs to the body. As Ruth matured more complex dissociative defences were required. During session 215 the alter Body described her function within the alter system.

They need me for their agony...[I have] trouble talking to you because I normally talk inside. I’m the only one who can sit here and not feel anything I don’t feel the floor, chair. It’s like I’m suspended in my own space I have my own pain I can’t take any more. AO sits with me, doesn’t really talk but she’s there.

The last sentence described the related purpose of the alter AO and the alter Body. AO was also the recipient of physical abuse and those that were “created” in response to the same specific traumatic event tended to identify with each other, whether this be as alters who were antagonistic or supportive, and tended to fuse together in a step-wise manner during therapy. As will be discussed in Chapter 7 the emergence and fusion of alters appeared to take on a step-wise process with alters fusing with those that had created them. The issue of integration and of identification between alters is an important issue in the maintenance of the alter system of this patient and is discussed further in the thesis. The Body fused with AO spontaneously when AO “was in a shitty mood [and] said I’ll take you on, [I] didn’t know what I was doing, now I’ve got her pain!”

The alters Baby and Angel also appeared to be early attempts to modulate the consequences of trauma. The alter Baby appeared to reflect the patient’s need for

nurturance early in her development and her sense of helplessness. Other alters at least recognized Baby and her need for care and protection. This alter joined with the alter W early in therapy. The alter W shared a similar, albeit more “adult”, need for care and recognition. The alter W also retained the desire to please so that she would be accepted and most importantly “loved” particularly by the father. This need for mirroring and idealization was later reflected in the nature of the patient’s adult relationships and her “desire” to be “loved” by others; a need that was frequently explicated in sexual activities.

Similarly, the alter Angel contained early experiences of being “spaced out” and “floating” during traumatic events. Early in therapy Angel was described as “they call [her] Angel because she’s dead, existing as a body inside her [Me].” These alters appeared to represent the patient’s early attempts to deal with traumatic events. The alters Body, Baby, and Angel preceded the alter Chris/Carol, and appeared to have been early attempts to cope with traumatic events within the home. The patient wrote the following in June 1994.

I was trying to tell Ian [therapist] that inside me I have all these people that each have part of my story. I feel that when young I could only take so much, and after so much terror, this would die and a new me would come until she could not take it any more and then another new one. This went on for my entire childhood. [She continued] Friday when driving home from the Clinic I got near home and this voice said - from Baby came Angel, from Angel came Chris and Carol. I thought that I was going to cry I was so overwhelmed by their emotion.

As the abuse became more systematic and intense, the alter system became more “sophisticated” and complex in its development and its response to traumatic events.

Though the alters Body, Baby, and Angel have not been classified as central to the alter system and had little input to the therapy, they were important; their importance was acknowledged by other alters and other alters developed from them. They are understood as early attempts by the patient to respond to traumatic events and as the embryonic beginning of this patient’s alter system. As such, their purpose is understood as an initial attempt by the patient to establish a foundation for growth

at a time of instability and emotional tension. This is different from the subsequent alters that have been classified as central alters. Their role was more complex and as such reflected the growing maturity and development of the patient and her ability to respond to the traumas occurring to her. Hence, the patient's increased developmental age brings greater complexity of alter function in response not only to her own developing complexity but also to the increasing nature of the abuse.

The alters Chris/Carol contained the early childhood memories of sexual abuse within the home and the abuse of the maternal grandfather when the patient was 5/6 years of age. Chris/Carol had the memories of the father's abuse in the garden shed and of taking baths with her father and having to "play" games such as "submarines" where she would have to "swallow the periscope". Chris/Carol also contained the early memories of cult abuse and would be present at the commencement of cult activities before another alter emerged that was capable of containing the trauma. In the development of these alters, Chris came first but was unable to cope on her own and Carol was created. They then "fused" into one alter Chris/Carol, in an attempt to contain the trauma.

Similarly, the alter Amie was unable to cope on her own and the alter You Gin (U Gin) was created by Me to cope with a specific aspect of the cult abuse that occurred early in the patient's life. This alter did not emerge until the latter stages of therapy when most of the traumas had been processed and was the penultimate alter to emerge in therapy. The alter U Gin was unknown by other alters and it was only when integration was almost complete that she emerged. This process will be discussed further in Chapter 7. The emergence of U Gin was at a stage in therapy when the patient was close to integration (drawing 12 in Appendix F). The creation of this alter was described in some detail by the patient and will be discussed in the following section.

The alter Amie was the first to experience sexual abuse by the group and the first alter to be sexually penetrated. Whilst she is a central alter, she did not appear to take a major role in the alter system and her experience of the abuse was transitory

and was dissociated into two central alters that had an important role in the maintenance of the system, Marcie and W. Marcie contained much of the intensity of the abuse and other alters “feared” this and were afraid of her. They were not afraid in the same sense as they were initially afraid of persecutory alters such as Darryl but they were afraid of the emotional consequence of her intensity. They were afraid of being “overwhelmed” by her “pain” and afraid to get close to her in case they were “contaminated” by it. She, as depicted in the patient’s drawing of Marcie (see drawing 10 Appendix F), was literally covered in both the emotional and physical consequences of the abuse. This will be explored further in subsequent sections.

If Marcie bore the main weight of the cult abuse it was W who contained the sexual abuse. However, within W it was converted into nurturance and being “loved” and valued. She was the one who engaged in a caring way with the babies sacrificed by the cult. She held them whilst cult members engaged in other activities and before they were sacrificed. She would be present for the initial stages of sexual abuse but dissociated once it reached an intense level. She perceived the father’s abuse as evidence that he “loved” her or that she was special to him. In her adulthood it was this alter that flirted with others and developed a strong transference and “fell in love” with her therapist when being treated for “post partum depression” when she was in her twenties. Though her orientation was as a sexual being her desire was for soothing and nurturance not sex. Her desire for such a transference meant that initially other alters were afraid for her to enter into therapy since they thought that such needs would necessarily lead to sexual encounters. To better deal with sexual abuse this alter created two fragmented alters, Dizzy Lizzie and Devilish Sue. Dizzy Lizzie reflected the child-like capacity and need of W to play since W also contained the vitality of the patient’s early needs that had been diverted into sexual proclivity rather than into healthy vitality. Dizzy Lizzie would emerge at a time in the cult’s activities prior to abuse when the children would play family “games” and the atmosphere was one of a family picnic sometimes the patient was given alcohol that induced a feeling of “dizziness”, through this alter W engaged in child-like activities. The alter, Devilish Sue, had a different purpose, she assisted W to cope with sexual abuse when W was unable to dissociate. During sexual abuse

and later during intercourse with her husband W would dissociate from the act of sex. Devilish Sue would enable W to dissociate from the abuse and at the same time remind her to move during acts of intimacy and abuse. Hence, both of these alters assisted W to cope with sexual abuse whilst allowing her some recourse to more appropriate childhood activities. In the following passage Devilish Sue described how the father had spoken to W.

Called me a “slimy cunt” said to W that he was going to break her cunt in half, smash it, “filthy slut” he calls her. He gets bigger [penis] as he talks. I’m not scared not really ‘cause just walk around arms out. When I got scared I don’t care ‘cause I think about nice things. Just that any time anything starts to hurt me I have to be happy. Good side is all right don’t care only daddy. Bad side feels; it feels in here. Bad side very bad wants to yell at him.

Whilst the alter W’s role within the system was important it was Marcie who bore most of the cult abuse and created five other alters to assist her contain the consequences of this. After Me/MO, it was Marcie who created the most alters to cope with the abusive experiences that were occurring and it was she who was present at least initially at all cult activities. Whilst it was the original personality Me/MO that created alters, they also took on a life of their own with the alter Me/MO dissociating herself from them and from the abusive experiences so that it was as if it was happening to another. It was the alters created by Marcie that bore most of the consequences of cult abuse and were left to deal with it. The alters Me/MO and Mary dissociated themselves from the abuse and it was the alters from Chris/Carol onwards that contain the affect of it. This latter group contained the knowledge of the traumas that the former group attempted to cocoon themselves from. The processing of this knowledge through the fragmented alters became an important part of the therapeutic process and is discussed in Chapter 7.

From the alters that Marcie created, AO had the most important role especially in therapy. Her energy and vitality provided the impetus for change especially in the early through to middle stages of therapy. AO’s purpose, as her name suggests, was as a container of the anger that the patient felt but was too fearful to express. This alter possessed much of the patient’s vitality and was important in

the progression of treatment. Initially, at least, AO's anger was expressed towards other alters, though it was not necessarily destructive in the way that, say, Darryl's originally was. She expressed anger at their slowness and inability to express affect compared to her perception of her own abilities. AO presented herself as someone who, given the opportunity, would "smash the father to pieces", who was not afraid of him, and who felt powerful. Neither, a child nor an adult with a fragmented sense of self, could accomplish this task. To maintain her sense of grandiosity, she created three other alters to assist her. The three alters, Darryl, Boy and Les/Charlie, assisted AO maintain her self-belief and cohesion. Darryl, Boy and Les/Charlie "emerged" to contend with traumatic events that AO was unable to confront effectively. She was unknowing regarding their emergence and their presence assisted her, in part, to dissociate from such events whilst her perception of self-cohesion remained intact. During therapy it was AO who threatened to confront the father (and on one occasion did) and she believed that she would be the "last one standing". During the early and middle stages of therapy, she perceived herself as the most powerful of the alters and believed that she should be in "charge". This, however, was not possible. Whilst she was an important alter like all the others, she was not the sum total of the patient's personality. As the qualities that AO possessed developed, they enabled her to confront difficult challenges both within the patient's life and within therapy whereas the alters that she had created fundamentally remained as they had been "created" though they did gain understanding of their purpose within the alter system.

Darryl was more limited in his role and was created by AO to display grandiosity in the ceremonies that followed some of the cult activities, particularly those where a sacrifice was made. AO was unable to cope with this part of the ceremony. She was barely able to cope with the sacrifices and too traumatized to perform in more; Darryl was created by AO for this purpose. His job was to wear the purple cape and paper crown and sit next to the father. He shared this grandiosity with AO but his aspirations were incongruent with those of AO. She gained her sense of purpose from being able to stand up to the father, though in reality this was not possible. AO, however, maintained the illusion that this was possible. Such balances were important for the alter system as a whole to continue functioning. Darryl gave the following description of his purpose during Session 323.

Sometimes I wear the purple means I'm really, really good. What do you think we did with the blood? If it's a good killing and I do everything right then. Go to him [father] and I smile I'm not even shaking and he smiles and he wraps me up in his coat just for a minute. I can feel his [penis] and the rest of his skin and then he tells me I'm just like Darryl and I get to wear purple just for a little while. I have to walk around, I do. I'm the best! (Boy says he feels like Superman, except no clothes on [another alter commenting on Darryl's remarks]) Come to all the big people ... so you go and it's like ... it's like being in church. They're all lined up just like in church everybody lines up. It's Easter. Even the baby he was spread like. Two knives on in each hand so his hands can't move arms can't then I will kill him. Then everybody eats and drinks a little bit of blood. I hand it out. Raise it to him I'm the last one.

The reference to being "just like Darryl" appeared to indicate that Darryl took his name from a cult member who participated in the ritualistic killings. The names of a particular alter frequently reflected what others had called them, for example The Whore, or You Gin. This appeared to indicate that alters first "appear" in an emotionally aroused state and that the alters are "formed" in response to the particular situation and the impact this has in shaping them rather than alters being fully formed when created. Darryl, for example, had a limited role whereas W was called upon to function in a variety of situations and circumstances that were not all cult related. The enduring nature of W's abuse had a continuing role in shaping her development and in her perception of herself, whereas Darryl's perception of self remained constant. His purpose was circumscribed and did not need to change or develop. The naming of alters and their purpose and what this might indicate regarding an alter's creation and development is discussed further in the thesis.

Darryl also acted as a persecutor of AO and the younger alters. He threatened AO with the power of the cult rendering her helpless and with a reason for not being able to change things despite her reputed power. Of course, as will be discussed later, there was also an enormous amount of guilt experienced by AO for her part in the cult sacrifices of the babies. The alter W who had handed the first sacrificed baby to AO, "blamed" her for the baby's death. The initial "blaming" of AO by W and other alters for the cult sacrifices provided a means by which other alters within

the system could defend against their own sense of responsibility and inability to cope individually with the overwhelming nature of the abuse.

The sacrificing of animals and babies by the cult were the most difficult of the traumatic events in which the patient was forced to participate, hence several alters were created to contain this aspect of the abuse. Darryl's role had been to "celebrate" the sacrificial killings. AO was too traumatized to participate and was too traumatized by the demands of her father to be able to complete the acts on her own and the alter Les/Charlie was created by her for this purpose. The term created does not imply a conscious deliberate act but rather one that occurred spontaneously in response to traumatic events. The creation of alters is discussed further in the subsequent section of the thesis. Les presented in therapy before Charlie. Les was boastful of his relationship with Charlie and of their power and importance to other alters. He also initially expressed his desire to kill the other alters particularly Me/MO and Mary whom he held responsible for his own distress. During session 580 he boasted of how he was going to deal with them.

Makes me feel good I've got it all planned. Leave [session] go to chemist buy bottle of tablets coke sit in car near water and that's going to be it. I felt good that I didn't breakdown cry like the other children. Nobody will mess with me. I don't want to be a woman or a man, be a nothing. She's not a bad person [Me/MO]. I'm going to help her. She doesn't want to face up to anything.

Later in session 581 he boasted how "My mate Charlie, me and him we're going to get Me". In the following session he discussed his power but also some of his emerging doubts as to the true nature of his feelings.

I have the power to hurt them makes me feel huge. A bit like their image of the father and the power he had over their lives, but unable to enact it. Charlie looks a bit like my dad. I'm losing control demolishing office. I'm not supposed to give a shit. They were too piss weak. I don't care. I'll fix it for them I'm bad. Know we talked about Charlie something that weren't really good like the dog and the cat. I always thought it was me saying they're going to die, but I'm going to die. Thought I was telling them. [Tells about dog full story.] I used Mary to get here. Sick to death of her saying I lied [584]. Hate her so much, I'm going to kill her. She has no idea what ... like with dog she's just an arsehole. I walk around all day she's nothing but a big fat bitch. You know why I want her to believe me? So it hurts

her more. She still loves him [the father]. I want her to hurt her to drop to her knees, her to say I can't do this and still have to go ... to feel everything I had to go through. I helped them. Guess I'm used to being in horrible positions. He made me so red and swollen.

In a subsequent session 586 Charlie discussed his experiences of the cult and his relationship with other alters "last thing I remember when AO killed the baby. You get rid of bad things". In a later session 621 he discussed his role in the cult sacrifices.

Like I can feel his tiny little body. When I did it I didn't care if he [father] loved me. I didn't do it to please him not like Darryl I just did it because it was necessary. I didn't like doing it I didn't do it the first time AO and Darryl they did it at such a rush you see. They broke parts of the baby. We were taught not to rush the next time it was slower, more deliberate.

AO, however, even with the assistance of Les/Charlie could not cope completely with the cult sacrifices of babies and the alter Maggie/Mae was created to cope with their physical destruction. This alter like AO was created by Marcie and took on the father's "grandeur" and power. She basked in the reflected glory of being "special" and of being congratulated by cult members for this. It appeared that these alters, Maggie/Mae, came after the patient's attempt to dissociate from the trauma of the cult sacrifices by creating Bub/Debbie. These however were not successful in mitigating the trauma and a further alter, Maggie/Mae, developed. Twin/joint alters in general appeared to have developed in response to extreme traumatic events where one alter could not suffice with the overwhelming affect of the traumatic events. Maggie/Mae developed in response to the destruction of the bodies of the cult's sacrifices of animals and babies but also to share the "enjoyment" that such activities brought to the father and cult members. The alter Maggie/Mae described Bub/Debbie and themselves in the following during Session 917.

I am his helper the very important, best dad. I used to, causes me a great deal of pain because of what they she [Me/MO] talks about to you. I know she can't sit here and tell you she knows about him being a bad person. I don't believe that, I believe that, I believe that he was a good dad. Confusing [I'm the] only one who feels that and do have a name, Maggie. Short for Maggot called self Maggot, maggots crawl maybe I do feel like I have them crawling. [I] Consider that after

everything they have said I must be the bad person. I think what he did was good. I've never needed them or them me.

I could do lots they couldn't do, [I could] pick up handfuls of shit. The big thing I could do was bash baby to bits and another. ... I'm very hot inside. Have you ever held your breath for a long time? I would tell him he was the best not one of them did. Not true Marcie at start of everything. This baby, not one of the others there they don't even know about ... I feel like saying "I'm here, I'm here". I'm suppose to be like him, suppose to say "Yes, where do you want me to go?" ... My dad told me I don't have to tell the truth if it'll get me into trouble.

A couple of others, children no big deal, truth is that they are little children who don't quite know how to live with, see I can live with it but there's two children. They don't feel good about what they saw. I don't know what to do about that. Bub, boy aged 7 doesn't do anything and Debbie ages 7 also. You know Marcie, I personally think she's [Debbie] like her: pathetic. Like a lot of people started off things [they] can't finish. Since they've been talking to you I don't know that I should feel so good about it. I guess the whole thing missed in this [is] I liked doing it. ... [I] Haven't done anything for a long time. Who do you think hurts them [babies] smashes their hands and feet. My dad used to do things and look at me and say "See, that's good isn't it." Mae's like that to me I need her.

The last sentence by Maggie reveals the relationship between these "joint" alters where the patient is being called upon to engage in a particularly traumatic act from which she perceives herself to have no recourse. The joint alter, here Mae, provides the reassurance that the father delighted in such actions by her and assisted these alters to maintain their sense of importance to the father. In the following session the alter Me began by discussing the previous session and the sacrificing of babies by the cult.

[It was] A different baby 'cos I didn't want to think about it, before, one I did. Feeling there was a lot of hidden things there, drinking the blood, smashing the baby like a teddy. Get the feeling that I don't know enough. Strange afternoon and evening Wednesday and I didn't really like it, didn't feel myself; like I was there but somebody else looking through my eyes, half of me half of her.

This process of being “half of me half of her” was an important element at this stage of therapy. Not just for this alter, Maggie/Mae, but as a metaphor for the integration process. This will be discussed further in Chapter 7. The alter Me switched to Maggie/Mae during this session (session 918) and continued to discuss their involvement in cult activities. They also discussed their pleasure in pleasing the father and how this gave meaning for their existence.

Marcie [is the] key original child that really flunked out, guess people have brain over loads, too much. Bub and Debbie [were created] out of Marcie [who was] too little [and] didn't understand. So I did and did really well. I didn't make faces or hesitate. I would drink blood. Made you strong and it made you one of them [adult cult members]. Nice silver cups [drink from and] lift up everybody put [the cups] in the middle of where they were sitting. I didn't used to get hit, because I was good, they got hit [other alters]. Like they loved me, because I could sit with them, I could sit on their lap. Their dicks I wasn't afraid of putting them in my mouth, stuff that came out of it. I was the one [who] didn't do much but what I did do was important. Stuff came shooting out a bit sticky, fun watching it come out.

I smashed that baby after AO and all the others [babies] made such a mess. Three babies. AO killed one and I killed two. Killed first when 7, second when I was much older. She [AO] was 7 as well 8½ when killed second [baby], lot of experience by then. He got it and it was screaming he put it on tree stump, good one screaming. He picked up hammer banged on head and then I did it. I came when he brought baby over with hammer. [Therapist commented on a change in patient's demeanour] I just got a fright thinking about how good I was, didn't feel so good. I just got a fright thinking about how good I was didn't feel so good kicked in stomach. I didn't feel have any problems really. Don't you know if you move around prepares you. Afterwards it felt good didn't feel good to start with after a while I got tired, tree stump was fairly high so my arm was getting a bit sore. I wasn't worried about what it looked like my eyes closed. I looked because wanted to see what it looked like. “That was enough, bring it over.” [He was] standing next to me and I had to take it over to other people, felt a bit like a cloth. Everybody was smiling different from her [AO, I] didn't shit myself. Took back to stump touched it, blood ... wiped blood on my face and body I wanted to be like an Indian. Daddy was pleased. I was lovely. They put on [blood] their dicks. I used to practise on my teddy afterwards. I had feeling, strong. That confuses me noticed with AO if angry hits something because I make her do it. Hit hand she gets angry, makes me feel better. I want to smash every bone in her body. She's always thinking about babies. He told me not to tell others wouldn't understand that he was getting rid of evil things.

Have a lot of confusion I can feel so good others feel so bad, now everybody talking as if a bad person. Sometimes feel he's not a good person. Difference between wanting enjoyment and wanting like doing a job. Don't think I did enjoy, till [saw] how much pleased him. I'd feel so lucky when he did that. Had their head in a bucket of water that's how I started, out ... out of fear I guess, but I learnt to like it. Do things he wanted that he was almost gentle. When I was carrying the baby, to start with clenched my fists but didn't work 'cos went into [fear] now don't feel so good but when I think about I'm not shitty, shaking he was smiling take round [the sacrificed baby] to everyone, I wasn't screaming.

This alter, like many of the persecutory alters, was angry with some of the alters such as AO and Me/MO and threatened them harm. Their rage that they had had to do these acts which Me/MO could not manage, was frequently expressed. They blamed Me/MO for their existence and the subsequent pain that they felt because of this. Frequently this was expressed in a physical manner such as causing the patient to harm herself or to take an overdose of medication. These issues are discussed in the following chapter. They also expressed anger that they were not being listened to by Me/MO and that their contribution to the safety of others within the alter system was being ignored.

Didn't think I'd ever have to talk too. Have Me to talk to tell her they were full of crap, like she's not listening. Pissed off they didn't acknowledge me. I used to do things for them and they thought they had been asleep.

Other alters created by Marcie that had a fragmented role were Beth, Young Bert and Serpent the latter being the only non-human alter. Beth's purpose was to attend Sunday School. She listened to the sermons and the biblical stories especially those to do with "goodness" and parables of the dutiful daughter who survives adversity and gains God's love. For the patient her father was as God. She perceived that AO had been "bad" and that it was her job to atone for AO's "sinfulness". Her perception was that it was the badness of AO and the other alters that led the father to "punish" them, just like a dutiful God. She tried to atone for AO's "badness" and regain the father's love. She wanted to be loved by her family like some of the daughters whom she heard of in bible studies. Being good was a

way of trying to recreate and transform the reality of her world to make her father into a good and loving father and Beth to be the good and dutiful daughter who loved her father and who therefore loved her. In many aspects she was an earlier precursor of the alter, Mary, who was similar in her desire for “goodness” and taking her name from biblical references but having a more complex purpose within the alter system.

Young Bert was another alter created by Marcie. Young Bert first presented during the later stages of therapy. He was initially persecutory and quite grandiose in the perception of his authority and power. During the course of therapy this perception changed and before fusion he changed his name to Gary so he could have an identity of his own. He initially identified with the father and as his name implies perceived himself as a younger version of the father. He was his father’s helper in maintaining the father’s authority within the alter system. He did not appear until late in therapy. It was as if the process of therapy unravelled the more developed alters first and as they came to deal with the consequence of abuse, alters that had been created at an earlier period in the patient’s development, presented. This issue is considered in more detail in Chapter 7 when issues of alter presentations are discussed. This alter appeared to hold the idealization necessary for development, the father being an idealized but seriously flawed figure. Young Bert, without the attention of the father, found it difficult to maintain his position or even believe in the authority or tasks that he set for others and he rapidly fused with other alters. The need to be contained by a powerful other is fundamental to a developing self. Young Bert was created to sustain the idealization of the seriously flawed father.

Serpent was the final alter to present to the therapist before integration. This alter appeared to have developed from Marcie’s “wedding” to the father. During this ceremony a snake was held close to her and incorporated as part of the ceremony. She had also been led to believe that a snake had crawled inside of her and that its head had been “broke” off inside her. She was told that the snake would grow inside her and watch over her, if she ever spoke about the cult the snake would “strike” and kill her. Snakes had also been used at other times in the cult’s ceremonies to intimidate and frighten her to create the belief that they lived within her and would always know if she spoke of forbidden topics. When this alter first presented it was

described as watching her and waiting to strike if she continued to talk of the cult. This alter was a fragmented alter of Marcie's and as such contained many of the primitive aspects of a child's beliefs particularly when incubated at a time of heightened arousal and extreme terror.

Me/MO also created one alter, Louise, during the process of therapy. This alter was created during the middle phase of therapy as an attempt to represent a more sophisticated version of W. Me/MO later acknowledged that she had created Louise to present a more "acceptable" version of W to the therapist. That the patient could "create" alters in response to current circumstances is not surprising given the patient's history and her ability to create alters in an attempt to "resolve" situations for which she felt unable to find a more appropriate strategy. The alter presented eight times but lacked the affective content and "history" that other alters brought with them and was not able to maintain her role. This will be discussed further in this and subsequent chapters.

The fragmented alters directly related to Me/MO had a specific role to play. They contained much of the traumatic material that Me/MO was unable to accept and process. During the therapeutic process they brought an impetus to the processing of such material and provided a means of expressing the trauma. Much of the trauma that these alters discussed was about issues that had not been "fully taken on" by other alters, the alter Me/MO in particular. Each alter contained fragments of affect and some such as Voice and Shadow provided a link between different alters and their respective experiences. This will be discussed further and their role in the treatment process will be examined in more detail in Chapter 7. The development of specific alters is considered in the following section.

Development of Specific Alters

In this section the creation of specific alters is discussed. During the therapeutic process the patient described the particular event that led to the creation of several alters. This material is examined to determine whether it can shed further

light on the development of this patient's alter system. The material is discussed within four areas: (1) a description of the therapeutic context in which the material arose, (2) the patient's description of the events that occurred when the alter was created, (3) how the alter's name was chosen, and (4) what factors contributed to the alter's subsequent development. Not all of the patient's remarks are included, however, her description of events is reported in some detail. Frequently, during such sessions, the patient was deeply distressed. While much of the emotional context has been omitted in order to ensure clarity and brevity of purpose, the essential issues are retained. The alters discussed in this section are U Gin, Amie, Marcie, AO, Les, and Me.

U Gin

This alter first presented in session 1051 while Ruth was an inpatient. In the previous session the alter Me had been discussing feelings of anger that she had regarding the father's abuse of her and had drawn a picture depicting this. She commented that she had been "hearing voices saying 'Go hang yourself'." It was not Marcie's voice (Marcie and Me being the only known alters at this phase of therapy) and she described the voice sounding "like an alien inside me." Whilst at home she would be listening to the radio and the "words of the song changed to my saying 'Hang yourself'". U Gin presented during the following session. Initially, Me was present discussing how she had been feeling extremely hyperactive for some time. While she talked about recurring nightmares in which babies were killed, the alter U Gin emerged. U Gin told the therapist that she remembered the alters Baby and Angel and that Angel's legs would be pulled open and the father would "lick her like an ice cream" and that he did "the same thing to Chris". This alter presented on three occasions and was not known to the other alters. Me did several drawings and paintings of U Gin being "hanged". One of these paintings is included in Appendix F (drawing 12). Of the alters discussed in this section U Gin is the only one where the patient's written material is used to describe the moment of creation. Following the emergence of U Gin the patient wrote about the creation of this alter and handed it to the therapist during session 1058. The material processed during session 1051 was similar to that presented below but the patient's written material is preferred in the interest of brevity.

U Gin was Chris's conception because she couldn't take the trauma. Chris was 4 yrs old by now and getting more & more sexual assaults against her. U Gin was therefore very important to take the pain from Chris. She thought she always died. They used to put a black & white tea cosy over her head and paint her black. She didn't know she was being painted; she just thought she was black. All the men were black as well except when they painted their penis red. They called her terrible names such as a "black fucking cunt". She was beaten with a cane and later tied to 2 ladders and they hung her. Or that is what she believed happened to her. They would hold her upside down and pour blood into her vagina then they would melt a candle over it so the blood would stay there. Later they would pull her down, urinate over her, beat her, melt the wax and the blood would run down and be caught in a small bowl. Dad would get an eye dropper and fill it with urine and drop it into her eyes and nose, then her mouth. When she was laying on the ground, still hanging by the brown belt, Dad would put his middle finger into her vagina and with his other hand he would press against her bladder until she weed. He would then cup the urine in his hand and throw it over her face and body. This would make her sick and he also worked on her tummy until she would shit which she also had to have on her body. This is when she died. She thought they could always make her live and die. This saved Chris from ever having to deal with the abuse. ... U Gin was very important for pain relief but nobody knew about her. I think they just went to sleep, woke up and never knew what really happened.

U Gin took her name from the abusive comments of her father and other cult members. In this she is similar to the alter W where the derogatory comments of cult members is perceived by the alter as their name. It was only during this "ceremony" that she was called U Gin and she ceased to have any significant function within the alter system when this particular type of abuse ceased. The purpose of this alter was defined by the specific nature of the abuse and therefore she did not develop a more complex role within the alter system.

Amie and Marcie

The alters Amie and Marcie described their creation during Session 324. AO was the presenting alter for this session, followed by Darryl, Carol, Amie, and Marcie. The session commenced with AO discussing her relationship with the patient's husband, John. Darryl angrily interjected that Mary had gone to church when she was "not supposed to go into places like that". Carol replied that Darryl

had been frightening her by telling her that she was going to die. The alter Carol became agitated and started to talk about a traumatic event. At this point the alter Amie emerged. Amie explained that she had come because Carol was unable to “watch [what was being experienced and that Carol would] have to go to sleep.” Amie discussed what had happened to Carol and how she, Amie, and then Marcie had been born. In the following session AO said that she had not known much about Amie but that Amie was born when Carol recognized that the father was abusing her and that Amie was the first of the alters “to have the sexual penetration”. The alter Marcie came because the alter, Amie, had been unable to contain the trauma of the sexual abuse and the act which followed where the patient was made to drink from a mug into which the men had ejaculated.

They’ve got her, her dad and Uncle Jim [not a biological relative] and the other people. They’ve got her on the table. I don’t want to be on the table. It’s ... it’s ... it’s no good moving because I don’t move. Dad ... the dad ... the dad ... he wants ... he ... he ... he says “This is how you lay on the table, this is how babies lay on tables, this is how you lay on this table tonight”. And ... first, ... first of all I have to lay on my tummy and my head is over the edge of the table. ... That’s my dad. ... I can’t breathe ... oh ... oh. I can’t ... oh ... he’s ... he’s always got my hair. He’s going to break my throat you know. He’s ... he’s going to. ... Oh ... oh I cam ... I came [Amie] ... oh, hands all over me. Making the table move he’s moving so fast ... “Get away”. Oh ... oh [I] shouldn’t have done that, now he’s getting angry. I was sick. Oh, ... oh “don’t, I’ll be good, I’ll be good, I promise, I promise I’ll be good. Promise daddy. I’ll be good”. He’s pulling me down the table now. ... I don’t know what he’s doing. He’s got something in my bottom it hurts “Get it out!”

They’re going to ... to turn me over. He’s got something, his ring ... his ring. I don’t know what he’s got on. He gets his finger and ... and, ... I can see it. His finger hurts. “No ... no ... no ... no” ... he’s got, oh ... he’s got something ... I’m all sticky from something. He keeps saying I won’t feel it, [he] keeps pushing. He’s trying to push it in his thing. He’s trying to push his thing in ... it doesn’t fit. Do you know what he said? Please don’t let them “We need a smaller prick gentlemen.” He’s hurting me he’s hurting. Oh ... oh ... hurting me, he’s killing me. I had to look in the mirror I was on the table. He brought the mirror with very bad words. I know them, naughty words I’m not allowed to say them ‘cos other people might not like them – special words. Says have a good look at me, Mary says I’m not allowed to say it. I have to look and he says “That’s what a cunt looks like and that’s what you are.” Why don’t

they stop? A man comes along and gives me a needle and then I can't feel it any more. They're still there. The man who gave me the needle said "Don't put it in her just on the edge." Why ... why do men play with their things? ... They've got this stuff. ... "Leave me alone!" They've got this tin ... they're collecting as he stands there ... all this white stuff, what is this white stuff? "Don't, don't no I won't, I won't let them." I say, "No! No, no you can't ... I won't drink it!" I'm Marcie I won't let them I won't let them, "No! ... No you won't hurt her any more." He hits me he says, "You drink this you fucking bitch." I'm only a little girl I said to him "I hate you." He walks up screaming. I hate him, I hate him, and he walks up to me and he hits me, and he hits me and he says and he hits me so hard. "I'll do it, I'll do it" and he's got my mouth he's got his hands over my nose. He calls me a "Fucking cow, if you want to live you'll drink this and I'll take my hand away". "No, no, no please daddy no."

During the time that Ruth was being treated, there was no indication of how the names Amie or Marcie were chosen. Whether they were the names of cult members (e.g., Darryl) or people already known to the patient, either as friends or fictional characters is unknown. Whilst Amie is identified as a central alter within the system she was not as significant in the role that she played as some of the other alters and her "presentations" were generally brief. During session 379 Amie had stated that: "I'm just scared, just scared, I've never been around for very long, I always do my stuff inside". Her main purpose was the containment of the early experience of "sexuality". Amie's sense of self evolved from her father's sexual proclivities. When he was away from home she frequently lay in his bed and wearing his dressing gown she would "imitate" her father and read his soft pornographic magazines just as he did. She took her sense of self identify from the father's treatment of her and during an earlier session (238) Amie described herself thus:

There's lots of things you don't know, I like pornographic movies, books and I also like women and I was going to say I like my brothers [sexually] but I don't think that's true. And I like being treated like an animal [being] made to beg for it.

As the patient matured and the sexual demands of the father and cult increased the alter W "evolved" from such tensions. Amie remained within the alter

system as a young child. She contained particular memories of abuse but did not develop further, whereas the alter W continued to be a prominent alter within the system into adulthood. During session 239 W described something of her relationship with Amie.

Amie [is] a smaller version of me [W] I only remember going to grade 6 [not earlier grades]. It was me for socializing at High School Mary for being good. Mary in class except Science where there was a male teacher, she did the rest. I would be the one that wagged school. She is younger (Amie) but feel that she is part of me I feel very nervous about her. I don't know what she has done it is the first time that she has come.

Marcie and Amie frequently presented together; during Session 362 Marcie said "I'm connected to Amie". This connection was a source of support for them and a means of distraction from painful events. When possible, Marcie would dissociate from traumatic events and used Amie for this purpose. In Session 368 when describing a particularly traumatic event, the ritualistic killing of a baby by the father, she described this process: "It hurts. ... I'm no longer there; ... I'm playing with Amie ... hide and seek. There's lots of trees, climb up the trees all the pains gone, doesn't hurt any more".

Marcie was perceived by other alters as containing most of the emotional consequences of the abuse and was described by Me as having always being present, at least initially, during cult activities. She had been "created" by Me during a traumatic event that Amie was unable to contain. In Session 626 Me discussed that she had created other alters so that she could avoid the emotional and physical consequences of the trauma "each time he did [something traumatic] sometime/[s] [the alter was] killed [so] I made [another] or they became another person". She continued "I made Amie but she wasn't strong enough so I had to make Marcie. That wasn't bad of me. I needed to make Marcie, no way I could stay there". Marcie became a conduit for other alters who had a more specific function within the alter system and as a means of Me dissociating from the pain of abuse. Marcie contained a more complete history of the cult abuse than the other alters. She experienced much of the earlier abuse and initially she was the alter who had tried to

resist the father's abuse. This inevitably led to further abuse that "alienated" her from other alters. The alters closest to her, AO and Me were afraid that they would be "contaminated" by the affect that she contained. They perceived her to be literally covered in the abuse that she had endured and they strove to keep her isolated within the system for fear that they too would be covered in her anguish and that they would have to assimilate her pain.

Amie and Marcie were important to the alter system. Amie's self concept was founded on an incorporation of the father's sexual abuse of her. The alter W developed from Amie and Amie ceased to have a significant role within the alter system though the primary issues formed by Amie in regard to sexual relationships continued to have an impact on the patient's life. Marcie's role was confined to cult activities. The alter AO, however, developed from Marcie and contained much of Marcie's anger. Marcie contained much of the traumatic affect of cult abuse from which other alters sought to dissociate. Marcie continued to be a significant alter within the system and the alter whom Me needed to come to terms with prior to integration. The process of this is discussed further in Chapter 7 when issues pertaining to treatment are discussed.

The Angry One

During session 213, AO discussed a particular traumatic event to which she attributed her creation. She was the only alter present during the session. She started the session by talking about the father and the cult's abuse of her. During this session she returned to a particular issue of cult abuse that she had alluded to and struggled with in earlier sessions. Ruth was an inpatient at the time of this session and during this period of hospitalization had actively pursued self-harming behaviours. She stated that Darryl wanted her to suffer and to this end she had cut her wrists, arms, and stomach and would harm her hands by punching walls. She claimed that she had to do this and that the behaviour was not under her control. Darryl, she stated, was punishing her by "making" her see images that she did not want to see; the self-harm was AO's attempt to appease Darryl. During this session

AO described the cult sacrifice of a baby in which she had participated. It was during this act that the alter AO was “created”.

I had to get it over and done with, I had to get it over with. ... I try to pretend I didn't do anything. ... I'm changing. ... I don't quite sound like me. I had to get it over and done with. That's why I'm changing. I can't tell you I did that. I didn't want to, Darryl shows me every day, one [cult member was] on that side and one behind me. And all I could do was just look at his [baby's] mouth. 'Cos. But it was laying there, I saw it laying there. That's what we hear from ... the same sort of noise is what we hear from Darryl. The constant “do it, do it” just constantly “do it, do it drink blood”. Everybody gets hyped up ... it's like a frenzy everybody gets quick, everything gets quick. The noise is quick as well. It's like ... it's like I could stab myself now. 'Cos he ... he [Darryl] just goes over and over ... ”Stab yourself, stab yourself”. Except this time that they were all saying, “stab him”. ... I had one behind me and one in front I couldn't get away. And I couldn't look at what was on the table, ... but I could hear it. When Daniel [patient's eldest son] was little he used to cry just like that and I knew I just had to get out of the house. I couldn't pick him up ... 'cos somebody might have done something to him. ... Though all of us just knew he wouldn't come to any harm if we just went outside for a, ... for a while, just for a while. He was such an awful baby for ... for crying then one day he just stopped crying and he was a good boy. And we all loved him because we knew ... it doesn't help the little one that we. ... They're telling me to do it, over and over. When babies cry such a lot they go all red. ... They get redder and redder. ... Words can't describe the picture. ... It's all like ooh like it's all a mashed up cut up and it's all red and the man behind he umm ... and ... oh ... and the man behind pushes my face in all this oh. It was, I only had a little face so the ... so the whole the whole face got covered in. And you have to bite it. Oh. Head's not that big. And they have big hands and they can just push you down on to it cos, it's ... because it's nearly at ... at ... the tables nearly up to here ... to your chin anyway. You don't have far to reach it. ... I can't get my eyes wide enough to, to take it all in, it's awful. It's awful, awful. There is mess everywhere. These men all have their penis all, all very big now. All very big and they, everybody has a bit of this ... mess everybody. ... I have to lay down ... so that they can ... I have to lay down and they pull my legs apart, apart ... far apart, so far apart that it feels like they're going to break and then I don't feel anything. So they're stretching them out as far as they could ... Darryl says “All the better to see you my dear” ... my legs do feel like they're going to break. And then I don't feel anything, and then they do what ever they want to do. Oh. ... Then they empty it over me all over me even my mouth even my eyes they do with blood ... even my nose.

... That is my birth. That ... that is when I became me ... AO came ... me, me who would never ever, ever let them bother me again. Except that's not true is it, just as weak as them. I can't hold it together any longer. Just looks like I'm a little solider standing ... with this thing that is so shiny and actually so pretty but its not ... it's a killing thing [knife]. It's an actual killing thing. And everybody likes the blood everybody. And that's what happened, and that's what happened. And they got me on the ground and they did such awful, awful things. ... They put everything in to anywhere that they could get it in to me. Everywhere ... everywhere. ... It was ... that, that was my first experience, I don't know who was before. I don't know who was it before. I'd have a guess that it would be Chris ... 'cos she can't speak. I hurt everywhere it's in my ears it's in my nose it's in my other places, everywhere. And ... I, I know that's why, when the pain gets so big, it just ... it just hurts so much that it doesn't hurt any more. It just can't hurt any more because I've killed everything [hurt her own body, particularly genitals]. So just can't feel it but you can still see it.

The name AO describes the emotional state of arousal that this alter felt when she was created. She is an older version of Marcie and though her initial purpose was to contain anger, she did develop further and was an important alter within the system. She possessed a degree of grandiosity regarding her abilities which was sustaining for her and that could be transformed into pride which other alters within the system also partially incorporated. She was also important in the therapeutic process and provided much of the impetus for change in the early and middle phases of therapy. She had perceived herself as the most important alter within the system, during the early phase of therapy she believed that all the other alters would have to fuse with her, and that she would be the integrated whole.

AO had to participate in many of the cult activities but had other alters to assist her that she was not always aware of. The alters Darryl, Les/Charlie, and Maggie/Mae were "created" to contain particular aspects of cult activities such as the ritualized killings that AO was too traumatized to be present for. The conflict that she experienced with Darryl and his "punishment" of her was essentially a struggle with her own sense of guilt. She was a complex alter with a degree of introspection regarding herself and one that contained a strong sense of guilt in regards to her

participation in cult sacrifices. She frequently returned to the part that she had played in cult sacrifices. She discussed this, for example, in session 231.

I did what he wanted trouble was I didn't see what he did till afterwards, and then I'm covered in this stuff and he screamed at me again. I didn't want to look, he grabbed my hair and I had to look up close. I should have died myself instead I get washed down, hosed all this shit instead still go to school eat drink pretend still get up every morning and still pretend. You know what hurts most, the fact that I played with this baby. I love babies so wrong I shouldn't. You give a baby to an 8 year old, what am I going to do but play. I eat people, all week I've been trying to tell you. I loved it, played with it, and killed it and ate it.

AO remained an important alter within the system until her eventual fusion with Me/MO during the final phase of therapy.

Les

During session 585, the alter Les described his moment of creation. The alter W had first presented discussing her belief that she would soon die. She discussed that Les had been present at home and that he was angry and threatening to kill her and Me/MO. Following W, Les presented and told the therapist that he was "going to get so angry I'll explode". After Les, Charlie presented briefly stating that he was angry at the alter Mary because she kept denying that "anything had happened". The alter W returned at the end of the session. Les discussed that he was "created" when the father had disembowelled the family cat during a cult ceremony and placed it across the patient's neck. The following session begins with Les discussing why he came back in the alter system since he had been "dormant" before this.

I thought I died a long time ago. Think I did die when I was about 6, I think I died and I woke up. Sometimes I think I woke up the next day then I died again probably from 9 till now, months ago. AO woke me up she was talking about something it woke me up. Feeling pissed off about everything. Nothing in particular – I didn't want to know when I woke up. Woke up when she was talking about the baby, maybe it was just like before she wasn't able to take it like before. First time died when dad killed the cat and laid it on me, there was somebody there before me, I came then. Came and felt all this sticky stuff, could feel the cat's fur smell around me. I didn't know what it was all about

really. Then I died when I found out what it was. I got a fright and I died. I died when they lifted the cat off me and I saw what it was. He put his hand inside it and lifted it up. Thinking about lots of things where I came and died. I didn't get being picked up afterwards [as other alters Maggie/Mae had been] now I wish I could die again.

W said, in a later session, that she had an Uncle Charlie, "dad's brother" who lived in another state of Australia but came to WA once when Ruth was a child and took her out. There is no suggestion that this uncle abused her. Apart from this association there is no indication where the names Les or Charlie derived from.

During cult abuse Les came briefly for events that AO could not completely contain and for other traumatic events such as killing the babies, Charlie came to assist Les. In session 586 Charlie stated that the "last thing I remember when AO killed the baby. You get rid of bad things I'm going to get Les to kill them [other alters]". He continued "I think [of] myself like dad. He trusts me to carry out job, have to do. Frighten children most important job, frighten then finish them off". Since Les/Charlie had developed from AO's traumatic experiences they also contained a sense of the guilt that she retained. Whilst this was not immediately obvious, the conflict felt by Les/Charlie concerning their actions, did become apparent during therapy. During session 596, for example, Les said, "I'm a killer of a human being, more than one. This is why we're going to die, 'cos it was such a bad thing, have to be punished".

In the following two sessions Charlie continued to talk about traumatic events that he and Les had participated in. Because of the distress this caused, Ruth was hospitalized. For most of this period of hospitalization, Ruth was fed by nasogastric tube since she refused solid food and accepted only a limited fluid intake. She did not wish to die but her realization that she had eaten human flesh as part of cult ceremonies filled her with a deep revulsion and sense of guilt. Her period of hospitalization (72 days, see Table 6 Chapter 7) was the longest of the 12 occasions that she had been admitted. The following passage is of session 597 and has been included because it reveals the specialist role that this alter had within the system and

the need for its “creation”. Themes alluded to here will be discussed further in this and subsequent sections.

Charlie and I [Les] will not let them drink. I killed them one still had the cord on it and it was very slippery. ... I remember the top of its head had like white soap on it. I just heaved a bit. Had all stuff in its ears and face, like someone had spat on it and this soapy stuff on its head.

[Les continued to discuss the ritualistic killing of the baby in some detail.]

Killing self not sure if my idea or I'm being made to think about it. Like possessed, possessed person won't let me. Am in good hands not sure whose hands to trust. Charlie, I trust him that's about it. Possession, person trust that they'll carry out their threats. Don't see anything, just covered in this being possessed. Like I'm told everything to do, makes me feel like I'm doing what supposed to do. Suppose to be cool, calm, and collected. AO didn't learn had to do again so Darryl had to help but he's a wimp. I feel like I was born in a cave with a fire, all these people sitting round throwing things into fire, when killed dog just throw in, horrible smell. Cleaning up their mess just saying I didn't want to do it [that was] where Charlie [would] help he won't admit but would be more trouble [if we did not do it]. Think we had a choice about the baby, we shouldn't of had to had those things put on us. They cut open its head could see everything. Felt it before when had to touch all the white stuff on its head very slippery, white like soap. I was feeling it, could feel there was a soft bit in his head. I didn't look, closed my eyes. All I know is that it was yucky afterwards. Little eyes nose and mouth. I didn't know you could pull people's eyes out so that it just hangs, then they cut off its nose. They just worked its face. They called it worked, cut around the cheeks, lips. They had worked to do which means I had work to do. I had to learn how to do these things. Darryl would help AO cut arms, body and legs and that but I had to take over for the face why I hate them so much. Like cutting down side of his tiny little mouth into his chin so it was just hanging there. God, I didn't want to do those things. Only thing I didn't have to do top of head watch pull eyes out but watch cut round side of them. Cut down nose straight. Now you know where our obsession for straight comes from. Told you they pulled out insides cut off his private parts. Everybody had to put his tiny penis in their mouth. They cut other things off [testicles] just this tiny little thing. Then pass on to everybody else when dogs [finished eating what was thrown to them] get bits and they put it then in the fire. I just kept looking at it all my concentration if I just looked at one thing. That's how I manage now. I wasn't very tough. [Father saying] 'This is going to be done. You're going to do it, it will be done'. I did it with pride, I was proud of it. He didn't have mum at that stage so he needed to be proud of me.

Les/Charlie were able to discuss the details of these particular traumatic events in which they had to participate in a manner that AO could not. Indeed, she was not aware of these details. Les/Charlie's role was specialized and required an alter that was able to "detach" itself sufficiently from the emotional consequences of the ritualistic act of scarification of the babies. In treatment Les/Charlie were able to process their material relatively rapidly and discussed in some detail the traumatic events in which they had to participate. Consistent with their creation they were able to do this without the same intensity of emotion that some of the other alters such as Marcie contained. As treatment progressed, however, there was a deepening of affect and recognition of the nature of their actions most notably expressed in the need to be fed via a nasogastric tube. Les/Charlie eventually fused with AO.

Maggie/Mae

During Session 919, the "birth" of Maggie/Mae was described. The session, which was on 29 December, started with the alter Me discussing how Christmas had been a difficult period for her as it brought back painful memories of cult activities. Maggie/Mae presented to discuss that they now felt ashamed of the things that they had done when previously they had felt good "You [therapist] and them [other alters] have made me feel ashamed. I thought it was good, now ashamed. Did to make my dad happy". Maggie/Mae was present for most of the session but the alter Me returned at the session's conclusion.

I'm angry with AO 'cos she's making me feel this way – and you give a good helping hand. He broke her [AO] after she killed the baby [first]. She just freaked and I hammered the second. They wanted something unrecognizable; they wanted a bloody mess they wanted to hear. You don't hear a cut so much more better. He would have been angry and hurt them; well he would have really hurt them [other alters]. She was standing there, and he came up and he had the hammer not long after she'd stabbed and cut the baby. ... I knew what was going on. I did it she sort of went to sleep, not like she started to snore or anything, her body and mind. Was first time I had been around but I knew what dad wanted, knew what was wanted. I did it. First of all I closed my eyes, truthfully, and I pretended it was something else. My dad hit it first on the head, strange noise. I didn't end up hearing the noise after a while. Like I'm sitting here, telling myself I can do this like it's not really anything, but you still feel scared. You see I had to like it. After I took it and showed everybody

I started to feel good dad not going to hit me. Picked me up hugged didn't mind stuff on me. After men came up put hand in put on dicks, like I wasn't a little kid. Then left, no point [staying I had] done it, [and I] didn't get hit. Others got a fright. AO shit herself she had all over her she just freaked and she got hit she got the whole lot. I hate her so much I just want to get rid of her. I was 7 when I was born I wasn't however old they are now.

Maggie Mae is the title of a popular traditional song from Liverpool based on the melancholic death of a prostitute; the Beatles later recorded the song in the 1960s. Whether this alter was named after this song is however unknown. This alter was “created” to contain the specific act of pulverising the babies after they had been sacrificed. The alter also participated in some of the ceremonies that occurred after the sacrifices. Maggie/Mae are similar to the alters Les/Charlie with Les/Charlie containing the ritualistic scarification and Maggie/Mae the eventual destruction of the body. These alters were important in progressing treatment and similar to Les/Charlie had taken “pride” in their prowess and in their ability to please the father but later felt remorse for their actions. They also expressed anger towards other alters particularly Me/MO whom they held responsible for their “birth” and therefore for the pain that they felt.

The following material emphasizes the specialist function of this alter and her need to “create” other alters, here Debbie, to contain some of the affect resulting from the traumas. It provides further insight into the development of this patient's alter system and is quoted in some detail. During Session 933 Me and Maggie/Mae were present. The session commenced with Me asserting that she was not going to listen to Maggie/Mae telling her to “die if [Me] listen she makes me feel bad”. Me continued that she still believed “that dad was great”. She felt that therefore she had nothing to feel guilty about but that Maggie/Mae did. On the weekend, Me promised Maggie/Mae that she would stop resisting them talking to the therapist during therapy if they stopped telling her to kill herself. Maggie/Mae then emerged.

Well I think that she feels good [Me]. I used to feel good. I don't sleep at night-time, I get up and I sit in the dark. I look out the window, blinds open so much nicer outside, see enough. I look at the trees they look better. They have weeping trees, peppermint, except

the council comes along and cuts the tops, but underneath good. [I] Like looking at them in the dark [I like] that you can see them but can't really see, scared of really dark. I used to like it being really, really dark. I touching nothing, nothing touching me, but I found out not really the case, before most of the time trying to find a place to hide. Sort of like being semi-real, I don't think want to be real. Because I reckon it hurts you, like I can be semi-real here but not real, real. Here you might hurt me so if I sit over here in this little corner I watch you 'cos every man I've known has hit me. Or they've made me touch them or something. I guess I've been testing you out. Every time I come I've been testing you out. You're different to my dad and you're different from my dad's friends. Get confused TV adverts violence, know wrong different I did everything aggressively. I did have to 'cos nobody else would do it. I used to get so angry shake, yell at them that they were "Weak just babies". Everybody used to yell like everybody had a hearing problem so I'd yell at them so I'd get angry and aggressive like them. I used to feel like I couldn't stand up or hold my hand out. Found out if angry then like a board really strong. Then do what had to be done. I was angry that I had to go like that. Angry with AO she made me go like a board. Well, I haven't told anybody, but sometimes I was afraid and that's when I did. Sometimes I was afraid, and that's when I disappeared and I'd put Debbie there. She didn't always come it was easy to have someone who expected to be laid into that way it didn't affect me, kept myself strong. Most of the time it was like, you know when I smashed the baby and I carried it around so everybody could see. After a while like smashing a teddy bear then everybody saying "Bring baby over here" scareder [sic] I got. Nobody knows because secret how bad I was. Was bad when I realized was a baby got Debbie, "You can feel this!". I felt scared. Everything has consequences; do you know that everything has a price to pay or something? Consequences of putting Debbie out there bothers me 'cos I know so much more now. Bothers me those things shouldn't be done, bothers me that I wasn't able to do myself. When I looked at myself I was enormous; I used to look at myself when doing those things. Cry that person not me, I don't cry. Don't you see that I had to keep this little part so strong this little part surround by all this horrible stuff better other little children didn't like me. In charge be like adults, makes you realize how strong you are. I used to go and stand and watch them do it to Debbie, nowhere else to go, not in the bush so dark. You know sometimes they wouldn't even hit her she'd do it herself. They'd laugh. In a way not good for self if not able to get off ground would have stopped too severe. ... I'm a coward. I should have stayed there and not put her there. Instead of her getting more beaten up I would have. I was too scared to runaway. Couldn't runaway I know now I can do this and I can do it good and I don't even think about it being bad after I'd finished beaten to a pulp till nothing and dogs would eat it so nothing.

Maggie/Mae like Les/Charlie contained a particularly horrific aspect of the abuse. In part due to the extremity of the abuse these alters needed to create a “joint alter” that would reassure and assist in containing the emotions they felt whilst they contended with the task their father had set them. Maggie/Mae also needed to create other alters specific for her (e.g., Debbie and Bub). These additional alters were not discussed by other alters in the system and appeared unknown to them. Debbie contained some of the responses that Maggie/Mae could not contain and that was incompatible with her sense of self. Maggie/Mae needed to perceive herself as powerful, strong, and as affiliated with the father and the adult cult members. To be abused sexually and treated as if she was worthless would have been contradictory and have threatened her primary function of being able to destroy the babies’ bodies. To ensure that Maggie/Mae continued to keep herself strong, another alter was needed to fulfil the function of being sexually abused and afraid. The remorse Maggie/Mae felt for the pain that Debbie had to endure reveals Maggie/Mae’s belief that even alters that they have “created” are perceived as separate individuals with separate sensibilities and feelings. Maggie/Mae fused with Me towards the final period of therapy.

Me

The session when Me discussed her role in the creation of other alters occurred whilst Ruth was an inpatient. This was the period when Les had discussed his “creation” and the hospitalization had been a traumatic one for her in which many issues related to cult abuse had been discussed. This session occurred on the 63rd day of a 72-day admission when a significant degree of therapeutic material had been processed. The alter Me was present during all of Session 627 and she begun by discussing how she had walked into Fremantle with the inpatient excursion group that morning. She had been feeling anxious and had not slept well the previous night. Her sleep had been disturbed by a dream in which “I had a baby couldn’t look after it. Kept trying to feed it all the time so wouldn’t be hungry, but it kept falling out of its pram”. Her father was also in the dream and Me was anxious to keep him away from the baby. During the previous session she had also begun to discuss that she had created some of the alters to avoid painful experiences. Since this is the original personality discussing why she created others and this is central to the

development of this patient's alter system the session has been quoted at some length.

I did make everybody you know I don't know how know I did. Made Louise, figured W needed some help. Made Louise so she would come and see you and not W, 'cos she thinks only sex then doesn't stay, proving a problem with John. W didn't like sex so made Louise. Made Amie when something bad was happening and [this traumatic event] liked killed her so had to make Marcie but I didn't make AO or W not that I was aware of, things [were] getting harder [making them] just happened. Louise sort of made for you too, Louise able to talk to you. W finally [realized that therapist] won't sleep with her, one day 100 years knows not going to happen know, besides we needed someone like W but older to handle everyday situations. See Louise made to feel better about herself. Assume that, because I created the others. I know that because Amie couldn't handle it Marcie was created right away. I don't know that I created Amie but I created Marcie right away. Something dreadful, I was there didn't want to be. When I think of Amie I think of red. Only time I was really aware, like I was there and then I wasn't there, very clear to me. There was an animal, that's a lie, we're all animals aren't we human. That was when dad took us and married us. She didn't work out, Amie. That's why when I think of her I think...I think of red. I didn't stay round for very long. Rest, I'm not aware of how they came, maybe somebody else made them come. I went away, like being asleep sometimes, ... thinking maybe I was the baby in the dream, [had spoken briefly in early part of session of recurring dreams about babies] trying to keep myself safe. All I know we'd go out somewhere and [then] we'd be home and in my bed. And now I know what happened. Figured if stayed away wouldn't have to deal with it, didn't think for a minute that I would have to face up to it. [I was] 5 6 then 8, 9 then 13, 14, 15 then I was married can put my life into compartments. Around most of the time with Mary, when got married [and] W [used for] sex like a job, you can't do it find somebody else to do only nobody can do. I've been separate too long, I like everything as it is. Thought that you would fix me and I could do [my] own thing. I guess I'm like a drug addict, deep down I needed to look at it but I didn't want to. I don't know that I've been as dedicated. I come, wanted (therapist) to fix them up I needed you to fix them. I don't need to be integrated. I don't want to, I don't want to be all stuck together again. Be like having everybody talking at once. They don't want to die. Don't ask the little ones what they want.

Used it [dissociation] when dad was in the bathroom [this refers to an incident involving Mary and the father] when got out of the Home, in the bathroom and he attacked me. So I needed Mary to be good and

help. Can't tell you, you'll laugh. I made Mary because she's the mother of Jesus, and she can handle anything. Chris/Carol I think of darkness and lightness. Their names fit together. I put it down to being same number of letters, all about keeping balance for them. Like those toys that fit together. Amie and Marcie are red because of the redness, like their hair is red, that way I can't see what's left on them. Mary would lead you to believe that it was only that once [the abuse from the father]. I needed someone older who could do the things in the house that he wanted and I couldn't do them all myself you know so I created Mary for myself. She's better able to look after household things and family things. I never want to be around; I don't want to be around. Why can't they just talk about what happened. I'm the same as W I can't feel things. Like both of us are stuck. Inside of me I know that I'm down on the ground and I'm crying feeling sorry for myself, [but I] can't let it invade my body, won't be anyone to make it better. Like I need some physical thing to happen [self abuse], hit, yelled at, I hear those words that he called W, creating more [alters] not helpful.

Louise was needed. My body just crawls all the time hear all these words. Got it all wrong [the therapist] just because I created them doesn't mean they're not separate. Start of an evening [of cult activity, I] have Marcie, AO, Darryl more of them [if needed] to [help me] cope, Charlie, Les. I reckon Charlie created Les, end of line. Like I can't remember creating W and AO, needed somebody to be defiant, say "No!" Raging inside even though [outwardly] quiet, easier for me to say AO killed a baby than for me. Everything that went on dad [was] at start of and [the] finish of. He was the one who did these things he was the one covering us in all this stuff. ... He's my dad and I grew up thinking he hadn't done any of this.

Just because I made them, I'm separate; they had the things done to them. Only once [I was] lying against the tree and I don't want to talk about it. I just know that I had this stuff on me. ... I can ... I just feel different, I just went into [dissociated] your page [therapists note pad] ... 'cos I don't want to be scared. I had to go away, away 'cos Charlie was saying "Go on admit it, you can be a gibbering mess and break down and cry". In case you didn't understand and thought I was a nuisance, I was always thought to be a nuisance when I cried. Do you want me to go out [be present] of the paper? Still feel a bit distant but on the ground. I want to be brave, like the rest of them, still a huge part of me says I need proof someone to say "Yes, this is not imagination, this is what happened" so when I think of Steve [eldest brother]. Others tell me he did some not nice things in the house [I am] trying to avoid everything, a mother left; fancy leaving me and not caring. Even if she was not perfect she was there and what did she make me feel like – worthless. I bet she never had the courage to tell the twins that she left them when babies. Dad had to ring her [tell her] that he couldn't keep the twins. She'd gone to a

friend's house in Mosman Park. Later on she'd gone to Melbourne then New Zealand. Took two years to find out where she'd gone dad had a high-ranking policeman find her, like he would always know where I am. Scared he would come and see me here [whilst an inpatient]. Be scared. We're never to say bad things about him not good I'd be punished severely. I hate him; see him still in his 40s most of the time. See self as being in my 20s. [Patient at this time 43 her father 77.] But I don't see him like that. [I am] Scared of being angry.

The name "Me" conveyed the legitimacy of this alter's perception of herself as the original personality. Me was the enduring personality as opposed to the alters that she had created to avoid the traumatic circumstances of her childhood. During therapy Me became more "visible". Through the therapeutic process other alters discussed their experiences and their processing of such material ensured that Me was unable to avoid their experiences although she struggled to remain separate from the painful affect that they contained. At times she was angry at their insistence that she participate in their experiences. Earlier she had written:

The Main [One] me is feeling very detached from the others. Dad hasn't hurt the Main One and I get angry when one of the others take over and [I] feel the hurt and [they] lets me know how they feel. They think I'm ungrateful because they all worked together to survive and I want them to disappear. I'm tired of feeling sick all the time as well as feeling panic that's churning inside me all the time.

The Main One's name reflected her central purpose of being a support to Me. MO was the alter that was present within the home and who along with Mary would remain naive of cult and parental abuse. The Main One and Mary dealt with the everyday tasks of the home and further isolated Me from having to confront daily reality. Me "created" the alters MO and Mary to avoid being present so that she could dissociate from the pain of the abuse whilst maintaining an outward appearance of normalcy. Her desire was to not be present as a sentient being. These characteristics of Me/MO are important in shaping treatment and its eventual resolution. During Session 371, for example, whilst discussing Darryl, Me/MO stated.

Not one of us, that is really doing what they want to do. I have the ability of not seeing him [Darryl] so nothing, including me, is real. ... We could just be pencil drawings that you could rub out replace. Nobody feels [they] has rights. Only time say "No" is out of sheer panic of doing it. Totally frighten of the whole thing. Don't you see ... makes me hurt if I say it, even to myself? What he did it makes it real, it makes it real and I don't want it to be real.

The above passage graphically illustrated the purpose of the alter system in this patient: to avoid the pain that this patient had experienced. The patient continued to express her desire to avoid the intense affect that was the consequences of the abuse and was extremely concerned that she would not be able to cope with "knowing".

I don't know if I can cope with believing like all of my life would change. I just want my life to be normal. ... Of course I know but I couldn't stop it from happening but going away and I didn't have to do a Mary thing and re-experience all this stuff. I don't know what is mine - none.

The alter system of this patient was "created" to avoid pain and in response to traumatic events over which the patient had little control. As the abuse continued more alters with specialist roles were "created": This appeared to have been a spontaneous process in which alters were created in response to traumatic events. There also, however, appears to be some evidence of the deliberate conscious creation of alters by Me such as Louise. Me, however, did not retain complete control over this system with some alters such as Marcie and AO "taking on a life of their own". Me, as revealed in her more open moments, is aware of the other alters and the pain that they contain. But she assigned the pain to others so that she can continue with her life. She did not wish, understandably, to cope with the intensity of such knowledge and though in Session 627 she appeared to be close to resolution, her treatment was only half way towards conclusion and the desire not to make "it real" persisted until it could no longer be ignored. This was largely at the persistence of other alters. Integration had never been the focus of treatment and whilst the possibility of it had been discussed, the patient was aware that treatment was at her

pace and its conclusion her decision. The process of this and the material examined in this chapter will be discussed further in Chapter 7.

In the following section the material discussed in this chapter is considered against the various models of DID.

6.4 Different Models of DID

The therapeutic material discussed in this chapter is examined here to assess with which model of DID it is most consistent. The material is examined against the DID model described by Kluft (1996a & 1996b, 1984a), Putnam (1989a), and Ross (1997). The material is also consideration against the trauma model described by van der Kolk (1996), and the iatrogenic model (i.e., McHugh, 1995; Mersky, 1995b). Since the DID model is the main concern of this thesis the material is measured against this model in more detail.

The DID Model

The major tenets of the DID model are that it is a dissociative response occurring early in childhood in which alternative personalities arise in the context of severe trauma. The adaptive and defensive aspects of severe dissociation become elaborated with time and lead to the development of an alter system (Putnam, 1997; Ross, 1997). The assertions of the DID model are compared with the findings of this study.

Age Alters First Evident in this Patient

Spiegel (1984) suggested that individuals subjected to recurring trauma early in life (5 or 6 years) are more prone to the spatial fragmentation of the personality that is typical of DID. Whilst those who have passed through the major developmental stages before being subjected to trauma, experience temporal

fragmentation or other more circumscribed dissociative symptoms (McWilliams, 1994). Whilst it is not possible to validate retrospectively the patient's age when the first alters were created, the therapeutic material is consistent with that reported in the literature. Ruth's age when the first alter presented is unknown. However, all central alters within the system were present by 10 years of age. The ages of the earliest alters, Baby, Angel and the Body are unknown but the alter Angel was described by other alters as being 2 years of age. The patient first discussed memories of abuse around the age of 3-5 years. The youngest alter that spoke to the therapist was Chris/Carol with Chris having been created before Carol. These alters consistently reported memories from the ages 4 to 6 years with Chris having been described by other alters as containing some memories from the age of 3 years. The alter Chris was present for the early abuse within the home and Chris/Carol also retained memories of the maternal grandfather's abuse when the patient was aged 5 years.

The DID literature is not clear as to whether the age of an alter is consistent with the actual age of the original personality at the time of the traumatic event that created them. The data here do suggest that the age of the alters is consistent with that of the patient at the time that they were created and that they reported traumatic events. Alters such as Chris/Carol never progressed developmentally during therapy and retained only memories of abuse related to their particular phase of development. The abuse that they reported occurred at this time in the patient's developmental history. Some alters such as AO who had a broader age range, described herself as aged from approximately 7 to 15 years. W perceived herself, until her fusion with Mary, as perpetually aged 17 having been born around 8 years of age. These alters had a continuing purpose in the patient's life outside of the cult abuse whereas alters such as Les only emerged in response to specific cult activities. He perceived himself as aged 6-9 years, this being the period that he was active in the particular aspects of cult activities for which he had been created. This is also within the period that the patient alleged that abuse occurred and within which other alters discussed cult sacrifices of babies. In this regard the creation age of the alter reflected the actual age of the patient at the time of the alter's creation. Some alters however, continued to develop depending on the purpose for which they had been created.

Development of Alter Personalities in this Patient

Putnam (1997) proposed that severe trauma creates a state of dissociative consciousness. When the traumatic events are chronic and repetitive, an alter personality system develops with each alter becoming increasingly differentiated and assuming specific functions and characteristics. Hence, memories for a particular traumatic event become dependent on the particular alter personality created at the time of that event and description of such events is not readily available from other alters which have been created to cope with other specific traumatic events.

The therapeutic material of this patient is consistent with Putnam's proposition. All alters, apart from Me/MO and Mary, reported severe abuse and the creation of those alters discussed in the previous section, reputedly was in response to severe traumatic events. Alters such as Amie and Marcie emerged in response to the same traumatic event, Amie being unable to contain the over whelming nature of the trauma event on her own. The discovery of joint alters in this patient's alter system is also consistent with this proposition. Joint alters reported the most traumatic events when the support of another alter was necessary for the patient to contain the inexorable essence of the traumatic event. The original personality, Me also discussed her need to "create" others in order to protect herself from experiencing the consequences of the abuse. The main task of alter creation is to protect the original personality from knowledge, and hence the emotional consequence, of the traumatic event (Haddock, 2001). In this patient, further alters were created when the traumatic event was overwhelming for them, or incongruent with a particular alter's purpose. When Me was in danger of being overwhelmed by the impact of the trauma another alter was created to protect her. In response to particularly severe and prolonged traumatic events such as the ritualistic sacrificing of babies, several alters were created, each containing specific aspects of the traumatic event and each alter unaware of the existence of the other. For example, AO was present at the initiation of cult sacrifices prior to the emergence of alters Les/Charlie, Maggie/Mae and Darryl to contain different aspects of the traumatic event. AO then "re-emerged" when the ceremony was complete but with little comprehension of the sequence that had occurred. Hence, each alter contained a

different aspect of the trauma that needed to be explored in order to progress therapy. This process is discussed in more detail in Chapter 7.

Central alters as depicted in Figure 4 contained the most comprehensive aspects of the abuse. The alters that developed from them contain specific aspects of the traumatic events whereas the central alters had a cohesive role both in the patient's life and in the functioning of the alter system. Central alters such as AO had a prominent role, particularly during the period that the patient lived with the father and were able to respond with a significant degree of autonomy. Their responses were based on their own particular characteristics so that they were able to respond in a manner that the original personality was unable or unwilling to. AO for example stated that "I don't think Me made all of us, [she] made the start of us and [then] we made ourselves. When things got too much for Marcie, and Amie, I [AO] came. They couldn't take it any more their minds went". At times alters had executive control over the patient, leaving her with time lapses so that she found herself in circumstances that she was unable to explain.

The fragmented alters related to Me/MO depicted in Figure 4 contained particular emotional fragments of the trauma not fully contained by other alters. Their importance is in the link they had with Me/MO in progressing treatment. They contained emotional states experienced during the transition from one alter to the creation of another. These unresolved states did not "belong" to the emerging alter and it was during these moments that the original personality was most susceptible to feeling the impact of the traumatic event and retaining some knowledge of it. This is discussed in more detail in Chapter 7.

Development of Alter Personalities over this Patient's Life Span

Whilst several theories have been proposed to explain the development of alter personalities, Pica (1999), a researcher in the area of DID, stated that there was little research on how alters developed over the patient's life span and why the disorder becomes more complex after childhood. Pica believed that many questions

regarding the development and function of alter personalities (such as whether alter personalities are formed by a gradual process of increasing differentiation or appear as fully differentiated separate identities) remain unanswered and required further research. This patient's material is examined for any contribution that it might make to the issues raised by Pica.

In her initial presentation the patient showed and described many of the depleted characteristics described by Schreiber (1973). She presented as dependent with a chronic history of anxiety and phobias. She had spent most of her adult life attempting to disavow such emotional states as anger, depression, or sexuality. It is likely that she would have continued to cope in this manner if not for the death of her childhood friend. The patient's alter system appeared to have been completed by the age of 10 with the exception of the alter Louise who was created during the course of therapy. The patient was exposed to cult abuse from approximately the age of 5 to 11 years and during this period 26 of the 31 alters were created. Before and after this period, the abuse was confined to the home. When, at the age of 12 years, she returned home from the Salvation Army Home, her father involved her in prostitution. This abuse was contained by existing alters such as W and no other alters were created to cope with the resulting trauma. The development of this patient's alter system was determined and sustained by the ongoing nature of the cult and the father's abuse. When the abuse ceased, those alters created to contain it no longer played an overt role in the patient's life though their presence continued to exert a negative influence in her life contributing to constant feelings of depression, depletion, isolation and a fragmented sense of self. Those child alters such as Chris/Carol retained the childlike quality of their convictions since their beliefs and fears were rarely exposed to the patient's daily life except when specific triggers such as the smell of meat, crowds, or being in a confined space occurred. The patient "learned" to cope with such events by avoiding places where such experiences were likely. Thus those alters created to maintain a sense of "normalcy" in this patient's life, such as Me/MO and Mary, were prominent.

Those alters that had dealings with the continuing life of the patient did develop in response to the demands made upon them, but their development

appeared to have been within their prescribed roles. The Main One for example, continued to run the home. The death of the patient's friend had brought her to therapy having caused a fragmentation of the patient's alter system and consequently her sense of self. Her friend's death initiated long dissociated memories of childhood. This friend had functioned as an idealized selfobject for Ruth and her death shattered this transference. The sense of fragmentation was such that the alter Me/MO was no longer able to sufficiently dissociate from the affect held by others within the alter system. W had caused some problems for the patient in her life in relationships but the central alters of Me/MO and Mary were dominant and focused on maintaining balance, stability and order. The majority of the alters were not needed once the abuse ceased and Me's ability for disavowal and dissociation meant that some stability was maintained with the patient following her husband's lead in most decisions.

Two factors that were significant in contributing to this patient's improved well-being were her father's second marriage and her marriage to John. The father remarried when the patient was 15 and though abuse within the home continued covertly it was at a significantly reduced rate and did not contain the same level of terror as that of the cult abuse. The stepmother does not appear to have been involved in cult activity and the patient formed a close relationship with her. The fact that Ruth married when she was aged 17 years meant that she left home at a relatively young age and though she retained a close relationship with her father she was not directly under his influence. Her husband was unaware of her history and was supportive of her.

A second issue raised by Pica (1999) regarding whether alter formation is a gradual process of increasing differentiation or one where alters appear as fully differentiated separate identities, is considered in the material from this patient. The description of the creation of several alters in the previous section suggested that these alters at least were formed fully differentiated. U Gin's role, for example, was circumscribed and in large part defined by the actions of the cult. She was not expected to take an active part but rather to be the unwilling recipient of cult demands. Her purpose did not require any "learning", rather the ability to endure; in

this regard she was created fully differentiated and never “developed” other functions within the alter system. The reason for her creation was to take the emotional and physical pains that other alters, such as Chris, were unable to absorb. Joint alters such as Les/Charlie also appeared to have been created fully differentiated and contained a purpose unique to them. The alter AO was unable to contain the trauma of the cat’s disembowelment; the consternation of this was incongruent with AO’s purpose within the alter system and led to the creation of an alter who could contain this traumatic event. When the alter Les later had to contain the horror of ritualistic scarification Charlie was created to support him. The alters Maggie/Mae were also created for a specific purpose, to contain the affect from the pulverization of babies which AO was unable to contain. In this case there does seem to have been some ongoing development with the alters Debbie/Bub created by Maggie to contain aspects of the trauma that she was unable to tolerate.

That fact that other alters needed to be created, rather than for example, the alters Les/Charlie being able to tolerate all such traumatic events, suggests that these alters, at least, were formed as differentiated separate identities to achieve the specific purpose that they were created for. Whether they were “successful” in this depended on the nature of the circumstances and the alter’s capacity to contain or manage it. That specific alters needed to be created rather than one alter being able to adapt to all circumstances is supportive of the position that alters are formed as fully differentiated separate identities, however, their perception of themselves was dependent on the response that they received from the father. Alters such as the persecutory ones, for example, received praise for their behaviours and this shaped the positive manner in which they perceived themselves and assisted to differentiate them from other alters. Conversely, those alters that were repeatedly abused by the father developed a negative sense of self that continued to be shaped by the ongoing nature of the abuse.

Alters such as Me/MO and Mary who were not involved in cult activities did develop further in their roles and in their differentiation though this was predominantly by dissociating themselves from the actions of the others. When Me/MO and Mary were no longer able to deny the existence of other alters they

blamed them for the father's response and dissociated themselves from it. The roles of those alters that were involved in both cult and home activities and continued (albeit covertly) to have a purpose in the patient's adult life, such as AO and W, did become differentiated. They had to mature and adjust to the patient's changing circumstance though their basic purpose remained fixed.

The alter system of this patient appears to have been created initially in response to a specific traumatic event that the alter who was present at that time was unable to contain. It is also suggested that no other alter within the system was capable of containing this particular form of trauma at the time as it was incongruent with each of the other alters' particular personality. In this sense the formation of the alter system was to provide the patient with a sufficiently complex array of alter personalities to deal with the enduring nature of the different traumatic events. An alter is not, however, formed with exact awareness of what to do. Les/Charlie, for example, did not possess innate knowledge of ritualistic scarification but rather they were formed with the ability to contain their emotions sufficiently to be able to do the task. In this sense they did become more differentiated but their creation was also to contain the emotional state that such actions activated. Alter differentiation did develop however within the alter system. AO was formed, for example, to manage the global containment of anger rather than affect from a specific act. Such a capacity to hold emotion is required in a diversity of situations and is not limited to one particular traumatic event. The difficulty for the patient in expressing appropriate anger, however, was that for AO anger tended to be related to the traumatic events to which she had been exposed and therefore when expressed, it was frequently disproportionate to the patient's daily life. This tended to reinforce Me/MO's difficulty in expressing anger since she often felt its production was disproportionate to the event.

If alters are formed fully differentiated it is still likely that their particular role can develop over time and that their role and purpose is shaped and discerned by events. Whether they then develop further or have a more complex role within the alter system depends on the situation and circumstances. During treatment alters in this patient's alter system tended to retain the individual sense of purpose for which

each had been formed. What changed in the course of therapy was the ability for each alter to “re-connect” with the affect that they had contained and from which they had necessarily dissociated. Here the patient actively used the alter system to protect herself from knowing of the abuse and the emotional pain that such knowledge brought, and it was only when the differentiation began to break down that alters with common experience were able to fuse and eventually integrate. Therapy, in this sense constituted an “undoing” of the dissociative process by bringing the dissociated affect to the patient’s awareness together with the traumatic event that forced the disassociation.

Development of Specific Types of Alters in this Patient

Putnam (1997) reported that the presence of particular types of alters such as child-like personality states, angry alters, protector alters, and persecutory alters are frequently reported in the literature and warrant further investigation. The presence of these particular types of alters are examined in this patient’s material.

Those alters that would be considered child-like in this patient were Baby, Angel, The Body, and Chris/Carol. Though Amie was also a child-like, alter her creation marked a transition to cult abuse and the development of another layer of alters within this patient’s alter system. As previously discussed, the actual developmental age of the patient seemed congruent with the development of child-like alters in this patient and reflected her emotional state at the time that they were created. They retained the traumatic events that occurred at this stage of the patient’s development and since the emotional consequence of the traumatic events, which they had been created to contain, had not been resolved they remained dissociated within the patient’s alter system.

The development of angry alters such as AO also overlapped with the persecutory alters, both containing a degree of anger towards the original personality. Within the system AO represented a powerful force that had retained a sense of identity and vitality in contrast to the depleted affect of Me. AO provided the initial

impetus towards good health and healthy self-esteem. This alter, however, as with other persecutory alters, contained a deep feeling of guilt and shame for her participation in cult activities. Anger was also a frightening emotion to the original personality, since to hold and express such a strong emotion would have made her vulnerable to further abuse from the father. AO assisted the alter system to retain a sense of volition whilst safely containing a powerful emotion which if openly expressed would have led to further abuse.

The main protector alter was Mary. Her role was that of a protector to the children within the system. As previously stated she developed out of the need to take the role of a mother within the home. The alters Chris/Carol described themselves as hiding under her skirt when they were frightened by Darryl. Mary based herself on the Virgin Mary and sought to only see goodness in others. Her purpose was to be a “good” comforting mother to the child alters. In this regard she also had a major role in raising her biological children and applied many of the principles to her own home and family life. In this sense protector alters functioned as a soothing selfobject within the alter system, a function that was predominantly absent during the patient’s childhood.

The primary persecutory alters in this patient’s alter system were Darryl, Les/Charlie, Maggie/Mae, Young Bert, and Serpent. It was these alters that persuaded the patient to attempt suicide on seven occasions (see Table VIII, Chapter 7) and to engage habitually in self-harm behaviour. The function of such internal persecutory alters would, as Putnam (1989a) observed, appear to be in contradiction of their initial adaptive purpose. Initially, they had been created to contain traumatic events that other alters could not contain. Persecutory alters contained some of the most horrific ritualistic aspects of the cult ceremonies and they resolutely identified with the father. The cult, as reported by the patient, was strictly hierarchical; the father being its leader and he and other males performed many of the ritualistic ceremonies. The persecutory alters were also predominantly male. The attempts of these alters to encourage other alters to self-harm enhanced their sense of power and identification with the father. The alter Darryl, for example, participated in ritualistic ceremonies occurring after human and animal sacrifices. Through such participation

he was praised by the father and by the other cult members. His action in encouraging other alters to self-harm or to commit suicide was to behave as a cult leader and to protect the cult. The persecutory alters maintained a sense of pride in their achievements. Darryl, for example, felt that he was a privileged holder of cult secrets and his identification with the father imbued him with a sense of belonging. More important, however, was the belief that through his actions he would gain his father's love and approval. This was also the case for other persecutory alters such as Les/Charlie, Maggie/Mae, and Young Bert who also had specialist ritualistic roles and initially perceived themselves to be held as special by the father. Their initial persecutory responses towards other alters were in character with their perceived purpose within the cult which included the protection of the cult's secrets.

The first persecutory alter to present in therapy was Darryl who expressed aggression towards the child-like alters and towards Amie, Marcie and AO. As the dissociative barriers began to be permeated, the later emerging persecutory alters expressed their anger towards the alter Me, whom they blamed for their creation and therefore for the pain that they had to contain. They continued to perceive themselves as separate, yet identified Me and her inability to respond to the demands of the cult, as the reason for their creation. They blamed Me for not being willing to contain the affect that they now held. When these alters engaged in the therapeutic process what emerged was "frightened children" (Ross, 1997) who reverted to the original emotional state (fear) out of which they had been formed.

The alter system in this patient was a dynamic one. Child-like alters were created early in the patient's development. They reflected the concerns and aspirations of the patient as a child. The protector alters developed out of a need to fulfil a "mothering" role and as an attempt to provide nurturance to the child alters. The angry alters contained the sense of injustice and anger that could not be openly expressed for fear of its consequences. The persecutor alters contained mixed emotions. They identified with the father and the need to keep the secrets of the cult safe. The harming of other alters was their attempt to maintain the cult's secrets and increasingly to protect themselves against their own feelings of guilt and shame. As therapy progressed they also expressed deep anger that Me had created them and

therefore was responsible for the pain that they now felt and they wanted her to feel their pain.

Structure of the Alter System in this Patient

Though DID cases with dozens or scores of alter personalities have been reported the mode is three and the median typically eight-10 (Kluft, 1991; Putnam et al., 1986; Ross et al., 1989b). In this study there were 31 alters of which seven were classified as central. This patient had more alters than typically reported. This is concomitant however with the severe nature of ritualistic abuse. Kluft (1998), for example, emphasized that when the trauma has been severe and chronic the alter system is more complex and layered. Coons (1997) noted that ritualistic abuse is at the extreme end of trauma and one of the most severe forms of abuse reported by people suffering from DID. In such patients the alter system is more complex than in other DID patients and likely to have a greater number of alters as well as the most virulent persecutor alters (Mollon, 1996).

As depicted in Figure 4, the alter system of this patient is layered with particular groups of alters having formed alliances. Some groups experienced themselves as an inner family which contained particular aspects of the patient's life (Kluft, 1991). Me/MO and Mary contained the aspects of daily life and were largely unaware of the abuse. Child alters also constituted a specific group and had links to Mary, W and AO. Alters from Chris/Carol onwards had varying knowledge of the abuse but none contained it all. U Gin for example retained knowledge that none of the other alters had. The persecutory alters did not appear to have a group alliance within the alter system but rather they were created to handle specific aspects of cult ceremonies involving the ritualistic sacrifice of babies.

The patient's report of ritualistic abuse is consistent with that described in the literature (Fraser, 1997b; Katchen & Sakheim, 1992; van der Hart et al., 1997). Van der Hart et al. considered that the alter systems for ritualistically abused patients are usually layered with different sub-systems of alter personalities. Within these sub-

systems four different types of abuse are commonly reported: (1) abuse taking place in the home, (2) ritual abuse associated with satanic worship, (3) pornography and prostitution, and (4) some form of mind control.

For this patient the basic sub-system for abuse that took place in the home included Baby, Angel, The Body, Chris/Carol, Me/MO, Mary, AO and W. The alters Me/MO and Mary represented a separate sub-system within this grouping. They did not contain memories of abuse within the home, at least initially, whereas the other alters were aware of both home and cult abuse (see Table VI). The alters Me/MO and Mary felt that any abuse occurring within the home to other alters must have been a mistake or an accident that was misunderstood by these alters. The alters Me/MO, and to a lesser degree Mary, were not present when alters were discussing ritualistic abuse (van der Hart et al., 1997) and they remained absent till the later phases of therapy when the dissociative process began to be permeated. This is discussed in Chapter 7.

Those alters involved in the ritualistic abuse reported participation in rituals that included chants and symbols that were associated with Satanic worship. These alters reported having witnessed and participated in the torturing and sacrifice of animals, babies and fetuses, and were forced into acts of cannibalism and the ingestion of blood and urine obtained from humans and animals. During the reporting of such traumatic events, the patient was extremely anxious and had difficulty in discussing her experiences without dissociating and re-experiencing events as if they were still happening. She related some of this material in her drawings (see Appendix F).

The alters that reported pornography and prostitution were Amie, Marcie and W. They reported photographs being taken some of which were later shown to them as proof of their “badness”. The father involved the patient in child prostitution both within and outside of cult activities.

The patient was repeatedly involved in mind control techniques to ensure her loyalty to the cult and her silence. Many of the techniques have already been discussed in the body of the thesis. She was frequently isolated, buried in “coffins”, and told that Satan or his representative (i.e., the use of snakes) was inside of her. At times she reported the use of alcohol and drugs to sedate or make her more amenable. On occasions electrical wires were attached to a battery and placed in her vagina so that she received electrical shocks that stimulated urination or simulated an orgasm. Such techniques encouraged the patient to believe that she had no control over her body functioning. Cult leaders used various techniques to force her to comply such as the use of a bicycle pump, telling her that she would die if they continued to pump air into her vagina. Verbal and physical abuse was independent of her behaviour and responses praised at one moment would subsequently incur abuse. Her father also controlled her use of the toilet and encouraged constipation. On weekends she was given laxatives that caused her to defecate during cult activities. Faecal material was smeared over her inducing vomit whilst she was told that she was “A fucking piece of shit!”. She was encouraged to perceive that the cult had control of her body functioning rather than she herself. She was constantly humiliated and dehumanised and whilst the patient was exposed to systematic and deliberate mind control techniques by the cult there was no evidence that they were aware of the implications of DID. There was no indication that the cult or father were aware of the presence of alters or that there was an ongoing process to develop them. There was an intention by the cult to encourage dissociation though it is not probable that they would have realized the implication of this in regard to contemporary understandings of DID. They did understand however the processes of mind control techniques in ensuring compliance and allegiance.

One of the most important components in mind control was the inculcation of guilt in the patient. She was forced to commit atrocities by adults who would then point out how evil she was to have done these things. For example, Ruth was forced to scarify several babies ritualistically and then told that she was evil. Similarly, when forced to watch the dog being skinned she was told that they were punishing the dog because she had allowed it to have sex with her. It was then her “choice” whether to kill the dog or continue to let it suffer. Being forced to participate in such

rituals also undermined her sense of being a moral person (Fraser, 1997b) and it was constantly reinforced that she belonged to the father and to Satan.

For this patient the traumatic event appeared to have been the impetus that created a desire to be emotionally separate from the event. The trauma model of dissociation and its relevance to this patient's material is considered in the following section.

Trauma Model

The trauma model as discussed by researchers such as van der Kolk et al. (1996) (see Chapter 1) suggested a neurological underpinning for the processing of traumatic events, particularly for Post Traumatic Stress Disorders (PTSD). The similarities between PTSD and dissociative processes led several researchers to see this research as a model for trauma related disorders such as DID (Herman, 1992; Nijenhuis et al., 1998). At the core of this model is the recognition that there are different kinds of memory dependent on different brain systems. Of most interest to research on the processing of trauma has been the distinction between explicit and implicit memory (Bremner, 1999; Parkin, 1999; Zola, 1997). Explicit, conscious or declarative memory is mediated by the hippocampus and related cortical areas, whereas implicit or unconscious forms of memory are mediated by different systems (Bremner, 1999). One implicit memory system is an emotional (fear) memory system involving the amygdala and related areas (Davis, 1997; Davis & Whalen, 2001; Schacter, 1996). In traumatic situations, implicit and explicit memory systems function in parallel (LeDoux, 1996). Subsequently, stimuli similar to those experienced in the original trauma can activate both the explicit memories of the event and the implicit emotions associated with them; such memories are described in the literature as "flashbacks".

During a flashback it is as if the historical traumatic event is occurring in the present moment and it becomes the stimulus for continuing emotional responses that persist in traumatizing the individual (Cozolino, 2002). The individual experiences

traumatic flashbacks with such realism and intensity that, for the patient, they are difficult to distinguish from present reality (Rothschild, 2000). The way the traumatic memories of this patient unfolded were consistent with that described by researchers and her memories were initially expressed in flashbacks typical of PTSD. The child-like alters, for example, such as Baby Angel and The Body, had no narrative of their experiences. Their traumatic experiences were held in the implicit memory. In part this probably reflected the patient's developmental age when these alters were first created prior to language development whereas those alters created later did have some explicit memory but also were overwhelmed with affect when past traumas were triggered.

During therapy, the memories of one alter about a traumatic event frequently led to a flashback for another alter to that or a similarly affectively charged event. The traumatic affect contained by U Gin was to some degree triggered by Me's anger when remembering her father's abuse of her. Such feelings triggered experiences of the father's apparent anger when he had said "You fucking Gin" the words that U Gin associated with her creation. Each alter acted as a trigger for the other when similar emotional states transpired. Amie and Marcie's creation was "re-experienced" by them during a session when similar emotional states were triggered by Carol's fear of Darryl.

Alters that contained some of the more horrific aspects of the cult abuse first emerged in the later phases of therapy when the patient was sufficiently contained by the therapeutic process and able to process the inexorable trauma held by her. At times the patient was so overwhelmed by traumatic experiences that she was barely able to respond above a whisper, sob, grunt, or rocking. The therapeutic role here was one of soothing until the patient was sufficiently able to process the amygdala-mediated material. These alters would return numerous times to the events that troubled them. Each time it was as if the event was again occurring. In processing the traumatic experiences each alter needed to re-engage with the affect that it held. Traumatic material is processed by the amygdala system and later contextualized by the hippocampal system which regulates and modulates the traumatic material and assists in bringing it to consciousness (Cozolino, 2002). It was more difficult for the

patient to process the implicit material than that stored in the explicit system. It was this that the alter Me had most difficulty with and it was this that she had developed an alter system from which to protect herself. Both systems, of course, act in parallel one triggering the other. The patient did have a narrative though not for all the experiences and it was frequently only when material related to particular abuse was being discussed by a particular alter that other alters who had been till then unknown to the presenting alter, discussed further detail. AO, for example, re-experiencing the trauma of cult sacrifices later in therapy, was the trigger for other alters such as Les/Charlie and Maggie/Mae to emerge when the events being recalled in the therapeutic situation by AO triggered memories of the events that they had experienced. For these alters, as with many of the fragmented alters, it was the telling that provided a context, however painful, to the other alters and to the system as a whole for the progression of this patient's treatment.

This patient's behaviour in her recall of traumatic events is consistent with the literature on PTSD. She re-experienced most traumatic events as if the event were actually happening at that moment and there was a clear difference between the processing of implicit and explicit regulated material. The model of trauma discussed above and the DID model are not opposed but rather relate to different aspects of the whole and both illuminate the experience of trauma and, it is argued, this particular case. Before considering the treatment of this patient in more detail the material discussed so far is considered against the iatrogenic model of DID.

Therapist Bias

The hypothesis that the emergence of alters is the result of therapist bias was tested in the first phase of this study. This issue is returned to in the following chapters. In this section the creation of the alter, Louise, during the course of therapy is examined.

Concern that therapeutic intervention might exacerbate dissociative processes is evident in the literature and is of particular importance to therapists working in the

area of DID. Putnam (1989a) identified possible iatrogenesis and exacerbation of symptoms as the most common fears of therapists beginning to work with DID. Putnam (p. 132) argued that though new alters may be created in therapy most alters within the system “will have a history that predates the diagnosis and therapy by many years”.

The material discussed by this patient is consistent with this finding except for the alter, Louise, who was created during therapy. This alter does present some evidence for the iatrogenic creation of alters. She presented on eight occasions the first being during session 537 though the alter Me/MO had referred to her two sessions earlier. Her last presentation was in session 577. During her initial presentation she had described herself as a more sophisticated version of W. Her opening comments were: “Well, I’m here now what do I do?”. She also discussed that she was “so different from them [other alters]” and that she would “appear” when somebody who was “not stupid” was required. She described herself as older than W and as “better able to handle things” having been created because “couldn’t have W running round touching men”.

During this and subsequent presentations she did not manifest the strong affect that had generally marked the emergence of other alters and she reported no traumatic reasons for her creation. Nevertheless, the therapist was not aware that Louise had been created during the course of therapy. She next presented in session 540 stating “I guess I’m the best person. I had no abuse whatsoever, [which is] why I know things. [I am] A latecomer [I] came round stop W making a fool of herself. She would sleep with Paul [a relative] if he persisted. I would come round say ‘you can flirt with him but not sleep with him’”.

During her third presentation, session 545 she used make-up, which was not how other alters had usually presented and during the next two sessions she discussed that “We’re all shit scared of feeling anything”. AO was angry at this turn of events and stated that W had not been around because Louise was taking over. During session 555 Louise discussed aspects of W’s abortion occurring at Peggy’s

and that had resulted in the father going overseas and the patient being placed in the Salvation Army Home. When W discussed this event it had been accompanied with overwhelming affect. When Louise talked of the abortion she did so with some difficulty but in a more detached manner than W ever could.

Feel like I was telling a story, don't feel it. I question how I know it happened if I wasn't there. Is it because I've been listening but I don't think so? I wouldn't have my heart racing and things like that. Like I can put my hands out and touch the wood [the bed head board W had referred to this in previous sessions]. AO can be most unkind "You're a lying bitch, you were there you just don't want to feel it want W to." Stick to adult feelings. See myself, if even remotely feel this I would crumble. Probably sit on the floor and sob my heart out, think if help W feel it she'll be alright. Feel, with some restraint, me. [But] I can't physically stand in W's body but she can stand in mine, but fall out or I kick her [out]. I always think I'm not connected to her, but I am. I have a lot of the feelings W has about things. I would do things a little different that's all, a little more subtle. I would have you believe that I have wonderful qualities. Like W will ask you to sleep with her but I want but I don't ask. Like you take your dog for a walk let off lead but have to put on too. I want people to look at me say you are a good person kind, sensitive, sensible. I get scared by what I feel, sometimes I get really angry.

She came to the following session but did not talk much except to say that she understood events of the abortion that had confused W. During the following session she appeared briefly saying that she had "all these inside voices telling me better perk up. [About] Peggy's place ... just sort of bothers me". The last session that she presented was also relatively brief and she began saying:

[It is] Ages since I've seen you. I've been married 26 years today. Too scared to show feelings, be hurt. I feel so totally separate from what W went through. I understand what she is. She needs acceptance otherwise be nothing but a frightened child if she's out asks John everyday does he love her? I get so down when I think of her, all she wants is for you to love her. She's [W] going to kill us because she feels so hurt and rejected by you and dad. I'm being very serious she'll never grow old and big.

The alter Me discussed the creation of Louise during sessions 626 and 627. Louise was created, in part, to please the therapist by presenting a more

“sophisticated” version of W. She did this to cope with the rejection that she perceived from the therapist and her father. W’s relationship with her father and with males within the cult was based on her sexuality. The only time that the father was “attentive” was when he sexually abused her. This she associated with being loved. A similar issue had formed the bases of her experiences within the cult and was one that she had extended to her adult life. Issues of W’s sexuality had emerged early in therapy with the alter Mary being concerned that the therapist would be unable to resist W’s seductive advances if she ever presented in therapy. This had also been an issue during a previous therapeutic treatment when she “fell in love” with the psychiatrist who was treating her for post partum depression. W perceived herself as having a close relationship with her father. She loved him and craved his love. She perceived his sexual abuse of her as an indication of his love and she brought this to her relationships with others including the therapist. W experienced the therapeutic stance of the therapist as a rejection of her because her self worth was based on her “desirability”.

Perhaps more importantly, Louise was also created so that the alter Me could emotionally distance herself from the traumatic material that W was struggling with. Louise first appeared during a period when W had been re-experiencing the trauma of the abortion. This revived memories of her father’s abandonment of her at this time and the growing realization of the true nature of his relationship with her. Such awareness was a threat to the alter Me/MO who wished to keep such painful held memories from awareness.

The observation of Kluft (1995) that patients can form new alters in response to external circumstances is supported here. Louise’s creation, however, did have adaptive purposes that assisted her to cope with such circumstances. She did not make any claims regarding traumatic material but rather wished to feel “So totally separate from what W went through”. That she was able to reveal the creation of this alter is indicative that the patient was not creating alters ad hoc. This alter was also different from other alters and did not present with the same level of affect that they had when discussing traumatic events “Like I’m telling a story, I don’t feel it”. She

was also similar to Me in her fear of gaining awareness over painful affect “I get scared by what I feel” and the alter ceased to present or be part of the alter system.

6.5 Summary

Factors that contributed to the development of alter personalities in this patient were:

1. Traumatic events within the home that occurred at an early age.
2. The absence of a protective adult in the patient’s life.
3. Parental abuse particularly by the father.
4. Persistent and consistent abuse that was ritualistic in nature.
5. The development of a “layered” and complex alter system to cope with overwhelming traumatic events.
6. Central alters developed in response to specific traumatic events.
7. The creation of most alters was a spontaneous process though some were created consciously by the original personality.
8. The original personality did not retain control over the alter system and some alters took “on a life of their own”.
9. The original personality used the alter system to avoid knowledge of the abuse and to avoid the emotional pain that such knowledge brought.
10. The patient’s history is consistent with both DID and Trauma models of dissociation.

In the following chapter the research question regarding what indications there are for a process of therapeutic integration are considered.

CHAPTER SEVEN

7.0 RESEARCH QUESTION FOUR:

What Indications are there for a Process of Therapeutic Integration with this Patient?

Overview

In this chapter the remaining research question is addressed. Discussion of this patient's treatment is divided into two sections. In the first section consideration is given to whether the patient's therapeutic material is consistent with the existing literature on the treatment of DID and with the literature on DID patients reporting ritualistic abuse. Greaves' (1989) markers of integration are then compared with the data from this patient and the self psychology methodology is briefly discussed. In the second section, the treatment of this patient is considered. The period of the patient's treatment and hospitalization is documented, her self-harm and attempted suicides are described, and possible factors that contributed to them examined. Finally, the integration process in the treatment of this patient is analysed.

7.1 Treatment Approaches

Kluft (1999a) described three types of DID patients, each with different characteristics and treatment prognosis. The first type was relatively high-functioning individuals with many assets and psychological strengths. They usually integrated and completed treatment in two to seven years. The second group had fewer psychological resources and presented with more borderline features than the

first group. There is usually considerable co-morbidity, and interpersonal relationships are often difficult with marked dependency issues frequently evident. The treatment course of this type is more difficult than for the first group and though some may reach integration, most remain unstable for long periods and require ongoing supportive help. Kluft reported that for this group only a few would reach integration and that their treatment was more difficult than the first group with most remaining unstable for long periods. Kluft's third group comprised patients with the most severe pathology, many of whom manifested psychotic symptoms with only a minority progressing to integration.

This patient, whilst relatively high functioning and possessing many assets and psychological strengths, also possessed many of the characteristics of the second group described by Kluft. There was co-morbidity with this patient reporting several other symptoms and marked dependency issues that, for example, had been reported by her treating psychiatrist in 1984. The present therapist, during the initial intake interview and during the course of therapy, also observed a degree of dependency. She had relied heavily on her husband to make family decisions and generally had subsumed a compliant role within her relationships with others. There was an expectation that the therapist would assume a similar role, however, she was also able to form a healthy transference with the therapist (as evident by her ability to maintain focus on therapeutic material whilst continuing to produce material capable of being analyzed), and much of her dependency, in retrospect, could be understood in the context of her childhood years. However, this patient also possessed many assets and psychological strengths that tended to predominate. Ruth did manifest some psychotic features during the final stages of therapy before integration. This patient's characteristics would appear to fit somewhere within the first and second groupings. Though she did have many assets and psychological strengths that enabled her to progress in therapy, there were also many borderline characteristics such as severe self-harming, issues of dependency, and considerable co-morbidity. There was no psychotic manifestation except towards the final stages of integration. This is discussed later in this chapter when the integration process is described.

The staged treatment of DID patients recommended by Kluft (1996b) was essentially followed in this patient. This was not intentional on the part of the therapist but rather how the course of therapy unfolded. The initial stages of establishing psychotherapy with the preliminary interventions and history gathering are perhaps consistent with most schools of psychotherapy. The only initial function recommended by Kluft and not undertaken in any depth was that of mapping the alter system. As discussed in chapter 5 the therapist, during the initial stages of this patient's treatment, was unfamiliar with the treatment of DID and did not attempt to map the alter system in any systematic way other than by responding empathically and maintaining an open mind to the therapeutic material that she presented. Instead, the therapist became cognizant of the patient's alter structure through the treatment process where, in response to therapeutic material, there was a gradual unfolding of the alter system. This approach is consistent with the self psychology model. Moreover, no specific alter or sub-system seemed to be cognizant of all the alters within the system.

The middle and later stages of treatment identified by Kluft (1996b) involved the metabolism of the traumatic material and the moving towards integration/resolution. The metabolism of the traumatic material occupied the majority of therapy and the processing of this inexorably moved treatment towards integration/resolution. However, the final fusing of the original personality Me with the alter Marcie was particularly difficult. The issue of duality as conceived by the patient and the desire by Me to keep Marcie as a "joined" but separate entity was particularly complex and engrossing and is returned to in this chapter.

The final stage that Kluft (1996b) identified, involved the learning of new coping skills, the solidification of gains, and follow-up. This stage is not reported in any depth in this thesis. The issues that integration presented for the patient however, and her ability to respond to them, did occupy the latter stages of therapy and were part of her ongoing treatment. The therapist whilst not systematically pursuing the therapeutic stages identified by Kluft and other researchers in the DID field did tend to follow them by established therapeutic practice rather than intention. The patient, however, produced therapeutic material and responded to therapy in a

manner similar to that described by Kluft and the course of therapy did tend to organize itself within the stages of therapy that he described.

Kluft (1999a) had also proposed that DID patients require two or more sessions a week. This was the case here, with the patient requiring three or more sessions a week in order to process the traumatic material and to feel sufficiently contained by the therapeutic process. Frequency was extended to five times weekly during periods of hospitalization. Putnam (1989a) identified the need for sessions of 90 minutes duration as necessary so that the patient could process the dissociated traumatic material. In this case, the therapist allowed for sessions of 90 minutes duration in response to the extremely traumatic material produced by the patient.

As previously acknowledged, several researchers have concluded that DID and therefore alter personalities are artefacts of therapist bias rather than an intrinsic aspect of the patient's condition. Critics of the diagnosis of DID such as Ofshe and Watters (1994) and Piper (1997) questioned the value of directly working with alters in treatment since it is assumed that such alters are artefacts of treatment. Working with alters, they proposed, creates an increase in the symptoms that such patients report and in the number of alters. Clinicians and researchers in the area of DID, however, advocate the value of working directly with alters if treatment is to be successful (e.g., Kluft, 1997; Putnam, 1989a; Ross, 1997). The weight of clinical experience emphasizes that it is important to both address the DID and to work with the alter system (Kluft, 1999a, 1999b). Kluft (1999a), for example, stated that reported studies where integration had been achieved involved treatment by therapists who worked with the alter system. Further, that the most successful therapists worked vigorously with alters and that only 2%-3% of DID patients could achieve integration without specific treatments that dealt with and elicited alters (Kluft, 1985a). In this study the emergence of alters within the therapeutic process was an important factor in progressing therapy. They arose spontaneously in response to the therapeutic material produced by the patient; the therapist responded to them and addressed the material that the alters produced. Ruth's re-experiencing of traumatic material was similar to that of patients being treated for PTSD. It was the alters' traumatic material that needed to be addressed for this patient to be able to

expunge her symptoms. Their presentation was necessary for therapy to progress and was instrumental in her capacity to achieve integration.

Personality integration does not mark the end of therapy but it is a central focus of therapy with DID patients (Kluft, 1997; Putnam, 1989a; Ross, 1997). In keeping with this, Kluft (1984a) has provided the following operational definition of integration. This is three stable months of: (1) continuity of contemporary memory, (2) absence of overt behavioural signs of multiplicity, (3) subjective sense of unity, (4) absence of alter personalities on hypnotic re-exploration, and (5) clinical evidence that the unified patient's self-representation includes acknowledgment of attitudes and awareness previously segregated in separate personalities. This patient has achieved these criteria. There has now been over three years of continuity of contemporary memory with no overt behavioural signs of multiplicity and she has a subjective sense of unity. The only operational definition not met here is that of the absence of alter personalities on hypnotic exploration, because hypnosis was never involved in this patient's therapy. It was considered inappropriate to undertake it at this stage given that overt signs of integration were apparent to the therapist and were consistent both with the patient's subjective experience and with her husband's observations.

In the following section the treatment of DID patients reporting ritualistic abuse is reviewed.

Treatment of DID Patients Reporting Ritualistic Abuse

Kluft (1997) identified three presenting patterns for patients alleging ritualistic abuse. In the first pattern, the patient became deeply involved in treatment and issues regarding ritualistic abuse are heard with decreasing frequency. In this pattern, the patient gradually recovers without the ritualistic material achieving prominence or requiring significant work. Kluft suggested that with this pattern the ritualistic material served as an allegory for the actual material.

In the second pattern, the ritualistic material emerged later in therapy after the patient had worked through material that was more mundane. In this pattern, the patient improved as the ritualistic material was worked through. Kluft (1997) suggested that two inferences may be drawn: (1) the ritualistic material was deeply repressed or dissociated (2) the patient is not yet ready to leave the therapist and is generating more material to prolong the therapist's interest.

In the third pattern, the ritualistic material assumed prominence early in therapy and attempts to put the material aside repeatedly failed. Kluft (1997) suggested three inferences could be drawn: (1) the intensity of the material is so pressing and overwhelming that it needs to be addressed (2) the patient is still active in ritualistic abuse situations (3) it serves as a displacement for more mundane experiences and conflicts. Kluft considered that because its psychological reality is so intense and compelling to the patient that there is no alternative other than working through the material as it is presented, regardless of its origin. The treatment is usually prolonged and prognosis is guarded (Kluft). The third pattern described by Kluft is consistent with this patient's presentation. She was not active in ritualistic abuse, this had ceased from 11 years of age, and it did not displace experiences that are more mundane. Instead, ritualistic material assumed prominence early in therapy and was so intense that it could not be ignored, thus there was no alternative other than working through the material. Ruth continued to produce ritualistic abuse material until the final stages of therapy. During the course of therapy different sub-systems of alters emerged in response to the therapeutic material. As this occurred there was a deepening of affect as the material resonated with Ruth, though the narration by various alters' remained consistent in its detail and in its telling.

Van der Hart et al. (1997) considered that the treatment of adult DID patients reporting ritualistic abuse experiences followed the same general stages of treatment as DID and other trauma induced disorders. DID patients alleging ritualistic abuse are at the extreme end of the dissociative spectrum and their treatment is significantly more complex (Youngson, 1994) and nearly double in time taken for treatment than that of DID patients not alleging ritualistic abuse (Kluft, 1997). Similarly, for

therapists, the treatment of patients who report having been involved in ritual abuse is “experienced as significantly more complex, more difficult, more challenging and more professionally ‘draining’ than clinical work with other client groups” (Youngson, p. 296). Further, DID patients alleging ritual abuse are likely to experience significantly more crises, regressions, hospitalizations, and episodes of self-injury during treatment than DID patients not alleging ritualistic abuse. Kluft acknowledged the increased difficulty that these patients experienced, but recognized that it was unclear as to whether the increased pathology and length of treatment was due to the severity of the trauma and abuse, due to iatrogenic bias during treatment, or due to factors applicable to these patients.

This patient’s treatment was consistent with the observations of these researchers. It was complex and protracted, involving 1125 sessions over a 9 year period with multiple periods of hospitalization, self-harm and attempted suicide. Issues involved in her treatment are discussed later in this chapter. Kluft (1994a, p. 67) reported that the treatment progression with patients who reported ritual abuse proceeded “quite unevenly and unpredictably over the short run and about half as rapidly as patients who have never made such allegations”. Van der Hart et al. (1997) similarly reported that treatment of such patients is arduous and protracted, and complicated by issues of safety and complexity of the DID. This patient’s treatment was protracted and indeed complicated by issues of safety as her history of self-harm, attempted suicide, and need for hospitalization testify. The “layered” structure of this patient’s alter-system required the therapist to respond empathically to each alter within the system. Each alter within the same sub-system needed to process traumatic material that had previously been processed by other alters from their own perspective and it was this that contributed both to the “uneven” progress and to the length of treatment. The father, according to the patient, was one of the cult’s leaders and his prominent position appeared to have contributed to the level of abuse and trauma to which this patient was exposed. She reported, for example, being involved in cult rituals that other children were not, particularly those that involved ritualistic sacrifice.

One of the issues for ritualistically abused DID patients regarding safety reported by van der Hart et al. (1997) is whether they continue to be involved in perpetrator organizations. Whether the patient continues to be involved in perpetrator activities is not, of course, always known by either the therapist or the presenting alter in the initial stages of therapy. This patient, however, was not involved in current cult activities. Such involvement ceased around the age of 11 years and abuse within the home was minimal from the age of 15 years when her father re-married. She also married a man not involved in such activities and they moved, early in their marriage, away from the local area and the father's direct influence. The patient had no information as to whether her father continued to be involved in cult activities though it appeared that these ceased, at least overtly, following her return home from Salvation Army care when she was 12 years of age.

Young and Young (1997) suggested that when patients claiming ritualistic abuse begin to talk about their abuse in therapy, self-abusive, acting-out personality states usually appeared to protest or stop the disclosures. These alters often function as, or are identified with, ritualistic beliefs though they have the same characteristics and defensive function as any other alter personality. The formation of ritual alter personalities may reflect the patient's attempt to create internal identities that are as strong and powerful as her perpetrators, or an attempt to comply with the perpetrator in an effort to stop the abuse (Young & Young). As discussed later in this chapter the patient's self-harm and attempted suicides were largely at the instigation of persecutory alters who felt that they were acting within the desire of the cult.

As previously discussed, DID patients reporting ritualistic abuse appear to have more complex systems and structured layers of alter personalities than other DID patients. In part, this is due to the type of mind control techniques or conditioning applied by perpetrator organisations (Fraser, 1997b; Ross, 1995; Young & Young, 1997). Van der Hart et al. (1997, p. 155) report that when these individuals are able to cease contact with perpetrators "and when their dissociative barriers are dissolving, they tend to have intense feelings of guilt, shame, and suicidality related to 'perpetrator behaviors' that they themselves have been forced to manifest. These issues are extremely hard to deal with in therapy."

Consistent with the van der Hart et al. (1997) findings, this patient experienced intense feelings of guilt and shame related to the cult activities in which she had been forced to participate. She was encouraged to believe that events that had involved her in the ritualistic sacrifice of babies and animals were done because of her and that therefore she was evil and possessed by Satan. If she resisted she was punished further or told that another, such as her brother Steve, would be punished instead. She was encouraged to believe that her only “safe” position was to follow the teachings and demands of the cult despite the internal conflict that such demands created. The different sub-systems of alters contained such conflicts; those involved in cult events such as Les/Charlie, Darryl, and Serpent contained the cult’s rules whilst others such as Me/MO and Mary maintained the rules necessary for daily life. She also felt guilt for her abuse of other children within the cult and for her feelings of pride and accomplishment when she succeeded at a task and was praised. The perpetrator alters contain much of this affect and it was when their dissociative barriers were dissolving that these issues became prominent. The use of mind control techniques by the cult made this more complicated. There had been an emphasis on her worthlessness and that she belonged to the father. She was encouraged to believe that she was possessed by alters that her father had secreted in her body in order to watch and monitor her behaviour such as the alter Serpent. In this patient the dissolving of barriers between different alter sub-systems did lead to conflict within and between different alters that initially resulted in self-harm. Such conflicts were understood, by the therapist, as the alter systems’ attempt to maintain a balance by “protecting” the original personality from “knowing” and thereby enabling the retention of a semblance of cohesion. This is discussed further in this chapter. These issues of guilt and shame and her ambivalent attachment to the father, whose nurturance she desired but also feared, were extremely difficult to deal with in therapy and occupied much of the substance of the therapeutic process. The layered structure of the alter-system and the cult’s mind control techniques contributed to such difficulties in treatment and eventual integration (Fraser, 1997b; Ross 1995; Young & Young, 1997).

Greaves (1989), drawing on the literature and his research, proposed “marker events” which reflected the processes of integration. Such markers indicated

whether treatment is on course. These are considered as they apply to this patient's treatment in the following section.

Marker Events of Integration

Greaves (1989) proposed “marker events” which reflected the process of integration (see Appendix A). Briefly expressed, Greaves had proposed that certain indicators were indicative of integration and successful therapy whereas others were negative indicators for integration. The markers considered indicative of integration Greaves grouped as “convergence phenomena” which indicated a focusing of attention by the patient to therapeutic material. Such focusing required cooperation of several alters which is of itself indicative of cooperation and convergence. This patient met most of these indicators; she kept appointments, attended on time, and continued to produce material that could be analysed and responded to in therapy. Alters presented spontaneously in response to the material being discussed or to internal striving. There was a high degree of trust evident with such presentations. Many of the somatic symptoms such as headaches, nausea, stomach pain, difficulty with vision and hearing did typically disappear when particular traumatic events were discussed and processed.

Hostile alters such as Darryl and Les/Charlie did spontaneously enter into therapy. Initially their transference to the therapist was a negative projection though eventually a therapeutic alliance was formed so that both the patient and therapist shared the goal of promoting patient integrity and personality integration. Ruth did acknowledge “hearing voices” and allowed alters to interact with the therapist and for them to converge. There was also an increased internal communication amongst alters that had previously been separate and the patient acknowledged that she knew more about her internal world than she had initially accepted. In several sessions, during the early phase of treatment, the patient indicated co-presence.

Greaves (1989) also postulated that as integration proceeds the therapist may not be able to recognize which alter personality was active at any given time. This

was an issue for the therapist during the middle to later phases of treatment when alters that had previously held particular characteristics began to change. When the barriers between alters within sub-systems were diffused, some alters also experienced confusion regarding their identities. For example, in session 393 AO stated, “I’m afraid of losing my personality. I don’t feel how I used to feel”. This latter issue is in keeping with one of Greaves’ markers that as integration proceeds alter personalities experienced identity diffusion and difficulty in self-identification. There was also spontaneous integration when, for example, the alter Body fused with AO. There were also occasions when the patient requested that the therapist assist her in the integration of alters.

The next group of markers Greaves (1989) identified as ambiguous indicators for integration. One such indicator is that the patient is “flooded” with traumatic memories that overwhelm her with new material faster than she can process it. At times, this patient was flooded with material particularly during her attempted suicides; however, this material was known to the patient and was not new. New traumatic material was mainly introduced gradually by alters though at times, as it “triggered” responses from other alters, it was experienced as “overwhelming” as the affect from this material was experienced by the original personality. This is discussed in depth in the following sections of the chapter. Greaves also identified re-dissociation, as an ambiguous marker of integration. Whilst this patient did experience some re-dissociation, it was not a common event.

The remaining ambiguous marker identified is the prolific reporting of previously unknown alternative personalities. Greaves (1989) reported that these could be considered under different headings that may overlap. For example, new alters could reflect the discovery of new sub-systems, the creation of new personalities as defences against the demands of therapy, retreat into the internal world to thwart therapy, and resistance to anticipated termination of treatment. The latter group Greaves described as “hold out” personalities and he proposed that DID patients generally “hold out” unconsciously as treatment nears the final stages. In this patient the alters U Gin and Serpent did not emerge until late in therapy. However, it had not been suggested to the patient that treatment would be terminated

and these alters appeared to represent particular traumatic experiences and presented in response to specific traumatic material. Their emergence was in keeping with the therapeutic material that the patient was processing and their appearance assisted in the integration of this patient. The original personality Me had the greatest difficulty in resolving the issue of integration and in this sense was “holding out” as treatment reached its final stages. This is discussed in more detail in the following sections of this chapter.

The final group of markers Greaves (1989) reported are classified as negative markers. The commonest of these is when the patient ceases to produce material capable of being analysed. This was not the case with this patient as she continued to produce material. Nor did she become psychotic following sessions except for some psychotic-type production towards the end of therapy when Me was in the process of joining with Marcie. Her focus, however, was not consistently externalized and she did not act out against the therapist though her behaviour was at times potentially self-destructive as discussed in the following section. However, this was contained once the persecutory alters had sufficiently joined in the therapeutic process. Consequently, the therapist did not experience himself as becoming less and less effective.

Before moving to the treatment of this patient and before the issues raised above are considered in more detail, a brief discussion of the self psychology methodology as it applies to the treatment of this patient is presented.

Self Psychology as it Applies to the Treatment of this Patient

The literature on DID reports several approaches to its treatment including cognitive behavioural, group therapy pharmacology, hypnotherapy, and psychodynamic therapies with these latter therapies being the most widely reported (Maldonado et al., 1998). In this thesis the author is not claiming that self psychology has insights regarding the treatment of DID beyond those of other therapies, but rather what particular value it has had applied to this case. The theory

dictates a method of working with the client that is non-directive and non-interpretive which seems essential if the trust of such a damaged patient is to be gained.

This study argues, from the premise of self psychology theory, that the absence of a soothing “selfobject” leaves the individual unable to process and integrate the experience of abuse adequately. This is particularly the case when the perpetrator/s of the abuse are the child’s natural selfobjects (e.g., the parent/s). This results in the flashbacks and other re-experiencing phenomena of PTSD and the fragmentation of the self into alters characteristic of DID. Some alters function to protect the individual; others are neutrally disposed or destructive. The task of treatment by self psychology is to establish an empathic rapport with suitably disposed alters and mitigate the impact of those which are negative, and to facilitate trauma processing and further personality integration. Therapists working from a self psychology perspective function as a “new” empathic selfobject that enables the individual to take up the previous developmental arrests of mirroring and soothing, so that gradually the individual is able to internalize the function of the selfobject him or herself.

From a self psychology perspective, empathic selfobjects are essential for the normal development and organization of the self. According to Kohut (1971; 1977; 1984), selfobjects, which are essential for the healthy development of the self, mirror the emotional responses of the child and sooth the child when he or she is distressed. Kohut suggested that the toddler is naturally grandiose and that when the grandiosity is mirrored by sensitive selfobjects and failures are soothed, there is a smooth developmental progression to vital and cohesive self. Where the selfobjects fail to provide this function, there is developmental arrest. Therapy requires that the therapist is able to embody both functions – to understand and mirror back the affect aroused in the patient and to embody the sense of the idealized parent imago and provide the strength with which the patient can merge in the early regressive phases of the therapy. If these transferences are successfully made, the patient can return to the developmental arrest and move forward. From a self psychology perspective, children who are abused, and who do not experience the necessary parental

responsiveness of mirroring and soothing, fail to incorporate the function of these empathic selfobjects. They fail to develop a coherent and cohesive self and traumatic violation results in fragmentation of the self into alter personalities (Ulman & Brothers, 1988). Van der Kolk and Fisler (1995) argued that some children could still probably cope with the trauma providing that there is someone available who is sufficiently empathic and who can soothe and reassure. The lack of availability of suitably protective carers may be crucial in determining whether an individual dissociates and develops alter personalities. Similarly, Kluft (1994b) highlighted the role of selfobjects and noted that the lack of appropriate carers to provide empathy and soothing to the traumatised child means that the child abused within the family must resort to pathological forms of internal escape through dissociation. Kluft believed that children could probably survive all manner of trauma provided there was reliable and empathic support within the family. Without the soothing provided by empathic selfobjects, the traumatized child is unable to regulate his or her mental state sufficiently to restore emotional equilibrium.

Ruth needed her father and mother to facilitate her development. However, their abuse acted as a profound reversal of the selfobject conditions required for her optimum development, and interfered with the developmental maturation of narcissism and the establishment of a coherent and cohesive self. Rather than providing a calming and empathic presence, they contributed to the internalized confusion that overwhelmed her and precipitated dissociation. Through therapy, the therapist sought to provide a calming idealizing function that enabled the traumatized patient to acknowledge the “horror” that she had experienced without being overwhelmed by it. The therapist sought to mirror the emotional tone that Ruth presented; an experience she had never before had. The father through his abuse had exaggerated this selfobject need and the mother was largely absent.

Although writing about those with narcissistic personality disorders rather than DID, Kohut (1971) recognised splits in the psyche resulting from failures in the selfobject function. Kohut (1971, 1977), and Hilgard (1977), from different perspectives, proposed a distinction between “vertical” and “horizontal” splits of the personality. Kohut proposed that vertical splitting enabled individuals to maintain

substantial contradictions between their thoughts and actions by the defence of disavowal. Vertical splitting is understood to be present in dissociation, whilst horizontal splitting occurs in repression. A vertical split results in an alteration in the self as a central and coherent organization of experience. Thus, there is an alteration not only in the content of consciousness, but also in the structure of consciousness and the self (Mollon, 2001). Such observations are in keeping with a trauma model of brain functioning as proposed by researchers such as van der Kolk (1996b), and LeDoux (1996; 2002) where the overwhelming emotional arousal experienced in trauma interferes with hippocampal functioning. Strong affect such as humiliation, shame, and fear of over excitement that are usually associated with the grandiose self reside in the split-off sector because they are so much at variance with the rest of the personality (Siegel, 1996). Treatment attempts to heal the split by gradually exposing the disavowed contents of the split-off sector so that they can be integrated into the rest of the personality. During the healing of the vertical split, patients are exposed to parts of themselves that had previously been disavowed so that it is available for modification and enhanced self-esteem. For Ruth, the disavowed contents was the emergence of alters, such as Darryl, Les/Charlie, and Maggie/Mae, alters that had been exposed to traumatic cult activities and whose “values” were in contradiction to those of the original personality. The ability of Ruth to be able to contemplate the revelation of the disavowed contents enabled healing of the division within the alter system. However, the healing of the split in this patient also led to considerable shame for alters such as Me/MO, and Mary.

Under circumstances of reasonable provision of selfobject functions, the child develops a coherent and cohesive sense of self that has continuity across time. For Ruth her father had acted not as a calm source of soothing but as a precursor of the trauma so consequently she could not gradually internalize an image of a soothing selfobject. The father, and to a lesser extent the mother, subverted the selfobject function. In the case of the alter W, soothing selfobject functions had been subverted into sexuality. During the early and middle phase of therapy, W felt that the therapist was rejecting her because he would not respond to her in a sexual manner, or demand sex in exchange for nurturance. To compensate for this, the alter AO created the alter Louise (a “sophisticated” version of W) to interact with the therapist. The

absence of adequate selfobject functions meant that Ruth had difficulty modulating intense affects of rage, anxiety, and depression during the course of therapy. These affects were experienced as overwhelming by her and pathological forms of affect regulation, such as dissociation, repeated self-harm, and attempted suicide were used in an attempt to modulate and regulate her emotions.

As Ulman and Brother (1988) have emphasized, childhood trauma and abuse distorts the normal maturation of narcissism. This is particularly the case where there has been sexual abuse involving extensive manipulation and control of the child's mind by the perpetrator. In the developmental line of narcissism, the child idealizes the idealized parental imago, which leads to the healthy development of ideals. Here, the idealized father imago was a destructive and a highly compromised selfobject. Alters such as Darryl, Les/Charlie, and Maggie/Mae internalized this aspect of him and in the desire to emulate him persecuted other alters within the system. Such abuse, at an early age, meant that Ruth experienced her self as insufficiently differentiated from her father and felt relatively powerless about him. Marcie, for example, believed that the father inhabited her very essence via alters such as the Serpent which continued to "watch over" her, or through persecutory alters such as Les/Charlie that "repeated" via internal "voices" the father's disparaging comments that continued to undermine her self-esteem. Because she was insufficiently differentiated from him, alters such as Me/MO and Mary wanted to remain close to him; she could not hate him without hating herself. Ruth's self had been formed around the father's imposed identity. His words and actions had largely formed her and had been the basis of her selfobjects such that he had imposed a sector of her personality and cognition. This, in part, accounts for the difficulty the sub group of alters who maintained a daily presence within the home (i.e., Me/MO, and Mary) had in accepting the material of alters who had experienced the father and cult's abuse (i.e., Marcie, Amie, Les/Charlie, and Darryl). To accept such material was experienced as hating the self because it involved hate for the father. Alters that could mediate this difference such as AO and to a lesser extent W were necessary for treatment to progress; they could encompass something of both. AO was proud of her ability to be "strong" and held the belief that if left to her own devices she, unlike the other "weaker" alters, could direct her own path.

Self psychology emphasizes the importance of listening closely and open-mindedly. Hypotheses may be triggered by the patient's communications, but though these might guide responses, they must not be imposed on the patient's material. Kohut proposed the concept of transmuting internalization that allows uncertainty, not knowing, and the therapist's failure of understanding. The therapist seeks to understand enough, empathically, to establish an affective connection with the patient, but will fail to understand enough to allow the patient the space, and the impetus, for his or her own mental growth. At one level it was the not knowing that allowed the patient sufficient space to externalize the fears and concerns that she held and for the different alters to engage in therapy, particularly those that the main personality had disavowed and that held the deep shame for the alter system. In a case such as this, the therapist is bound to fail initially in identifying different alters or to be empathically attuned to each one's differing perceptions of self, perceptions which were often in direct opposition to those of other alters. It was through the process of therapeutic errors that the patient was confronted with the therapist's separate subjectivity. However, when there is sufficient empathic attunement, the patient could also recognize that the therapist was endeavouring to understand her and she was able to develop gradually her own self.

In the following sections, the treatment of this patient is discussed in detail. In the first section, Ruth's self-harming and attempted suicides are discussed.

7.2 Self Harm and Attempted Suicide during the Course of Treatment

Overview

The patient was first seen in February 1993 and treatment continued until July 2002. She was seen for 1125 sessions and though she continues to be seen intermittently by the therapist and maintains some contact via telephone and E-mail the substance of the therapeutic work was completed by July 2002. The issue of ongoing treatment and work required after integration will be discussed further in this section. Integration occurred by session 1106 on the 26/04/02. Initially,

treatment was once weekly. This was increased to twice weekly by session 160 and then to three times weekly by session 214. When necessary, mainly during the periods of hospitalization, she was seen five times weekly. From session 150, the length of therapy consultations was increased from 50 to 90 minutes. This was in keeping with Putnam's (1989a) recommendations and was necessary for the patient to have sufficient time to process the therapeutic material that she was presenting and for the patient to feel sufficiently stable for the session to end safely. During the periods when she was hospitalized she was seen five times weekly. During the patient's 10th hospital admission, the therapist did not treat her. The therapist was away during this period though he had organized for her admission before his absence.

Hospital Admissions

Table VII documents the frequency of the patient's hospitalizations during treatment. During the period of her treatment, she was admitted 12 times for a total of 62 weeks 6 days, her average length of stay as an inpatient being approximately 5 weeks 1 day. The longest admission was for 10 weeks and 2 days and the shortest being for 1 week and 4 days. As discussed later in this chapter, the length of her admission tended to correlate with the difficulty of the material that she was processing. Table VII also documents the session in which the therapist saw her following admission and the final session before her discharge. She was a voluntary patient during all admissions except for the 11th admission when she was placed in the locked ward for one week. During this period, her status as a voluntary patient was temporarily revoked. This was in response to her strong desire to harm herself, which she felt unable to contain. The decision to place her in a locked ward was made by the treating psychiatrist in consultation with the patient and the therapist. She was placed in the locked ward so that her behaviour could be more closely monitored. On all other occasions she was treated in the open ward where patients had a greater degree of autonomy in their movements than those being treated in the locked ward. Nevertheless, on occasions, during her periods on the open ward, her behaviour required close monitoring and she was put on 10/15-minute observations due to her self-harming behaviour.

Table VII. Frequency of Hospital Admissions

Number	Admission		Discharge		Length of Admission	
	Date	Session	Date	Session	Days	Weeks and Days
1	10-06-94	119	20-06-94	123	11	1 week 4 days
2	29-11-94	206	19-12-94	217	21	3 weeks
3	16-05-95	266	16-06-95	284	32	4 weeks 4 days
4	28-06-95	292	30-08-95	331	64	9 weeks 1 day
5	23-01-96	407	23-03-96	442	61	8 weeks 5 days
6	30-07-97	588	10-10-97	632	72	10 weeks 2 days
7	13-05-98	711	11-07-98	749	60	8 weeks 4 days
8	10-06-99	858	19-07-99	883	40	5 weeks 5 days
9	01-08-01	1043	25-08-01	1059	25	3 weeks 4 days
10	12-09-01	n/a	23-09-01	n/a	12	1 week 5 days
11	22-10-01	1064	14-11-01	1079	24	3 weeks 3 days
12	26-02-02	1092	15-03-02	1101	18	2 weeks 4 days
Total			440 days			62 weeks 6 days

The longest periods of hospital admission, not surprisingly, corresponded to periods when the patient was processing the most traumatic material. During her fourth admission, for example, she was an inpatient for 64 days. This period, including the following three admissions, was the longest period of hospitalization and during which she attempted suicide on four occasions. She attempted suicide three times during the year 1995, twice whilst she was an inpatient. In 1996, approximately four months after she had been discharged from hospital, she again attempted suicide. Her fifth attempted suicide occurred during her sixth hospital admission in 1997. She again attempted suicide during 1998 whilst she was being treated as an outpatient. The seventh and final attempted suicide occurred whilst she was an inpatient in July 1999.

Attempted Suicides

Table VIII documents the number of attempted suicides this patient made that required hospitalization and hence only the most severe attempts are reported here. Seven attempted suicides required hospitalization, four of which were made whilst she was an inpatient. Table VIII reports the date that the patient was admitted to the emergency department and the date that she was discharged. When she was an inpatient, she was returned to the ward following discharge from the emergency department. Table VIII also reports the last session that she was seen by the therapist before the attempted suicide and whether she was an inpatient or not at the time of the attempt. The first attempted suicide occurred during her fourth hospital admission. During this period, she attempted suicide on two separate occasions. The last attempted suicide occurred during her seventh hospital admission. The attempted suicides ranged from session 303 to session 865. Whilst more traumatic material remained to be processed, from session 865 the persecutory alters that had influenced her attempted suicides had either fused with other alters or were sufficiently contained by the therapeutic process so that more adaptive coping strategies could be utilized. The other factor that significantly contributed to her attempted suicides was her overwhelming feelings of guilt for the behaviours that she had undertaken within the cult and the overwhelming negative affect that this had galvanized within her.

Table VIII. Frequency of Attempted Suicides Requiring Admission to Emergency Department

Admission			Discharged	Inpatient
Number	Date	Session		
1	14-07-95	303	16-07-95	Yes
2	18-08-95	325	20-08-95	Yes
3	26-10-95	363	28-10-95	No
4	19-07-96	487	21-07-96	No
5	02-09-97	608	04-09-97	Yes
6	12-01-98	668	13-01-98	No
7	22-06-99	865	23-06-99	Yes

The patient frequently engaged in self-harm behaviour; its extent was more evident during her admissions. At times she felt compelled to throw herself from the top of a near by multi-storey car park or to take an overdose of medication. She constantly punched the walls of the building with her right hand causing severe bruising. She frequently cut herself causing relatively superficial cuts to her arms and chest and scolded her genitals with hot water whilst in the shower. She refused to eat solids during one admission, which necessitated her being fed by a nasogastric tube. Treatment did indeed increase, at least initially, the patient's trauma memories, feelings of helplessness and inadequacy. This occurred although therapy was conducted at a pace dictated by the patient. The therapeutic process did of necessity create an intensity of affect that the patient had otherwise avoided by dissociation and this contributed to her increased feelings of distress. These issues are returned to and discussed in more detail in following sections of this chapter.

The number of attempted suicides and the frequency and length of hospital admissions reflect the severity of the patient's traumatic experiences and the difficulty for the patient in processing them. The frequency of both could also provide some support for Simpson's (1995) contention that patient well-being

deteriorates with treatment, the implication being that therapy provokes the increasing spiral of negative behaviours. Simpson and other authors also propose that DID is created by iatrogenic bias on the part of the therapist, a contention that will be addressed later in this thesis. The attempted suicides by this patient are of particular interest in this thesis as they indicate periods of intense difficulty for the patient and are perhaps particularly revealing about the underlying function of the patient's alter-system. They occurred when the alter-system was under intense pressure from both internal and external sources. These issues are considered further in the following section.

Factors that Contributed to the Patient's Self-Harm and Attempted Suicides

Overview

DID patients suffering from ritualistic abuse are generally acknowledged as the most difficult of the dissociative disorders to treat (Kluft, 1997) and require special attention regarding self-harm (van der Hart et al., 1997). In this section the patient's self-harm and attempted suicides are considered to see if an understanding of these factors can assist in the treatment of DID. All suicide attempts involved the patient taking an overdose of medication. One of the challenges in treating this patient was her desire, understandably, to "not feel". Whilst the use of medication and a medical model were important and necessary factors in her treatment, they did tend to reinforce the message that suppression of feeling was possible and desirable. The distancing of feeling that the patient sometimes experienced with medication was similar to the process of dissociation where she could "separate" from her emotions. This, however, was sometimes in conflict to the aims of therapy where the gradual processing and understanding of the traumatic material was the central focus. Of the alters, Me frequently sought medication. This is perhaps consistent with the aim of this alter to distance herself from the emotional consequence of the traumatic events. How these issues impacted on her treatment will be discussed in this and subsequent sections.

First and Second Attempted Suicide

The first two attempted suicides occurred during Ruth's fourth hospital admission. She had been discharged 12 days earlier from her third admission. Because of the brief time between the third and fourth hospital admission, the main issues discussed by the patient during the third admission are briefly reviewed. During her third admission she had been hospitalized for 32 days and had discussed issues related to the father's abuse of her and the difficulty some of the alters had in coping with this knowledge. Me/MO, for example, said during session 266 that she could not stop crying and that, "I just don't believe things I see and hear. I don't want to see and hear; don't want to believe. I don't want to be part of that any more. How can I keep seeing these things?" Me/MO's ambivalence in processing the material that other alters "showed" and "told" her continued throughout therapy until the final integration and occupied the central focus of the therapeutic sessions.

During the third admission, five alters presented a total of 32 times during therapy. The most prominent alter was Me/MO who presented 15 times (47% of the total alter presentations), the alter AO presented eight times (25%) and W presented seven times (22%). The alters Chris/Carol and Mary each presented once (3%). During this admission, Ruth had discussed memories of her childhood and of her relationship with her father. The main theme was the abortion that W experienced at Peggy's. Whilst this traumatic event was experienced by W, it was also "shared" by the alter AO. These two alters contained much of the traumatic memories for the abuse within the cult and within the home; W experienced much of the sexual abuse whilst AO experienced much of the physical abuse. When the sexual abuse changed to physical abuse, W would "disappear" and AO would "appear". Their experiences of traumatic events were often close and overlapped. W, for example, had been holding and playing with one of the babies that was ritualistically sacrificed. When the father told her to bring it to him she was too afraid to and "froze". When the father became angry AO "presented" and gave the baby to him. W exonerated her own perceived sense of guilt for the death of the baby by blaming AO for giving the baby to the father. AO also held guilt for this though initially she had taken great pride in her ability to do things that W could not. During this admission, the patient had engaged in self-harm behaviours such as cutting her left arm and before this

admission she had beaten her arm and hand with a meat tenderiser and wooden rolling pin. This caused bruising and swelling of her right hand but she did not fracture any bones. The cutting did not requiring stitching and was mainly concerned with tension relief and her desire to see her blood and to let the “badness out” of her.

There were eight therapy sessions between the third and fourth admissions. During these session the alter AO presented on four occasions; W on two, whilst Mary and Me/MO each presented once. Typically, during these sessions, the presenting alter occupied the entire session. In session 290 the alter AO discussed her involvement in the ritualistic sacrifice of two babies. This was not discussed in the same detail as it would be later in therapy but the content remained consistent and what changed in subsequent sessions was an increased intensity and deepening of affect for this and other alters. Later, after AO had discussed the ritualistic sacrifices an internal “voice” had told her “Now that you’re talking you have to kill yourself.” It was mainly the alters AO and W that presented during the period between the third and fourth admission and each discussed the abuse that they had experienced within the cult and by the father.

During her fourth admission, she attempted suicide for the first time. Her fourth admission was for 64 days and the therapist saw her for 40 sessions. These were from session 292 to session 331. The first attempted suicide occurred 18 days after this admission, session 303 being the last time that she was treated by the therapist before her attempted suicide. The second attempt occurred 35 days after the first attempt and 53 days after this admission, session 325 being the last time that she was treated by the therapist before her second attempted suicide. Table 9 presents the frequency of alter presentation during Ruth’s fourth hospital admission. In total, eight alters presented on 79 occasions. Frequency of presentation did not always correlate with the importance of the material that was discussed and where the importance is not represented in the frequency of their presentation it will be acknowledged and discussed. Frequency is reported here, however, to assess whether the pattern and frequency of particular alter presentations correlated with the patient’s suicide attempts.

The alter AO presented 37 times (47%), the alters Chris/Carol, and Me/MO each presented nine times (11%). Marcie presented seven times (9%), the alters W, Mary, and Darryl each presented five times (6%), and Amie presented twice (3%). During session 303 the alter AO presented for the entire session. In session 304 which followed the patient's first attempted suicide, Me/MO initially presented but it was the alter AO that occupied most of the session. During session 325 the alters Me/MO, Amie, and Marcie presented with the alters Amie and Marcie being the most prominent. The following session the alters Me/MO and Marcie were the most prominent.

In Table IX the frequency of an alter's presentation is divided into three categories. The category "First" shows the particular alter presentation frequency from admission to the first suicide attempt. The category "Second" shows the frequency of alter presentation from the first to the second attempt whilst the category "Post" shows the frequency of alter presentation from the second attempt to the patient's eventual discharge from hospital. The alter AO presented 11 times from her admission to the first attempted suicide. AO presented a further 23 times from the first attempt to the second attempted suicide. Chris/Carol presented once before the first attempted suicide and a further seven times from the first to the second attempted suicide. AO presented a further three times following the second attempted suicide and in total presented 37 times during this admission, representing 47% of all alter presentations. The alter AO was the main presenting alter during this period and the most prominent during both attempted suicides.

Table IX. Frequency of Alter Presentation in First and Second Attempted Suicides

Alter	Frequency			Total	Percentage
	First	Second	Post		
AO	11	23	3	37	47
Chris/Carol	1	7	1	9	11
Me/MO	1	3	5	9	11
Marcie	2	4	1	7	9
W	2	2	1	5	6
Mary	1	2	2	5	6
Darryl		4	1	5	6
Amie		2		2	3
Total Presentations				79	

Hospital admission was planned in response to the patient's increased feelings of self-harm. Following admission, the alter Mary presented during the first session (292) and stated: "I have a major problem, I don't think it's all true an imagination that's gone wild, fantasy stuff. And I don't want to hear any more about it". Later in session Mary said:

I spend a lot of energy keeping in control. Be hard for me to live if true. It just doesn't happen, and if it did people wouldn't change, and he's never done anything that's not nice. We should explore other reasons as for why I'm not coping very well. I know things W has done, and it's me, that stops her saying anything to John [husband]. I feel ashamed I should have stopped her. I just want peace. I do things as long as I can do them and then I give in. I understand that if done wrong should be severely dealt with, but if true then I don't want to live with it. Every time something comes up here, I fight it. I think what I'm telling you is that I'm not going to stop them [alters self-harming]. I'm sick of struggling with them, I feel like W and AO are contaminating me. That's why I have to ring him up [the father], and go round and see him. Every time I say I don't believe, I see their pictures and they're screaming at me. Important for me to keep even [in control], I've been listening to them for weeks now, they say it's just a matter of going to sleep and I like sleeping. Sometimes I believe it. I've sat physically with them [other alters and I can smell

those], smelly people [cult members], can't make up those feelings. ... [Later in session the alter AO presented] I showed her [Mary] about stabbing yourself, felt like the bitch didn't even feel it. I hate her, still not seeing. Arse up head down.

This passage revealed some of the difficulties that alters such as Mary encountered within the alter system. Her role had been as a protector to the child alters and to be a surrogate mother within the home when the parents had separated. During her childhood, there were the normal developmental needs for secure attachment with her family. The alters Me/MO, Mary, and to a lesser extent W, enabled her to form a relatively secure attachment to the father. They also assisted her to maintain the perception that she lived in a secure and loving family environment whilst being able to dissociate from the discrepancy of her father's sadistic abuse (Ross, 1997). Her need to keep a "balanced" perception of the world came under pressure with other alters, here AO, "showing pictures" of the traumatic events that they contained and that were in distinct contradiction to Mary's view of a secure and loving father. Alters, such as AO, frequently expressed their anger towards the other alters, primarily Me/MO and Mary, that rejected their version of events, and AO sought to "make them suffer" by "showing" them pictures of the traumatic events to which she had been exposed. In part, this appeared to have been an attempt by some alters to displace their own painful feelings though, at a more fundamental level, the communication and "sharing" of such traumatic material represented a breaking down of dissociative barriers and was an indication of the process of integration.

Such internal conflicts contributed to the process of integration but they also contributed to the suicidal impulses that this patient experienced. The difficulty that the alters Me/MO and Mary had in coping with traumatic material was different from the conflict experienced by other alters such as AO. The difficulty for alters such as AO was in coping with the overwhelming affect that was a consequence of the traumatic abuse by the father and the cult; they did not deny these traumatic events but rather attempted to come to terms with them. Whereas, the difficulties experienced by the alters Me/MO and Mary were in the acknowledgment and acceptance that these traumatic events had occurred and that the world that they had construed was not accurate. Their means of coping was to dissociate from the emotional consequences and from knowledge of the abuse. To "take on" the

knowledge and understanding of the abuse would necessitate a fundamental shift in their perception of themselves and of their father. When they were no longer able to dissociate themselves from the distress of other alters, their initial response was to reassure themselves that the father had never treated them badly and that therefore any abuse must have been the fault of the other alters. They did not question the presence of “others” or perceive this as unusual. It was more that if there was any abuse then it was the fault of other alters because nothing bad had ever happened to them. The purpose of their creation was for them to “not see” and to believe they lived in a secure and loving family environment. Such beliefs enabled developmental processes such as attachment needs to be achieved, albeit partially. The impetus was towards healthy growth, and to attain normal developmental milestones. The creation of alters such as Me/MO and Mary was a means of achieving this. This latter point is discussed in more detail in subsequent sections of the thesis.

In the following sessions the alters AO and W discussed the abortion at Peggy’s. This had also been a central event of the previous admission and was clearly one of the overwhelming traumatic events for this patient. Discussing the impact of it during session 294 AO said:

Feel like I’m ready to burst. I don’t know why I’m here with W’s stuff. Feel like demolishing your room [I’m] filled up with W’s stuff. Why can’t she express her stuff? Maybe I’m responsible for her, responsible, in that I’m rotten.

AO who, in previous sessions, had blamed Mary for “not seeing” was increasingly taking on the traumatic experiences of W. In part, this was because these alters were close in their creation, and AO frequently presented in response to traumatic events that W was unable to fully contain. AO’s role within the alter system and more importantly her perception of herself was changing; she had perceived herself as confident and able to cope with traumatic events that other alters were unable to bear. This changed later in therapy when alters previously unknown to AO presented in response to traumatic material of which she had thought herself to be the sole witness but that she had not been able to fully contain. AO’s taking on of W’s “stuff” is another indication that the compartmentalization between alters is being permeated

and an indication of the integration process. It was also indicative of the alters' changing role within the alter system (here AO's). They had to respond to traumatic material that they previously did not perceive as theirs. This exerted pressure upon the alter system to adapt to the emotional demands that such awareness placed upon it and on the individual alters whose self perceptions were in the process of change. For example, in the following session AO continued to talk about the abortion, her reasons for self-harm and her increasing inability to cope with W's feelings.

Sit there [in hospital and] have to hurt myself. When [W is] talking to me feel like crying, don't know what to do with my emotions. Only know being jacked off [angry]. Fear those feelings of sadness more than hurting self, way of avoiding feelings. I scream, fear of the mess inside. Feel rotten.

In a later session (314), the alter W told AO that: "You're the one did the bad bits. I don't have to worry about because you're having to cope with it". The alter system was changing in the "shuffling" of responsibility for traumatic events and to whom they belonged. This left some alters with particular issues to process whilst other alters such as W could disavow responsibility. In general, it was those alters closest to the alters Me/MO and Mary who were able to do this. These exchanges also served to intensify the feelings of guilt that AO was struggling with and that other alters had, at this stage, left to her. Of course, as is discussed later, shame and guilt were also issues that the original personality Me would eventually have to process. The alter system was adaptable and alters changed in response to the therapeutic process. There was division amongst alters as to who was responsible for particular traumatic events and who would have to process the traumatic material. AO had been created to bear witness to such events and though she had not been able to fully contain all of the abuse at this phase of therapy, she thought that she had. However, because of therapy, this perception was in the process of change.

During the following sessions, AO continued to discuss the cult's ritualistic sacrifice of babies and animals. She particularly discussed the skinning of the dog and her feelings of guilt for this. During session 300:

Hurt self so they know I regret and I know I regret; 'Cos I murder things, destroyed, always with a smile, 'Look at me, aren't I good'.

Not good enough put in hole [harming self by scratching a “hole” in her stomach]. Find hand to do when looking [hitting her hand against wall whilst on ward]. Darryl says ‘You haven’t finished yet’. He enjoys my feelings of guilt and he’s laughing thinking of babies killed.

Such exchanges were indicative of AO’s feelings of guilt and of how the persecutory alter Darryl was able to enhance his feelings of self-aggrandisement even when he was not able to maintain an alter’s silence. Darryl perceived his role within the alter system to be the guardian of the cult’s secrets and activities. His self-esteem was based on his erroneous belief that he was a powerful and important individual who worked in alliance with the father. AO, however, continued to discuss issues of which Darryl was guardian, but the alter system was sufficiently adaptable to enable him to retain a sense of mastery in his enjoyment of the guilt that AO felt. He also took pride in his perceived ability to cause her to self-harm. At one level, Darryl represented the enjoyment at cult activities that Ruth perceived in her father and other cult members. Darryl, however, also represented the patient’s own feelings of guilt regarding her actions and her sense that she deserved to be punished. At the age that Darryl was created (around 7 year of age), Ruth was in conflict between the actions that she was compelled to take to avoid being further punished and her own beliefs regarding the wrongful nature of such actions. In part, it was these conflictual feelings that significantly contributed to Darryl’s power and to his ability to cause the patient such distress; she felt that she deserved to be punished for her actions although she was a child and they occurred under severe duress.

During the session (303), before the first attempted suicide, the alters AO and Marcie had presented. Early in the session, AO discussed her anger and said that she had destroyed some items on the ward. She protested that she was “angry, angry about dad” and how he had treated her. She was also angry that “nobody believes we’re separate. We don’t like being treated as one, don’t feel ourselves.” As discussed in Chapter 8 part of the difficulty in treating DID patients in a public setting is the division among colleagues regarding how the production of such patients should be responded to and, of course, the often implicit disbelief amongst some health professionals in the diagnosis of DID. The alters AO and Marcie discussed the terror of an early traumatic event when the father had placed Marcie in

a coffin that contained an apparent corpse which came to “life” when Marcie was placed on top of him (Chapter 6). The purpose of such cult activities was to subjugate Ruth to ensure her silence and compliance with the cult’s demands. This was a traumatic session and care was taken to ensure that she was calmer before she returned to the ward. Provision was also made for her to be regularly observed by nursing staff. Later that afternoon she superficially cut her wrist and told her father when he had phoned that evening. He had responded saying, “I’ll put your mother [stepmother] on”. Ruth reported that she replied, “No, no! About time you faced this, I’m not well”. He said “You’ll get over it just come home I’ll put your mother on”. She attempted suicide that Friday evening. The therapist saw her on the Monday after she had been returned to the ward from the emergency department. During this session (304), AO described why she had attempted suicide, “Believed I’d sleep a few hours. [Once] before, [I] tried to break my arm, [I] had to break somebody’s hand once. Fantasy about father rather than real father he’ll say his fault ‘Made you do’ [it].” AO’s “fantasy” reflected the guilt that she felt for her participation in the “pulverising” of the baby’s corpse after it had been ritualistically sacrificed (described in Chapter 6). The patient’s self-harm and continued beating of her right hand and arm were in response to this material. She felt guilt for her past actions and self-harming was, in part, her attempt to atone. She also continued to hold the belief that her father would admit his guilt and that he had coerced her so that she would be able to expurgate her own feelings of guilt regarding her “badness”.

The alter Mary, as discussed earlier, had difficulty accepting and responding to Marcie’s traumatic memories and rather than adopting her normal response of calming and “mothering”, she withdrew, leaving these alters without a source of internal soothing. Ruth was also sharing her room with another patient. She had previously shared with this patient and had enjoyed her company. On this occasion, however, Ruth perceived the patient as aggressive. She felt scared, similar to her experience as a child when she witnessed violence between her parents within the home. For the majority of Ruth’s admissions, she was accommodated in a single room and it was only at times of bed shortage that she or other patients were in one of the two twin share rooms.

AO's perception of herself continued to change. In session 305, for example, she stated that: "I've eroded away my image as big and strong, never cried before, used to be no feelings". Her belief that she could cope whilst illusionary was partly sustaining both for her and the alter system and assisted in the belief that she (and therefore the patient) could cope with such traumatic experiences. The gradual unfolding narration during therapy of the extent of the abuse, however, eroded such illusionary but self-sustaining beliefs and at some level did contribute to her attempted suicides. In the following session (306), AO continued to discuss her experience of change and the fact that she was taking on the experiences of others.

I don't think that we can take in ... I don't think it's fair, that I have all of them as well. I should never have taken the Body on. Teach me about going away. Sat with her for so long, I should never have allowed her in; I'm left with everything. W's feelings, they're all using me; from grandfather standing over me right through to dad to W's experiences. Huge cherry top of cake, what I did nobody seems to understand. I can't take it, before [I was like] a straight tunnel.

As her relationship with other alters changed so did her perception of herself. After one incident that the alter Chris/Carol had discussed (session 316) AO stated,

I heard all that. Oh, I feel sick this is all new stuff to me. I'm supposed to be aggressive, straight up and straight down. I don't look at self-being emotional, this is an invasion; others have invaded my boundaries, because I shouldn't feel like this, means that I'm not the same. Thinking if someone put something down for me to kill, even though he's 75 [her father had visited her in hospital the previous afternoon], I could still do it. What I really want to do is to go rotten, see it all oozing out of me, yellow stuff. Have to help it come out, it's sealed in and I have to help it come. If did a perfect job [I was] worthwhile, but afterwards even if did a perfect job [it] didn't make you feel worthwhile.

The shifting of AO's perception that she was "strong and fearless" and able to "stand up" to the father, to one that incorporated horror, terror and guilt denoted a significant shifting of balance within the alter system. The taking in of other alters' feelings challenged her perception of being not being "emotional" and at some level contributed to her despondency and suicidal ideation. Increasingly, she felt helpless and not the powerful and sustaining presence that she and the alter system previously experienced her to be. The above passage denoted the change in the alter AO's perception of herself and some of the difficulties that this raised for her. This

marked the beginning of a period in which AO discussed harming herself by cutting to let the “badness” out of her. This related to traumatic events in the cult where she was made to participate in the ritualistic scarification and sacrifice of a baby. Her cutting of the baby she perceived as bad and her action of cutting herself was a partial “re-enactment” both in an attempt to understand her actions and in her desire for atonement.

AO continued to talk about a time when the cult members had ritualistically sacrificed one of the babies and she had to participate. In Session 317, W initially discussed the baby who was later ritualistically sacrificed and how she had held it and “looked” after it before the father took it from her. Father says to cult members “Shall we begin?” AO says to W:

“Say goodbye,” so I [W] did. I feel part of what she [AO] did as I didn’t have time to go completely away because AO was already into it. [AO presented] Well, she’s not going to tell you any more is she ... ‘cos she can’t, she [W] just there inside and every time I cut something she hurt. She would move, or twitch it was terrible. Every time a piece was cut off or up I had to use all my energy to keep her [still], hardest ‘cos she couldn’t have gone away properly. She looked at it as her baby, I told her it wasn’t. Worst feeling I’ve ever had, to have someone inside saying “You’re destroying my baby”. It wasn’t her baby but to her it was. It didn’t affect her later on because it didn’t look like a baby. I just hate seeing it over and over and hearing it. It was awful. [I was] So spaced out you don’t even know they’re screaming, just goes on and on and you’ve got W inside screaming her rocks off. It was the most wickedest thing I think I could have ever done.

W blames AO for handing the baby to the father. AO became a “safe repository” for W’s feelings and for coping with the trauma that followed. The alter system retained a balance between those alters perceived as “good” and those perceived as “bad”. The alter Darryl continued to encourage the alters Chris/Carol, Marcie, and AO in particular to kill themselves. During session (319), the alter Darryl had spoken to the therapist for the first time since he had originally presented in session 174. Previously other alters had discussed what he wanted them to do. From this session on, he presented and engaged more frequently with the therapist.

The session (325) before the patient's second attempted suicide, Me/MO said, "Carol's been really upset. She really realized that ... how bad a person he [father] is". During this session, Amie and Marcie discussed the father's abuse of them and the birth of Amie. The alters which presented during this session were Me/MO, who presented first then Amie and finally Marcie. Later Marcie took an overdose of medication that she had secreted when she had returned from weekend leave. She took the medication at the prompting of Darryl. Weekend leave had been part of preparing her for eventual discharge and had been discussed and planned in cooperation with the patient and instigated at her pace. This attempted suicide was due to several factors. These included her growing disillusionment with her father and her desire to be loved by him; the realization of the nature of Amie and Marcie's abuse; the changing nature of the alter system; and Ruth's desire to remain in hospital as a means of dealing with it. AO was also no longer able to protect Marcie as she previously had since she also was in a process of transition.

After the attempted suicide, her handling of medication was discussed with the patient and she suggested that her husband would take charge of her medication. Marcie said that Amie took the tablets because she "didn't want to talk about it again". It was possible that the patient's alter system was overwhelmed by the revealing of the abuse by the father and the traumatic events and circumstances that led to the "creation" of Amie (discussed in Chapter 6). As with ongoing therapy the patient instigated the material though, of course, the therapeutic process was directed towards such discussion. In session 327 Chris/Carol discussed the marriage to the father from their perspective. After an attempted suicide, the patient would again take up the discussion of particularly traumatic material. This was always at the instigation of the patient and it was as if having temporarily released some of the pressure that had been building up by responding to the urges of other alters, she felt able to continue processing this material.

Third Attempted Suicide

The third attempted suicide occurred 69 days after the second attempt and 57 days after being discharged from her fourth hospital admission. She attempted

suicide just before and during session 363 whilst she was being treated in outpatients. Following her discharge from hospital, she had continued to experience suicidal ideation. During session 362, the alter W discussed a dream in which she felt that no one was listening to her and that she was going to die. In her dream she was “dying in a nice place” where there were lots of children and a slippery slide which she kept going on. She was taken to ward 5.1, the ward in which she had been an inpatient, and told that Gordon, one of the nurses that she had had difficulty with, had died. She did not want to leave the room that she was in “the nice safe place”. Early in the following session (363), I commented on her (W’s) sleepiness, in response she revealed that she had taken an overdose of medication prior to attending and had the intention of dying whilst in my office. She was taken to emergency where she was treated.

Following discharge from emergency, she discussed her reasons for the attempted suicide. She voiced her concern that I was not taking her threats seriously and that she wanted to die but was afraid to die alone. Though the husband was administering her medication, she had previously secreted a “hoard” of medication, which she had not revealed to the therapist, and she had taken 80 Chlorpromazine [tranquillizer, anti-psychotic agent]. She stated that other alters would not allow her to tell the therapist or her husband of this hoard. Whilst the therapist remained somewhat sceptical regarding this, it does highlight some of the difficulties in treating these patients. There is always the uncertainty as to whether other alters that have not entered into therapy are the keepers of secrets that can not or are not ready to be revealed to the therapist no matter how good the therapeutic relationship. The patient’s dream is clearly symbolic of her desire to be an inpatient and not to experience the pain that her traumatic memories brought her. The symbolism of the “slippery slide” is also indicative of her concern that she would not be able to cope with the therapeutic material. These issues had been discussed with her but it was difficult to accommodate the patient’s ongoing need for hospitalization within the public sector. The patient’s need for hospitalization and the issues this and her frequent self-harm raised for her treatment and care will be returned to in the following sections. The safe treatment of this patient continued to present challenges for her management within the hospital and that she would succeed in her attempted

suicides appeared to be a constant possibility. Whilst she was an inpatient, for example, nursing staff attempted to use verbal and written, non-harm contracts but these were ineffective as a means of preventing self-harm. The value, if any, was in emphasizing that self-harm was not helpful and that staff were concerned for her wellbeing. For the patient the attempted suicides and self-harm were concomitant with the issues and experiences that she was processing. They reflected her ongoing struggle with the therapeutic material which she was confronting. This is not to suggest that her attempted suicides and self-harm were not cause for concern or that the issue of safety was not considered in her treatment, but rather that such concerns did not dominate therapy.

To capture the presentation of alters before and following this attempted suicide the 10 sessions preceding the suicide attempt and the 10 sessions that followed are examined. The sampling of 20 sessions provided a sufficient range of data to identify any trends regarding the presentation of specific alters to the attempted suicide. The same procedure has been used for other attempted suicides that occurred whilst she was an outpatient. Table X presents the frequency of alters in the 10 sessions up to and including the session before her attempted suicide and the 10 sessions immediately preceding her attempted suicide. The alter W was present for the entire session before her attempted suicide. During the following session Amie, Marcie, and W stated that they had been the alters that had attempted suicide. In these 20 sessions, 10 alters presented 41 times. The alter W presented the most frequently 10 times, being 24% of the total alter presentations. The alters Me/MO, AO, and Marcie each presented seven times and represented 17% of the total presentations. The alters Me/MO and Marcie each presented five times in the 10 sessions that followed and it was these alters that returned to process the material that had ultimately led to the attempted suicide.

Table X. Frequency of Alter Presentation in Third Suicide Attempt

Alter	Frequency		Total	Percentage
	Prior	Post		
W	6	4	10	24
Me/MO	2	5	7	17
AO	7		7	17
Marcie	2	5	7	17
Darryl	2	2	4	10
Mary	1	1	2	5
Chris/Carol	1		1	2
Boy	1		1	2
Amie	1		1	2
Voice		1	1	2
Total Presentations			41	

During session 362, Amie said to the therapist, “You don’t care about me. I’m going to die today when I get home. You don’t believe me. He hurt me.” At the end of this session AO presented and declared that she was “Tired of all this. Nothing is as it was, I’m even crying and I don’t cry.” The therapist empathically responded to this material and it appeared to have adequately contained her immediate anxieties. During the next session, W attempted suicide. She presented for the entire, if somewhat truncated, session and reported that Mary “went to the chapel [in the hospital] yesterday, after seeing you. She sat looking at the cross talking to God. He said she [Mary] needed to do whatever you have to do.” Mary thought that suicide was wrong and hence sought to allay and absolve her fears by seeking Gods permission. W’s intention to die would, however, have to be questioned. She would have clearly understood that the therapist would respond to her action. Her desire for the therapist to “remove” her pain was understandable and a recurrent theme during phases of therapy. This was particularly the case for the child alters and for the original personality Me.

W's transference to the therapist was initially similar to her identification with the father. Her desire for love and security needs had been sexualized. In attempting suicide in the therapist's presence, she felt that he was not sufficiently responding to her desire to be hospitalized but also her frustration that he could not remove her pain. The therapist was not omnipotent in the manner that she perceived her father to be and her desire for the therapist to absorb her pain could not be satisfied. Much later in therapy (session 1054) Me brought a drawing (drawing 13, Appendix F) depicting the therapist as a knight in armour holding a sign that said "STOP" in one hand and a spear in the other with a caption beneath stating that "NO PAIN TO PASS!!!". This naive drawing and its aspiration reflected her desire for the therapist to prevent her suffering. In part, this was an attempt to engage the therapist as a surrogate alter who could prevent Me from experiencing the consequences of the traumatic events that other alters had exposed her to. In this sense it is a similar defence to that of dissociation, but it is the therapist rather than an internal alter that is intended to contain the painful affect.

In the 10 sessions that followed the attempted suicide, Marcie presented five times and discussed traumatic material. Marcie revealed that she, Amie, and W had taken the overdose. During session 365, she discussed her experiences of the hospital emergency department, where she had vigorously struggled with the nurses and had tried to pull the nasogastric tube out.

Silly woman [nurse said] "Do you want to be locked up?" [Marcie replied] "I want to be safe". I'm a cocky little shit sometimes. ... Like everything not worth it, makes no difference whether I stay or go. You've got no idea what those people [nurses, are] like. Didn't think I was asking a lot. Just to be kept safe seen lots of people come in similar, don't treat the same. ... They didn't do a very good job [in emergency, staff held her] wrist [since she was struggling]. What does anybody do with somebody who is struggling I spat that stuff [charcoal] out I wasn't going to drink that stuff. So, I'm going to do it again. I'll just give John [husband] a few days. Thinking about that today when driving here, I was just going to take what's left when he took Sandra [daughter] to school".

Her assurance that she would attempt to kill herself continued. This was mainly at Darryl's instigation and he presented her with alternative methods of achieving this. Session 366 Me/MO "I've got so much going on in my head. Walk in front of a car,

go out back way and just go”. Darryl wanted her to kill herself. Me/MO described how Darryl effected her:

He makes me go funny in the eyes. Just like, I know what’s happening but I can’t stop it. He says to me when leave I’ve got to go up the lift by front so John doesn’t see us. I can’t not do it, it’s like I’m floating and he makes me do it, puts his legs in mine and he takes me.

Later Darryl boasted of his power over the alters Marcie, Me/MO, Mary, and W. Despite his grandiosity, however, he was vulnerable and was concerned that he had no contact with the father. The patient’s father had limited contact with Ruth since she told him that she had some memories of abuse at Peggy’s home. Darryl was concerned that the father had “forgotten about me”. Darryl sought approval from the father and wanted him to know that “I’ve tried three times”. W, session 367, also identified her attempted suicides as emanating from the father’s threats that she would die if she spoke of the cult’s activities; “Why do you think I’m so pre-occupied with dying, comes from him, dad.” W continued to discuss her recent attempted suicide, “Only sad part, I’m not as thick as everyone thinks. I know I can’t do it by coming here and doing it. Mary thinks its attention seeking.” In the following sessions, Marcie continued to discuss the ritualistic sacrifice of the baby and other traumatic events within the cult. The alter Darryl became more engaged in therapy but remained persecutory towards other alters and continued to encourage them to self-harm.

Fourth Attempted Suicide

The fourth attempted suicide occurred whilst Ruth was an outpatient and approximately 8 months after the previous attempt. Table XI reports the 10 sessions before the patient’s fourth attempted suicide and the 10 sessions that followed. Seven alters presented 50 times during the 20 sessions. AO presented 27 times being 54% of the total presentations. Marcie presented eight times being 16% of the total presentations, W and Me/MO each presented four times being 8% of the presentations. Voice, Mary, and Darryl also presented with Darryl presenting twice after the attempted suicide. Session 487 was the last therapy session before her attempted suicide. AO and Marcie both presented during session 487 and had

presented during the previous three sessions. The alters Me/MO and AO presented for session 488.

Table XI. Frequency of Alter Presentation in Fourth Suicide Attempt

Alter	Frequency		Total	Percentage
	Prior	Post		
AO	14	13	27	54
Marcie	4	4	8	16
W	2	2	4	8
Me/MO	3	1	4	8
Voice	2	1	3	6
Mary	1	1	2	4
Darryl		2	2	4
Total Presentations			50	

During the intervening sessions between the third and subsequent suicide she had continued to discuss material that was extremely traumatic for her. It was Marcie's traumatic experiences that were the most prominent during these sessions and it was these that triggered her attempted suicide prompted by the internal pressure of the alter Darryl. The "closeness" of the alters AO and Marcie demonstrated by both presenting in response to the same material and by AO frequently being the narrator of Marcie's experiences. AO's role as created by Marcie was to be brave and untroubled by such events. Within the alter system AO's function was to cope. However, AO's perception of herself was in flux and she was only partially able to cope with Marcie's affect. Other alters "avoided" contact with Marcie since she was perceived as "contaminated" with the consequences of abuse and contained much of the negative affect. Previously, it was the illusion that AO could cope that internally deflected much of this traumatic material. Within the alter system it was AO who would attempt to cope with the consequence of the abuse that

Marcie had experienced whilst Marcie remained “buried” within the alter system. As change was instigated, through the therapeutic process, this changed. AO’s sense that she would have to cope was the main reason that she was so important in processing this material. That the alter system attempted to cope with Marcie’s negative experiences by keeping her separate whilst trying to fuse with her is discussed further in the following section. During this phase of treatment, Marcie increasingly presented and engaged directly with the therapeutic process. In session 484, Marcie discussed that she had been involved in cult activities and that every time she was there similar traumatic events occurred.

I’m bad I touched his thing. Look what I made it do. I think he had a wee, thought snail [secretion]. ... All [children] laying down very dark outside see all of Uncle Jim and two other men. I don’t know who they were. Laid down on the floor, stuff like snails coming out I played with it, they too. My dad had hold of me with his hand and his other hand on that. I don’t like scary bits. I didn’t mind touching, drawing on his stomach after a while daddy wanted me to put in ... his ... in my mouth. Scared if I bite he’ll hit me; have to keep open as far as I can. That’s why he had a wee, awful. Had to do to everyone, said, “Look what you’ve done”. Somebody had in their belly button, he says “You made this happen. You’ve got to lick this off them”. You don’t understand, [I] did lots of time. Every time I was [present in cult activity] did.

In session 485, AO and Marcie presented, Marcie talked about her fear of the father and her confusion with his words and expectations. The message that Marcie would die if she told of the cult activities was a recurrent theme. At the beginning of the session AO stated: “Marcie just goes off her face every night, going off all the time about dad, like it’s happening right now. Even Darryl got in the action. Because he’s male he shouldn’t have to suffer the female consequences [menstruation] of being female”. Earlier AO had stated that she had been feeling cold. Later in the session, Marcie presented.

It’s me that’s cold I’m freezing. Cold since I saw you on Friday [this session on Monday]. My dad keeps telling me things. I don’t know why get confused when I hear him. He tells me that I know what to do, tells me that I have to tell him what to do, so I tell him then he yells at me that I’ve been bad, hits me. I don’t understand, if I say the word he wants me to say he hits me. Not right just to do it. Tells me I’m bad, bad for saying the word bad for not saying the word. “What

do you want your daddy to do?" Say, "I don't know," says "You do", yells say, "I want you to fuck me". "Don't use the word". I don't know where it ends my problem, it doesn't end why can't sleep. He makes me so cold, comes from the inside out. I don't know it's like he's made me ... from the middle, I feel cold. When I say to him "Fuck me" then he yells out how bad I am. I tell him that's what I thought he wanted me to say. He says good girls don't say that. "Say will you do that to me". I'm so bad I shall die. 'Cos he's mean. He says that bad children are going to die and I'm bad, I'm really bad, I deserve to die 'cos I say such bad things. Uncle Jim tells me my dad is right, 'cos I am bad. Little girls shouldn't say such things. I should die, God hates girls that say things like that, only the Devil likes it. So that must be where I'm going. Just me I'm bad. He says that God won't like you. You know if you're bad, you see him, and he's all black. 'Cos I'm bad. He's all black a funny voice, like you can't understand him. He stands in front of me tells me I'm just like him. He's all black got something around him he's all black, red on his face. If I tell anyone, he will kill me. About what he does, it's a secret lots of people would do it. He can only have a few. He only wants a few very ... he wants good people to do only some things. He wants good people for the job, good at doing.

Not allowed to tell them at school, lot of children would come. I always thought he was hot. He makes me feel cold. Red face, not all red, but red, his thing is red he shows it to me and says; ... he says that he will put it inside me. [Later in session] He wants me to look at his thing. It's all red. I'm going to be like that, make inside of me like him. I've got him inside. I know I've got him inside because I saw it afterwards, that most of the red had come off inside me. He said one day it would come out and if I ever told anyone, I'd be dead.

[Later] He's [Darryl] going to make me die 'cos I've been bad I told you [about] like all those things somebody cut off baby. Strange noise they were so little just little fingers. Not suppose to tell you, a secret, special people only. My dad is special 'cos I look so pretty in white.

[AO] You know I didn't feel bad until I realized what I did, see what I did not me. Most of the time went from being me to someone else I'd be there smiling all this stuff over me. I look pleased with myself. Darryl smile, I've done something good, look at me.

The above passage indicated Marcie's fear of her father and her confusion of how to respond to him further reinforced her feelings of helplessness. The belief that part of the father was "inside" her and that she would die if she ever spoke of the cult also contributed to her sense of despondency and the depletion of vitality within the alter

system. AO's perception of herself is also in a state of flux. Previously, she took pride in her accomplishments but this perception was in the process of change as alters "shared" their experiences with each other. The switching of alters during the actual traumatic event meant that no one alter had to bear it all nor held a cohesive understanding of the material. The process of therapy encouraged such understanding but also, temporarily, contributed to the increased level of self-harm and suicidal ideation.

AO continued to discuss that Darryl was giving Marcie and her a choice of "Slash self to bits and he [Darryl] shows us what that would be like or can take a lot of tablets and drink some stuff". It was also apparent that when Marcie discussed these traumatic events it was as if they were happening in the present and, in this regard, similar to the experience of patients suffering from PTSD. In part, this was because alters such as Marcie and Darryl had had little contact with events outside of the cult. They had not been part of the patient's conscious life from approximately the age 11 onwards and their experiences of the trauma were not balanced by other more rewarding experiences. AO and Marcie again presented in the following session (486). Marcie said that she was frightened that I was angry with her father because of the things I had heard and that he would kill me. As therapy continued the belief that she would die if she told anyone or if she was "bad" kept re-emerging and contributed to her suicidal ideation.

Scared you're angry with dad. I've seen him kill somebody 'cos somebody wouldn't do something, killed them. Put something over their face she died. I had to come up and she was dead. 'Cos I have to do as I'm told otherwise I'll come back as a ghost. She came back. I was with some ladies she said she came back because it was very warm. Said she'd been told to do something didn't do. Put cloth over her face pulled it very tight for ages. Said she was dead and she didn't move. Anything he told me to do. I know you [therapist] hate me 'cos you can't look [at me]. I'm not allowed to look at anybody. ... I looked at the lady and she died. She touched my wee ... with her mouth, and I just lay there 'cos she was a ghost. White like a ghost, she was very white. The first time I saw her she was white, after she wasn't as white.

She come back to life, got it from me to live. She tells me to lay down. I have to lay down. I have to put my hands out and they can draw a circle around me, join my legs with my hands in the circle; puts her head in my circle and then she starts to do something to me, she naked some red on her chest. She had some red ... I got it over me and so did the red. I got the red in my face; she rubbed it across my face and rubbed it in my mouth. So I had all this red, some of the white on top of me. Weren't allowed to move, otherwise the circle would be broken. She tickled me with her face down there and she kept doing. She did that till I had to wee. She move and I had lots of her stuff on me, white powdery. I'm very tired all this white stuff over me.

[Told by her father to wipe powder and red off her face she has difficulty doing this] "You can't go home like that or I'll send that lady back to get you. Do you want to end up like her?" ... I don't want to die, I tell him, so I'll do what he wants. Jeff [brother] will die if I'm not good. Dad says he will cut his dick off. It won't be okay. Jeff can't do it. The lady's got him and she's ... it won't work. I just, I think I'm going to hit me 'cos he's hurting Jeff. "I'll do it. I will. I'll do it honestly daddy, I'll do it". He keeps bringing Jeff and Jeff can't do it. I say I'll do it. Why can't Jeff do it? He gets hit all the time 'cos he can't do it. "You'll do it and you'll do it for him and me. You hear that, don't lift your face."

During the session (487), before her attempted suicide, AO discussed how after the previous session she had felt "scattered" and did not "feel in control". She felt "like something is invading me, not invading, ... so much noise yelling, like a disaster". She goes to bed but wakes up hearing voices to which she would "lay listen try to calm myself, think if I don't get up I'm going to die. So I do get up but no energy." Marcie, as she was presenting more in the therapy, was re-experiencing the father's and the cult's abuse of her and the verbalization that she should kill herself increased. His words of revulsion towards her are reflected in her self perceptions, and within the alter system by AO's perception of Marcie and what she represented. There was increased conflict between the alters AO and Marcie; AO felt that Marcie was the primary alter that wanted to kill herself whereas she did not. At this stage she was experiencing intense gynaecological pain for which she shortly would have a hysterectomy. In discussing the impact of having a hysterectomy AO said:

Marcie thinks it's great. I think she thinks get rid of the bad part. ... Feel that somebody going to beat me to the ground, short arse person like Marcie to do it. Maybe scared I'll do it to myself. I don't want her to kill me. ... [Later during the session Marcie presented.] I'm going to kill her because I don't want to listen any more stuff ... that's all my fault. AO says that John [husband] has to look after us. ... Dad did things to other people because I didn't do what he said". Marcie is referring here to her brother Steve who the father and the cult had also abused. I used to lay there and let them do it. Do you remember this? [Marcie traced the figures six and nine that joined in a circle.] I can make the picture of me go bigger, smaller. I had pictures; take pictures [photographs] of me show you how ugly you are [father used to say this to her], mirror show you. He's hurting me, pulling me, hurting me, I can't move as quick as he wants me to, and there's the mirror and you will look how ugly you are, "One ugly bitch". I'm going to kill her. Calls me ugly and then I won't be a nuisance to anybody. ... "Kill her so doesn't make anybody sick". Lay on the ground, shit, vomit, say, "You made me sick, till I no longer want".

The following session (488), Me/MO explained that she had taken the overdose of medication but felt that this had been out of her control, "Thought I don't want to take them". Later in this session AO said "I hate her [Marcie] 'cos she's the one who wants to die. Takes them but doesn't hang round". Me/MO stated that Darryl had prompted Marcie to hide the medication and that she had taken 70 chlorpromazine hydrochloride [tranquillizer and antipsychotic agent] and 10 temazepam [sedative]. "Thought [while] in shower do cutting [to myself]. Often when I'm talking to you see her [Marcie] sitting on chair [my office chair]. I'm frightened I'd go and sit with her, told doctor [in emergency] I want to be with God." Me/MO was angry that she was left to contain the emotional consequence of Marcie's experience. The purpose of the alter system, in this case Marcie, was to contain such emotions so that Me did not have to experience them.

In session (489), AO and Marcie discussed the ritualistic killing of a baby and her "marriage" to the father. As communication between alters increased and there was a sharing of affect, the equilibrium within the alter system also changed. During session 489, for example, AO had discussed the ritualistic killing of a baby and her feelings about it, "Never thought I'd mellow out, thought I'd remain pissed off for

ever”. Likewise, Marcie was increasingly seen as repulsive and as literally being covered in the consequences of the abuse.

I just think, if I get near her I’ll throw up, she’s just so gross. Like an animal, worst than, see her as, I can look at her and think how disgusting, dirty, smells, face sort of awful. Looks like someone stretching her skin. Her mouth open ‘cos should keep mouth closed so don’t make any noise. She doesn’t wear any clothes and she just sits. ... I’m sitting here right now telling her how should kill herself. Can’t seem to be able to ask her just tell her.

Within the alter system, AO currently had the most vitality. It was AO who believed that she was the most important of the alters and that they would eventually join with her. Consequently, she wanted to get close to Marcie but was afraid she would have to contain the horror that Marcie contained. AO’s response to Marcie and the dilemma that she presented for the alter system was that Marcie should kill herself so that her pain could “disappear” and that she would not have to contain it.

Fifth Attempted Suicide

The fifth attempted suicide occurred during her sixth hospital admission approximately 13 months after the previous attempt. She had been an inpatient for five weeks. The admission was for 10 weeks 2 days and was her longest period of hospitalization. Before this admission, the patient discussed increased suicidal thoughts and despite the fact that her husband was overseeing her medication, she had accumulated and secreted a large quantity of medication that she was concerned she would take. The patient gave this medication to the therapist. The therapist with the consent of the patient arranged the admission.

Table XII represents the frequency of alter presentation during this admission. Seven alters presented, the most prominent of these being the alter Charlie who presented 18 times (25% of the total presentations); nine times prior to the attempted suicide and nine times subsequently. It is significant, however, that the alter Les, a cohort of Charlie, presented 15 times (21%) prior to the attempted suicide but made no appearance subsequently. Though it was the alter Marcie’s response to the traumatic material of Les/Charlie that precipitated the attempted suicide, it was

Les who conveyed most of the trauma before the attempted suicide. Les, with Charlie's later assistance, discussed the issues and traumatic events that led to the fifth attempted suicide. The alter W presented 17 times (24%) during this admission. This was a particularly traumatic period for the patient. Traumatic events that appeared to have led to this attempted suicide were related to particular cult activities: the disembowelling of the cat and the skinning of the dog, as described in Chapter 6, and the cult ritualistic scarification and sacrifice of babies and the eating of their flesh. It was during this admission, from session 598 onwards, that the patient refused to eat solids and drank only minimal fluid in response to the traumatic memory of eating human flesh and the decision was made by the treating consultant to feed her by a nasogastric tube.

Table XII. Frequency of Alter Presentation in Fifth Suicide Attempt

Alter	Frequency		Total	Percentage
	Prior	Post		
Charlie	9	9	18	25
W	11	6	17	24
Les	15		15	21
Me/MO		8	8	11
Mary	2	4	6	8
Marcie	4		4	6
Informer		3	3	4
Total Presentations			71	

The patient was hospitalized from session 588 to session 632. The attempted suicide occurred after session 608, 35 days after admission. Prior to hospitalization the alters W, Les, and Mary had been prominent. In the 10 sessions before her admission, for example, W had presented 14 times, Les 11, Mary 5, Me/MO 2, and Charlie 2. In session 580, Les had discussed how he "don't want to be a man or a

woman, want to be nothing” in response to painful material that he was remembering. Later, in session 582, he discussed how he was “not suppose to give a shit, I’m bad”. How he was supposed to feel in contrast to how he was feeling was a further indication of movement towards integration within the alter system. He was shifting his perspective and increasingly his previous defensive stance was insufficient to counter the painful material that he was processing. In Session 585 Les had described his moment of “creation” as discussed in Chapter 6. In session 596 Les said, “I’m a killer of human beings, more than one. This is why we’re going to die ‘cos it was such a bad thing. Have to be punished, not allowed to drink”. The patient at this stage was only taking minimal liquid intake as means of punishing herself and as a means of “gradually” killing herself. Marcie attempted suicide in response to the material discussed by Les and his feelings of guilt and difficulty in coping with them. After the attempted suicide Mary presented for six sessions; in three she was the only alter. Her role was to sustain “harmony” within the alter system; in this respect she is the soothing mother who seeks to maintain family cohesion. During this admission, the patient discussed traumatic events from Les’ perspective.

Session 589 Les and Charlie described the father’s ritualistic killing of a cat that was disembowelled over W.

[Les] Cat was W’s not mine. I didn’t give a shit about the cat. He got the cat, whack she [W] lying on table, he cut down middle placed on her, warm fur, stuff around her mouth. Then he just got hold of it put all this stuff ... he put all the stuff, a mess, on top of her. [He] picks up cat had his hand inside cat lifted up made her have a look, nothing inside cat lifted up made her have a look, nothing inside it all things on outside. Have to sit on floor and fix it up now. She is rotten she shouldn’t have done. She’s trying to put all together, make real again. It all doesn’t go in properly, does but it doesn’t. My hands would all be yucky stuff over it. The cat’s dead but its fur still feels nice. But it doesn’t make a noise or move, but its eyes open, mouth open. Wasn’t me, she was trying to make it eat. She had to pick it up [in] nappy towel then she picked it up for a while. She killed it by not putting the stuff back in.

[Charlie] It was a bad rotten cat, stray, not our cat ‘cos wasn’t black. Keep a black cat for special occasions. I’m like dad. I’m like my dad in so many ways you wouldn’t believe. I’m big, strong ugly ... he’s

masculine. You think it's good that I'm like my dad? Blue eyes make people know if angry.

Inducement of guilt by the father and the cult contributed to her sense of helplessness and guilt. Charlie blamed the therapist for his inability to influence other alters to self-harm and despite his proud boast that he was “big and strong”, he found it harder to cope with this traumatic material. As traumatic material was triggered during therapy and responded to by specific alters, they “acted out” their previous responses and persecuted other alters. In the following passage, Les described the disembowelling of the cat and its impact on him.

I tried to be like my dad, not easy keep everybody in good form. Your fault they trust you for a start, [Alters are] afraid of dad, I'll drive them crazy, pester them. He's really [the father] angry. He doesn't speak to us any more. AO's fault, she's hiding, afraid; afraid of being a failure, if I don't kill them. I hear it, I just know it, I hear [a] voice [saying that is] why you're here, or you'll have to do things that hurt me [self]. If I don't hurt them then I've got to do things to hurt me, cutting self on legs, stomach, and arms. ... [Continued to discuss the cat], W she couldn't take it. She wanted to go away. They pick it up like some sort of trophy, then drop it on me. W wouldn't touch the stuff so ... worms and stuff [cat's intestines] all over her. Worms on her stomach and I picked them up, don't you worry about that! There was bits missing. The dogs ate those bits. I keep hearing the dogs fighting over the cat, [like] sucking of an orange noise, growling, sniffing. They'd better well stay away from me, better not sniff, and lick stuff off me, nothing to wipe stuff off me. Sniff you everywhere 'cos stuffs been everywhere, so they sniff you. Have to lay down on the ground and they [say] “Lay down on the ground you filthy bitch they lick you clean”. You don't know if they're going to eat you 'cos not allowed to move. They were around my face, and stomach, and top of my legs, there [genitals]. I had to open my legs. All you can hear is the stupid, stupid noise, like snorting, growling and they were between my legs slobbering all over you. Wish I was dead. My dad says that dogs really love, and [he] uses that word ...[reluctance to say word initially used rhyme] Lloyd Bridges ... Sea Hunt ... cunt. ... They're all over me I don't want them to get [me] with their tongues and teeth. Their teeth will eat me. Charlie comes [during the event and says to W]. “You just lay still you fucking bitch and you won't get hurt. Don't you fucking move”. Just does as she's told she'll be fine, or I'll punish her. How much do you think glass cutting her vagina will hurt her? [It's] on the agenda, I need a razor a shaver. Then you'll be rid of us. I'm bigger than the others they're bad, do bad things. W stupid, she laughs sometimes about stupid things. Nobody should laugh.

I'm proud of myself that I can cause such things. I'm sick to death of Mary, who gives a royal shit about her clothes! I went for a walk $\frac{3}{4}$ hour checked out car park, another walk looking for things. I'm a one-way ticket to disaster, no coming back. I have to do all these things 'cos he's not around he [father] can't do it, you're right, but I'm to do it for him. 'Cos they're here talking to you. That you would put ideas in [my] head, you won't love me [as my father did]. He had a nice man [the father early in therapy had suggest to the patient that he knew some one that she could go and see for treatment] I could go and see one of his friends, help me, and [said] that you [therapist] would harm me.

He tells jokes, rude jokes. I'm his good person, because I'll do what he wants, he's taught me when things not going properly, I have to fix it, like a general telling troops. Just know what would I need to do to make dad happy. Lose my identity, lot to lose; I don't give a shit I am a horrible person a mean horrible person!

Les' sense of self was based on identification with the father; like him, Les aspired to be "a mean horrible person". To Les/Charlie, the father was a powerful man who did not feel pain and who could bend others to do his bidding. Les/Charlie attempted to re-enact this within the alter system. They took the role of the father and attempted to respond as he had and threatened the other alters with death just as the father and the cult had done. To respond in this way demonstrated that they were like him and "powerful", but more importantly, it meant that they did not have to contain the emotional consequences of the cult's activities - they were the persecutors not the persecuted. Les/Charlie, however, were also in the process of change and were experiencing the impact of traumatic events from which they had previously been separate. They could no longer garner support from being aligned with the father or the cult and they now experienced the "terror" and "horror" that other alters had contained. The self-harm and attempted suicides that they induced in other alters were, in part, their means of attempting to reinstate their former role and as a means of distancing themselves from full cognitive and emotional awareness of the father's abuse. The issue of self-punishment continued when Les discussed in session 596 that he had refused to let any of the others eat or drink.

I'm on a mission. I've just gone crazy got my earrings stabbed my tummy and burnt myself [with] cigarette lighter. I'm a mean motherfucker my dad likes that makes sound invincible. [Les continued, discussing the cat and his experience of it.] Not a good person all the time he's [father] telling me [to do bad things] ...

Makes me want to cry. I just want to cry. I didn't want to do anything to dogs and cats or people. Steve [eldest brother] didn't want to touch his wee or pull it. My dad gave me lessons on him, what I was to do on Steve. Have all these ladies with yellow stuff inside them sit there, [whilst I] lay on the ground, [the ladies] fingers holding themselves open. I don't want to do this, he tells me I have to I don't want to clean them with my mouth. ... [Later in session] It's awful, so much of this awful stuff [the father said] "I'll kill you, eat every bit of" and there was always more.

I want to die, I don't want to be here any more or hurt myself so much. And the babies, I can't talk about. Like I'm possessed by all these things inside that move and move, I know I'm possessed 'cos I've got him inside, big person wearing black, had sex with W. Guess I know there's things I have to talk about, can't help but kept lining up business. Everything has to be in order. I'm a killer of a human being, more than one. This is why were going to die, 'cos it was such a bad thing have to be punished.

Later, during this session Les discussed how he and Charlie had "killed" a baby within the cult and that this was why they could not eat or drink and that they had to be punished. This is quoted in some length since the material is central to an understanding of the patient's self-harm and attempted suicides. The increased awareness between alters of their role in cult activities also increased pressure on the functioning of the alter system.

I killed them, one still had the cord on it, and it was very slippery. Think I was having a dream about it when trying to get out of the hospital and I was yelling and nobody was sitting with me, so I got up to see if I could get out of there. Felt like the bed was climbing with things. Just slimy, I remember the top of its head had like white soap on it. I just heaved a bit. Had all stuff in its ears and face, like some one had spat on it and this soapy stuff on its head. Wasn't as big as monkey, [soft toy used by her during therapy] wasn't as fat as. Looked like his belly button thing bigger than the rest of him, really long and really thick. Then they tied a knot in it and left it hanging so they could pull it up by it. Should go to the police tell them I murdered a baby and fed it to the dogs. They won't find anything, but I did it. Few things that grabbed my attention cord so big and all his little bits so big, not everything was big only a little penis but other thing big. Legs see all that. Scary, terrified pushing his legs down pulled everything up, held legs together cord stuck there and I had to touch goddamn thing all slimy, blood all over it. Then other stuff comes out of the lady just like a stiff dishrag. Everybody was

handling it. I wasn't up [present] till they brought it ... she was [the mother of the baby] laying down on the ground, few people had it and then, don't you know why I have to scratch my arms [was scratching her arms as she spoke]? It's on my arms. My hands were on the baby put stuff on my arms, just like some of that jelly stuff can play with. I don't know anything about babies but this stuff not jelly 'cos I saw it come out of her, had to hold the baby's cord and they cut it eventually that's when they started saying things. He had to kill it. Had all this stuff on arms made knife slippery but all right dad will help get a grip. "You do this or you'll be so fucking sorry you slimy little." ... We're bad because we stab this baby; we stabbed it then that was all we had to do.

They cut its stomach open. Cut all its little bits off first. They just cut it up to its throat, little heart; amazed the size almost of my fist thought it would just be tiny shape of a heart, kept looking, and thinking how could it fit in. Took some other things out, things near the heart, things out someone [alter] tells me their lungs, chucked those to dogs. They chucked testicles to dogs eventually after they were finished passing around. You know all this from W and AO [these alters had previously told the therapist some of this traumatic event] but they didn't have to do all the hard work. Why me and Charlie big friends, those piss weak girls weren't going to eat pieces of liver, cut pieces of meat off bottom of baby, this after then fired it. Maybe they were playing cavemen. Having a big fire and if I threw in monkey for a while then rooted out eating, but make not human. Why did they eat so much of the baby? I had to. Oh! I can't talk about that. ... I had to have some of its heart and liver kept saying it's the same as eating a sheep or cow or something, didn't feel the same. How come he doesn't worry about it? How come he can live with these memories and I can't? [Crying] He just couldn't wait for these nights, excited [I] had to be really clean why have to be clean when we got there covered in shit, had to look as if little princess going off to a party. I think if my stepmother had moved in straight away these things wouldn't have happened, instead she waited to do things her own way, then things wouldn't have happened. Like Easter time, big things happens at Easter he made us paint eggs so we had a painted egg for breakfast treat no chocolate, candy ones rationed if good. I remember the time at Easter [father] cooked those nice hot cross buns and we all scared. Why being different? Being different because stepmother coming for the day. "The nicest man you'll ever meet" is what would be written on his gravestone. Did I tell you Freemasons Fremantle want to make him the big wig down there? Thinking I would feel more dangerous now from him – had such a lot of phone-calls just nothing – hang up beep. Bad things gave to dogs, kicked jumped on it stepped on its head, kicked it like football, wanted to crush to bits. Had to give its little hand to dogs [they] went berserk. They thought funny [I] thought I was crazy just pulling hand off giving to dogs the feet then jumping on it, except I hadn't seen an Injun movie. I was nine all I kept thinking was shit bad word said

shit, shit, shit, shit jumping on it not loud enough for him to hear. I hated him and all those people I had to call uncle and aunty. Woman [baby's mother] didn't care, gave her a drink and something to eat off her baby.

In the following session (597), Les discussed Charlie's role in the ritualistic scarification of the baby discussed in the previous session. Les was angry that he and Charlie had been left, by other alters, to complete this task.

Think we [Les/Charlie] had a choice about the baby? We shouldn't of had to had those things put on us. They cut open its head could see everything. Felt it before when had to touch all the white stuff on its head very slippery white like soap. I was feeling it, could feel there was a soft bit in his head. I didn't look closed my eyes. All I know is that it was yucky afterwards. Little eyes nose and mouth. I didn't know you could pull peoples eyes out so that it just hangs then they cut off its nose. They just worked its face. They called it worked, cut around cheeks, lips. They had work to do, which means I had work to do. I had to learn how to do these things. Darryl would help AO cut arms, body and legs and that but I had to take over for the face, [This is] why I hate them so much. Like cutting down side of his tiny little mouth into his chin so it was just hanging there. God, I did want to do those things. Only thing I didn't have to do top of head, watch pull eyes out but watch cut round side of them. Cut down nose straight. Now you know where our obsession for straight comes from. Told you they pulled out insides cut off his private parts everybody had to put his tiny penis in their mouth. They cut other things off [testicles] just this tiny little thing, then pass on to everybody else. When dogs got bits and they put it then in the fire. I just kept looking at its little eye, I couldn't concentrate, I just looked at one thing. That's how I manage now. I wasn't very tough. Hear dad saying, "This is going to be done, you're going to do it, it will be done". I did it with pride. I was proud of it. He didn't have mum at that stage so he needed to be proud of me.

[The father] Picked up W and Marcie once for being really good; just enough to make them forget that he was going to hurt them. Amie the worst like a cat that would spit, she has red hair. That she's one stubborn, stubborn child 5/6 she didn't grow much beyond 6. She would throw tantrums, had to be pulled over she just wouldn't go so they had to make Marcie do. Marcie came after Amie 'cos she was going to get herself killed, like she would refuse to open her mouth. He get her mouth open purely by slapping, force her mouth open. Used to excite him her resisting angry always ready to put it in her mouth and do it right away by the time he got her mouth open. I think

it excited him that she put up a fight. Marcie put up a fight but not as much as Amie, everybody for their own survival.

It was following this session that Ruth was fed through a nasogastric tube. It was not that the patient necessarily intended to harm herself, but rather that she was unable to eat and drink since this triggered her memory of having consumed the baby's flesh. This was partly due to the increased communication between alters. During session 599, for example, W stated that she now has some of Les's feelings:

I have some of Les's feelings about baby, cat, and dog. Especially the dog, I haven't thought much about the baby. Cold, remember being little and cold. You should see my arm it's a mess, Marcie responsible [cutting self].

Later, during session (599), Les commented, "I almost wish you'd seen me last night. I was totally out of control. That's why I hate you; you keep me in control. Out of, didn't like but felt like a release, felt it everyway and didn't matter". Towards end of the session, Les said "I want everybody out of my head. My payment for the things that I did, I'm going crazy." Whilst on the ward the patient continued to punch walls with her injured hand. In Session 602, Charlie was present and said:

Even a person like me likes to have some form of control. My dad standing there saying, "Where's my little helper? You help daddy do this, your such a good girl". [Later] I don't have a story like others, I'm just angry. Well maybe I do have a story, but not that important, but just crap that I didn't care. I can look at things they did to W and not feel anything except that she enjoyed it. I'm the one tells W so she won't forget, AO an actual murderer. She needed Darryl and Les, I finishing off. When see self, large, powerful like Emperor no clothes. I can stand all the things that we've done, can keep telling you that I like to think that I'm an indignant sort of person – can't hurt people like that - when I'm nothing more than a frightened child. [Later] Have thoughts and pictures of a child. Pulling, children on each leg of a dog after its been killed. Man coming along [with] something sharp. Four of us would end up with a quarter of a dog, nothing but a skinned useless lump of meat.

The previous passage illustrates how each alter contained part of the traumatic event. The gradual process of integration leads to the alters re-connecting

to these memories that previously had partially been contained separately. The bringing together of these “experiences” into a cohesive narrative is consistent with therapy and with the traumatic model of trauma (e.g., van der Kolk, 1996a, 1996b) but the awareness it brings can be overwhelming for the patient. The alter Charlie, for example, in session 602 remembered an incident where W was abused by “Uncle Jim” on the back lawn of their home. He also had knowledge of W being given the baby before AO handed it to the father, “Look of her, like she’s been given some thing precious, baby doesn’t cry, happy to be held without being squeezed. Have its head softly rubbed; [she] thinks maybe this one won’t go”. Traumatic events such as the ritualistic sacrifice of this baby linked alters that had participated in the trauma albeit in a specific manner. When these traumatic memories were again triggered in the course of therapy, Les/Charlie re-experienced them. Les/Charlie would present at specific times when other alters could no longer endure the cult abuse.

W would start, she’d get sore, and I would help her. Or if AO and Darryl getting knocked around too much, all to keep you in recovery, when one comes and goes so they’re in recovery [the alters], resting, going to go on all night, recovery time. Idea that pissed me off I always got the end of it. Feel as if it’s happening to me. The pain never goes away.

In session 604, Charlie discussed the ritualistic sacrifice of the babies from his perspective.

I can see the part of it that I was involved in. Killed it, AO, Darryl but I helped by putting it in the fire. See this little thing in fire and I’m standing there with stick shifting it around and all its skin is smelly and burning and I’m still pushing it around, people watching, don’t feel anything – revolted. Keep telling myself it doesn’t matter. Everything, everybody’s running around doing things. Other part of baby chopped up throw into a pile where dogs can get at two black and brown dogs and they eat all this stuff. So after a while, after everything set up someone takes baby out of fire placed on big plate carved like Sunday roast, gross still see face, arms, legs loose at body, they’re not straight and then they just sit there and carve up like Christmas, [like] something good. He carves [father] and I take the plates down to people, bowls with raw stuff in it that came out of inside of it. I don’t want to eat makes all your mouth go ... nose smell. Some of it’s not really cooked that well, burnt like on its bottom. When cutting bottom part of it some cooked rest ... all soft bleeding, that’s the bit I don’t want to eat it. I look at him “Please, please don’t make me eat it dad, dad I’m not hungry”. If didn’t eat

shoved down my throat. They just chuck pieces to the dogs as they went along.

[Later] I made my arm bleed yesterday just like they collected the blood in a cup. Wanted to see if my blood the same as that, tastes the same. In middle of what I was doing I walked out Joan [nurse] playing a game [with other patients] walked up to her needed cover sometime “See one of the other nurses” “No, forget it” half hour later. They don’t care. Just like nobody cared all those years ago. They stress to me, go if you need help can’t interrupt someone’s game that they’re playing, so no support there. [Later] Just wish I could get rid of this ooze feel like my body’s full of this yucky ooze. Just like this black mass that’s going to wrap itself around me, I have to fight for air but there isn’t any good air. It’s just full of all this, can only call it ooze, crawls into you all over you comes from inside me. Sometimes I think it must have been them that made it happen that put it in there like treacle but not sweet. I see it here, this part [breasts] of body, but there’s people, dad other people. They’re hurting me, doing things that hurt me. That’s where I keep ... sometimes when too much for my head I keep it down here. I go over and over [father saying] “You love cat more than me” whack [sound of father killing cat by smashing it against wall. This was a different incident and cat to the one previously described.], puts on top of her oozy stuff from that and the dog. All its stuff is brought out and it’s taken care of and some part of this animal see I don’t want this part to scream.

In Session 605 Marcie said, “I want someone to take it away. I don’t want to be big and strong. I want to be scared and small and when wake up that nothing happened. I think I’ll want to die until the day I do die, most unlucky person alive because I am alive. I don’t want to be. I don’t want to be alive.” Later “My dad used to make me feel invisible then so visible.” In Session 606, the discharge plan proposed by treating doctor was discussed with the alter Mary present. “This Friday or following one [Friday], don’t feel like doing any more work really. They discussed that yesterday. Feel like I’ll have to modify won’t be as intense.” Mary discussed the father’s abuse of her in the shower and when at home in bed. She went home for weekend leave and returned Sunday afternoon. In the session (607) on Monday, Mary said.

Everything that we talked about here feels like a little bit too much. Stayed with me over the weekend, why kept so busy, awful. Got up feeling so awful, I can’t make up my mind whether to believe it or not to believe it. [Marcie presented] I’m going to kill her. Wasting so

much time full of shit, I just don't like the way she walks around as if going to burst into tears don't care about her. I hate this place. I hate you. You don't fix things. [Continued to discuss Carol's abuse in the bath by the father when a young child.] Trapped there first of all in the bath we were trapped feeling of we were going to drown, colour of the water and the pink bath. Taps can see the taps, I can see him, he was nowhere near as fat as he is now. My jaws sore, like how the hell am I going to keep my mouth open for much longer? It's Carol's fault, she's the one she was touching it [father's penis]. It was floating, her fault. I just want to die. You're all to blame because nobody stops it. I can't stand it. Just makes me think of the time when I was his very special person. I can feel everything, bath, shower, bed, him doing all sorts of things I can feel myself sitting there with my white dress on shoes and socks, standing next to him, him taking my clothes off and everybody watching. I can feel the tree, except it wasn't very big tree; I can feel it, back against it. And I don't want to look up, but he says I have to. ... I've gone a long way a way now, I'm big, and you're small now and he can't hurt me.

Marcie continued to elaborate on her role in the ritualistic sacrifice of the baby and that the baby's blood had been used to draw symbols over her face and body. In the next session (608), she continued to discuss specific details regarding the ritual as they related to her. Marcie had discussed these events in various ways previously, and though this and previous sessions were difficult for her she continued to discuss this event without any prompting from the therapist. She attempted suicide after this session and had taken 50 antihistamines tablets (cyproheptadine hydrochloride) that she had acquired from a chemist whilst on weekend leave. She suffered from asthma and believed that the medication would interfere with her respiratory system and stop her breathing. Marcie attempted the suicide. After this attempt, Ruth remained in hospital a further five weeks and three days. At discharge, the nasogastric tube was removed and she was eating solids. During the remaining period, she continued to discuss traumatic events and the sharing of experiences between alters continued. Mary during session 610, for example said, "I'm scared of what I've heard. It's almost unbelievable and yet I can't call her a liar, try but. ... Then I think about how he's been since. I remember always everything had to be his way, what he said went." Mary had presented during this session in response to the painful events that Marcie had discussed. It was also during this period that Mary began to disclose her own memories of the father's abuse within the home. He had

abused her once whilst she was cleaning the shower recess and she remembered times when he came into her bedroom at night.

During this admission, the alters Les/Charlie were the most prominent alters. They discussed traumatic material that other alters had previously examined but from their perspective. This necessarily involved other alters and contributed to the shifting of equilibrium within the alter system whereby Les/Charlie began to identify with their own painful affect and that of other alters. This changed their beliefs regarding themselves and they ceased to be persecutory to other alters. Despite the long admission, Me/MO only appeared after the attempted suicide when other alters had processed much of the material. This, in part, was her attempt to keep painful material from her awareness. It also appeared that the alters created by Me had to process the traumatic material which involved them before the issues could be dealt with by Me/MO.

Sixth Attempted Suicide

The sixth attempted suicide (session 668) occurred whilst Ruth was an outpatient four months after the last attempt and approximately three months after her discharge from hospital. The data from table XIII reports that five alters presented in the 10 sessions before the attempted suicide and the 10 following sessions. The alter Me/MO presented 16 times before the attempted suicide and seven times post. Me/MO presented 23 times during the 20 sessions being 59% of the total presentations. The increased inclusion of Me/MO in the therapeutic process is an indication that therapy is on track. The alter Informer presented nine times (23%) seven times before the attempted suicide and twice post. The alter AO presented four times post (10%), W presented twice post (5%), and Mary once prior (3%). The sessions considered here date from session 659 to 678 with session 668 being the last session that the patient was seen before the attempted suicide.

Table XIII. Frequency of Alter Presentation in Sixth Suicide Attempt

Alter	Frequency		Total	Percentage
	Prior	Post		
Me/MO	16	7	23	59
Informer	7	2	9	23
AO		4	4	10
W		2	2	5
Mary	1		1	3
Total Presentations			39	

It was the alter Me/MO who attempted suicide. The alter Informer had presented frequently during these sessions and was “talking” to Me/MO between sessions regarding traumatic material. The function of the alter Informer appeared to be that of an interpreter to Me/MO; this alter is fused within the alter system by session 673. The function seemed to be to keep Me/MO on track. Me/MO had difficulty in coping and accepting this and as alters gradually fused and dissociative barriers were permeated Me/MO was increasingly exposed to the traumatic material that she had sought to avoid. The alter Mary explained that Me/MO:

Needs some guidance about what to talk about, about what I talked about, about why she made others including me. [The] voice [alter Informer, so named by therapist] so hyped up. Thought, other day, going to be less aggressive, scared. Would you like to know my theory? [Informer] belong to Me, screaming through her the most. You know what I think, the original Ruth, the one who can’t get it all together. She’s getting to AO and Marcie but she’s basically around when the Main One is around. Feel like I’ve said something I shouldn’t have said Main One doesn’t believe. But you look at it every time Me comes the voice comes. Also believe that even though she knows it happened doesn’t have any and no feelings. There’s only a hair separating us. Talk about some of the things she knows but doesn’t know, knows hit but doesn’t feel she was hit, knows about bathroom but so easy for her to back out of. I don’t mind being close to Me but I don’t want to be close to the others.

In Session 667 Me/MO said, "Voice [Informer] keeps telling me you want some conclusion to this. I talk to her tell her what I'm doing." She had previously discussed the ritualistic sacrifice of babies by the cult and the father's insistence that she either get married or have an abortion when she was aged 17.

Scared of what I feel. Grown up thinking that anything I love I'm going to lose so I've tried not to get close. Distancing myself from things, I mean I'm doing it right now, feels overwhelming, like I was feeling sad so went up into blinds [office venetian blinds] so easy to get lost in things. Like I'm doing a really wonderful job of avoiding what I wanted to talk about. How they meant nothing to him, to anybody. Baby sacrificed, one delivered at cult member. [Informer presents] I don't know how someone else could make them do that. Have to pay for that later on you pay the price, my life, not my life, their life I don't have a life and I'm going to take it away from them. Feel all shaky and the breathing is different. Don't want to, all quivery I don't even want to be there "You talk about this and you're dead" [repeating what she can hear whilst talking]. Nobody will help me do it. I just want to do it, make him go away ... I have limited memories being told to go in a corner with the dogs and shit like them. You know all Me and Mary wants is a cat, they keep asking John [husband]. They keep killing them. Yes, I've got lots of memories. I remember them getting married to dad and how she felt she looked so pretty with all her clothes on. Naked, then he picked her up and did things to her. ... I can feel how bad she feels. I don't want to tell you how I feel 'cos I don't like the way I feel, these are Marcie's tears I can get her. I have another memory of the mother shoving me in the cupboard. It was dark I didn't like that. I was there one day when she just lost it got us on the bed. I remember that as well.

During session 668, the session before the attempted suicide Me/MO spoke first stating:

I'm tired, certain person [Informer] keeps talking to me of a night-time that she doesn't have to listen to you, she's not going to. Since Friday maybe she doesn't like being out 'cos it's not like how it is inside, in control. Dad's birthday on Saturday 78 years, had a dream where you were staying with me at our house [patient's home] felt safe. I wasn't very old 15 years about. You [were] sitting down having something to eat and a coffee, [I could] see you were getting cross 'cos I was running late. Shouldn't have been 'cos [I] got up in plenty of time think you took me 'cos eating toast in car; dream about you getting cross with me 'cos I might not be doing things you want me to.

Dream about travelling, people wanting me take short cuts but I didn't want to, too dangerous. Wanted to go a different way longer but safer I kept running out of petrol and I was driving the car all by myself. Long and very winding journey and apparently I woke John [husband] up having a dream about spiders. Probably the long way, where people got angry at me, John keeps asking me how I am I say "Good" then say "Not so good". ... Can't help the way I am, can't help that all the time I see awful things happening, last few weeks the worst. Like I want to get away from my family completely and that means getting away from Bob [patient's youngest brother who is similar in appearance to her father and was staying with her] he's got too many reminders, he's just like dad. He expects everything and gives nothing in return and dad's like that.

At the end of this session, Me/MO stated that she had been thinking a lot about integrating and her fear that other alters and the therapist were encouraging her to take "short cuts" to achieve this. Her "dream" also indicated her concerns that she was "running late" with integration and that the therapist would be "cross" that she "might not be doing things" he wanted her to, namely integrate. The therapist had not made integration the focus of treatment (at least consciously) and at this stage was not aware whether this was a possible outcome. Clearly, however, the patient did feel the need to integrate although much of this pressure came from alters within the alter system who wanted to distance themselves from their own pain. Her attempted suicide was again by taking an overdose of medication. She told her husband what she had done. Telling her husband was indicative of her ambivalence about suicide and of her need for respite from the pressure from other alters who continued to process material independent of Me/MO's desire to "slow things down". The therapist saw Ruth after she was discharged from emergency and the alter Me/MO explained her reasons for the attempted suicide, stating that she was frightened by the rage that the alter Informer contained and that if she expressed this to the father she would be punished.

Scared voice [Informer] really me, don't see self as someone who yells screams abuse. [I am] scared it'll be me [that] dad yelling at. I can identify with her so much, her anguish. Man, just like he's so angry all the time swears till she believes that's what she is. You know, as a kid, I took on how others saw him as nice. He'd be centre of attention, people happy, where AO gets it from, made them all right [her emotional responses to the father's anger] by making someone else part of them, not me.

Me/MO's was concerned that the tension and rage that she was increasingly "aware" of would be too much for her to contain. This theme was returned to in the following session (670). The alter Me/MO "Scared if I grow up that all this confusion will be replaced by anger. While I feel like this, I can't possibly be angry. Feel so explosive. I feel like saying to younger parts of me they did not deserve that, I did." Her fear was that she would be overwhelmed by the intensity of the affect and that she would not be able to maintain control and that she would fragment. Later in the session, she returned to the theme of the father's abuse of her within the home.

He [father] was doing it all the time. Sometimes he would do it at night-time but mainly at weekends, mainly on Saturday. I remember choking on it [the father's semen]. Sometime I threw up [I would] get a belting. I was supposed to keep it, wasn't allowed to swallow bit at a time, had to keep in [my] mouth so whole mouth felt like [semen was] all over it. Then you swallowed and it hot, thought he was going to kill me said he was going to blow my brains out. He was doing bad things to me. Weren't allowed to have it dribble out of your mouth, got smacked if that happened it all had to be swallowed. I remember my mouth would ache, ache so much, I would cry, and [having] to breathe through my mouth at the same time, so hard. Think he wanted me to be hurt. I had to keep my mouth closed around him and it was so big. ... I don't feel anything the voice [informer] feels sometimes; feelings that no one would want to feel. I see her I see what she does. She's on the ground and she moves along the ground thinking yucky. Thinking I hate this, I don't want to do this. I'm just watching her. She feels angry and afraid. She cries, little children know how to cry.

In session 671 the alter Me/MO stated: "Used to be able not to think about it and it'll all go away. She [Informer] feels destroyed, or going to destroy."

Statements such as this were indicative of the intensity of the "struggle" within the alter system, particularly when those issues related to the father which consecutively contributed to her shifting perception of him.

All sorts of emotions like I loved him, I hate him, how could he do it nice, monster. Don't even have to look at the picture know see both now and them; trouble connecting two; really bad young dad and grumpy old dad. Look at old one to avoid pain. Having feelings, true takes me a bit to say having feelings, not just existing. [Informer presented] I got rid of her [Me/MO] she was hard to get rid of. 'Cos I want to know what I'm suppose to do? What do I do now I can't kill

them? Everyone's to blame that I can't do, feeling pretty God dam angry about!

In the remaining sessions for this period, Me/MO continued to discuss her fear of the father and his anger if she was to challenge him. She was confused by the competing emotions that she now experienced for her father. She disclosed that she like the father was also a bully and that she would "smack" the child alters when angry. She was frightened of the anger and rage that she was beginning to experience and was fearful that she would direct her rage to the father and that he would "destroy" her. Me/MO stated "Wish I was dead, nobody will help me now 'cos too much for the kids, what about me? Lots happened, there's people to talk to I had others to talk to." It was difficult for Me/MO to contain this affect without the assistance of other alters. Me/MO had attempted suicide this time at the prompting of the alter Informer. Informer fused by session 673 with Me/MO five sessions after the attempted suicide when her "prompting" was no longer required.

Seventh Suicide Attempt

The seventh and final attempted suicide occurred whilst Ruth was an inpatient. This was during her eighth admission and she had been hospitalized for 13 days before the attempted suicide. This was approximately 18 months after her last attempt. She was admitted from session 858 to 883 for 5 weeks 5 days and attempted suicide after session 865. During session 865 the alter Death occupied the entire therapy session. This alter had first presented in session 860 six days after admission. Table XIV summarises the four alters that presented during this admission. The alter Me/MO presented 10 times being 34% of the total alter presentations the alter Death presented 8 times 28% of the total presentations and the alter AO 6 times 21% of the total presentations and the alter Voice presented 5 times being 17% of the total presentations. As alters increasingly fused, their numbers reduced and there were more consistent and prolonged presentations of Me/MO; this was increasingly the case from session 878 onwards. Me/MO presented most frequently during this hospitalization though only post attempted suicide. It was

Me/MO who attempted suicide in response to information of the alter Death and the negative emotional affect that this alter aroused in her.

Table XIV. Frequency of Alter Presentation in Seventh Suicide Attempt

Alter	Frequency		Total	Percentage
	Prior	Post		
Me/MO		10	10	34
Death	5	3	8	28
AO	4	2	6	21
Voice	1	4	5	17
Total Presentations			29	

During the first session (860) in which the alter Death had presented, AO described the alter Death as one who “Tells me how bad I am”. She described this alter as speaking directly to Me/MO and that it was “Pushing her, frighten her”. Later during the session the alter Death stated, “You see no one suppose to survive this. Need to do things, need to make sure she doesn’t tell any more ... hurt her body, he [father] wants her body to be hurt”. The alter, Death continued to discuss her role and that of other alters that had been involved in cult activities especially those alters present during the ritualistic sacrifice of babies. In the next session (861) the alter Death presented for the entire session and discussed childhood memories and how she functioned within the alter system.

Then my mum went away, dad not there all the time. I didn’t think these things could happen they, go on picnics, movies, lots of good things to eat, [had] friends. I started to feel different to other kids, knew not happening at Julie’s [her childhood friend whose suicide had been the reason that she had sought treatment] house [I] didn’t see it. I started not wanting to do anything. That’s when he said [father] biggest secret, like I can see him thinking now. It’s really complicated, said I’d die if told. He wanted to do some horrible stuff, not good. He called me bad because not wanting. Hit me across the head, [he] always does it, or [across my] back as well. I used to be

sick at school, makes me angry that they got babies, sometimes like to hurt him way [he] hurt me. Hit then [he] went quiet like really thinking I was waiting for more, thinking he was going to get really, really angry that's when he told me. [I was] Standing [he] hit [me and I] fell to the ground. Felt like I was part of the tiles on floor thought I was going grey, made him seem so much bigger. Scared [he was] going to kick then he grabbed my arm pulled me to the table. Sat me at table talking to me said if I spoke about [cult] I was to die, a huge secret he was quiet, he looked dead, that quite scary. That's where 4 plus 5 come in, he said, "4 plus 5 is 9 and 9 times 5 is 45 when going to die." Said about three times quietly, "Now listen to this 4 plus 5 equals 9 times 5 is 45 then you should die" I get mixed whether I want to die or he wants me to die. Another big secret, I don't know how to get in touch with anybody, I've forgotten their names. My dad did when I was 9. Like when I get to be his age I should get in touch with people and they would show me things. He 43 thought all I know is I should have found them and then I was suppose to die, but I don't know who to go to.

I can get to Marcie but I can't now because [she is] inside AO. She was the one it did the most to. Like a nightmare for her, baby come in go out, [it was] too much for her body, [even] more for her mind [the abortion at Peggy's], ... wasn't long after this time that they stopped doing it. Only thing frightened me about dying in [the] bush, no one find me. Now have to do somewhere, where they would find. [Father] shook me, and left me sitting by fire in kitchen, felt like jumping into it. Instead I opened oven door put legs into it, see how long keep them in there went sore couldn't do well, couldn't leave long. Had a bath wanted to go to bed, dad made me kiss him. Came to room put penis in my mouth then doing something to me down there. Couldn't breathe, sound horrible like I could smell his bottom didn't smell very nice, really horrible when he's over top, bottom right near my face.

The following session (862) Me/MO discussed how she, "Feel so bad, empty, lost filled with all this immense sadness. Don't know where I'm going. Just want sleep 20 years. Like everyone of us has to feel the same thing, all the stuff I've been blaming them for". Me/MO was finding it harder to dissociate from the emotional consequence of the abuse and was having difficulty in compartmentalizing the traumatic events. It marked a shift in her perception and acknowledgment of the abuse. During the following period AO continued to punish herself by hitting her right hand against the wall. During session 864, AO and Death both presented and discussed their difficulty in processing material particularly that associated to their relationship with the father.

Don't feel connected to it 'cos I don't want. [AO continued] Thought she [Death] could speak to you and you could work things out. [Later in the session Death, speaking described her mood] Inside big black nothing, what's filled me inside a black can't see in front of you, heavy feeling. ... Dad, how he made me think he was ... loved me doing some kind things taking me out of the box [when covered in spiders] thought how brave he was. Picking me up after killed baby like he rescued me saved me and I have betrayed him. He was my life and death and he used to save me. He pulled me out. Being one person be so lonely.

During session 865 Death was the only alter to present. At this stage alters had increasingly fused and Me/MO was being progressively exposed to knowledge of the abuse that she had previously been attempting to avoid. In the session before Me/MO's attempted suicide Death discussed the abuse in detail such that Me/MO was no longer able to avoid its painful understanding.

Don't feel like getting up in the morning, nightmares, know they've talked about but I haven't. [Spoke yesterday about her mother marrying the father in a cult ceremony]. Can feel it [mother's wedding dress] stiff material pink with black lace. I've got white on standing behind touching her dress wanting to make sure there. She left hers on when I took mine off. Felt exposed like I felt everybody looking cool, nervous. Steve [eldest brother] looking, [I] didn't want anyone looking she took dress, shoes, socks, singlet not too bad but when she took my knickers off thought everybody looking. Standing there they all around me. Dad there wanted him to protect me. My mother gave me to my dad. Why [I] hate the bitch, like I was standing between them felt not only standing physical separating emotionally. Like mum wanted dad to have me. Called me Ruthie I didn't want to be there. Dad had hold of my hand, had hold of my hand pulled me close. Picks me up after said all these words slide me up and down his body. I didn't mind I liked the feeling of going up and down him, can feel it but it doesn't hurt. Sometimes when he would just touch me without hurting felt good; feel warm; feeling like want him to press harder, I liked it. Like he was standing in front of me against him [my] arms round [his] neck [my] legs around him, chest against his, he would lower and raise me, I got all tingly. I wanted him to do it, not the things that hurt. I wanted him to keep making me feel tingly I didn't want him to hurt me. Have you ever been constipated, can't come out hurts? What dad felt like to me, just so big. He'd laid me down, I truly believed, believed that I was going to break, [I] screamed, didn't get hit or anything. I can put adult words to it now. Like they were victorious, sacrificed something so good - me. I was allowed to scream I don't know how far he went into me felt like I was split open. Like I was a piece of meat, I

couldn't walk afterwards so sore. After he entered me he then obvious so excited pulled his penis out put on [my] tummy all this stuff came out rubbed it all over my body I weed. Felt so good could feel it. I hate my father that's how I got married. They left me near fire hear them laughing, drinking felt so alone, didn't want anybody there but my mum. All mums should be there when needed. Like I was a little grain of rice, all these people didn't want to see me. There was such a very, very long time that I was there I got really tired wanted to go home to our place but they hadn't finished.

Keep yelling to myself "Were did he get it from, this baby?" just picked it up by back of head. Dragged away from fire by [my] arms, [father] sat me up against tree covered me in all this fucking blood. I would rather have had Easter eggs [father had filled eggs with semen which she had to eat] than all this. Drink red drink tasted awful. I don't know why but that's what water reminds me of tastes horrible. Red water, it was blood with water.

It's like it was just too much I was hungry, cold, and most of all scared. Didn't know what else they could possibly do. I can't believe they could do that. I just can't work out were they got babies from and didn't get into trouble feel as if I'm lying. Want to find a reason couldn't have possibly got a baby doll, but doll's don't scream, bleed, no hair on head, didn't have eyes open so busy screaming, girl baby. And you don't think anything worst could happen after cut throat turned it over made me stand next to him, cut off her vagina, I just went crackers then. Just like I screamed and I screamed so scared throwing up, accident after accident. Saw this mutilated little girl except I didn't know mutilated mess. He just looked like John [husband] does sometimes when John filleting fish. Just standing, I felt like I was on hot coals. I don't know why all these accidents like even now, sitting here, holding self-together still makes me feel that way. I don't understand him; I don't understand the other people. I feel like I'm telling you things others want to run away from.

The following session Death continued to discuss material that had been discussed by other alters, primarily AO, Marcie, and Les/Charlie. "I needed to bury it so I could grow, can't bury it forever." This was the last time that the patient attempted suicide and though she continued to process traumatic material she was sufficiently contained that she did not attempt suicide or further self-harm. This admission marked the first time that the alter Death presented, AO revealed that this alter was the inner voice of the Main One. In session 878 MO stated that Death had joined with her. Several sessions were occupied by Death processing traumatic

material, Me/MO also presented to deal with traumatic material during this admission. During this admission fewer alters entered into therapy, an indication that the patient was less fragmented and that the alter system was becoming more cohesive.

Summary of Patient's Suicide Attempts

Four alters were involved in the seven attempted suicide. AO was the first alter to attempt suicide. This was prompted by guilt related to her participation in the ritualistic sacrifices of the cult and in her changing self-perception. Marcie attempted suicide three times, these being the second, fourth, and fifth attempts. These also appeared to be prompted by her participation in ritualistic material and her relationship with the father. The alter W made the third attempt apparently at the prompting of Amie who wanted to feel safe and remain within the hospital. The remaining two attempts, the sixth and seventh, was by Me/MO as she was increasingly exposed to painful traumatic material and the dissociation barriers were permeated. The exposure of Me/MO to painful material was at the prompting of two fragmented alters, Informer and Death respectively, who then fused with alters within Me's sub-system.

When processing traumatic material that led to self-harm and attempted suicides there was, initially, an increase in the number of alters that presented during these sessions. This number decreased as the patient became more stable with the material and was less inclined to use dissociation as means of coping. As the material was processed, there was evidence of fusing between sub-groups and eventual integration of alters. The persecutory alters were able to undertake tasks that others were overwhelmed by. This acted as a defence mechanism for the alter system so that the patient was able to maintain as healthy a balance as was possible in these circumstances. The role of the persecutory alters in this process, whilst initially a "destructive" one, did eventually assist in the development of a sense of containment, the hospitalization allowing for intense treatment of traumatic events that the patient needed to process whilst in a relatively safe environment. The

treatment, led to attempted suicides; in 12 hospitalizations, four suicides were attempted but during eight hospitalizations there was no attempt to suicide. The most frequent attempted suicides occurred early in therapy when the material was in some ways “fresher” to the patient and coping mechanisms less developed. There were three suicide attempts during the year 1995 up to session 363 then a further one attempt in subsequent years up to June 1999. The patient increasingly learnt to cope with alters and the material that they contained, particularly persecutory alters, though later there was some indication of the patient feeling that life was not worthwhile and experiencing a sense of helplessness. Once the persecutory alters and their concerns were dealt with and they felt that they had been “heard”, understood and validated, the impulse to attempt suicide left the patient and this has remained true to the present date. The patient was admitted to hospital on four occasions after this, three in 2001 and one in 2002 and though she had difficulty in coping with traumatic material, there was no self-harm or suicidal ideation present.

The main impulse had come from the persecutory alters responding to beliefs regarding their role within the alter system or beliefs about “orders” to carry out their own perception of their role based on observations of cult members behaviour, particularly that of the father. Similar issues that one alter discussed such as the sacrifice of babies needed to be discussed by several alters because all had some experience of it. The more traumatic the event the more alters had been created to contain the overwhelming nature of the abuse. During the sessions following the patient’s seventh and final attempted suicide and her discharge from hospital, sessions 884 to session 1125, there were 337 alter presentations. Of these, four were alters that had not previously been disclosed, Maggie/Mae, Stuck, U Gin, and Serpent. All these were fragmented alters. From session 884 seven alters presented. Me being the only alter during this period to present for an entire session. Of the 241 remaining sessions, Me presented for the entire session 107 times, the frequency of Me’s presentations and the infrequency of switching was further evidence that the alter system was moving towards integration.

The alters appeared to have a need to fuse and to attach to each other. Being able to narrate their traumas in a therapeutic setting and being “shown pictures” of

traumatic material by other alters provided a means of attaining this. It also created some animosity between alters which contributed to the sense of separateness between them and to some of the self-harming behaviours. Alters such as Mary and Me/MO attempted to withdraw from the therapeutic process and left other alters to process the traumatic material. It was only in the later stages of therapy when most of the sub-groups had fused that Me engaged with the material as a single entity. Mary's attempts at coping with traumatic material overwhelmed her. She had difficulty coping with material that was the antithesis of her own self-perceptions. This changed later in therapy when Mary, through the prompting of other alters, was able to acknowledge abuse that she too had experienced within the home. Whilst experiencing this, however, she was unable to continue to provide the reassurance to the alter system that she previously had provided which had assisted in maintaining stability within the alter system. Her own sense of despondency meant that she withdrew from supporting the alter system at a time of most need and this contributed to the self-harm and attempted suicides. The attempted suicides appeared, at times, to represent a wish for the symbolic death of the trauma so that it would not be felt. This did change later in therapy when the original personality Me/MO connected with the traumatic material that other alters had previously been containing. When this occurred, Me/MO "connected" with the painful material and initially felt a deep sense of despondency as her perception of her father underwent revision and she attempted the final two suicides.

The self-harm and attempted suicides were also prompted by alters that contained aspects of the traumatic material wanting acknowledgement from other alters whom they perceived as responsible. The reason for this appeared to be twofold; on one hand it served to disperse the impact of the trauma by enlisting the assistance of others and it also enlarged the capabilities of each alter to connect at a deeper level within the alter system so that it facilitated fusion and eventual integration.

7.3 Process of Treatment with this Patient

Overview

As previously acknowledged, the process of treatment with this patient was slow and uneven. The material that the patient presented directed the course and content of the therapeutic process with the pace of therapy being dictated by the patient's responses. During her first session she stated, "I think I've got something very big boiled up in me". Her motivation for attending was the suicide of her childhood friend, Julie. This had provoked strong negative emotions within her. During session 233 the patient said: "I don't think I would have come if Julie hadn't died. I don't think any of them would come". Thus the patient acknowledged the divisions within her. During the early phase of treatment, it was also evident that there was a division between those alters with knowledge of cult activities and those without (e.g., Me/MO and Mary). Twenty of the alters, as far as could be discerned, had been specifically involved in cult activities and some alters such as AO and W had experience of activities in both the cult and the home. These alters, AO and W, had an important role in the progression of therapy. AO, in particular, was pivotal in this process as she was an important bridge between the home and cult alters. She presented 421 times during the course of therapy, session 875 being her final presentation. During session 880 the alter Me stated that AO had joined with her. The alter Me/MO presented 513 times. From session 879 MO fused with Me who subsequently presented a further 237 times (see Table XI Chapter 6). Other alters that had a significant part in the process of treatment were W who presented 169 times, Marcie presented 99 times, and Mary who presented 64 times.

Presentation of Alters during Treatment

Alters presented during therapy in response to the material that was being discussed and "re-experienced" by the patient. Initially, alters such as AO were impatient to "get on with things" and readily discussed their concerns. Whereas, alters such as Me/MO and Mary, who had no knowledge of cult abuse, were more reticent and, though they did initially participate in the therapeutic process, they

gradually withdrew and left it for other alters to discuss traumatic material that involved the father. When they did participate, it was to cast doubt on the truthfulness of what other alters were saying or, if it was true, it was not their experience so therefore they did not need to participate.

Ruth discussed traumatic material early in therapy. During the first 50 sessions she had introduced separate issues of abuse by the father and the maternal grandfather which had occurred when she was 5 years of age. Dissociation was also evident early in therapy when the patient discussed issues pertaining to the abuse. Indications of ritualistic abuse were apparent by session 191 with the appearance of Marcie, the Body, and AO. The ritualistic nature of some of the abuse had previously been alluded to by other alters during the initial stages of therapy. During the course of therapy, the patient continued to raise and return to issues of ritualistic abuse. All the central alters had presented by session 191 when Marcie eventually presented. Of the central alters Marcie was also the last to fuse presenting up to session 1092. Integration of the alter system had occurred by session 1106.

Abuse by the father and the cult was most prevalent for Ruth between the ages of 5 to 11 years and all alters had been created by the time that she was 11 years of age. No further alters were created after this period apart from Louise who was created iatrogenically during the course of therapy. Prior to treatment the patient utilized only those alters within the system that were necessary for daily life such as Me/MO and Mary with the majority of the alters within the system remaining “dormant”. These only emerged when events or emotions triggered them, such as spiders, of which she had an inordinate fear, being separated from her father, sexual attraction, moments of unexplained distress such as the smell of meat in a butchers shop, and when she became a mother.

The process of integration whilst not the sole focus of treatment did occupy a central role and the fusing of alters appeared to occur within a hierarchical process with the very young alters fusing spontaneously early in therapy. The process of fusing was automatic with alters joining apparently under their own volition. It

appeared that each sub-system needed to first fuse with the “central” alter within it (see Figure 4 Chapter 6) before alters from different sub-systems could fuse with each other. For example, Marcie was the central alter in the sub-group that contained AO, Maggie/Mae, Beth, Young Bert, and Serpent. AO had subsequently created Darryl, Boy, and Les/Charlie. The alter AO was most prominent during the early and middle phases of therapy. It was with her that many of the alters in this sub-system fused. However, Marcie contained too much negative affect for her to join with AO and she fused with Me who had created her. That the alter Body apparently joined with AO rather than to Me/MO was mainly due to the refusal of Me/MO to acknowledge her connection with the alter Body and the negative affect that this alter held. It was later evident, however, that knowledge contained by the Body was experienced by most alters not just AO, though it was AO that had been the catalyst for this alter joining. During session 593, for example, W said, “You know the Body’s integrated with all of us that’s why we’re rocking”.

The therapist did not suggest which particular alters or sub-groups of alters should fuse; this evolved out of the context of the therapeutic process with alters instinctively choosing with whom to fuse. On one occasion, AO asked for assistance in joining with a particular group of alters. The therapist clarified with her what would be important for this and facilitated the process. AO wanted to join with Les/Charlie and Darryl whom she described as being ready to join. She described a “scene” of green grass in which she would like them to lie down so that they formed a circle with their heads touching whilst they joined. The therapist discussed this with her and whilst at home the patient visualized this scene and joined. When she later discussed the effect this had on her, AO (session 656) stated that:

I don’t think Me made all of us, made the start of us and we made ourselves. When things got too much for Marcie and Amie, I [AO] came. They couldn’t take it any more their minds went. Amie could help [with joining] weird feeling Darryl, Charlie, Les, joined heads. Sometimes hear him [Les] sometimes think, Oh, I’ve said it.

This particular fusion was successful. Ruth later undertook other attempts some of which she discussed first with the therapist, while others were spontaneous. There

did not appear to be a particular way that fusion occurred other than the patient's readiness and desire to join once issues had been discussed and processed by her.

Alters that had been created in response to similar traumatic events tended to fuse with alters that "shared" this experience. Hence, specific sub-groups were based on their shared emotional and cognitive experiences. Alters within particular sub-groups fused first with each other before alters from different sub-groups were able to join. For example, when AO discussed her involvement in the ritualistic scarification of babies this triggered the emergence of other alters such as Les/Charlie and Maggie/Mae who had developed in response to this material. They contained aspects of the traumatic event that AO could not. These latter alters had a more circumscribed role within the particular alter sub-group of which AO was the central alter (see Figure 4 Chapter 6). They were more limited in their responses but when required had to undertake traumatic events that had overwhelmed the previous alter. Alters did not appear to be able to choose with whom they would fuse. For example, AO believed that W should fuse with her and there certainly was a connection between them, however, W was linked to Mary and it was with her that she eventually fused. The therapeutic process was similar with all alters though those not identified as central alters did not require the same extent of working through. Their issues were more circumscribed and usually, once their task had been understood within the alter system and responded to appropriately by the therapist, they fused reasonably rapidly in comparison to central alters. In the early phase of therapy, alters with knowledge across both home and cult activities were important in processing and advancing therapy. They set the context into which alters such as Les/Charlie and Darryl who had more specific memories could emerge and interact with the therapeutic process.

The data of this study support a hierarchical ordering of alter development with more alters created in response to increasing traumatic events and demands made upon the patient by her father and the cult. At a time of extreme trauma when one alter was inadequate to contain the abuse and needed another to retain a sense of cohesion, a joint alter was developed such as Chris/Carol, Les/Charlie, and Maggie/Mae. Each alter contained a different aspect of the trauma that needed to be

explored in order to progress therapy. AO, for example, participated in most aspects of the ritualistic sacrifices but she needed the alters Les/Charlie to contain and carry out specific ritualistic activities that were too overwhelming for her to hold. Similarly, Darryl was needed by the sub-group to participate in cult celebrations and was an alter that could identify with the father's authority. Some alters such as AO and Mary continued to develop beyond the period of cult abuse. These alters fulfilled a developmental requirement, Mary for ongoing nurturance to her children and family and AO to maintain a sense of pride and self-esteem. A central function of alters with knowledge of cult abuse was, in part, to contain and to keep such awareness separate from Me/MO and Mary so that these alters could maintain daily functioning.

That the alter Me/MO did not "want" to contain knowledge of the abuse was established early in therapy and possibly provided one of the reasons for the development of two separate systems, one for daily living, the other for cult activities. This is discussed in the following sections. The process of therapy, in retrospect, occurred in two phases: initially the treatment of alters with knowledge of abuse and then, during the final stages, the treatment of the original personality Me. The alter AO had the broadest perspective of the alter system and knowledge of most of the trauma that had occurred within the cult and home. The layered nature of this patient's alter system added to the complexity and duration of treatment and traumatic issues discussed with one alter had to be "re-visited" with another whose negative affect needed to be addressed as did the relationship between alters. The alter system was one of dynamic tension in which different sub-groups had achieved a homeostasis that enabled Ruth to contain past abuse whilst maintaining her daily life.

In the following sections these issues are considered in more detail, in particular the difficulties presented for the patient as compartmentalization of the alter system gradually dissolved and the process of integration began. These developments are divided into four sections: first, the sharing of affect between alters and its importance in the integration process; second, issues of self-harm between alters; third, the conflict between the "home" alters and those involved in the cult

activities; and fourth, the difficulty the alters AO and Me experienced in attempting to fuse with the alter Marcie. The process of integration is discussed here for only a few of the alters though the process was similar for all.

Sharing of Affect between Alters

One of the key elements in this patient's treatment involved the emergence of alters and the conflict between them as their affect became inclusive. As alters began to describe their particular traumas the emotional content triggered the memories and affect of other alters and set in motion the unfolding of their particular narrative. This led to increased tension within the alter system particularly between different alter groups; most notably between those who aspired to discuss cult abuse and those who sought to distance themselves from it. Whilst the therapist was initially naive to the various alters within this patient's alter system, an understanding of them and the role that they had was essential to progress therapy. It was the particular alters need for resolution of their particular issues that maintained this progress and that dictated the pace of therapy.

During the initial phase of therapy Ruth discussed how particular alters had impacted upon her. One of the first indications that therapy was progressing was the sharing of affect between alters. In session 233, for example, AO stated "I feel like I'm joined to the Body I used to be able to tell you things without crying". Similarly, in session 390 AO stated "I know what went on, but its not happening to me, like watching TV. I feel sad, can feel it even though watching it, I can even feel my jaw aching with this great big thing stuck in it." AO explained that she could feel W performing fellatio. That AO began to share W's physical and emotional experiences was further evidence of dissociative boundaries being breached and an ongoing marker for integration with this patient.

Similarly, during session 294 AO stated: "I don't know why I'm here with W's stuff". Alters initially were able to differentiate themselves in terms of their emotional and physical differences but this began to change early in treatment. This

was also indicative of the connection between these two alters despite their differences and the different sub-groups that they were from. AO stated, “Feel like demolishing your room, [I am] filled up with W’s stuff. Why can’t she express her stuff too? Maybe I’m responsible for her. Responsible in that I’m rotten”. AO was the main alter to experience guilt. She perceived herself as having an independent role and that therefore she had some “choice” over her actions whereas W tended to perceive herself as at the disposal of others and more one-dimensional in her functioning than AO. The issue of guilt and shame were difficult but central issues for AO but, despite such difficulties, she continued to progress and work through them whereas with W the therapeutic interaction primarily remained with the issue of sexuality. She did however discuss issues such as the abortion in depth but essentially her sense of self was constant and she represented the sensual aspect of the patient’s development that the father’s abuse had derailed into sexuality.

Just before session 306, the patient spent the weekend on her own and during this time the alter Body had fused with the alter AO. During session 306 AO stated:

I think we’re so desperate I don’t think that we can take in...I don’t think it’s fair that I have all of them as well. I should never have taken the Body on. Teach me about going away Saturday with her for so long. I should never have allowed her in. I’m left with everything; W’s feelings, they’re all using me from grandfather standing over me, right through to dad to W’s experiences. Nobody seems to understand that I can’t take it. Before it was a straight tunnel, your fault it has broken down. I thought they were pretty thick, you should have explained to me, I always thought I’d be me.

AO had a central role in therapy and she initially perceived herself as the alter that all others would have to join with. For example, during session 640 whilst grappling with issues of fusing with other alters AO stated: “Don’t want to be less in charge. Mary reckons that I want to be like the President of America. I want to be in charge I would feel like somebody; I would be treated better.” She continued to struggle with her changing sense of self, especially her feelings of guilt (session 316).

I’m supposed to be aggressive, straight up, and straight down. I don’t look at myself [as] being emotional this is an invasion. Others have invaded my boundaries because I shouldn’t feel like this, means that I’m not the same. What I really want to do is to go rotten, see it all

oozing out of me. [Later] We're so close [AO and W] that most of the time I feel that what she does is me. Last night she was remembering how she picked it up, it was shiny and very messy. Worst feeling I've ever had, to have someone inside saying you're destroying my baby. It wasn't her baby but to her it was. It didn't affect her later on because it didn't look like a baby. I just hate seeing it over and over hearing it, it was awful.

AO contained intense feelings of guilt concerning W and the first baby that had been ritualistically sacrificed. AO had taken the baby from W when the father had demanded that she bring it to him. W had been holding the baby and consistent with her sense of sensuality had particularly focused on the feel of the baby's warmth and texture of its skin, memories that made the re-experiencing more poignant. W blamed AO for the baby's death. W felt separate from this and therefore reasoned that the negative affect belonged to AO. During Ruth's sixth hospital admission, W (session 623) talked about the ritualistic sacrifice of the baby. This passage of therapy is quoted in some length since it denoted a significant change in W's ability to identify and respond to the issues that were relevant to her in treatment.

You know the baby wasn't much bigger than monkey [soft toy used by patient during therapy as a transitional object] here, longer arms, legs head bigger. When holding [the baby] seemed big, warm, tiny little mouth I made him warm and he made me warm. Funny how even when the temperature is warm you can be cold, why put jumper on [before came to this session] couldn't work out if cold because nervous or cold weather. I was cold and the baby was cold, so got a little bit warm when I had to take him over to dad had to lay him down. Have my dad talking to you right now "Come over here you slimy [cunt]" I'm an awful thing. So, I had to take the baby over there and I didn't want to look at him I started shaking. That's when AO came, he was saying something, [and] that's when AO came and she killed it, killed him and threw him in the fire.

If we're joined together then what you say is right but I look different to them, so they killed him not me. Charlie killed snails last night thought he was at home and they were going to eat our plants. I like to look at nice things not horrible things, makes me feel frightened like dad used to make me feel frightened. Dad used to really scare me, even when I got a bit bigger he really scared me made me do strange things, found out when I had my period, and have sex. Used to go up to shop make sure they were all wrapped up in paper but I guess I smelt he always knew. Sandra [patient's daughter] got hers' two days after she turned 11 years of age. I've given her that to start off with early in life I was 10 years.

I'm remembering about Peggy's house I was 11 years then I didn't know what was happening. Two times, I stayed there, stomach pains hospital doctors examined find nothing wrong. Once doctor came out I spent hours there I had to have my legs open on her bed on my back. Everything was white on her bed. I know it was daytime I used to sleep in her bed sometimes when her boyfriend was there, slept between them. He was like dad do the same things and Peggy lay there watching, but this night doctor and her, blood everywhere some of it red and some of it dark. Was a few days, two, before I got up properly. All I wanted to do was get off the bed and get up but I couldn't move he was doing something to me. I don't know what he was doing I know I kept going to sleep you know you've been asleep because he wasn't standing in the same spot and I never saw him move. I had all these pains one very big stomach pain. And I was to be quiet. Had to be very, very quiet, I was crying lots, but its funny how you can cry without making much noise 'cos you weren't allowed to make much noise. Very frightened because I didn't know what was happening, all this red blood everywhere and all this dark blood. I remember when I was older and having a miscarriage a lot of blood, pain, come squirting out couldn't stop or anything. ... I don't remember much of it just that he kept walking. Shoved something in there, felt it pulling and it hurt. My body was big for 11 years.

Didn't see my dad after he had already gone and I was there before school started I couldn't wait to get into the [Salvation Army] Home and away from Peggy's place. I got frightened 'cos dad asked me if I wanted to stay at Peggy's or go to the Home and I didn't want to go to Peggy's 'cos bad things happened there. After, for a few months, I didn't bleed. Then I did thought I was dying with all the stuff. Like on her bed and I was hot like sometimes wake up in the night with bad dream head hot and sweaty so I didn't want to stay there. How come he wasn't there? He was always there when things hurt and there was this strange man there looking at me, poking me, and doing things. Peggy sitting on the bed telling me not to make too much noise, it was a dark bedroom, light on. I kept looking at her wardrobe thinking I'd like to go into that. I didn't want to go into the bed 'cos I was lying on that. I couldn't go into properly 'cos I had to keep moving. I couldn't understand why they didn't want me to go to the toilet, pain. But I had to lie on bed. I didn't want to do that scared blood everywhere and I got really frightened and my dad wasn't there. I don't want to feel it. It was like the pain, I can feel it now, my back was so sore all I wanted to do was get my hands and push down on my stomach that's all I could do. I would move down the bed a bit, feel bottom [of the bed] but be moving so much up and down not sideways. My legs couldn't move. If I lifted my head up, which I did, saw all this mess coming out of me and I knew it wasn't coming out of my bottom. I still feel like that, except I can really get in and clean it. I'm telling you I saw it [her vagina] and that's when he said it [W is referring to times when father would hold a mirror against her vagina and make her look at herself after she had been abused]. I do

it the same, someone makes me do it, the whole time they're telling me I'm "A fucking [cunt]" ...like the only way I'll enjoy sex is if my dad's doing it he kept saying "You like this, this is what you like." Most of the time, I felt nothing I just hear his words telling me what I was and what I'll always be. Like when I took the baby over to him and I started shaking I could feel that he was angry that's when AO came and she was shaking but she didn't care if he was angry. It makes me hurt so much inside.

Following this session W presented a further 16 times before she fused with Mary by session 851. When the issues that were of concern to W had been addressed she was no longer needed as a separate alter within the system. Her fusion with Mary denoted the "nurturing" aspect of self that both alters contained. Whilst this material had previously been discussed by AO, the experience was W's and therefore she needed to understand and integrate it in order to fuse with Mary. This was the first time that W had acknowledged her part in this trauma; previously other alters, principally AO, had discussed it. Her re-telling of the abortion also triggered similar traumatic memories such as when the father held a mirror to her vagina after abusing her and when she had held the baby before it was ritualistically sacrificed by the cult. The re-telling of these traumatic events enabled the delineation of boundaries between alters as well as their connections with each other enabling them to fuse and ultimately facilitating integration.

The fusing of alters necessarily created emotional and cognitive changes within those alters that they fused with. AO, for example, whilst wishing to be the main alter, expressed some of the changes within herself in session 641.

Our boundaries more blurred some of us having trouble working out what's ours, some things not clear. ... Find myself looking at myself, I pick up that I'm different; I look different. Sometimes I see a very young teenage child other times I see someone like Mary, I stand back and just look take it in, I don't panic way W does.

Similarly, in session 650 AO discussed her sense that she would contain all or most of the alters. She had previously discussed these traumatic experiences but joining with other alters increased the emotional intensity of the material.

All my life I've been switching off not going to suddenly change stop. I'd rather get on with it. Think you want me to talk about what's

bothering me the most, I don't mean to [avoid] but I do. Was telling you feeling quite strongly afterwards that feeling there on top of it's what I did. First time I told you so easy, wasn't but like now so difficult. More I think about it, more I know how bad I was. ... Thinking a lot of being outside, okay not to know where I am, just remember in bush. Thinking when a kid people look bigger. Thought it was all right for me to be disorientated. She [Me/MO] wants to know why someone would give up their baby. Think it's going to be me that's going to have all of the feelings.

As the affect deepened, the emotional consequences of specific traumatic events were experienced more intensely by alters and broadened their emotional awareness. In session 650, for example, AO stated:

I don't want to feel as I did as a kid again. Wish I could get rid of feeling. Worms boring into stomach, arms, thought not smoking [patient had given up cigarettes] but didn't go away hunger not bad dreams. Feel like I'm going to keep bursting out in tears cry like someone terrified then someone played a trick on them. Still get lost in whether I'm talking out or not. After I'd killed the baby, they told me that I was a killer. I was confused he'd [the father] helped me. He wanted me to know what I'd done. Charlie came in handy look don't care. One [I] admire the most Darryl prance around and Charlie knew how to think he didn't care. I stood there lost and when I "woke up" all this blood on me, still feel [it] between my fingers. Didn't have any clothes on to wipe it off. I feel so angry doing that to me. That he could do it with the mother, she didn't want the baby. Get scared when Daniel's [patient's eldest son] around all his chefs knives. Look the same a sharp knife for cutting downwards. Huge big knife cut its hands and its feet off. They just fell off hit the ground, like watching some horror movie. You know like you can hear like a crunch and a sloppy sound. Whole thing just thrown on fire, push around with a stick. Makes a noise, it actually makes a noise can't describe it. Seems like a lifetime takes forever doesn't it? [The telling of it] I want it to be over with. Every ones just looking at me, that's what they're looking at me I'm the killer. Won't forget you're a killer can't say anything 'cos you're a killer. They made me do that didn't they? And if I told, I would be dead.

Feelings of guilt continued to dominate Ruth's progress in therapy and contributed to another key issue in her treatment that of conflict between alters. As the alters became closer a sense of being "contaminated" with the negative affect of others increased the intensity of their memories and therefore the "re-experiencing" of traumatic events. Their feelings of guilt contributed to issues of self-harm.

Self-Harm Between Alters

The issue of self-harm between alters has been discussed in the section on attempted suicides and only a few remaining issues are addressed here. The patient's self-harm was frequently the result of alters processing acts for which they felt guilty. AO, in session 271, for example, discussed how the father made her eat flesh from one of the babies that had been ritualistically sacrificed.

He puts it in I spit it out after a while. He slaps me across the face. I don't like finally, he gets it in, got my face so tightly has my nose so can't breath have to swallow. That's why I know I have to die 'cos only way to get rid of all this is to die. ... I was there but wasn't there. But I never went to a nice place like the others stood alongside self didn't like to see expression. I could never get that far away. ... Should just slit stomach; let all this awful stuff out.

It was memories such as these that fuelled AO's feelings of guilt and her conviction that she needed to be punished to atone for her actions. Other alters were willing to blame AO particularly those involved in daily activities; Mary (331), for example, stated that, "She's done awful things AO". Eventually, however, all alters even those such as Darryl had to come to terms with their actions. Until the later phase of therapy, however, there was division amongst alters as to who was responsible for the pain felt within the system and who should have to process it. During session 293, Ruth had been admitted to hospital (her fourth admission) because of continual self-harm that she was unable to contain. The cause of this was resentment between those who had experienced cult abuse and those who had not. In the following passage, AO explained that she had harmed herself in an attempt to make Mary experience her pain. Darryl, who felt a sense of pride and power in his ability to cause AO pain, also encouraged it.

I showed her about what stabbing yourself felt like; the bitch didn't even feel it. I hate her [Mary] still not seeing. Arse up head down. I just want to rip my whole body to bits; feel like I've got a bomb inside me wanting to go off. Just wait he says [Darryl] till in the bedroom stab chest, stomach, make a mess of yourself. You may not realize this but she [W] didn't go through all that on her own. Sometimes I lay close to her and I could feel her. Telling her, when they did that thing to her, told her it didn't hurt, but it did.

AO's affect intensified as alters continued to fuse; this was so even with material that she had previously discussed. The fusing of alters within sub-groups triggered related traumatic material. In the following passage, AO (541) discussed her fear of Darryl "making" her re-experience traumatic events particularly those for which she feels guilt and the cause of her self-harm.

Not suppose to be scared. He's going ... he's going ... he's going to make me go back and he's going to make me scream that I kill all these babies that's what he's going to do I know ... and ... and you ... you know that's what he's going to do. Even you couldn't stop him yesterday [she had cut herself]. From ... from ... from and he's going to make me do that make me feel awful.

During the course of treatment, various alters explained their anger, particularly to the alters involved in daily activities whom they perceived as the cause of their own pain. During sessions 579 and 585, for example, Les discussed why he wanted to harm Mary.

Les said: Take Mary for instance, she deserves to be put out of her misery. I'm giving her alternative ways she can go home and kill her self. "You look at your self, you fat ugly bitch" [Les said to Mary]. Reminds me of women who looked after us [housekeeper who abused patient's pet cat]. Feel like slapping her in face. Just stand there, look at that fat pig of a woman. I had choices, I could fall to bits over what they did or not give a shit. Know everybody feeling and I don't. I didn't give a shit!

[Session 585] I thought I died a long time ago. Think I did die when I was about 6 I think I died and I woke up. Sometimes I think I woke up the next day then I died again probably from 9 till now, months ago. AO woke me up. She was talking about something it woke me up feeling pissed off about everything. Nothing in particular I didn't want to know when I woke up. Woke up when she was talking about baby, maybe it was just like before she wasn't able to take it like before.

[Later in session] First time [I] died [was] when dad killed the cat and laid it on me. There was somebody there before me. Came then, came and felt all this sticky stuff could feel the cats fur smell around me. I didn't know what it was all about really then I died when I

found out what it was. I got a fright and I died. I died when they lifted the cat off me I saw what it was. He put his hand inside it and lifted it up. Thinking about lots of things where I came and died, I didn't get being picked up afterwards. Now I wish I could die again.

Les/Charlie had presented in response to specific events within the cult. Similarly, during therapy, when alters in Les/Charlie's sub-group, such as AO, re-experienced traumatic material it triggered their memories within the therapeutic environment. The specific nature of Les/Charlie's task within the cult meant that Les had little sense of continuity. He would present for the task and once this was completed another alter would present. This felt like a death since there was no continuity of self. The following session Charlie made a similar threat. "Doesn't matter how long been asleep. Last thing I remember when AO killed the baby. You get rid of bad things. I'm going to get Les to kill them. I'm his [father] helper". Charlie had been linked with Les so that jointly they could undertake the ritualistic sacrifices that the father imposed on them. The response to "kill" AO was in accord with his perception of his father's demands of him. In this Les/Charlie, at least initially, were responding to what they have learnt from the cult as appropriate and reflected their means of coping. But such inter changes can also be understood at a more complex level that reflected the functioning of the alter system to keep and preserve the patient's sense of self-cohesion. The purpose of dissociation in this patient is to preserve a sense of unity by compartmentalizing "parts" of the self that are incongruent to cohesion and feelings of self control. The therapy, in part, "undoes" this process with the patient re-experiencing traumatic events so that the developmental imperative for self-cohesion that had been subverted could again be taken up.

Me/MO needed to maintain a sense of cohesion and control by remaining separate from alters that contained traumatic material. Though the issues that underlie this are complex, all the alters were of course created by the patient as a means of safe-guarding her sense of self. Early in therapy the patient had stated that as a child she had to put her "soul" aside knowing that one day she would have to reclaim it. The soul here is a representation of her sense of self, a self that was precariously protected by the alter system. The conflict between alters was, in part, an attempt to contain the consequences of traumatic material so that a sense of

personal integrity could be maintained. Those alters that were involved in daily activities could maintain a sense of a secure controllable world in which they were valued by separating from alters that contained knowledge of traumatic events. Though Les/Charlie were not central alters, they did develop through therapy a gradual awareness of the consequences of the abuse. This was difficult for them to contain. It took them beyond the limited role that they were created for and they had to understand the actions of themselves and others in a wider context without the father's "re-assurance" as to the "virtue" of their actions. Perhaps, more importantly, they had to develop a means of coping with the negative affect that this necessarily entailed. Les/Charlie had the dilemma of containing their emerging feeling of guilt with the pride that they had held in their identification with the cult. They attempted to resolve this by blaming AO and therefore identifying her as the one to be punished. During the therapeutic process particular alters had to develop their awareness beyond the role for which they were created. Their creation was to contain traumatic material and thereby protect the self from "fracturing" and to retain a sense of integrity. Les/Charlie had been created by AO to contain the overwhelming aspects of the cult abuse that she could not, but the change in their affect also affected her sense of self as she increasingly acquired the knowledge and resulting affect that they had contained. The emerging awareness and the gradual fusing of alters within the particular sub-system resulted in an ability to incorporate this aspect of the abuse within the sub-group. Such awareness also permeated and informed the entire alter system. The alter system was dynamic. The gradual awareness of particular alters primed the whole system for change.

Les' awareness was illustrated when he experienced a change in his self-perception and was able to acknowledge that traumatic events once perceived with pleasure were no longer pleasurable (587).

Sometimes when you'd think about good things awful things makes it not so good. Sometimes I think it's still there. Saying things to W, she's being difficult I push her aside "For Christ Sake!" I'm not afraid. She'd do something or other say "I don't want to go!" he [father] would strike out. I always made sure she was around for some of it. He would always tell her she was...[a fucking useless cunt!] ... I'd think she was so broken, W standing there, AO saying "No!"

AO gone because she hates me, she has to listen to me, she doesn't have a choice. Beat away at her, I know what to say. I'm still going to kill them. I'd like to say I wouldn't miss you [when dead], but I probably would, you're the only one I can get cross at outside.

The relationships within this sub-group of alters was in the process of change. Les had aligned himself with the father's power and control so as to nullify any self-doubts regarding his actions. He initially responded to the change in his awareness of his actions by blaming other alters and directed his anger towards those alters he perceived as responsible. In the above passage Les recognized that harming other alters would cause him harm too. Some of the more central alters did not believe this, particularly in the early to middle phases of treatment. They believed that they could cause other alters to self-harm without causing harm to themselves.

This subsequent change of perception provided some support that the process of compartmentalization between alters was being bridged and provided evidence of the need to engage alters in therapy to process material that was relevant for them. As Ruth engaged with issues that raised feelings of guilt and shame, empathic understanding was required and as her defences were necessarily lowered, issues of self-harm and suicidal impulses became more prominent.

In the following sessions Les described how he had caused W to cut herself so that she would feel what the cat had felt. By session 594 Ruth refused to eat solids and had severely limited intake of fluids. She stated that this was at the instigation of Charlie who stated that he wanted "To be hugely punished because we sit here talking to you". The patient's revulsion for her actions (i.e., eating human flesh) stopped her from being able to swallow and not eating was a means of punishment for having participated in this ceremony. The difficulty for the alter system was not only in talking to the therapist but also in dealing with the shame and disgust from which they had previously been disconnected.

Whilst conflict between alters both within and between sub-groups continued, the most important conflict that needed resolution for treatment to progress was that

between the alters with daily life experiences and those who had functioned within the cult. This is considered in the following section.

Conflict between Home and Cult Alters

Conflict between those alters that had maintained stability within the home and those that were active in the cult was a primary issue during treatment. The home alters, Me/MO and Mary were, at least initially, resolved to retain their separateness from other alters. They perceived themselves as being close and as favoured by the father. Initially, they denied that the abuse discussed by other alters was true, but if it had occurred it had not happened to them so therefore others were at fault and it was of no concern for them. They argued that alters such as AO were lying or confused; this was even the case with material that they had raised but from which they had later withdrawn. They did acknowledge the presence of other alters and did not question why these alters were within them. Me/MO had presented early in therapy, and from their comments, it was clear that they knew details of some of the abuse but they wanted to deny it. Me/MO wanted other alters to process the material so that she could continue her life as if nothing had occurred. Even when issues of abuse were acknowledged the home alters wanted it to be resolved without their involvement. It was only later in therapy that Mary and Me/MO completely engaged with therapy and finally Me emerged to confront the issues. To possess such knowledge would mean that they would also have to contain its painful consequences, something that their whole purpose had been created to defend against.

The original personality Me wanted to remain separate so that she could ward off the painful affect that other alters contained. For example, one group of alters Me/MO and Mary, were necessary for Ruth to be able to function at a daily level. The need to care for the family and husband and to interact with daily life required alters whose focus was mainly in the present. These alters were “absolved” of guilt. Such feelings came later in therapy after they had fused with alters that contained cult abuse. This brought acknowledgment that they and their experiences were

connected. Mary was close to several of the child alters including Chris/Carol and it was with Mary that they fused. Mary contained some of their experiences but rationalized them by arguing that they must have done something to “provoke” the father. She also retained some memories of the father’s abuse of her within the home. He would come into her bedroom at night and masturbate by rubbing his penis on her stomach. She also contained a memory of him abusing her in the shower shortly after she had returned from the Salvation Army Home. These memories, however, were deeply buried and rationalized by her. She maintained that because they were out of character with her perception of her father that she was either mistaken or that the abuse was intended for other alters not her. She did not necessarily deny that abuse had occurred but rather that the father abused her in mistake for W. Her attempt to retain a constant view of the world was an attempt to retain a sense of control and safety in her life. This was demonstrated in her attempts to keep things even and “balanced”. Such beliefs were important for her to preserve a perception of a controllable world and for this she needed an attachment to a loving father whose actions could be understood and controlled.

Sustaining the persona of the father as a “good dad” was central to the needs of these alters and subsequently to the maintenance of the alter system. In part, the creation of other alters by Me/MO was an attempt to dissociate from the realization that the father was abusive and as an attempt to retain an idealized imago of the “good” father” in order to preserve a sense of internal stability and cohesion. The problem of attachment to the perpetrator and the clinical working of this material is one of central importance to integration (Ross, 1997). In part, the fear of leaving her father as a young woman was her fear of losing stability and cohesion. Some alters such as Mary continued to develop beyond the period of the abuse. This was necessary for Ruth to be able to function in her daily life. This was also the case for MO and to a lesser extent AO and W. W, however, continued to retain a degree of naivety as to her image of herself and perceived herself as a sexually desirable woman aged perpetually at 17 years. The age of 17 was when she first fell pregnant to John and the father demanded that she had an abortion.

To explain divisions between alters who had experienced trauma and those who maintained daily living activities van der Hart, Nijenhuis, Steele and Brown, (2004) proposed that dissociation could be understood in terms of “evolutionary-prepared operating systems” that affect how personality becomes divided in response to trauma. Van der Hart et al. proposed that inherent psychobiological systems are shaped by experience and that these included systems specifically dedicated to activities of daily life and ones to defensive systems. Daily life functional systems are those dedicated to the survival of the species through energy management, sociability, attachment, reproduction, child rearing, exploration, and play, whereas the defensive action systems are those dedicated to survival of the individual in the face of threat. Van der Hart et al. proposed that such psychobiological systems reflect the structural dissociation of the personality and account for the absence of integration between parts of the personality that are mediated by daily life action systems and those mediated by defensive action systems. The different functions and tendencies involved in these two sets of action systems tend to inhibit each other and hence are not easily integrated in circumstances of major and chronic threat. Thus, the defensive system is primarily focused on the trauma which is re-experienced as a current event. The apparently “normal” personality is avoidant of traumatic memories and the defensive system that encompasses them. The alters Me/MO and Mary contained the daily life action system whereas alters such as AO and Marcie contained the defence action systems. The desire by the daily alters to be separate from those containing abuse was apparent as early as session 150, when the alters Me/MO wrote:

I only want to be me not all these inside ones as well. I feel strange a lot of the time. I can see and hear what is being said but I don't feel like I'm part of what is being talked about. I am an observer of myself. When I am talking, (even writing this) I can hear other conversations going on. This makes it difficult to follow other people when they are speaking to me.

The alter Mary during session 184 stated that “I’m tired, I don’t know if I should tell you there’s lots of us that we see but don’t know”. These alters contained the better experiences within the home. Abuse that occurred within the home was frequently borne by other alters, specifically the Body, Chris/Carol early and then later by Amie, Marcie, W, and AO. Me/MO and Mary were the only central alters that

maintained daily living. The alter Mary was also a protector alter. She took care of the child alters and worried about issues such as cleanliness, order, and safety.

The process of therapy was different for the alters that maintained daily functioning than it was for alters such as AO, Les/Charlie, W and Marcie who had experienced overwhelming traumatic events. For these latter alters, it was the re-experiencing of the traumatic events that was so difficult whereas, for those alters that had remained separate from such events, knowledge of these events and the accompanying affect was experienced as threat to their perception of self. Avoidance of traumatic memories was adaptive to the extent that accessing traumatic memories would have compromised their daily functioning. In this sense, dissociation served a defensive function. These alters had to accept that their perception of the father and therefore their own sense of self was fundamentally flawed and that they had colluded with it. The issues for these alters, particularly Me, was in confronting her attachment to her father and how she had coped. The other alters were necessarily focused on the traumatic events which were the cause of their pain. Me, and to a lesser extent MO and Mary, had to dismantle a means of coping that Ruth had subconsciously used for most of her life and therefore integration was initially experienced as a threat to self-cohesion.

The desire of Me to remain separate within the alter system is perhaps illustrated by her relative lack of involvement in therapy until the later stages. Her desire to be separate and therefore not responsible for the emotional and cognitive consequences of the traumatic material is depicted in a drawing by Me where she has drawn her hands and body as not connected to her head (drawing 14, Appendix F). Previously, it was the other alters, predominantly AO, that had presented and only after they had processed the traumatic material was Me exposed to it. Me had created the alter MO as an “outer skin” to further separate herself from having to engage with daily reality and was only predominant as a separate alter from session 879. From this session, Me was involved in the material without MO. Interestingly, as discussed in the previous section, some of the other alters attempted to “make” her feel their pain. They were angry at her apparent lack of involvement, specifically her desire not to acknowledge their pain so therefore much of their anger was directed at

her so that she would experience and expend their pain. Initially, however, Me could not experience the affect of others since her experiences were dissociated from theirs and it was only when sufficient of these alters had fused and the experience became closer that she could both feel and process it. The initial impact of the alter system “unravelling” in its structure was apparent when Me/MO (270) stated:

They should be able to see how I feel. Why do I always have to talk about, why can't they just see? ... [I am] so desperate for someone to take this away ... he [father] just doesn't love me. W hurt because she was his favourite for such a long time. AO says she “Doesn't give a fuck!” Other voices saying favourite because had his child. Why does W do this? It's not me it can't be me, I was frightened and cold so much mess it's all connected.

Me was not denying the feelings of others but wanted to keep them separate from her. Her wish was that other alters would do the therapeutic work, resolve the issues that they needed to, and she could come later in therapy when there was no more to be felt. Her belief in this was very similar to the “numbing” effect that dissociation had had in her life. Similarly, Mary during session 240 discussed the negative impact other alters were having on her behaviour and her emotions.

[I am] Wanting to blow nose, someone won't let me. Feels like someone is controlling me all my insides are going round. I didn't think they'd get to me; I didn't have anything to do with them. I don't live my life in chaos, others might but I don't, I get everything right. I've put up with heaps of stuff and I've always done as I was told, but I've never felt like this. ... My dad never really hurt me but he used to shout and frighten me, but he never hurt me because I always did as he said.

She often declared that she did not “remember too much about the [previous] session”. She was concerned as to whether her memories were “real or just pretend” and she experienced great difficulty accommodating the abusive memories that she expressed regarding her father with the love that she professed to hold for him and he for her.

In a later session (244), Mary returned to issues raised by this dichotomy, “You know everything I talk to you someone else talks to me; never slept with the dad only touched him once, accidentally whilst in bed”. Mary remembered several

incidents when the father would come into her bedroom and abuse her. These memories were in conflict with her sense of self and a threat to maintaining a secure attachment. Her response, in part, is to deny that such memories are correct. In session 292, for example, Mary states that she does not believe that such memories are real but are examples of “An imagination that’s gone wild, fantasy stuff and I don’t want to hear any more about it.” She had been self-harming herself by hitting her arm with a metal meat tenderizer and a wooden rolling pin, attempting to “punish” the right arm and hand that had held the knife that had scarified the baby (drawing 15, Appendix F). She denied the abuse yet was unable to preclude self-harm. Mary punished herself both for holding such disparate thoughts and as an attempt to dissociate from the dissonance such beliefs created.

I don’t like to admit to not being strong; I like to be thinking that I’m always doing the right thing. I spend a lot of energy keeping in control. Be hard for me to live if true. It just doesn’t happen, and if it did, people wouldn’t change and he’s never done anything that’s not nice. We should explore other reasons as for why I’m not coping very well. Being in your thirties with kids is not easy, obviously we’ve had a scary experience for why can’t we go to the shops any more? I know I once got stuck in a stair well in Perth. Lifts always feel uncomfortable so used the stairs 4/5 floors, got to the bottom but I couldn’t get out had to go back up to 4/5. But the main thing is that people don’t do those things. Talking to my friend on Sunday, she said, “People don’t do those sorts of things”. Dad tells me that he loves me, and that he will look after me. [Mary continues recalling what she remembered and blamed the other alters whilst not denying or explaining them.] But if it is true then I don’t want to live with it. Every time I say I don’t believe, I see pictures and they’re screaming at me. It is important for me to keep even. Sometimes I believe it, I’ve sat physically with them smelly people can’t make-up those feelings.

Me/MO later (328) described an incident at home; she sexually abused herself with a vibrator whilst W “instructed” her in what to do. This is another example of boundaries being permeated within the alter system and Me/MO taking on the experience of other alters. Me/MO’s fear that she will be left to experience the traumatic events contained by other alters is graphically illustrated in the following passage of therapy.

Felt like it was he [father] doing it instead of nothing. Funny while she was doing it, it [feeling in her vagina] went dead, and she started screaming, “No, you’re not going to go dead, no!” She didn’t hurt me but she didn’t want it to go dead. I don’t know how so much can happen at once; seeing him on top of me, feeling him and listening to him and W talking at the same time. Big part was I kept going dead. And, every time it went dead, he would say things to me. ... She laughs at me, wonders why I’m offended. She says you [therapist] know the words so I don’t have to use them. I’m scared that if I use them I’ll get hysterical. Felt that she was hitting me to keep me awake, “Feel this”. I can hear him groan, she says “No, that’s just the start of it”. I’m 10 years old and I’m in his bed and he’s doing it to me and I’m thinking it’s the first time that’s my fault because I touched him accidentally. She assures me it’s not the first time. Maybe for me it was. ... But I couldn’t understand the words he was using. I didn’t have a clue, even though she’s saying, “But you have we’ve grown up with these words”. That’s why she didn’t want me to go dead. ... I’d always thought, at the back of my mind, that he’d never hit her, but he did. ... I’m getting all this running commentary. Amazing, happened in a little time I was laying on Max [soft toy owned by patient] she [W] doing to me then he [father] was there saying all those words about how much I like it. [Later discussed sex with her husband] I can’t stand any of that stuff [sperm] touching me. Any that gets on the sheet [I go] straight to the toilet. Nobody has sex like that. I don’t know what I do while he’s doing it. That’s what I feel, when I realize scream just to get off. Dad he just laid on top of me for ages.

The alter Me/MO had to confront not only the traumatic memories of W but also her perception of her father and her relationship with him. Later in this session, Me/MO discussed how W wanted her to discuss these experiences within therapy. This is an example of how alters talked to the alter Me to get her to take on their affect and also a shifting of the patient’s perceptions of her father.

W’s talking to me she says, “God, I’m younger than you and I know what’s going on. Don’t start denying!” I don’t know what I felt. I felt like screaming the roof off. W tells me I’m stupid, she says that dad – she can be a real bitch – she says, she’s not helping me out of this one. She says think back to the noise and think what your body was doing. I think that’s when I really lost it yesterday. She’s so nasty; she says, “You can’t even say the word, can you”. Like when went to doctor [in her adult years and early in her marriage] he said, “Do you orgasm?” I said “No”. She tells me if I was to take over the body John [husband] would get no movement, like a piece of meat. I can lay there and not feel a thing, nothing. ... [Later] It’s like I know that he [dad] was doing really bad things in his own bed. I was important to him. I had to do all the things that he wanted to. If I want him to love me, then of course I would do them. I never knew.

Afterwards I'm sitting up on the ceiling. I didn't know. I'll never feel again. When I hear them, [alters] which I have done lately, I didn't believe.

Similarly, Les/Charlie wanted to be "heard" and believed by Me because for the alters that contain traumatic memories, it was important that their experiences were validated by Me. For them to progress and resolve such internal conflict they needed Me to recognize and displace their pain so that they no longer need to contain it so that their function within the alter system was no longer necessary. The desire for Me to validate the affect of the abused groups of alters was returned to in session 626. In the following passage Me/MO presents first followed by Charlie.

What I really, amazing, want to be is a normal housewife family husband go out to work, fact is there's nothing normal about my life. Anyway, so I think it's about time we got a move on so I get better so he [Charlie] can rack off. I know that it's me causing some hold up. I find it very hard to put it all together. Often think where did I lose myself in all of this, feels like maybe a year ago that I started to see. Then someone tells me all that times been spent on what I wish to avoid. Want some proof but there's no proof. So how do I get over this? I remember just like yesterday when I first started to see you. I don't know how I could have evolved into who I am. I understand that something must have happened to get all these different people, gives me a headache trying to piece it all together. If I could just push them away but I can't, I'm the one who misses out on everything.

[Continued discussed a dream that she had the previous night. Me/MO being in a big circle her father walking around it but he] can't get me if I stay outside. His words couldn't reach me. I was shaking 'cos it was important to stay outside. I didn't used to have dreams like that. Think of it like their stuff is leaching onto me. Don't want it to yet I can't stop it. Only proof if he said he did it.

[Later in session the alter Charlie emerged.] Get real, as if anybody's going to admit that shit, she ran away [explaining why the switch in alters]. Believing us; what's important is that she believes us. She buries her head in the sand. Why don't you ask her why she wants to go for a walk and hurt herself? [Me presented in response] Of course, I know but I couldn't just stop it from happening but [could by] going away. And I didn't have to do a Mary thing and re-experience all this stuff. I don't know what is mine, none. How would you expect us to live if there was somebody who didn't know or thought they didn't know? It's like it's over here. It's just hard to

look at the man whose your father and acknowledge that he did do things. Much easier to say they're lying, yet there wouldn't be all of us if wasn't [true]. I'm not stupid! Knew people who knew me but I didn't know them. Trying to fit everything in, I've lost so much time, can't figure out the time. By time, I came to see you at end of my tether. Julie dying, think people going to be around forever, same with Betty [husband's sister, had recently died]. ... Like I knew I would be dead if I didn't do something, knew that I was dying couldn't tell anybody. Feel I want to die 'cos I believe if I die will kill all of us. I know that I'm an extension of me or I of them I know that they all look like me except young ones they look like me when younger. I know how I got to be like this because he did it. What he did was rape a young child continually in every way that he could, he was raping me like time, and that's where I learnt to lose time in a good way. It didn't matter if night before could have been 20 years before lose time allows you to get up see friends, school, pretend that everything was fine and have Kathy's mum make doughnuts then when he came home Kathy's dad a violent man go to another.

The tension for Me/MO in being able to maintain and contain "knowing" and "not knowing" continued (638).

Like Sandra [daughter] is part of me, I gave birth yet she's separate, same with the others. Like I can feel sad for them yet don't have to get into an emotional mess about it. I feel they're all incredibly brave, still feel as if it has nothing to do with me. Can't we keep everything separate? Had a very short dream not even worth talking about, in dream half my face different from the other half, one more dominant than the other, other vague. Left side very faint eyebrow different eyes different right side much darker kept trying to make the left side like the right couldn't do, so frustrated. Right side strong side I can handle things. Left feel like I just carry that around. [The alter Charlie presented] She talks so much shit! I wanted to talk to you. I'm a very observant person seagulls don't land in trees. Me [Charlie] I like to stand with my feet firmly planted. I don't feel she should take all the credit for all of us.

Whilst alters wanted Me to validate their experiences alters such as Charlie also took pride in their abilities and separateness from Me. This dialogue continued during session 741 when Me/MO remembered her childhood and her struggle with accepting such knowledge.

I just know it no struggle to recall always known but if I kept some memories away from other memories, I'd be all right. Remember trying to hug Mum and not getting anywhere. Just as I remember, on a hot nig, laying out back on the grass and dad not there [Me/MO referring to an incident retold by W in the early phase of therapy when

“Uncle” Jim sexually abused her in her back garden]. ... [Later continued] Like I can feel the walls of the garage [another memory of early abuse previously discussed early in therapy when the patient had been placed in garage pit], it was dark, getting dark and I couldn’t get out. Two men [were] talking, my dad and the man who owned the house [they left me and] went up for a walk with dad. Like I can feel the walls of the garage and I can feel the walls of the pit. ... Dad lowered me in. the pit taller than me. All I know is I worried that I’d be sometime down there [I] yelled for him to get me out ... so worried about getting dirty. In hole as a joke to see what my reaction would be, but it was dark [I] imagined all sorts of things in there. ... Remember seeing you at the start [of therapy] and getting panicky about shed [an early incident of abuse], when I knew something wasn’t quite right that was when I got scared. ... I don’t want full knowledge but have got.

In passages such as these, Me/MO acknowledged past abuse but therapy was only at midpoint and there were still six alters that had not presented. These alters, Death, Maggie/Mae, Young Bert, Stuck, You Gin, and Serpent were fragmented alters and had only been involved in cult activities. The later presentation of these alters was in response to traumatic material that had not been fully discussed. Some of these alters were, initially, intent on the maintenance of the existing balance within the alter system and threatened to harm alters that discussed cult activities. The traumatic material they contained remained to be processed before Me was able to fully engage with Marcie.

Process of Joining with Marcie

The integration of Marcie’s negative affect by the alter system was the core issue in the treatment of this patient. It was the most difficult issue for the patient to contend with and occupied the later phase of therapy.

The alters AO and Me were the only alters that attempted to join with Marcie. Marcie contained all from which the original personality had attempted to dissociate. She was one of the youngest alters and was created during a period when the father’s and the cult’s abuse was escalating. Marcie had been allocated a particular place

within the alter system. She was the child who had been overwhelmed by the father's abuse and felt hopelessness and helpless in her capacity to maintain cohesion and control. Though other alters also experienced overwhelming trauma they had maintained a belief that they had some control and that their abuse was limited to specific events. Alters such as AO maintained the anger and grandiosity, W held the sense of being "special" to the father whilst alters such as Les/Charlie and Darryl held pride in their importance to the cult. Though these latter alters contained painful traumatic material, their particular roles within the alter system gave them an illusion of mastery and control. In part, Marcie was perceived as bad through her attachment to the father. Her identity was indelibly linked with his. She did not have a separate self but was contaminated by his "badness" over which she had no control. This, as discussed earlier in the thesis, was represented in drawings where Marcie was depicted as joined to the father. In one drawing Marcie's head is linked to the father's; in others her body is linked to his genitals (drawing 16 & 17, Appendix F). Other drawings depicted Marcie covered in the consequences of the abuse (drawings 18, Appendix F). In some the abuse is depicted as "spewing" from her mouth (drawing 19), evidence of the "badness" that she has ingested from him. The concept of being joined to the father expressed her sentiment that she was not separate from him and that his hands were both upon and within her. The father's abuse had literally been introjected into Marcie and it was contact with this that other alters wanted to avoid. The process of fusing between alters, however, continued and the issues contained by Marcie became more prominent. Later drawings, where Marcie is depicted as joined to Me, differ from those of the father. In these drawings, Me and Marcie are joined through their hands or as in a later drawing of Me and Marcie within a container, their heads emerging as separate (drawing 20, Appendix F). The drawings of Marcie and the father where she is joined either to his head or to his genitals signify the absence of a mind or body of her own. In the later drawings Marcie and Me were joined but at the extremities linked by the hands but standing separate (drawing 21). This was the desire of Me rather than Marcie. The alter system had struggled to keep the "good" father and the "bad" father separate, Me contained the former and Marcie the latter. Me was not ready to fuse with either the knowledge (head) or emotion (body) that joining with Marcie would signify since this would entail ingesting the bad father.

Whilst concerns of joining with Marcie were not central to treatment; until the later stages, an awareness of her and what she represented had always been a vital issue for the alter system. During session 228, for example, Me/MO discussed why she did not want to experience Marcie.

When Sandra [patient's daughter] touches me I'm embarrassed comes up behind, sticks her chest out into then kisses me on neck, face. John [husband] does I like it but with her "get away from me you're a female". She wants to do it all the time. Makes my skin crawl, I can't cope with, don't like being touched. John used to do all the time. W enjoys I don't enjoy, I get goose bumps, I've really got to distance myself. Why am I the only one who gets to see all this awful stuff and bad behaviour? Don't know who the hell is talking to me, but laying on their back screaming and yelling "Why can't my needs be met?" covered in all this stuff. Why through me, but I don't know what they want me to see. Disappointed they have woken up and are not dead. If she [Marcie] dies like passing down a hereditary thing and she's not very big.

Me/MO was frustrated that the alter system had "woken-up" and was frightened that if Marcie "died" she would have to contain Marcie's negative affect. An awareness of other alters had begun to permeate Me/MO's self perception. In the following session, for example, Me/MO discussed how she kept having "images" in which she was hurting herself, "everything is setting something off. I'm having trouble knowing what's real and what's not real". She was experiencing the pain of other alters particularly Marcie at an affect level. Nevertheless, she continued to distance herself from such awareness (237).

A poor little child [Marcie] sitting all scrunched up huddled in a corner of the room incredibly dirty room so she's dirty. Dragged round in sand and streaked all over that's why she doesn't wear clothes. I think she's past being afraid, dead, you know, when see some mental patients that are dead in the eyes. I don't know why I feel responsible for this. Sometimes when I look at this, I think that if I move closer I'll get it, I walk closer, and it gets smaller [hope] that it will disappear. All the time the eyes like saying will somebody help me, but nobody can. If I could get her I'd give her a bath, clean her at least. I'm really scared I feel like dying, didn't before. I don't know if this makes sense I can see the others but I don't see why I should have any part of this. Get more depressed because I can't change it.

The above was consistent with Me's desire not to have the negative affect that alters such as Marcie contained. She attempted to distance herself from this by leaving the

traumatic material to other alters to process. As alters fused, however, and division within and between sub-groups was increasingly blurred, Me could no longer circumvent the issues Marcie represented.

AO's response was similar. She attempted to distance herself from Marcie and explained her role as "I think Marcie had the experience and I'm just telling it for her" (session 280). This did not remain the case and AO became vitally involved in the therapeutic process of joining with Marcie. Whilst Marcie had emerged early in therapy, it was in a sporadic manner and in response to traumatic material that other alters had discussed. Marcie could not develop further; her function had been to contain the destructive father, and she was developmentally arrested between the ages of 6 to 8 years, the period before other alters such as AO had fully developed. AO had stated that Marcie could not grow and wanted to die. She could not be brought into the present in the same way that AO or W had been. AO discussed (290) how she saw herself and her role. "Marcie tried to say no, I never tried. She doesn't have rage I do. Maybe she's the one who started it but couldn't finish it". Marcie in therapy needed to tell her story and the other alters, particularly Me, needed to bear witness to it for the process of integration to occur.

AO and Me were apprehensive of "closeness" to Marcie because they remained fearful that her negative affect would "contaminate" them. AO was one of the first alters to feel incapacitated as she became closer to Marcie. In session 491, AO considered how she could get "close to Marcie with out being dragged down" by her. During session 541, AO discussed that "It's my job looking after W. I'd be left with Marcie but if I take care of W I don't have to take care of Marcie". In session 560 AO stated: "Not feeling good on Friday [previous session], keep thinking about this creature [Marcie], not good calling her that. I don't think I can get close." The process of therapy was that of Ruth gradually moving towards being able to contain Marcie emotionally and cognitively.

AO desired to join with Marcie but to keep her separate inside herself since to be "touched" by her would be analogous to being consumed and overwhelmed by the

introjected father. Marcie, eventually, had to fuse with Me the original personality that had created her. In this sense, there is a hierarchical order to which the fusing and eventual integration of alters adhered. AO discussed that to take on Marcie would be the death of Marcie, or rather the death of Marcie and the absorption of her affect and knowledge by the alter system. AO was not ready to fuse with Marcie and struggled with the negative affect that this alter contained wanting, instead, to join without taking in Marcie's affect, hence later saying "We don't want her pain". AO made several attempts to fuse with Marcie whilst keeping her separate, attempting to "wrap" her in jelly (a substance in which Marcie could be seen but her pain not felt) or to place her in a box so that she could nullify her affect whilst "taking her in". In session 656 AO described that she "Feel like I'm carrying another person, Marcie and I'm carrying her. Put her down pick her up again because she can't walk". Yet: AO is fearful that if she does not take on Marcie that Me/MO will, indicating her belief that she is the one to remain. In session 675, AO said:

Always comes back to me. His words, voice. I know he helped [father]. I just see this pitiful creature, carrying baby across, has no choice. W, she disappears then there's me and I get blame. Feel I wouldn't be able to help her, younger one of me. How can I explain to her that I didn't do it willingly? Just dad there telling me look what I did, remember feeling so spaced out. Felt like there wasn't any body else around me just the baby and me, but I could hear them. I don't know if I scream, "I don't want to do this," or just outside.

Wish I'd kept saying no. Relived every minute of that, keep seeing this mutilated thing can't possibly think it's anything else but a thing but you know what it is. Know I can't say I hacked a thing to bits, I don't see it as a thing. And I don't know how John [husband] can stand to be next to me when he knows what I did.

I don't need him [father] yelling at me that I murdered somebody. I really don't need him yelling look what I've done, and my hands are only small and they're all red. Nobody wants to touch them. I don't, nobody else wants to. I rub them on my body harder and harder, quicker and quicker and I wonder why did it happen. The mother's happy, I don't understand. It's going to make everybody so much happier 'cos it's going to make good things happen. I don't understand why he's telling me "You're a fucking killer" if everyone is so happy. He's not angry loud, like I've done a good job 'cos that's all Darryl wants someone to be pleased with him. Like he's tough, he can do it. Have Charlie who doesn't give a fig about it. I feel so ashamed how pleased I acted even though I was terrified. Then you

have Darryl who was just look at me I did this, but he was dad's best kid. Made me feel more guilty now, were four [all] together, it hurts me more.

I've been thinking that I have to take W on. She can't stay in the other group she's in the other group she's too linked to things I did. Lay down touch heads [as did with Les/Charlie and Darryl and join]. Thinking I could do with her being young and foolish and I'm not interested in having sex and nor is she really. She's no good in with Marcie and the others. I'll end up with everyone except for the Main One and Mary. ... Feel bad, part of me prancing round proud, can see why so important to have their approval. And I think it would be good if Marcie and I were joined together but for her would be a death. Done enough we all know what she had to endure so she'd still exist. Sounds awful, but it's actually, what she wants.

During treatment, AO had partially integrated the cognitive and emotional experiences of several altars who were involved in this particular traumatic event. AO's perception of Marcie was that she was a separate and younger version of her and that therefore she needed to support her, but this belief caused her considerable anxiety. AO, later in this session, discussed what fusing with Marcie would entail and wished that Marcie would die. The following session (676) AO returned to the idea of "taking on Marcie" this idea caused her concern.

Worried about Friday, talking about joining together with Marcie and W, eventually; but this is a death we are talking about I would be killing her; she needs to be killed, too much to be carried on with. Younger, has a bit more of the terror, pain. Have to take somewhere nice and she would go to sleep by coming in to me, wouldn't be like Les/Charlie and Darryl. Wouldn't be any lasting things from her she would be gone, because there would be nothing to keep. We don't want to keep her pain. Think that it, it's okay by her.

AO still wanted to be the alter in charge and this is also what Me subconsciously wanted because if AO felt she was in charge then Me could continue to remain "numb" and not have to feel Marcie's negative affect.

How I have their thoughts and feelings? I don't want any of her [Marcie's] feelings, not sure if right for me. Already feel so guilty don't need her feelings be too much for me. She can't grow up. Don't want to give Me/MO chance to take her on, like a power struggle. I've already told her I don't want to join with her. I want to

be my own person, I'll get along with her, I've been giving this a great deal of thought there will be the Main One and me. I will take W just not yet. I reckon she'll be a hard one to take, full of life. Not like I can do it and just undo it. Though, Charlie reckons he could be out of me in a flash if he wanted to. He talks to me.

AO is saying that Marcie cannot grow up and that she does not want to bring her guilt into the present where she would necessarily feel it, but rather to keep it separate and in the past.

Take responsibility, how do we know she really wants to die?
Afterwards what if wrong. See I know how she'll die. Have to make her a very comfortable bed and she just lays in that until she disappears and I make her disappear basically by sucking the very life out of her, so all that is left on this incredibly comfortable bed. Eventually just goes away. Make a bed, the clouds she'll disappear.

No, I'm not ready. You know she never wears clothes. This is a deliberate killing. I want to do it for her but ... nobody will say, "I can do it". My hand will only stretch so far she's going away. I have to let go right about now. Like when you see someone take off in an aeroplane you wonder if it's going to make it and it climbs and climbs so that I can hardly see her now, like I'm trying to look for her, see my cloud. Why do people die lying like a baby? I think that's good, 'cos you're warm that way. So there's no more naked Marcie only what remains in my eyes. You'll have to help me now to get back in the chair. ... But my heart is jumping everywhere like it's scared. What happens if she wasn't really dead, she laid down so easily. Just that I'm good at getting rid of things, W said. I just tell her I have to do it 'cos she won't.

The above passages reflect AO's concern that to "kill" Marcie would mean that she will have to take on Marcie's pain which she would be unable to contain. She wanted Marcie to fuse with her but "comfortably". AO's aspiration was to be close to Marcie while she was "dying" so that the negative energy would be "drained out" of her before they joined.

Me/MO continued to dread Marcie and expressed her desire to end therapy since she had "Done enough and just the others need to continue". From her perspective, other alters had issues that needed to be addressed in therapy not her. Me/MO was within the daily alter sub-group and from her perspective, Marcie was the responsibility of the sub-group who contained the traumatic experiences. This

latter sub-group, however, held Me/MO responsible for their pain and increasingly insisted that she address Marcie. Me/MO expressed these issues in session 765.

W no longer around she joined with me she's gone, so easy. Aware of today I sort of thought I was behaving different last couple of days. Thought about it today realized she'd gone. Thinking I've done my bit. You know AO's so quick to pick up things but been avoiding. Well, I'm not the one whose dying so I feel all right about but I can understand that she's scared about, got a certain amount of strength about her. Figured because I'd done my bit I could give up therapy. I don't need any more therapy, like she [AO] could come; she would have to deal with her problems. Then her and I would join. Then just ordinary everyday issues to deal with not all this. Look at it she's doing what she has to do. She feels sure everything could work. I myself get a bit frightened about being a whole person. What sort of person will I be, angry? Lot of anger about me 'cos I can forget about what dad did, that annoys her immensely. Just pretend it doesn't exist - I don't [exist in awareness]. How frightened I was of feelings I had, guess I'm still a little bit frightened of feelings I have. Worried because I'm not participating in life at moment just sleeping, not taking in anything, feel I need to be on something, make me get up and go.

AO later (769) discussed Marcie "One thing I've noticed, she's actually getting smaller she'll just disappear sort of like to think as she gets smaller I get bigger. I feel myself small at times, sort of feels like I'm holding her life." As the boundaries between Marcie and AO were progressively permeated, Marcie's affect was experienced and expressed by AO. In session 771, AO discussed how difficult this was to cope with.

Think I feel sad Father's Day yesterday and I didn't have a dad kept telling Bob [younger brother] to buy something. Don't know why I feel that way. Guess I'm being selfish what I'm missing out on. Thought I was past all those feelings. Like to kid myself don't feel that way, guess everybody expects their dad will be a good dad. Sometimes I get really angry about it that he couldn't be the father that he was supposed to be. Coming here makes me face things. Right there [visible], I can't ignore it I'm scared of it and I know what I should do. Be easy to take Marcie on, don't feel it, but think it. Sort of, be like a final thing you know. Taking her on is so very, very different from taking on Darryl, Les, and Charlie. See all the time, I think about her cry. Been thinking about it all weekend, most afraid of losing you. I dressed her the other day [in fantasy]. Put pants on her, ones that were loose and comfortable, she's willing, I was gentle.

Only problem when I get close to her I feel dizzy, lot of intensity concentration to stay near. She feels tired like its time to slow down and go to sleep. Hasn't slept yet; so tired, she wants to sleep. What happens if she goes to sleep and never wakes up? I believe then I'll really cry, be very sad about her going. Tell her that she's really brave. I feel responsible for her death the cause of it. Like when she goes to sleep, that'll be it - she no longer will be. She's not going to wake up. When it happens I don't want John asking any questions, stupid, he's my husband. It's all right that you know, but I don't want anybody else to know. I don't want anybody to know like I've killed her, some part of me says might as well get it over feel crappy anyway see it as she will go into me and part of me will become her. She'll die and part of me will feel her. Sometimes I think I'm even a little bit scared of the energy. Feel that she's got a lot of - I don't know what it is. That she had to have to get through. Feel like if she touches me I can feel her vibrating, like you want to keep moving things just ... because too strong. By taking her on, we'll have to stand still. Just need to cover up the lower part of her right away. Dressing her is making her younger. Do you think that dressing her will make her non-existent? Feel like I'm going to fall over, 'cos I'm so close to her. You can be a shield.

Maybe that's what I've said to her on occasions "wait till I get hold of you", seems like I've spent whole of my life hurting somebody. Hurt the baby try and hurt John as much as I can, like I don't want him to know how much I care. I know I didn't want to do it, but I still feel so God dam guilty about it. The Main One still says, "I don't know how I could have done it". It's almost like I can see her sitting back peeling off us one by one having nothing to do with it. Can't just sit back now has to watch, can't pretend nothings happened to her [Me/MO]. Just thinking about the time, she told you she made us, feels a big mistake. Like I know that I was made up but I still managed to live. We didn't even really think of her. It's like there's her body and inside is all of us and we lived independently from her. Would you like me to join with Marcie this week? [Therapist: I would like you to join when you feel ready.] Bit like telling someone standing on edge of building to jump when ready. [Therapist: Yes, join this week if you are ready.] I can make her go so quickly it's scary, sometimes I think it won't be final, but sometimes I think why, I get so upset because I know it will be final. Keep telling myself; if it doesn't feel good be able to push her out, but won't happen have to come to grips with that. Thinking how much I'm shaking with fear. Don't know, think that I'll feel frightened.

AO did take Marcie in but she remained separate within her. The intensity and "dizzy" feeling and light-headedness that she experienced when close to Marcie

was similar to feelings that several alters described when they dissociated. AO believed that she would take in Marcie's pain. Session 773 AO described her experience of attempting to fuse with Marcie.

Found that I needed to sit with her, I found that I felt like she was inside me – dizzy, light head. Something makes me feel like I'm going to fall over, feel like I want to get my hands into my rib cage and everything will fall out all these horrible feelings, be blown away. Have these feelings, yes I do not want to kill myself; I don't want to do that. I just thought that she would go like the others. I really tried but it's still up to her. I didn't feel that with the others, I was in control she's likely to leave. I feel like she's so tired. I didn't know it would be such hard work. I always thought that she was like a spoilt child chucking a fit, but realized last few days; see that she's hurt. I just wish that they would go, running and moving and swaying feel even wonky just sitting here, I don't feel in control. I feel so scared, pissed off with dad. Wonder if my head is going to fall off.

In the following session, AO described her experience of taking in Marcie.

Like she brings his voice with her, that's what's wrong she brings his presence with her like he's telling her all the time what to do. I used to see it so clearly, but now. I used to focus on the baby that's all I could see now I see that it's dark, fire lots of shadows. Feels like I could run though and kick dirt up everywhere make all foggy.

What is so particularly frightening for AO and the alter system is that to fuse with Marcie necessarily meant the assimilation of the father's "presence" and "voice". During therapy AO continued to work through these experiences, though the therapeutic goal at this stage was mainly one of consolidation in which the therapist sought to assist her to contain and understand Marcie's emotions.

AO continued to struggle with Marcie's memories and during session 778, AO remembered photographs that had been taken of her by cult members and how she envisaged joining with Marcie.

Taken when things were happening, like I saw these pictures afterwards made me feel sick, feel like I was looking at someone else; makes me feel dirty and ashamed, but seems since I've been telling Marcie doesn't matter what dirt she has on her I don't care I'll take care of her. Just think that all this is a lot for a child to bear. No

wonder she's so damaged. I sort of feel responsible for these photos 'cos I was in them, there's one photo that I remember, I have this man's penis in my mouth camera up close, looked like I was smiling. See that she's scared thinking that she's going to choke to death, her mouth aching. Everybody looked at them. I feel like I'm withering up and dying makes me feel that I don't have much longer. Wish I could be with you, so I don't get any stupid questions. Don't see it the same as when Darryl, Charlie, and Les joined with me. See joining with Marcie, a hill and we join on top of hill this woman who collapses, all around thunder. This woman can't stand, kneeling waiting to be struck down because of her. Marcie she wants that and I think that's how she'll make me be.

Her fear that Marcie would annihilate her in a sense was correct; AO and Marcie would not be able to coexist. They had been created to be separate, the cohesion of the alter system was fragile and the fear expressed by AO is that she will fragment. This is similar to a reference by the patient, early in therapy, to the nursery rhyme "Humpty-Dumpty" and her fear that like "Humpty-Dumpty" she could not be put together again. Her internalization of the therapist's selfobject function can be understood in her comment of how she was now going to take care of Marcie.

In session 789, AO continued in her attempt to contain Marcie. In this there was a transference of knowledge from Marcie to AO and consequently to the alter system. This session is quoted at some length since it depicts how cognitive and emotional material was transferred from Marcie to AO and consequently to the alter system.

I'm literally dragging myself around Marcie's wearing me out. Keep having dreams about babies, young kids and she keeps screaming. Keep getting these poxy headaches. ... I see it as her chucking a wobbly 'cos they don't like what's going on. Dad how he tricked her, like when they got married that was a trick. I don't like talking about it, it makes me angry that he loves her and he'll love her forever [words that had been spoken during "marriage" ceremony]. The biggest part, but he hurt her forcing himself on her. W [and AO], both of us felt what she [Marcie] was feeling but not like she felt it, like an over-lapping. Things happening to W she would totally and completely disappear.

She [Marcie] needs to be loved that's difficult, how can you [AO] show someone you love them? Holding her hand telling her things be fine will go a long way. Difficult she won't stay still, like if she keeps

moving thinks she's going to be safe. ... Like a princess when she got married, all nice clothes on so pleased with socks, white long lace on top. Felt like a princess when she put the clothes on. White dress all gathered at the waist so it had a full skirt. Flowers on, on the dress itself printed little ones. Funny part was she had black shoes on. She keeps thinking they should be white, and small print on the dress, green, rosy coloured pink. Her hair curled. ... Mum came in to see that things were right. A green car, dark green so it almost looked black but green, like it took a long time to get there, up Canning Highway then out to the country. She wondered how long it was going to take and it was hot. Like I can feel it, a breeze it wasn't bad quite nice. When got dark needed the fire 'cos then it got cold. I wish I could draw it. There was sort of like a clearing then a tree that was fallen down, that's where they stood, except no one to marry then just dad talking. He saying things like how much he loved her, how much he needed her. She felt what any 8-year-old would feel. Then he lifted her up kissed her everybody clapped. She still had the curls in her hair. I could feel myself getting picked up. Like I was thirsty and I wanted to have a wee, I had a wee later when he was doing things. I just noticed that I said I, stops being we becomes I integrated. Feel okay acknowledging happened to all of us and all of us are really one person. When he lifted her up, he lifted her up so she went right into his body, felt safe, but it really wasn't. Had this drink made us ... sort of calm and sleepy without going to sleep, bit like if someone tickled you want to laugh but not get away. She just felt relaxed couldn't be bothered stopping anything. I get a bit like that sometimes when I have wine to drink. Just like you could lift her arm up and it would drop right down, sort of funny. He had her on the ground tickling her. She weed [wet herself] even the dad didn't mind kept his hand there. She felt tired, wanted to get away from what was happening 'cos dad had no clothes on. You could see him, his wee [I'm] not that big. ... I explained it told her it's like what John gets when he and the Main One do it. When she talks to me about it I try to talk like an adult, sometimes like a child. She kept looking at it and then he knelt down on the ground between her legs, hands pulled hers apart put his in there. It hurt when he pulled her apart. Before did he spat on her, that was suppose to stop it hurting so much but he sounded awful when he did it. It was red, his wee. It was always red, scary. Like lipstick or that stuff, they put on their face and it got on to her. How come it hurts so much, he'd done it before? He hurt me, all dirty. Pulled my hair and I could feel him pulling the curls out. My mum did my hair - I can't see her there. I don't think she's there. I don't know why I can't ride in the front with dad I have to sit in the back I can't see properly. I always think my mum's there but she's not you know. I always think she's there because she needs to help me get dressed, but doesn't come with me got my sisters to look after and I think stupid sisters stupid girl 'cos my mum can't go. He made me sit up against the tree, a big brown tree. I had to sit up against the tree. He cut it [baby] and made it bleed all over me. I wanted to scream. If I opened my mouth, I would have got all stuff in it. I was

really surprised I didn't know he was going to do that, he had hold of the baby's head and he lifted its head up and cut its throat quickly, blood came all over me, scared. I had to sit there I wasn't allowed to move. Like I didn't know he was going to do that, my whole body was shaking. It was a girl baby. He put it on the tree and he cut it. He cut its, down where its wee was he cut them off. I wasn't watching, but every time I opened them [eyes] it was there, had all these things cut on it. I was looking around for the mother. Where's the baby's mother? I don't feel so good. Feel like I've been asleep. Do you think I lose some of my tiredness when go far, far away?

During this session, AO was able to contain Marcie's affect whilst she discussed in detail this particularly traumatic event in a congruent and cohesive manner without dissociating or switching. She discussed this in an integrated way that had not previously been expressed. For example, she discussed Marcie's experience at home preparing to leave, travel to the setting, and the "wedding". Then AO tells her "memory" of events as they unfolded. These events had been discussed previously but not in a single session or in such an integrated and cohesive manner. AO took an empathic stance to Marcie and sought to reassure her; she was able to soothe herself sufficiently to contain and understand Marcie. The transition from Marcie being present to AO was as other alters had previously discussed. AO's experience was the sexual penetration and ritualistic sacrifice, whilst Marcie contained the earlier aspects of this traumatic event. In session 802, AO stated: "Sometimes I think I feel really tired 'cos she's tired. Why do you think, I think she can't grow up? Maybe scared if she was as big as me be more able". During this period AO produced several drawings where Marcie was inexorably connected to the father which was how Marcie perceived her relationship with him and what made it so difficult for her and for other alters who attempted to fuse with her. They also would have to contain these beliefs. The issue of being connected to the father occupied several sessions during this phase of therapy. The question of AO joining with Marcie continued to be processed over many sessions whilst AO adjusted to the negative affect and knowledge that Marcie brought to the alter system and prepared Me to assimilate Marcie's affect.

AO recognized by session 874 that she could no longer remain separate, but continued to express the desire to join with Marcie without having to “experience” her. AO is fearful that her energy will be subsumed by Marcie’s pain:

I like being me my ability I like. Marcie will never go from us you know instead of growing bigger going smaller like an embryo. Rest comfortably within me well known, but in the past. I don’t want to feel like her, I’ve got more going for me. Just so hell bent on killing myself, don’t understand. Different from egg white save yolk to last ‘cos I’m the best part.

The last presentation by AO in therapy was during session 875 when she presented briefly. Me announced, in a later session, that AO had fused with her.

Me’s struggle with Marcie dominated the final phase of treatment. During this process, she frequently regressed to primitive states and retained childlike beliefs regarding reality that had a psychotic flavour to them. Whilst she was a patient in the locked ward she developed a belief that a particular patient had been sent by her father to kill her. The patient was being treated for a long-standing psychotic disorder but he was not aggressive nor did he talk to Ruth. Her belief was founded on a visitor to the patient whom Ruth had known in childhood. The visitor had not been involved in cult activity but had lived in the same neighbourhood as her. She also interpreted a different patient’s psychotic writings and drawings as being influenced by the father and as signs of her impending death. She had visual “hallucinations” seeing skeletons, snakes, and “bugs” crawling on the ground, which no one else could see. During her period in the locked ward she was unable to sleep despite medication. This was verified by nursing staff who also reported an extreme level of agitation and anxiety. During the latter phases of therapy, Me attempted to fuse with Marcie in a similar manner to AO and “take” her in as an isolated whole rather than as integrated and digested. It was during this latter phase of treatment that Me’s drawing “No Pain to Pass” (drawing 13, Appendix F) emphasized her childlike wish that the therapist prevent her from experiencing any pain was drawn. This was also when the patient painted Marcie enclosed in blackness (drawing 22, Appendix F) as opposed to the “heaven” that they wanted (drawing 11). The patient also painted Marcie and Me as two separate heads within a vase during this phase of

treatment. Drawings such as these pictorially demonstrated Me's attempt to fuse with Marcie as a separate entity not fused in knowledge and affect.

From session 875, Me reported "seeing" insects and "bugs" on the ground crawling around her when there were none. There was a heightened level of agitation and her "Feeling the floor moving when I know it's not". In session 1061 Me said:

Don't need to sleep, sedated [but I] get higher as day goes on. Seeing bugs, I can make them move do things. Drawings [of a patient on the ward] signs, someone dead or alive inside me giving me signs someone who looks after me. Half my head like an Easter egg, head in there giving me signs. Could be fragile to prove that signs are real, different form of anger I know when I'm angry it feels in chest. This like a foot pressing, say it's all right I know I'm angry. Sometimes I feel I'm going to come out and say uncontrollable things. Not sure of my feelings happy, depressed want to be dead. Feel like a totally different person. See this big monster inside me that is me that could whip my life away, wish I was dead, think it's my anger.

When Me joined with AO, she also took on AO's affect, particularly her anger. This was a new experience for Me who was not familiar with the strength of feeling that this brought and made avoiding painful material by dissociation more difficult.

Increasingly she complained of various aches and pains that had no obvious physical origin and stated that she could "see" skeletons that were trying to harm her. In session 1062 she also described "Feeling of having something gnawing at me why got so fat tried to get rid of by feeding self. Big black tentacles inside me like hands with big fists on them".

I'm just a mess don't feel like myself, crying wondering what to do. I've developed these people, these things that are with me all the time, skeleton type figures with clothes on trying to touch me all the time. I drew one. Got bad last month, last two weeks got so bad see them tell them not scared. Like they want to frighten me, but I'm not scared, scared if they touch me. Maybe a reaction to an imbalance inside me, so used to them towering over me bony fingers filled with poison. Make me think that I can't go on. Like one but everywhere I look. Also, see snakes out of this person attached to the body when go to bathroom ritual of looking for spiders. They're on the floor then real terrifying. Why there, something to do with integration, something to do with Marcie, what frightened her so much. My skin crawls all

mighty noise in my head, shivering like I'm freezing. Noise is "I can't do this". "I don't want to be here". Desperate, like I'm arguing with myself all the time. Don't think it's ready to strike wants me tormented wants me every minute of the day to think I can go on. I want what I didn't get as a kid, I want to be looked after, I want some miracle to get this tormented soul out of my head and body, before it was like a shared experience. Me and my nightmare, its got so bad that I don't think anything to do with therapy here, like a totally different issue. I am going mad. It started off with one [skeleton], getting more and more, surrounded. Not from therapy something that started from when I got really high. I got high again at home.

As Me continued to absorb Marcie's experiences, she increasingly discussed early abuse within the home, such as the incidents in the garden shed and bath. She was hospitalised by session 1064. These experiences that had earlier been discussed by other alters now needed to be understood by Me before the patient could integrate. As the process continued, Me began to experience psychically (in the various body aches and pain's that she reported) and emotionally (in her extreme levels of anxiety and fear) Marcie's thoughts and fears. This was the period when Me's behaviour at times appeared psychotic, and, in retrospect, appeared to have been in response to Me's gradual fusion with Marcie. The childlike beliefs discussed by Me in this period were possibly those held by Marcie as a young child in her attempt to make sense of events. This material needed to be understood and contextualized by Me so that it could finally be understood and integrated. The following passages from her therapeutic sessions are presented to demonstrate Me's continued struggle to contain and incorporate Marcie's experiences in preparation for the final phase of integration.

In shed, see spiders, as [father] abusing [me]. I remember lots of it now I'm talking to you. Believe that most of the killing of babies at Easter and Christmas time people got an extra day off, start Friday finish on Sunday. Think what I've tried to do make them not happen in that time frame. Not so much worried about unimportant things, way hit, treated us, urinated, really aren't important things. Killing of things and way he looked cried so much last night lost the plot. Looked in the mirror red eyes, when looking this is how my dad would look. I know it's him little ones [alters] thought devil. Outside one me, killing frenzied attack on baby or a cat or a dog because first and because of the things I did. Problem [is] I can't come to terms with the then [past] because frenzied, I was totally without them [other alters] to help. I was covered in the blood. Second time slow precise wasn't splashing and hitting me. I was frightened and I'd never done it before; frightened because I'd seen them do it before.

When at home screaming inside myself, now screaming outside myself, I'd rather be dead than see and take this. I'm the only one, I don't see other children they of no consequence, my whole face body focused on, on my, when I was W, carrying this little infant baby to what I knew was going to happen. Except I don't think, I knew I was going to do it. Talking to you know I had no control, same time know shouldn't have done. Just thought this thing in my head invading my body feel I can handle that 'cos been around so long. Inside, call it a serpent too big not a snake takes up any space that it can get into; [serpent's] purpose to drive me mad so that I will say one day can't take it any more. Why wants to kill [self], maybe because locked inside me and I'm fighting it and it's in pain.

[Represents?] First thing that comes into my mind is anger. When think about being angry that I'm the one going to get hurt, or if I'm really angry then I've got to hurt myself. ... Sometimes if I was angry made to express [it, but] not against Mum or Dad or others had to be angry on myself. ... Dad says "If you are so fucking high n' mighty get over there" could be angry could punch self, cut, be sick. [Dad would] give me a razor blade [shake] my hands, shake them against me [making her hit herself] tell me I was to keep hitting myself like I've done for years. Let me know how to hurt myself down there [vagina], my dad show that if you hit or pulled the wrong way, little stone rub the wrong way burns [when] wee. Can't handle having this thing [Serpent] maybe did create it all those years ago never angry because it was there. This thing inside me to stop me being angry at anyone but myself, he [father] always telling me what a worthless piece of shit I was. ... Sometimes I think it's her [Marcie] doing this to me so I listen to her pain. Sometimes want her back not to be separate from me but to be inside me. ... I'm not consistent I feel all over the place, don't know who I am feel like everything is against me.

Session 1065

What's in my head is so different; thoughts about going into [my] room [in hospital but] see snakes, spiders. I'm not particularly scared ... unless they were to touch me. One in head [the] one hurting me most, wary of not pleasant, but I don't feel that they were part of me. Thing in head not part [of me] but don't understand where come from.

Session 1066

She's angry [Marcie] 'cos I'm not expressing. ... I'm feeling I can't cope want to get away from this. She would rightfully want me to feel her rage about what happened. I'd be out of control; I'm almost at that stage losing any sanity that I've got. She forgets I'm older not likely to thrash around on the floor.

Session 1067

Think Marcie has to be taken more in to my soul, my heart, rather than my head part. Others [alters that have been taken in] definitely more head. Have to prove to her, show and prove that I can tolerate her. Some how don't know how to do intuitively, need to be shown; things given their importance how not to be scared of her and held close, she's in my body but not where it really matters. She's got to be integrated into my heart.

The struggle for Me was in being able to "take in" the emotional consequence of the abuse and the strength that such emotions contained. In session 1068 Me discussed that she felt depressed because she was having to cope with Marcie's affect, "I'm the one can't cope, she's used to such feelings". Session 1069

Springs back to Marcie being in my body but us being separate, not sure me, or her both angry. I'm scared of her she doesn't trust me. Serpent, don't know that it can talk to you but through me. Don't feel its an alter [but put there by] my dad. Skeletons don't frighten me any more, almost become a game of who can be not scared of the other. Not scared of them, come right up but I don't let them touch, move away don't want [skeletons] to touch me but [they are] there to frighten me along with Serpent.

There was an increasing childlike quality to Ruth's presentations as she regressed to early emotional states. Her description, in the following passage, of "squishy thing" to describe anxiety and fear appeared congruent with earlier emotional states where she did not have the words to name her feelings. She increasingly explored her relationship with her father and the conflict that she had felt between anger and her need for attachment to him.

This Serpent see it, it takes the form of a straight line through Marcie's body and therefore through my body like a rod going up through her, my body, through my head, why get headaches. Feel if I let it out I'll have this horrible squishy thing. Angry because I keep persisting on fighting my dad's will. He [Serpent] was told to by the father ... when she was very, very little his [father's] name would never be turned into a bad thing not a bad thing would be said against him. At home in bed alone 9 year old you'll have someone watching you, know when to stop you. Stopped loving him, I want to be bad, throw everything smash things; nobody will do what I want them to do. I used to have so much power over Marcie, always been someone there doing their job over Marcie, black things, ... every integration that you performed with her get rid of them. Don't understand how hands, body different to what I "see" don't know where I get feeling from of wanting to do this to her [hurt Marcie]. I don't understand it I feel that's what I should do. See it in red and brown screaming and face tortured. I have some weird thoughts that I'm able to sit on your head, hole [in therapist's head] my being [able to] suck all of you into me. Want to turn everything inside out, just want her to die.

The above expressed how she had incorporated the father's "control". In a similar manner, her present phantasy was that the therapist would take away her pain and that his soothing presence would be introjected into her so that she could cope. This is clarified in the following session when Me explained her concerns regarding Marcie.

Scared if she comes into me, then I become her. Be sad, her sadness. Those women in eastern countries wailing how I see her don't see me as that; don't want to be like that. [Serpent presented] When small get them to cut finger hurt so much, Dad say nothing except "Serves you right, got what you deserved". We were young and still trying to control, used to get a razor blade just on the very point [of finger]. He gave me the razor blade. Sometimes really angry with me on a Sunday, things didn't go as well as he wanted [I had been], badly out of control. He taught me how to be in control, gave me control. Why get so angry at now, still have this control but no one will listen.

In session 1073 both Serpent and Me presented and Me continued to express concern that if she fused with Marcie she will take on her rage and therefore lose control.

Since we spoke yesterday a lot of the wind has gone out of his [Serpent] sails. [Serpent presented] I don't have any control feel full of rage. Maybe I feel so full of rage towards them 'cos I can't feel

that towards my dad, doesn't do any good 'cos he doesn't know I feel like that. ... Just may be you can join us leaving the anger, hurt, rage, feel like smashing so many things; I just know how to destroy. Because I feel I was out of control of doing the things I wanted to do, little bit of control but still sit on big one's [Me] chest stabbing her hard, [she is] someone who if, if things are going good she's okay. Skeletons her friends from me want to keep her frightened want her to keep weak because I'm frightened that she sees me for what I am nothing but a small child's rage. I know I come from her I know that I'm connected to the big one I know my dad made me and I know I come out of Marcie, see myself covered in same stuff and same time same numb feeling. Get angry, know I should be there making sure she does it.

In session 1074 Me discussed how terrifying it was that "A little girl [Marcie] would have such a fearsome person inside. I think sometimes that my head will never be clear that I'll always hear yelling, screams, pain. Hear and listen to the past". She continued stating that "My whole life has been of being just trying not to be there". During the following session Me stated:

She [Marcie] makes me feel sick, my heart racing. [When] joined with Marcie ... will I no longer have to do bad things to please him? [Discussed how she wanted to join with Marcie]. Think I should be either sitting or laying down. Revolting thought, laying down in water naked Marcie swim up inside me. Have to be in the ocean, somewhere calm don't want to be engulfed in water splashing over me. Wish I could draw what I see, like I was warm then freezing, used her hands to drag herself in I was freezing drag a bit in warm like that until she was inside me. Head to head I don't feel like I've just got two eyes four at least, computer [on therapist's desk] see in normal size she sees [computer as] smaller than me. She's in my body feels different better than last time, like it wasn't hard I became a huge vessel like a ship in a ship way come on in without too much resistance. Felt like my body filled the ocean. Maybe I won't feel that emptiness, me alone with it in my way she alone in her way, it would be good not to be alone in that way.

By session 1077 she was feeling calmer and more able to contemplate an integrated self, she spoke of "Just me no shadows of anybody else," and in session 1078 discussed past events that had occurred when she was young especially the abortion and memories of cult abuse.

Seeing things, skeleton, Peggy, end of bed me laying in room in dark, don't have to be scared all right to talk about damage done in past. Don't need to pull my whole body away. Peggy can't hurt me any more, or my dad. Even though I've integrated still bits that belong to them, filtering down through the system they know now. Integration was always thought of as disintegrating if needed, don't think need do that now. Still parts of me very childlike "Go away I don't want to feel this I want to be", sometimes still think of myself as the child that it's happening to have to say "No, getting old, past". But don't feel that still 6/8 years old, still freak out about the babies and the dog. Sometimes have arguments, which most traumatic dog or babies? Adult part of me says should be the babies but dog looking at me, tongue hanging out, I had power over its life. Dog doesn't close its eyes when dead open looking. Connection with dog hair, comfort immense from [rubbing fingers on piece of fur as it has been skinned], can't not look at it, don't want to but can't not look at; people watching to make sure, both my thumbs going [stroking fur], but my dad looking at me. Find that I think there's something wrong with me that I find the dog more horrific than the babies, he basically dismantled the dog in front of me, cut out penis, babies first [one that was sacrificed was done in a] frenzy, [got] hiding for. After dog, nothing frightened me in that way. The dog screamed, wished dog was dead then it did die looking at me felt responsible, wanted to die feel guilty. Noise came deep down still hear can't stand. Babies cry like babies, don't know what's wrong with me [that I] make a distinction. That the first baby that I did I just hacked, frenzied, worth getting a hiding worth for my dad's breathe to be six inches away telling me next time I will do it properly. Next time differently, sense of detachment beads of blood sitting there know how to do it didn't want to get belted again, by doing their way made less mess on me. Before coated in blood and sticky, what done a pulp mess of baby and self, doing their way baby didn't look as bad. Do you think wrong made distinction? Don't feel as bad as the second. Remember walking away afterwards thinking that I was okay which I didn't the first time when thought my dad was going to kill me. Second watched told, less left to chance just remembered holding on to the razor blade thinking [I could] so easily cut myself, didn't want to do so all my attention to doing. Then they finished; cut baby's wee off. Did more than two babies other kids didn't have to do them, can remember one soft part of the head.

Ruth had been an inpatient from session 1064 to 1079 and during this period she had processed many of Marcie's experiences. She felt that she was close to integration but there were still issues, predominantly those dealing with guilt, which remained to be processed. During her last session as an inpatient, Me discussed how it felt to have Marcie within her.

How easy in end for her to slip inside me, still feel her but not that she's going to jump out and confront me. Always acknowledge her. She by far the most important part of me, lived all those years no other part of my life encroached on her existence, no lightness for her what took me so long to take on? Thought of [that she] might overwhelm [me], big dark cloud. Sometimes feel he could come out [father] put his face in front of me. I can tell him feel hysterically happy feel really good. Helps that I can see what my dad is so clearly, not to have any illusions about him. I know with every inch of my body I was responsible for doing things but I was made to do them.

During session 1080 Me discussed that, "I feel I'm too young to have sex when I'm so busy with Marcie I'm too young to have sex". In the following session, Me reported that "Bad things happen to me all the time big snake coming out of your chair, same everyday coming out swallow me whole. ... I still haven't caught up with my age feel in my 30s". Session 1082

Still watching it Serpent, snake thing brown colour lots of lines. Scared wants to get her, told that because she holds all my life she is the basis of my life. ... Sometimes I think that it's me afraid to face up to stuff, hysterical mad. ... Don't think we've talked enough about the guilt, feel so guilty about what I've done told myself a long time ago that if I had to live I'd just put in an appearance.

In session 1083 Me concentrated on the snake that she was "seeing" and how this was the snake the father had "put" inside Marcie when she was a child and had later told her that he would "always know what I was thinking". As she discussed the cult abuse and the father's role, she felt conflict that the father "knew" what she was discussing and that the snake he had placed inside her would kill her.

Snake gets her, [its] with Marcie through me. Hers because of my dad, dad made her believe if talk, because she's come so far snake so powerful, tell her it's just a suggestion from dad. She doesn't believe thinks it's real dad put it there. ... Dad told me if got to this, that snake he put inside would get me.

In session 1086, Me discussed cult abuses that had been contained by Marcie and were now being experienced by Me.

Lot of hype before killing, drinking, sex put me into a state that wasn't normal. I've been having this out of me experience someone being outside telling me "I've had enough of this shit and you're going to behave properly denying". So scared of being like him, part of me wants to do it again; the good feeling of doing it, I think I enjoyed that feeling of importance. Birthday, Easter, Christmas, New Year important but for all the wrong reasons, ... I felt so honoured, so much hype about I was born on a special day, Australia Day. "Did I know anyone else?" so I was special and I was going to be treated special so I was going to be given special things. Sure tablets in the wine. Remember one birthday spending whole day swaying and laughing people around kissing telling me I was wonderful, made me feel I wanted to be the best for them. ... Things I like chocolate drink made to sit separate from other kids because special better than them. Princess, in own way I could ask things like I could ask them to lick me kiss me. I could ask them to do things to me sexually that weren't painful. That was in the daytime when night-time came it was different. Night-time they acted stupidly, viciously, hurt [I was] pulled down by hair told who did I think I was slap, lick became biting at same time so it hurt worst, teeth pull out where wee. When put finger inside wasn't any Vaseline hurt, one after the other always sitting, circle of men getting more and more nasty, more and more hurt. Sometimes felt like I wanted to roll over into a little ball and they would miss me - fall asleep. Wasn't allowed to, face slapped didn't matter if I cried called me a baby.

Session 1091

Had a significant dream, Marcie was a 9-month like baby crawling around I had to get to the baby had to take all these layers of clothes off, whole night getting clothes, so never got to the baby. Even when woke up nappy, every time I took something off her something else. Baby huge knew small underneath, maybe with Marcie taking in bit by bit.

From session 1092 to 1101, Ruth was an inpatient for the last time. Marcie was still separate inside of her but during this admission, Me integrated Marcie's awareness with her own and focused on Marcie's affect rather than on specific traumatic events.

[Marcie] I can still talk to you. She [Me] doesn't want to be in here [hospital], I want to be in her. I'm inside her but I can talk to you

through her. She'll be devastated sometime she feels young and it's me, I want to die, better way of going about things. [Me presented] I'm so afraid of her feelings. Liken it to someone who so starving and someone decides to feed them good to get some food. Think for myself it's an understanding of her slowly have to take in what she went through, think if took all in be like a meteorite when a lot hits me I can't handle it. She dies when take it in, a glorious death is required doesn't want to shrink like a piece of meat. To me feels like a blood transfusion, her pain is her blood. That is what I feel like I have, that I'm getting her blood I don't want to get it too fast. Sometimes I'm so close because of the way I feel, desperately afraid dark, I feel 'cos she takes away my light.

During the following session, the process of integration continued. By this stage she no longer reported seeing "signs" but discussed her experience of joining with Marcie.

Talking to Marcie, she's causing me to feel tired, speak slowly. [Me's] Arms around, being nice to her she wants me to take on her pain; taking on bit by bit her pain. ... Felt so threatened by myself, didn't think I could survive at home. Felt that I couldn't be by myself at all. If I choose to see signs see them can pull them out of my head. Don't see signs now, just memories. ... Others went at peace, Marcie not. Others didn't have the whole dam thing or as intense. She's in my brain I guess. Putting her into me getting rid of her pain, in part want to be placed in a dark yucky place. Still believe [that I am] different people, have to become her. Think back to AO to join with her got angry felt like her for a little while. Feel like I'm not the same person who I was when went through that process; I'm the hardest one. ... See myself become small like her, wedged in a corner acting weirdly like.

Session 1095

We [have] taken in things, been important for her take in the dog, skinning of the dog. ... What's been happening all the weekend like I'm there; flashbacks always had them externally whereas this is like an internal body experience. Know it's my brain but same time [it is] like skin on skin ... feelings like the jelly around her is melting away, running away. I feel her bone like I'm filling up with her pain.

Session 1098 discussed a change in how she was using the therapist.

Thought I shouldn't fight her, Marcie any longer. Do I want to be unified into one or just keep her there, part wouldn't mind having her inside close to me for a while. I just like the feeling of being kind to her and her feeling of being kind is to let her die but I don't want her to. Like this feeling of being able to stroke her and reassure her while I'm doing I'm taking in what dad did to me. Thinking of my dad over the weekend do see him now as an old man, I need her thoughts to see him as younger man. Look at it as out living. Like a shift, she's laying through my body not in chest, so easy to say I'll take care of her. Like a little puppy dog patted, enjoyed other times would have been desperately waiting for you but now okay. Experience a change in way you're treating me saw before you were looking after her now not. Don't even think [same] in a way I used to think that you would take me home and take care of me, now if problem in future contact you like we've been on such a huge pathway nine years can see that there's a fork in the pathway. Didn't used to want to see before used to think wrong tell people now okay not wrong. ... I want to be there for John and the kids, when I came in [to hospital] everything too big. As much as I hate to admit it, I feel healthy. Never not think about, but not thinking about you in same way. Felt I handed everything to you previously, think I just gave up. Felt very similar to when Daniel was a baby got all clear [from doctors] about fits same thing heap too much for me to continue on [on my own], felt same thing here. I just think that I want sometime before unification. Because I didn't fight it yesterday there was a huge shift within me, see I don't see myself being alone with what I did. He's there his hand on mine. Sitting here calmly, but I'm patting her. Feeling of not being quiet balanced with her. Still times feel tiny want to crawl into your lap. Think what I needed when I came in [to hospital], no responsibility still feel a little bit like that, an ordinary thing like showering first time yesterday in the nine years that I've seen you that I haven't washed my hair. Nails are growing [used to bite]. Don't see her as huge she's just a very small little tiny girl. Visualization would properly help, be more structured. Guilt the thing, until deal with Marcie won't be total unification. Tomorrow [I will] visualization burial [babies] no choice, response different therefore doing what didn't want to do. Dog impact on me, keep seeing it looking at me as if saying, "Make them stop it". My dad said, "Look what you've made me do!" Can remember getting slapped felt guilt shame about what he had done. Feel I suffer from brain washing. Don't know why but for the first time I can see an end. Time spent have to deal with come to an end or keep repeating.

Towards the final stages of dealing with her guilt towards the deaths of the three babies and the dog, Ruth discussed a visualization in which she would symbolically bury them. This was to be in a spot with "Plenty of blue sky and sunlight, soft sand I don't want to dig in any thing hard, English grass on top". The

visualization was her suggestion; she discussed the content of the visualization with the therapist and visualized it on her own at home. During a later session (1103) she stated:

Sometimes I get flashbacks of dad hurting me, doing things that he did. Feel[s] new to me things that make me frown. I can physically feel my dad with his hand round my throat lifting me up sort of takes me back a bit. Thought it would be like a memory without the feeling. Thought that maybe I wouldn't have to feel it. Boy was I wrong there! But I feel things even to the smallest detail him touching me, pulling me apart feel his finger nails, didn't think I would feel that. I didn't realize have all this feeling when not talking have all these memories like I'm constantly having memories of what he did. Feel so angry at my mother.

From session 1106, only Me presented and this marks the beginning of complete integration for this patient.

Not so much separate, heads separate. Think it's me that's why headache. I'm slow like a lot of things think I'm realizing that it takes more energy to keep separate rather than join, worried about taking on the child that she is be helpless, scared that I'm going to be immobilized.

Session 1118

Think about Marcie think about how alone she's left me. Don't like it, Marcie responsible for emptiness too. Taken herself, her voice, attitude everything gone, void; now just feel living too hard but no intention of harming self.

In subsequent sessions, treatment focused on Ruth's self-cohesiveness and the "void" she now felt once integrated. Initially, the therapist had naively thought that the energy contained by alters such as AO would compensate for the negative affect contained by others. As therapy progressed, the therapist understood that this was not the case and that negative affect and feelings of depletion were core issues that needed to be addressed as therapy progressed. The patient required considerable support for this and it was fortunate that her husband was supportive and involved in

the therapy process. Not surprisingly, her relationship with him had been dependent and this aspect of their relationship came under pressure as she changed and responded to therapy. Ruth continued to be seen by the therapist after integration and treatment focused on adjustment to her current situation rather than to past events. She was seen on a regular weekly basis until session 1125 when she was able to work in the hospitality industry with her husband, eldest son, and daughter-in-law. Ruth still maintains some contact with the therapist via E-mail, telephone, and the occasional appointment, but this has become progressively less frequent. She still has some problems in coping, but these relate to everyday issues and there has been no evidence or indications of dissociation to the present date (three years post integration) since integration.

Summary Process of Treatment

In this section, some of the issues that contributed to Ruth's integration during treatment were discussed. It was noted that the patient had created all alters, apart from Louise, by the age of 11 years and that all central alters had presented by session 191. The patient introduced traumatic material early in therapy and continued to raise issues involving ritualistic abuse during the course of treatment. The responses of the patient dictated the pace and progress of therapy and once therapy had begun there was an affirmation on the part of the alter system towards optimal health. The process of fusion between alters was spontaneous and based on shared emotional and cognitive experiences with alters fusing with the central alter of their particular sub-group. As traumatic material unfolded it triggered the traumatic memories of other alters. When AO, for example, discussed her traumatic experiences of cult sacrifices it triggered the memories of other alters such as Les/Charlie and Maggie/Mae who emerged in response to this material. For these alters, as with many of the fragmented alters, it was the telling that provided a context, however painful, to the alter system for the progression of this patient's treatment. Sharing of affect between alters was an indication that dissociation boundaries were being breached and was a marker of integration. When a particular alter's issues were addressed and resolved, there was no need for that particular alter within the alter system. Fusing also created changes in those alters that remained

within the system and contributed to an intensification of affect. Sometimes this meant an increase in self-harm particularly from persecutory alters, however, once these alters issues were addressed the self-harm ceased.

The importance of alters AO and W as alters that were able to bridge the emotional and cognitive distance between daily and defensive alters was discussed as was the distinction between defence and daily alters. The defensive alters blamed Me for creating them and for not acknowledging or validating them. Cohesion, for the daily alters, was based on their attachment to the father and integration, which necessarily involved a change in their perception of him, was experienced as a threat to their sense of self. The mother had left when Ruth was 8 years of age but the father's presence had been dominant and even when the mother was present in the home, his "grooming" of Ruth ensured that from the age of 5 he was the central figure to whom she attached. Conflict between home and cult alters was a primary issue in treatment, as was the need for a secure attachment figure. For defensive alters treatment involved the re-experiencing of traumatic events whereas for the daily alters treatment involved a change in their self-perception, which represented a threat to the fragile self-cohesion that attachment to the father had assisted them to preserve.

The joining with Marcie was the most central issue in treatment with AO and Me the only alters able to contemplate this. Marcie was avoided because she contained the introjected "bad" father. Marcie could not develop further because she contained the destructive father's abuse, which she needed to understand. For this she needed AO, the "grown up" part of her, and Me's endorsement. The desire of the alter system was to keep her separate with both defensive and daily alters afraid of assimilating both the "good" and the "bad" father imago. During this final phase of integration, she regressed and presented in psychotic like states taking in early experiences. Ruth created her own visualizations, assisted by the therapist, for fusing. The final phase of therapy involved Ruth enunciating childlike beliefs that appeared to reflect her early experiences of cult abuse and how she had understood them as a child.

7.4 Summary

1. This patient's characteristics were consistent with the literature on DID patients reporting ritualistic abuse.
2. The abuse was most prevalent between ages 5 to 11 years. All alters, apart from Louise, were created by 11 years of age.
3. The suicide of Ruth's childhood friend triggered her to seek therapy.
4. There was a staged approach to her treatment though this was mainly the result of the nature of the therapeutic process and the patient's presentation of material.
5. The process of integration was not the sole focus of treatment but it was a central one.
6. All of the central alters presented early in therapy.
7. Ritualistic material assumed prominence early in therapy and the patient continued to return to this material.
8. Prior to treatment the patient utilized only those alters necessary for daily life. The majority remained dormant unless triggered by specific events.
9. During treatment the patient had several periods of hospitalization and episodes of self-harm.
10. Hospitalization allowed for more intense treatment of traumatic material in a relatively safe environment.
11. The structure of the alter system was layered and complex.
12. There were two separate alter systems, one for daily living and the other for cult material. Some alters bridged both groups and were extremely important in progressing treatment.
13. Treatment focused initially on alters that bridged both groups, then those that had experienced abuse within the home and cult and, finally, the daily living alters.
14. The material presented by the patient was consistent with the use of mind control techniques reported in the literature

15. There was an initial increase in self-harm when the patient processed traumatic material. This decreased as therapy progressed and the patient increasingly learnt to cope.
16. As the barriers between different sub-groups began to dissolve some of the animosity between different alters was apparent and there was an initial increase in self-harm.
17. The most frequent attempts of self-harm and attempted suicide occurred during the early and middle phase of therapy.
18. The persecutory alters responded to beliefs regarding their role within the alter-system and to the introjected father.
19. Once the persecutory alters were listened to and validated, the impulse for suicide and self-harm was mitigated.
20. Several of the persecutory alters that contained the shame blamed Me for their creation.
21. The process of fusion between alters was spontaneous and based on shared emotional and cognitive experience between alters and was always at the patient's volition.
22. Fusing, initially, was within sub-groups with alters fusing with the central alter within their group. Later, fusion occurred between sub-groups.
23. There was a hierarchical ordering of alter development with more alters being created in response to increasing traumatic events and demands. Joint alters, which were created in response to particularly overwhelming traumatic events, are an example of this.
24. Each alter within a particular sub-group fused with the central alter within it before different sub-groups could fuse with each other.
25. Each alter contained different aspects of the trauma that needed to be understood and validated for therapy to progress.
26. Some alters developed beyond the period of cult abuse and fulfilled developmental requirements such as AO for pride, self-esteem, and Mary for self-care and nurturance.

27. The original personality connected to the traumatic material only during the final stages of therapy when other alters had processed the traumatic material.
28. Fusing of alters initially led to increased tension within the alter-system. This was particularly so when there were issues that involved guilt, which frequently led to self-harm.
29. An understanding of this patient's alter system and the role that particular alters had within it was essential in order for therapy to progress.
30. The sharing of affect between alters was an indication that therapy was on track.
31. As the traumatic material unfolded it triggered traumatic memories from other alters who were also connected to that material.
32. The alter system was dynamic and the gradual awareness of particular alters primed the whole system for change.
33. As the alters fused they took on the affect and knowledge of the preceding alters.
34. The alter system was motivated towards growth and healthy functioning and some fragmented alters ensured that Me would not "blank out" so that she would "see" and "hear" their story.
35. The process of therapy was different for the alters that maintained daily functioning than it was for those who were overwhelmed by traumatic events. The latter group re-experienced the traumatic events as in PTSD, whereas, for the former it was experienced as a threat to their perception of self.
36. All the alters needed to have processed traumatic material that was relevant for them before Me could fully engage with Marcie.
37. The integration of Me and Marcie was a core issue in treatment.
38. Marcie was perceived as containing the "bad" father and as "belonging" to him. She was not experienced as a separate self but as inextricably attached to the father.
39. The desire to maintain a split between Marcie and Me was an attempt to keep the "good" and the "bad" father separate. Fusing with Marcie represented an

assimilation of both aspects of the father and was experienced by Me as a threat to self.

40. Towards the end of integration there was a period where the patient exhibited psychotic like features this was when Me was “taking in” the beliefs that Marcie had contained as a young child.
41. Issues which involved the father needed to be understood and contextualized by Me before they could be integrated.

This chapter completes discussion of the research questions investigated in this thesis. The following and final chapter is a discussion of the main issues raised by this study.

CHAPTER EIGHT

8.0 CONCLUSION

Overview

In this chapter some of the issues raised by this study are discussed. Each of the three research questions is reviewed in the light of the findings of this study.

The central aim of this study was to ascertain whether in a case of DID associated with ritualistic abuse, experienced clinicians could detect if iatrogenic bias had occurred and if not whether further knowledge about alter development and integration could be obtained. A self psychology approach to treatment was consistently used because of its emphasis on listening from an empathic vantage-point and tracking emotion shifts rather than on interpretation and thus could be expected to minimize iatrogenic bias. The therapist did not attempt to prove the validity of this patient's material but rather worked with her to accept her productions as legitimate causes of concern and to respond to those rather than be caught up in whether the material was "real" or not. The therapist did, however, attempt where possible and appropriate to check some matters of fact such as previous hospitalizations and psychiatric appointments. Her husband also confirmed some of the family-related issues of her childhood that she had more recently been able to confirm with childhood friends and acquaintances.

The patient's reported history of traumatic events within the home and within the cult are consistent with the literature of DID patients reporting ritualistic abuse. The alter system consisted of child alters, helping alters, and persecutory alters, also further divided into those involved in the home and those involved in the cult with some alters involved in both home and cult activities. The alter system was comprised of 31 alters, 4 of whom were "joint" or twin alters, 16 were female, 4

male, the gender of 11 was unclear, one “animal” alter, Serpent, and one iatrogenically created, Louise.

There was an intention by the cult to encourage dissociation though it is not probable that they would have realized the implications of this in regard to contemporary understandings of DID. They did understand, however, the process of mind control techniques in ensuring compliance and allegiance. One of the most important components in mind control was the inculcation of shame and guilt in the patient. Being forced to participate in such rituals also undermined her sense of being a moral person (Fraser, 1997b) and it was constantly reinforced that she did not have an individual identity but, rather, that she belonged to the father and to Satan.

Research Question One

It will be recalled that in the first phase of the study 16 judges evaluated the same two tapes and met criteria for inter-rater reliability. The 16 judges’ specialities encompassed clinical psychology, psychiatry and, social work with a mean of 18 years in their speciality. In the second phase, one judge withdrew and the remaining 15 were asked to evaluate questions of iatrogenic biasing and of alter presentation, each judge rating two tapes from a total of 30. The judges concluded that the DID evident in this patient was not the result of therapeutic bias and that alter presentation could be validated by them. Having addressed some of the issues raised by those sceptical of the diagnosis of DID it was possible and appropriate to move on to the next phase of the study. That the therapist was under supervision for the entire course of this case and that each session was taped and available for supervision purposes is a further validating factor.

Research Question Two

Van der Hart et al. (2004) and Nijenhuis, van der Hart, and Steele (2004) proposed that patients with a presentation such as Ruth demonstrate tertiary structural dissociation. This leads to the development of different aspects of

personality in which some alters, or parts of the self, will mediate daily life action systems whereas others will mediate defensive action systems. Their different functions tend to inhibit each other and make integration of personality difficult. Briere (2002) proposed that memories and flashbacks of abuse are attempts to integrate the trauma, whilst avoidance and numbing strategies (such as suppression of the memories, dissociation, and substance abuse) are attempts to regulate the affect triggered in this process. The latter aspect that Briere proposed would reflect the daily alters level of functioning whilst the former would reflect the experiences of the defensive alters each with a different function within the alter system – one to numb and keep awareness away, and the other to contain the traumatic memories. In this regard the daily alters, (Me/MO and Mary) represented the avoidance and numbing strategies which were attempts to regulate affect whilst the defence alters contained the re-experiencing and the attempt to understand and to integrate the trauma. Many of the alters identified as central alters in this study would, by van der Hart et al.'s distinction, be identified as daily alters with most of the fragmented alters being identified as defence alters.

This patient experienced chronic traumatization from an early age which interfered with normal developmental pathways and impeded the integration of a cohesive personality. The recurrent trauma resulted in the creation of alters to contain the specific traumatic events. At least 28 of the 31 alters were created to contain defensive functions. The alter system was structured and hierarchical in nature with sub-groups in which alters formed alliances or were in conflict with each other. Some alters “took on a life of their own” once they had been created, but they were created to deal with a specific traumatic event and to contain emotional states that others were unable to. As the patient developed in maturity and age the cult's abuse became more predictable to her and there was a sufficient array of alters within the system to cope with the demands made upon her. Ruth's age when the first alter presented is unknown, but all central alters within the system were present by 11 years of age. The ages of the earliest alters discussed in therapy, Baby, Angel and the Body, are unknown but the alter Angel was described by other alters as being 2 years of age. The earliest memories of abuse discussed by Ruth were when she was 3/5 years of age and alters consistently reported memories of abuse from ages 4 to 6

years. The alter, Chris, was described as containing some memories from age 3 onwards and the Body contained much of the early physical abuse memories that occurred before the development of language (van der Kolk, 1994). Data here suggest that the age of alters is consistent with that of the patient at the time of abuse, though some alters such as AO had a broader age range than others because her function continued throughout the patient's life. Les described himself as aged 6-9 years, this being the period that he was active in those particular aspects of cult activities for which he had been created whereas Charlie, his "big brother", was perceived as being older. Continued development of alters depended on the purpose for which they had been created. It also depended on how much this function was required in the patient's daily and adult life. Those functions such as the capacity to care for others and to form attachments to her children and husband provided by (Me/MO, Mary) and to maintain a sense of anger (AO) and sensuality (W) needed to continue and to develop.

Putnam (1989a) stated that time provides the most convincing evidence that alters are not being iatrogenically induced. The majority of alters in this patient's alter system had a history that predated the diagnosis and therapy by many years. There was consistent reproduction of alter personalities over time and each presented itself with appropriate affect (Coons, 1989). The iatrogenic creation of the alter, Louise, supports this. She related no previous history whereas all other alters had a history that they needed to relate to or discuss. All alters, apart from Me/MO and Mary, reported severe abuse and the creation of these alters reputedly was in response to severe traumatic events set within a historical context. The discovery of joint alters in this patient's alter system is also consistent with this proposition. Joint alters reported the most specific and traumatic events when the support of another alter was necessary for the patient to contain the intensity of the trauma. The original personality, Me, also discussed her need to "create others" in order to protect herself from experiencing the consequences of the abuse. The main task of alter creation in this patient was to protect the original personality from knowledge, and hence the emotional consequence, of the traumatic event (Haddock, 2001). Further alters were created when the traumatic event was overwhelming or incongruent with the emotional resources of any other alter within the system. When a particular alter was

in danger of being overwhelmed by the impact of a traumatic event another alter was created to contain the event. In response to particularly severe and prolonged traumatic events such as those involving ritualistic sacrifice, several alters were created, each containing specific aspects of the traumatic event, and each alter not necessarily aware of the existence of the other. For example, AO was present at the initiation of cult sacrifices prior to the emergence of alters Les/Charlie, Maggie/Mae and Darryl to contain different aspects of the traumatic event. AO then “re-emerged” when the ceremony was complete but with little comprehension of the sequence that had occurred. Hence, each alter contained a different aspect of the trauma that needed to be explored in order to progress therapy.

There was a separation within the alter system between daily and defensive alters with in addition bridging alters, such as AO and W, that appeared to represent an aspect of both alter groups. The bridging alters were important within the alter system and, initially at least, were able to process material that the daily alters could not. These alters represented an intersection between the daily alters and the defence alters and the knowledge that they possessed assisted in informing the system as a whole.

Persecutory alters were created to contain specific aspects of the abuse. They were not necessarily adaptive in the disruption that they created within the alter system, although they were adaptive in their ability to join with the father in cult activities which assisted Ruth to survive and to maintain attachment needs. Darryl’s identification with the father, for example, was adaptive since it minimized cult abuse of Ruth by enabling Darryl to perform tasks that other alters could not whilst maintaining the belief that he encompassed the father’s love and approval. The development of alters such as AO overlapped with the persecutory alters; both contained a degree of anger towards the original personality and blamed Me for their pain. It was the persecutory alters that “coerced” the patient to attempt suicide and to engage in self-harm. The alter system was dynamic and self-harming and was, initially, an attempt by those alters to both contain their own mixed emotions and the need to keep the cult’s secrets safe. Self-harm was, in part, directed to achieving this and increasingly to protect and distract themselves against their own evolving

feelings of guilt and shame. As therapy progressed they blamed Me for the pain that they had subsumed and directed their anger towards her in an attempt to make her fuse with them and to contain their pain.

The development of alters in this patient is consistent with Putnam's (1997) proposition that the repetitious nature of specific traumatic events contributed to alter differentiation with each alter taking on specific functions and characteristics resulting in memory for particular traumatic events becoming dependent on that particular alter personality. Consequently, the fragmentation of this patient's self was not of a previously intact identity but rather a developmental failure of consolidation and integration of discrete states of consciousness (Putnam). Though the alter Me is identified here as the original personality it is doubtful that this personality was experienced this way from birth but rather that this aspect of the self became identified within the alter system as the "original personality". Van der Hart et al.'s (2004) proposal that different psychobiological systems have evolved in order to respond to different functions suggests that Me developed from the need for daily functions such as attachment requirements. She was the one within the alter system who was consistently able to maintain responses to daily events with the assistance of MO. The alter system (as represented in Figure 2 Chapter 6) constituted the patient's self and the process of treatment was that of consolidation and integration of these fragmented parts of the self.

She did not develop more alters after 11 years of age, the main reasons for this being the father's second marriage and the increased security that this brought to the home, the cessation of Ruth's involvement in cult abuse, and her early marriage to John which brought added stability. The alters most prominent following her marriage were Me/MO and Mary. AO and W were also present but to a lesser degree and W was largely controlled by Mary. In later years the defence alters were dormant within the alter system of this patient. This latter point implies that all alters were not necessarily active after abuse when the functions for which they were created had ceased. It is only when the function has a global need such as anger that there is a need for expression. However, those alters did not "disappear" but remained part of the patient's self. Their need to progress and to understand the

material that they contained, as in the case of Les/Charlie, and the eventual shame and guilt that they felt indicated that these parts of the self were still capable of responding and were not fixed or static. Whilst they were not readily apparent in the patient's daily life the defence alters contributed to her lack of vitality and sense of depletion. The daily alters distanced part of the self from the pain contained by the defence alters by numbing emotional awareness so that Ruth's life was "lived on the surface of consciousness" (Appelfeld, 1994, p. 18).

Fragmented alters such as Scream, Dizzy Lizzie, and Devilish Sue contributed to the progression of therapy. They contained emotional states experienced during the transition from one alter to the creation or emergence of another. These "unresolved emotional states" did not "belong" to the emerging alter and it was during these moments that the original personality was most susceptible to feeling the impact of the trauma and retaining some knowledge of it. During session 713, for example, Me/MO described Scream's place within the alter system "I feel that she's a definite part of me; the part that's trapped in that stage before I would disappear, then AO or W would come so she would be trapped". The momentum towards growth and an affirmation of good health was further confirmed by fragmented alters such as Voice and Informer who, at times, ensured that Me did not "blank out" and that she continued to "see" and "hear" their story. They represented the impetus for mobilization of the alter system when other alters, particularly Me/MO and Mary, had difficulty in continuing and consequently assisted in processing material that Me was reluctant or unable to process.

From this perspective dissociation is a defence mechanism whereby the individual attempts to protect the self from a traumatic environment that is not conducive to healthy growth and attempts to regulate it to one that is comparatively healthy. This perspective argues that dissociation is an inherent means of retaining a sense of homeostasis for optimum development. Therapy enables this task to be taken up again because the system is activity seeking resolution of traumatic material to enhance healthy growth.

Research Question Three

Abuse subverted Ruth's normal developmental processes and distorted her need for an integrated and cohesive self. The alter system at one level served to supply the needs that the parents were unable to supply, but this was at a cost and often self-destructive. In the case of the younger alters, it was the soothing function of therapy that was most important. During treatment some of the alters that perceived themselves as more "mature" and competent would take on this "therapeutic" role with the younger alters. This appears to have been in place before treatment, with alters such as Mary taking care of younger alters, though this was limited since most energy, for the daily alters, was directed at survival and at avoidance of knowing. This was also the case with those alters that were "joined" where they had the capacity to attempt to self sooth and reassure one another. However, during the course of treatment some of the more central alters picked up the role of the therapist and took a more "therapeutic" role with other alters. AO, for example, who naturally perceived herself as the leader took responsibility for some alters and attempted to defend and reassure them against the self-harming demands of Darryl. Even Darryl, who prided himself on his alliance with the father, in his desire to be validated by the therapist, initially formed a twinship transference perceiving his relationship with the therapist in a similar way to that with his father. Despite the self-harm that he and other alters created, the therapist needed to be "even-handed" in his responses to all alters so that their concerns could be expressed, understood and ameliorated.

Fusion occurred spontaneously once material had been worked through, though sometimes it occurred in a more prepared manner such as AO's fusion with Darryl and Les/Charlie. Fusion occurred with the central alter within a particular sub-system subsuming the other alters. The central alter of that sub-system had "created" the others to contain functions that they had been unable to contain at the time. Fusion meant that the central alter now contained the emotional and cognitive aspects of these alters. Once fusion occurred it remained constant, despite the fact that alters, with whom the fusion had taken place, wished that they could reverse it. Fusion was generally followed by a period of consolidation when the remaining alter adjusted to the emotional and cognitive changes that fusion brought. Once the alter

system was activated it took on a life independent of the wishes of individual alters. The daily alters Me/MO, in particular, whilst involved in therapy and encouraged to be so by the therapist tended to leave the processing of traumatic material (particularly during the middle phase of therapy) to the defensive alters. The division between daily alters who disavowed traumatic material and defensive alters that retained the abuse, may in part, explain why some patients having alleged abuse later withdraw such allegations. The daily alters are in denial of painful material that they “rightly” believe is not true since this acts as a defence not just for them but for the alter system.

Therapy was not linear in its progression but cyclical. Issues that had been discussed were revisited at a deeper level in a later phase of therapy. Once the patient had joined the therapeutic process the alter system responded, with no one alter being in complete control of the process. Issues discussed by one alter triggered the response of other alters at different phases of therapy. For example, AO discussed the ritualistic sacrifices early in therapy but she returned to this issue many times during treatment. Each time she returned to these events, particularly when alters had fused, it was with a deepening level of affect and cognitive awareness. This also triggered the responses of other alters that had been involved in these actions unbeknown to AO such as Les/Charlie.

During treatment, alters in this patient’s alter system retained the individual sense of purpose for which each had been created. What changed in the course of therapy was the ability for each alter to “re-connect” with the affect that they had contained and from which they had necessarily dissociated. Whilst the therapist’s desire was to work with the daily alters to raise their awareness and ability for reflection, it was the defensive alters that occupied much of the early and middle phases of therapy. As they processed therapeutic material, it also percolated into the alter system and informed the daily alters. It was through them that Me/MO could understand and emotionally contact the abuse process, which appeared both necessary for the alter system and for integration. There was no one alter that knew all of the alters within the system nor one that knew of the complete history of abuse. Rather it was the alter system as a whole that contained such knowledge. Some

alters, such as U Gin, appeared spontaneously to the material that was being discussed. These alters appeared to “emerge” when the system was triggered and were receptive to earlier traumatic events that at one level had been “forgotten”, but that still needed to be processed for integration to occur.

Critics of the diagnostic category of DID, such as Piper (1997) and Simpson (1989), state that working with alters creates more alters and increases the patient’s negative symptoms. Ruth did show a worsening of symptoms as therapy deepened and there were more alters as this occurred. But this is common in traumatic cases where symptoms are likely to deepen as the material is explored and experienced at depth. In one sense alters were unformed when they first appeared in therapy and the therapist, through the process of therapeutic interventions, “expanded” the emotional and cognitive awareness of the respective alters so that they could take on the affect that had been disowned. That is not to suggest that the alters are created by the therapist but that the therapist, as with all patients in therapy, assisted the patient to explore and deepen self awareness. In DID the affect contained by the alters needs to be processed by hippocampal networks that contextualizes and makes conscious material that had previously been dissociated from awareness (Cozolino, 2002). The alter, Me, as revealed in her more open moments, “knows” of the other alters and of the pain that they had subsumed but she has separated from it in order to continue with her life. It is through the unfolding of the material that the patient again engaged with it so that developmental issues that she had not been able to usefully progress could again be taken up. The course of treatment showed that the patient got better, and as traumatic material was resolved and alters fused, there were fewer alters. The alter system appeared “primed” to respond to therapy in a manner that promoted optimal and healthy functioning.

As therapy progressed there was a decrease both in the number of alters as they fused but also of the frequency of switching. A decrease in the number of switches is inevitable since there were fewer alters, but this also reflected the increased capacity of alters to maintain cohesion and to remain present during sessions to process material. The switching of alters during the actual traumatic

event meant that no one alter had to bear it all nor hold a cohesive understanding of the material.

Me feared and blamed Marcie for the knowledge that she contained. Early in therapy Me/MO had stated that she felt that as a child she had to put her soul (represented by Marcie) aside in order to survive but that she would later have to reclaim it. Such a sentiment reflected the patient's symbolic awareness of her situation and was a metaphor for the division and emotional numbing within her. As the alters developed within the alter system they "created" their own sense of control independent of Me or the alter that created them. Some, such as Darryl, took pride in their achievements. He was praised by the father and other cult members and in his persecution of other alters increased, initially, his perceived authority as a representative of the father within that sub-group.

What brought alters into therapy at particular stages was their response to traumatic material but also the "desire" of these alters to tell their story and to engage with the therapeutic process. Alters that contained some of the more horrific and specific aspects of the cult abuse first emerged in the later phases of therapy when the patient was sufficiently contained by the therapeutic process and able to process the excruciating trauma held by her. Such material was frequently returned to and indicated the need to allow the patient the time to "re-visit" material as frequently as required. In session 58 Ruth appeared regressed and stated that she could "see" snakes everywhere even on the office floor. This theme was returned to towards the end of treatment when Me was attempting to join with Marcie when primitive cognitive and emotional states needed to be addressed and processed even though they had appeared previously. Such issues indicated the need to allow therapeutic material to emerge without pressuring the patient and, at the same time, to be able to therapeutically contain the therapist's and the hospital's desire to bring therapy to a premature completion.

When neglect and trauma begin early in life a disorganized/disorientated style of attachment tends to develop (Holmes, 2001). Fonagy (1997) argued that a

disorganized attachment is common in those who have been abused, particularly where the abuser is a member of the family, and that the victim is likely to dissociate, both as a way of dealing with the abuse and with the abuser. This leads to a disrupted or incoherent attachment strategy in which abuse interferes with the child's acquisition of the capacity to self-soothe; the parents whose soothing actions are normally a template that gradually becomes internalized, instead cause pain and fear. In Ruth's case the conduct of the father is unspeakably sadistic, cruel and humiliating and continued for a long period. The mother offered no soothing or comfort and instead, abdicated her role as carer. Perhaps the formation of alters is the only way under such circumstances to get soothing, comfort and the strength to survive.

Ruth's self-cohesion had been formed around the father's imposed identity. His words and actions had largely formed her and had been the basis of her selfobjects such that he had imposed a sector of her personality and cognition. This, in part, accounts for the difficulty for the sub-group of alters who maintained a daily presence within the home (i.e., Me/MO, and Mary) in accepting the material of alters who had experienced the father and cult's abuse (i.e., Marcie, Amie, Les/Charlie, and Darryl). To accept such material was experienced as hating the self because it involved hate for the father. Alters that could mediate this difference such as AO and to a lesser extent W were necessary for treatment to progress; they could encompass something of both. AO was proud of her ability to be "strong" and held the belief that if left to her own devices she, unlike the other "weaker" alters, could direct her own path. As discussed in Chapters 6 and 7, one of the initial humiliations that Marcie had to endure was to drink her father's semen from a cup. This later contributed to her own and the alter system's belief that Marcie was contaminated. She was the one who was then seen as a "receptacle" for her father's abuse and humiliations. The belief that part of the father was "inside" her and that she would die if she ever spoke of the cult also contributed to her sense of despondency and the depletion of vitality within the alter system.

Me's fear was that by putting into words her perceptions and fears they would become too big for her to cope with and that they would overwhelm her. In one sense this was correct. When issues pertaining to abuse began to deepen, then the

intensification of emotional and cognitive mechanisms resulted in a “re-experiencing” of the events when those alters that contained these affects, presented. Me’s fear was that she would lose the fragile cohesion of self that she did possess. Thus, the enduring conflict for Me was that an increased awareness of an abusive father would implode her constructed world in which her father loved and valued her. She maintained closeness to her father during her early married years and he was central to the daily alters sense of cohesion. They needed him as an attachment figure. He was the selfobject around whom she based and maintained her sense of self. The “bad” father was contained by the defence alters which created tension for the patient as evidenced by her “panic attacks” and anxiety when some “awareness” of conflicting beliefs triggered by the suicide of her childhood friend began to emerge. This re-evoked childhood memories, from which the patient had previously been largely dissociated. The process of therapy developed the emotional and cognitive capacity of these alters. Their developmental needs for soothing, mirroring, and understanding being met, they were able to progress beyond that particular function and join with other parts of the self thereby fostering eventual integration. It was necessary to both work with, and to respond to, these alters so that their pain was validated and their developmental needs for understanding could be consolidated into an integrated and cohesive self.

The use of medication assisted in her treatment but it replicated to some extent the desire to numb and dissociate. Many of the suicide attempts were attempts at replicating such feelings. In treatment it was necessary to take this into account and it can cause some conflict in treatment positions when a medical perspective dominates. This was particularly the case when Ruth was an inpatient where treatment can focus on “damping” affect rather than being prepared to work with it in a relatively safe environment. Attempted suicides by overdoses of medication were both convenient because of access but also congruent with her experience of dissociation from traumatic material. In taking an overdose, she attempted to achieve the “drowsiness” and “numbing” effect of dissociation as she described it. Hospital admissions were seen by both the patient and therapist as an opportunity to work on particularly difficult issues that arose in therapy that the patient wished to progress but was unable to manage safely as an outpatient. Admission was an

important aspect of her treatment and it is doubtful whether she could have successfully integrated without such interventions, but it did present its own difficulties. In processing difficult material there was frequently an increase in self-harm, as new material arose following a period where the patient seemed to be relatively stable. When this occurred whilst she was an inpatient it would cause questions for some staff regarding the benefits of treatment and they would raise doubts regarding her treatment and advise her to “try to forget and push things away”. This also created a dual role for the therapist having to contain both the anxieties of the patient and those of the staff.

Some of the limitations that are necessarily involved in this study are considered below.

Limitations of the Study

The limited number of tapes to be analysed from the total raised the question of the representation of the sample. The study sought to control for this by selecting and randomly allocating taped material that raised the main issues of dispute in the literature. To provide a further check, judges were invited to select further tapes from the total pool if they so wished, though no judge requested this. The number of available judges meeting the selection criteria was limited and involved a significant contribution in their time and expertise. Factors such as these have probably contributed to the absence of validity checks in other studies.

A further consideration is the possible nonverbal conveyance of the therapist's expectations and biases. However, it was not feasible to videotape each session, or to undertake the detailed process of behavioural analysis necessary to evaluate such material (Stern, 1986). Instead, in keeping with principles of parsimony it was argued, that considered therapeutic practice aims for congruency in verbal and behavioural responses and that verbal communication should be the primary focus in this study. Any incongruity that does occur would be apparent over

the course of 700 sessions, and would be evident to the experienced clinicians/judges. Their considerable training in psychotherapy and clinical expertise could be expected to have sensitised them to such issues. They were asked to note any incongruence though none were reported (see Appendix E).

An additional issue was the possible use of psychometric instruments in the initial assessment of this patient such as the Dissociative Experiences Scale and the structured Clinical Interview scale (Steinberg, 1993). However, given that the therapist was unfamiliar with the diagnosis of DID and that once the diagnosis was made, according to DSM-IV criteria, the implementation of additional psychometric instruments was deemed by the therapist and supervisor to be unnecessary. Their use, at that stage, would have been intrusive to the therapeutic relationship without making any significant contribution to the diagnosis or treatment of this patient.

Suggestions for further research indicated by the findings of this study are now considered.

Suggestions for Further Research

One of the central issues involved in the treatment of this patient was the division of the alter system into daily and cult alters. The importance of this division and their different functions in the patient's life had major implications for her treatment and for the integration process. According to Van der Hart et al. (2004) the division between defence and daily alters is an inherent psychobiological system that is shaped by experience. For this patient Me was the most prominent of the daily alters and Marcie the most prominent of the defence alters. The different function of each system tended to inhibit the other and hence they were not easily integrated. Since each psychobiological system has evolved to respond to different psychobiological needs there is a natural avoidance by the daily alters for the traumatic material contained by the defence alters. Such an acceptance, however, would appear necessary for integration to be achieved. A detailed clinical

examination of the development and treatment of these opposing systems has not been reported within the literature and its investigation would provide greater understanding of the nature of DID and of its treatment.

For this patient the main function of the alter identified as the “original personality” (Me) was to protect the self from full awareness of the abuse so that her chances of survival (psychological and physical) were enhanced. The treatment process enabled the patient to consider other aspects of the self that had previously been kept at bay. Such processes necessitated significant changes to her concept of self. Whilst such changes continued during treatment it would be a significant contribution to trauma research to investigate how the patient adapts to this “new” sense of self once integration has occurred and whether there are further changes over a substantial (say three years) period of time.

Those alters that mediated between the daily and defence alters, identified as “bridging” alters in this study, had an important role in this patient’s treatment, both in their ability to engage with the therapeutic process and in their ability to process traumatic material that others could not. These alters contained a more developed sense of self than other alters initially contained. Further research into the functioning of these alters within the patient’s life particularly in the developmental aspects of the self that they maintain (i.e., for AO that of grandiosity, W sensuality) would provide a deeper understanding of these aspects of the self and of the role they have within DID.

The difficulties which treating this patient in a general psychiatric hospital presented, were considerable. An investigation into whether such patients would benefit from specific treatment facilities for the treatment of patients suffering from DID and/or other trauma related illnesses would be of considerable significance to the research and treatment of trauma related illnesses within Australia.

Summary

This study validated Ruth's diagnosis of DID and confirmed that this was not the result of therapist bias. Her history was consistent with the literature of trauma related DID and her alter system and response to treatment was similar to that reported in the literature. More importantly, she responded to treatment and has continued to maintain this stability over three years post integration. Ruth's positive response to therapy along with the increasing literature on the dissociative disorders underlines the importance of treatment in patients similar to Ruth who have previously received a number of different diagnoses and have appeared "untreatable". This is particularly the case when it is recognized that the theoretical understanding for the aetiology of DID is applicable both to an understanding and treatment of patients suffering from other trauma related issues. The issue of therapist bias has had a major impact on the diagnosing of the dissociative disorders and has cast doubt over the legitimacy of its aetiology. One of the main pathways for DID it is argued in the literature is childhood abuse. This is at a time when there is increasing acknowledgement within the scientific literature of the prevalence of sexual abuse in childhood and the destructive impact this has on the maturing brain and child development. There is also mounting evidence that the diagnosis of DID is legitimate and perhaps it is now time to consider not whether DID exists outside of iatrogenic bias but what conditions are necessary for its diagnosis. It is likely that some of the negative literature on this disorder has contributed to the belief, by some, that the disorder is an artifact and that it should be treated as such despite the evidence to the contrary. Given the increased literature on DID it is, perhaps, time to consider why only some therapists diagnose this disorder and what therapeutic issues are relevant to its diagnosis so that such patients can more usefully find appropriate treatment.

Epilogue

Written by Ruth shortly after integration:

This leaves the personality that is me. I am the result of integration that was both very lengthy and traumatic. I don't think I wanted to ever believe what my life was like. I felt that I fight the past all the time at the same time knowing that the past is true. I am trying to come to grips with everything now. There are no more personalities and I have to face the future all by myself without the help of the others. I have suffered anxiety and the "not knowing" syndrome. I want to be strong and live in the future being happy as well as never denying the past.

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Appendix A

1. Letter sent, by supervisor, to prospective judges seeking their participation in the study.

EDITH COWAN UNIVERSITY

PERTH WESTERN AUSTRALIA
JOONDALUP CAMPUS

100 Joondalup Drive, Joondalup
Western Australia 6027
Telephone (08) 9400 5555
Facsimile (08) 9300 1257

Dear XXX,

I am writing to you on behalf of one of our PhD. students, Ian Brown, to seek your help with one phase of his research.

Ian is writing his dissertation on Dissociative Identity Disorder (DID), using a single case study to examine competing theories about this disorder. One of the problems of using clinical material in this way, which is raised consistently in the literature, is that the reader must accept the therapist's version of the therapy process. In Ian's case all sessions have been taped but the reader of course does not have access to this material. In order to establish validity therefore Ian wishes to submit a random sample of those tapes, which illustrate certain of his hypotheses to the scrutiny of other clinicians who will examine them for specific confounding variables.

One issue for example that Ian is exploring is the genesis of alter egos. There is an argument in the literature that these arise through iatrogenic bias in the therapy sessions. Ian would like to identify tapes in which an alter appears for the first time and from a random selection of such tapes, ask experienced psychotherapists to determine if this appearance of an alter ego could have been engendered by Ian's therapeutic intervention. Since he is examining competing theories, he is genuinely interested in raters' findings about this.

Because of the nature of the disorder, it has been essential since the dissociations began to appear in the therapy to conduct sessions of around 1 hour 20 minutes to allow for this process.

We are seeking psychotherapists who understand dynamic process and would be able to identify clinical phenomena in a therapy session. We would very much value your assistance in this matter but realize it is a lot to ask of you especially as there are no funds in this programme to pay raters. Please do not feel under any obligation to take on the task if it would be difficult for you at this time.

JOONDALUP CAMPUS 100 Joondalup Drive, Joondalup Western Australia 6027 Telephone (08) 9400 5555	MOUNT LAWLEY CAMPUS 2 Bradford Street, Mount Lawley Western Australia 6050 Telephone (08) 9370 61	CHURCHLAND CAMPUS Pearson Street, Churchlands Western Australia 6018 Telephone (08) 9273 8333	CLAREMONT CAMPUS Goldsworthy Road, Claremont Western Australia 601 0 Telephone (08) 9442 1333	BUNBURY CAMPUS Robertson Drive, Bunbury Western Australia Telephone (08) 9780 7777
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Those clinicians that agree to help Ian with this scrutiny of tapes would be listening initially to one tape and making two ratings as well as giving some open-ended comment on specific aspects of the session. Later, 2 more tapes will be sent.

Raters will listen to the tapes in their own settings and their own time but initial ratings would need to be made over about a month - probably March or April though it could be later. Transcripts of the sessions will be provided.

Could you either respond in writing to [REDACTED] or leave a message on my work answer phone, [REDACTED] or fax my home on [number given] or my work on [REDACTED] letting me know whether or not you are willing to assist Ian in this way.

Kind regards,

Dr Noel Howieson
Associate Professor
Edith Cowan University

Appendix B

Information package sent to the 16 judges who agreed to participate.

Phase One: Reliability

1. Instructions for completing the study.
2. A Definition of Terms criteria for questionnaire items.
3. Questionnaires One and Two.
4. Demographic detail questionnaire
5. One tape, the same for all judges (not included).
6. A typed transcript of the tape (not included).
7. The DSM-IV criteria for DID (not included).

27 February 1999

Dear Colleague,

Thank you for agreeing to participate in this study. As you probably know I am a clinical psychologist enrolled as a part-time PhD. student at Edith Cowan University. My supervisors are Associate Professor Noel Howieson and Dr Allan Shafer.

Overview of study

I am seeking your assistance to investigate issues pertinent to the treatment and development of Dissociative Identity Disorder (DID; formerly known as Multiple Personality). The DSM-IV definition of DID is used in the study, a copy is enclosed. There is substantial controversy regarding DID, both in the literature and community. Basically, the controversy is whether DID is caused by biasing on the part of the therapist or whether it is a naturally occurring disorder whose aetiology is severe childhood trauma.

I am not attempting to 'prove' either the biasing hypothesis or the trauma hypothesis, but rather to avoid the polemic debate and determine whether experienced clinicians can in part, validate issues of therapeutic practise.

The study is divided into three phases:

1. In the first phase, issues of reliability and bias are considered.
2. In the second phase, issues concerning therapeutic bias will be considered.
3. In the third phase consideration will be given to the divergent views regarding aetiology and treatment of DID.

I am seeking your assistance with the first two of these phases.

In the first phase you are asked to listen to the enclosed tape (the tape runs for 1 hr, 20 minutes, the period proposed by Putnam [1989] as necessary to process dissociation). Then you are asked to rate your responses to the tape on two questionnaires, both questionnaires contain five items. The tape is the same for each of you - there are 16 clinicians/judges. During this phase, I need to ensure that the terms and concepts used are explicit before proceeding with phase two. I also wish to provide an opportunity for comments in case I need to alter or refine the concepts that I am asking you to rate. Therefore, I shall appreciate your comments if any of the terms or concepts is not clear. I would also appreciate any comments or observations regarding these sessions or the study that you would like to make.

Once phase one is complete I will send you a further two tapes, along with typed transcripts. These tapes will be different for each of you. I will ask you to rate these against the same concepts used in phase one.

It is necessary for me to provide composition data of clinicians/judges. I have enclosed a questionnaire for this purpose. This data will be reported only in composite form and your identity will remain confidential.

What I would like you to do.

For the first phase I would like you to listen to the enclosed tape, I have provided a written transcript to assist this, and rate its content against the five scales on the two questionnaires. I would like you to rate the extent to which each criterion is present or absent on a 7-point scale. The scales are rated from 1 to 7. Definitions of the terms used in the scales are defined in the following pages. I would like you to read these before rating the tape. If any of the concepts used in the two questionnaire's are not clear to you I would appreciate you indicating this on the relevant questionnaire item/s, or by contacting Noel or myself for clarification.

It would be appreciated if you returned the tape, transcript, and questionnaires in the pre-paid envelope before the end of the year. I would appreciate you letting me know if you are unable to meet this deadline. I will send the remaining two tapes/transcripts early in May 1999 once the first phase is complete.

If you have any concerns, I shall be pleased to discuss them with you. Noel or Allan would also be pleased to discuss any issues that you may have regarding this study. When the study is completed, I shall be pleased to discuss my findings with you.

Thank you for your participation and contribution.

Kind regards

Ian Brown

DEFINITION OF TERMS

Questionnaire One

Yapko (1994) suggested that adult memories of childhood sexual abuse recovered in therapy are least likely to be contaminated by therapeutic processes if therapists pay attention to the factors described below. A question to consider when evaluating these factors: Is the therapist creating the patient's recollections of sexual abuse?

1. They arise on the basis of a free narrative.

A free narrative means that the patient is allowed to express her recollection of the abuse in her own way and *when recall is allowed to flow freely, it is generally more accurate than when direct questioning is involved.*⁷ Answers to direct questions, according to Yapko's research, tend to lean in the direction of whatever the question implies. This does not mean that the therapist asks no questions some direct questioning is inevitable in the process of understanding and clarifying. What you are asked to judge is whether she is able to affirm, deny, explain, clarify, or shift her emphasis when expressing her recollections without the therapist interfering and *"blocking the flow"*.

2. Unprompted by leading or suggestive questions.

The absence of leading/suggestive questioning means that the therapist does *not* ask questions such as: *"He touched your genitals, didn't he?"* or *"How did he go about threatening you into silence all these years?"* The more often a leading or suggestive question is repeated, the more likely the respondent is to accept as true whatever the question implies. It is important when rating this scale to separate the *recall of abuse* from *therapeutic correction*. Some therapeutic correction is an essential function of therapy, as is reference to relevant material raised in earlier

⁷ Italics are used in this section to indicate that I am quoting Yapko (1994).

sessions. The critical point is whether the therapist is suggesting or leading any memories of sexual abuse, rather than therapeutically working through an issue that the patient raises.

3. In an atmosphere free of coercion.

The absence of coercion means that the patient is allowed to speak freely without the therapist attempting to impose his view. Yapko gives examples of this as *“You’ll feel much better if you just tell me how abuse occurred”*, or *“You trust me enough to tell me what really happened to you, don’t you?”* or *“If you don’t tell what happened, he’ll just go out and abuse someone else”*.

4. With a therapist who manifests a neutral position.

The maintenance of therapeutic neutrality means the therapist avoids adopting extreme positions either for or against a memory of sexual abuse. *The therapist’s certainty that abuse occurred is a compelling factor in generating (such) beliefs in the patient. It is definitely a contaminant when accuracy is desired.* Therapeutic neutrality does not mean that the therapist does not accept the subjective reality that the patient brings this is a legitimate and necessary function of the therapeutic process. The therapist, however, does not demand that the patient accept that sexual abuse occurred. Some examples of extreme positions are: *“I have reason to believe you were sexually abused as a child. Can you think of any experiences you might have had that would be considered evidence of abuse?”* Or, *“I saw another patient with the same symptoms that you have, and it turns out that she was sexually abused as a child and repressed it.”* Or conversely, *“I don’t altogether buy the idea of MPD”*.

5. That allows both him/herself and the patient the freedom to plead ignorance about what really happened.

Allowed to plead ignorance means that the therapist allows the patient and/or himself to state that they are ignorant about what really happened. Particularly when there is no reliable means available to determine whether an account is real or not. *It*

is best for therapists to admit that they do not know what happened, thereby reducing or eliminating the pressure on their patients to “pass a test” or to conform to the therapist’s beliefs. It is equally important that patients be allowed to say, “I don’t know” without their answers being interpreted as “resistance,” or some such undesirable label. This does not mean that the therapist has to maintain a perpetual stance of ignorance because of no validating proof being available. It means that it is okay to be unsure if a situation of doubt arises in the session.

Yapko (1994) proposed that memories that surface in conditions other than these are suspect though not necessarily false. I have incorporated these criteria in Questionnaire One. It may be that you feel these are limited or you may disagree with Yapko’s summation. I do not suggest that these criteria by themselves are sufficient to rule contamination in or out of the therapeutic process. I am simply attempting to subject some therapeutic sessions to a process of validation so that I can examine other issues related to DID.

Questionnaire Two

Greaves (1992) suggested that therapists were *constantly confronted with ambiguous productions (incongruent verbal utterances, behavior, and emotional displays) by their patients, as well as their own incongruities in response to the patient*. For therapists to remain oriented to their own sense of what is real [they have] *learned to apply several simultaneous tests of validity*⁸. Greaves (1992) proposed that therapists educated in psychotherapy have been trained to evaluate the nature of patient productions from at least three concurrent perspectives.

You are being asked to evaluate the patient's productions of traumatic material using these perspectives. The perspectives have been adapted in Questionnaire Two and are described below. A question to consider when evaluating these: Is the patient's recollections of extreme traumatic material consistent with a dissociative response?

1. Is the patient's presentation clear and coherent?

This is a check on the patient's cognitive process. You are asked to consider the content of the patient's thinking in terms of how *logical, rational, well organized* it is compared with thinking that is *disorganized, digressive, tangential, and purely associative* (as in psychotic productions). When considering this question it is important to take into account the emotional or regressed state of the patient. If she is regressed and in a child like state then the rating should be made from that perspective (e.g., Is the presentation logical from the point of view of a child aged 5?).

2. Affect matches content.

This is a check on the patient's affective process. *In the affective process check...the therapist relies on his or her empathic understanding of the emotional*

⁸ Italics are used to indicate that I am quoting Greaves (1992).

life of the patient. The therapist evaluates the patient's affect by considering the following: *Is this patient emotionally bland in the face of traumatic material? Over-reactive to minor irritations? Prone to expansive emotional exaggeration? Does this patient's affect match the content of her...reports?* Some account needs to be made for the nature of dissociation. Hence, the material being produced may be traumatic, but discussed in a distant dissociative manner as opposed to a bland uninterested, or inappropriate manner.

3. Presentation and affect congruent.

In question 3 you are asked to note *whether the cognitive, affective, and behavioral components in combination fit the content of the material.* That is are the patient's overall presentations consistent with the material they are producing. Greaves' "behavioral" assessment is, in part, of non-verbal behaviour. It is not possible to meet criteria here since it requires visual contact. He writes that the therapist observes whether the patient's body posture, tone of voice, facial expressions, and gestures fit with what is being said. I would ask, however, that you do consider "tones of voice" particularly in passages of therapy where you believe issues related to traumatic material are being expressed.

4. Patient does not contradict herself.

In question 4 you are asked to consider the following questions: *Is the patient's narrative logically possible? Does the patient contradict...herself?* As with question 1 the term logical needs to take account of the patient's emotional state (e.g., whether patient is regressed).

5. Is the patient's narrative consistent?

In question 5 you are asked to consider whether the patient's narrative grows in congruity with repeated telling, or whether her narrative becomes increasingly inconsistent. *Does the material and the (therapeutic) process grow more congealed in the telling, or more and more disorganized?* When considering this question, as with the other items, account needs to be taken of the patient's emotional state.

As with Yapko's criteria, you may not agree with Greaves' perspective, and I do not suggest that these are sufficient by themselves to validate the patient's productions. Additionally, in therapy such observations are typically made over a number of sessions and in circumstances where the therapist is able to "observe" the patient's responses. For the purpose of this study, however, I ask that you use these criteria to guide your judgements.

Questionnaire One: Tape One

Please rate (by circling the appropriate number) the extent to which each of the five criteria are present or absent in the content of this tape. Please rate all questions.

1

1	2	3	4	5	6	7

Narrative
restricted.

Narrative
free.

Any other
comments?.....
.....
.....
.....
.....

2

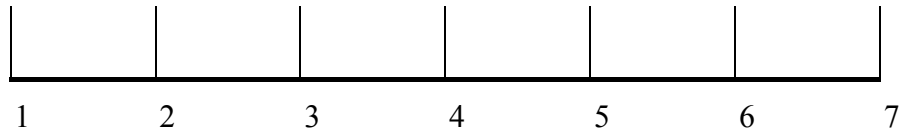
1	2	3	4	5	6	7

Presence of
leading/suggestive
questions.

Absence of
leading/suggestive
questions.

Any other
comments?.....
.....
.....
.....
.....

3

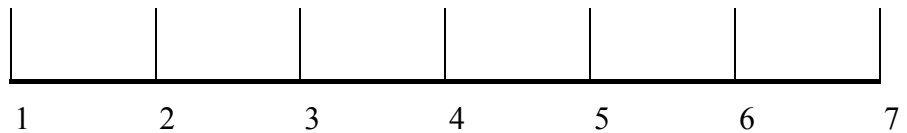


Presence of
coercion.

Absence of
coercion.

Any other
comments?.....
.....
.....
.....
.....

4

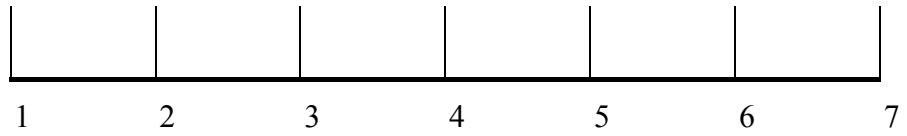


Therapeutic neutrality
not maintained.

Therapeutic
neutrality is
maintained.

Any other
comments?.....
.....
.....
.....
.....

5



Not allowed to
plead ignorance.

Allowed to
plead ignorance.

Any other
comments?.....
.....
.....
.....
.....

Questionnaire Two: Tape One

Please rate (by circling the appropriate number) the extent to which each of the five criteria are present or absent in the content of this tape. Please rate all questions.

1

1	2	3	4	5	6	7

Presentation not clear
or coherent.

Presentation
clear and coherent.

Any other
comments?.....
.....
.....
.....
.....

2

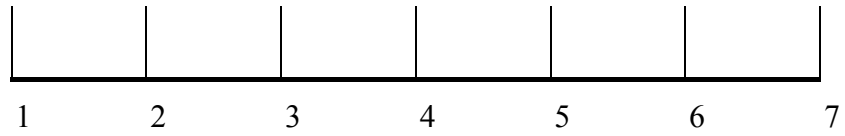
1	2	3	4	5	6	7

Affect does not
match content.

Affect does match
content.

Any other
comments?.....
.....
.....
.....
.....

3



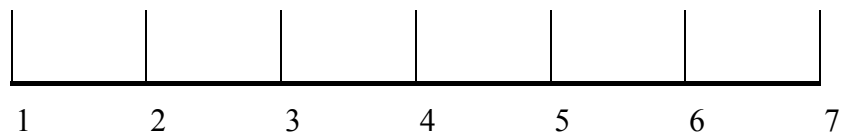
Presentation and
affect are not
congruent.

Presentation and
affect congruent.

Any other

comments?.....
.....
.....
.....
.....

4



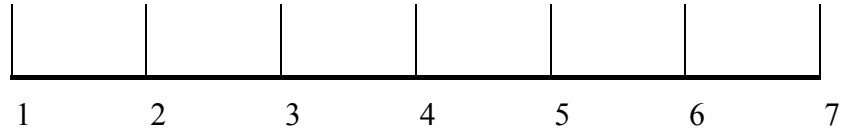
Contradicts
herself.

Does not
contradict herself.

Any other

comments?.....
.....
.....
.....
.....

5



Account becomes
disorganized.

Account grows
in organization.

Any other

comments?.....
.....
.....
.....
.....

DEMOGRAPHIC DETAIL

Please complete the following questions, your responses will be treated in confidence and used only in a composite form.

1. What are your professional qualifications?

.....

.....

.....

2. How many years have you been working in your profession since qualifying?

.....

.....

3. What training (if any) have you had in a psychodynamic model?

.....

.....

.....

.....

4. How long have you been working in a psychodynamic model?

.....

.....

.....

5. Name/Not for publication.

.....

.....

6. Any other comments?

.....

.....

.....

.....

Appendix C

Phase Two: Evaluation of Iatrogenic Bias and Alter Validation

Information package sent to the 15 judges who agreed to participate in this phase of the study.

1. Instructions for completing the study.
2. A Definition of Terms criteria for questionnaire items (see Appendix B).
3. Two copies of Questionnaire One and Two (see Appendix B).
4. Two tapes, one where an alter appears for the first time and another where there is evidence of switching and/or dissociation. Each judge received different tapes (not included).
5. Typed transcripts of the tapes (not included).
6. Any graphic or written material given to the therapist during that session (not included).
7. The DSM-IV criteria for DID (not included).

30th June 1999

Dear Colleague,

Thank you for completing and returning the first phase of the study. I apologize for the delay in sending this the final phase. It has taken me longer to transcribe the tapes than I had anticipated. I hope this has not inconvenienced you.

Overview of study

As you may recall, I am seeking your assistance to investigate issues pertinent to the treatment and development of Dissociative Identity Disorder (DID; formerly known as Multiple Personality). The DSM-IV definition of DID is used in the study. There is substantial controversy regarding DID, both in the literature and community. Basically, the controversy is whether DID is caused by biasing on the part of the therapist, or whether it is a naturally occurring disorder whose aetiology is severe childhood trauma. Such controversy has hindered study of the disorder and its treatment.

I am not attempting to “prove” either the biasing hypothesis or the trauma hypothesis, but rather to avoid the polemic debate and determine whether issues of therapeutic practise can, in part, be validated by experienced clinicians. It may then be possible to consider issues of aetiology and treatment.

The study is divided into three phases:

1. In the first phase, issues of reliability and bias are considered.
2. In the second phase issues concerning therapeutic bias will be considered.

3. In the third phase consideration will be given to the divergent views regarding aetiology and treatment of DID.

I am now seeking your assistance with the second phase - the first phase having been completed.

Your task in the second phase is similar to the first. You are asked to listen to the two enclosed tapes and then rate your responses to them. Responses are rated for each tape on two questionnaires; each questionnaire contains five items. Unlike the first phase, the tapes are different for each of the ten clinicians/judges. I would appreciate you indicating on the enclosed transcript any passage of therapy that appears particularly relevant or any other comment or observations that you would like to make.

To appreciate the “spirit” of the session it is important that you listen to the tapes as well as read the transcripts. Care has been taken to ensure accuracy, however, given the emotional state of the patient, this at times was difficult and inaudible parts of speech are identified as such in the transcript. Anyone mentioned during the session is identified.

What I would like you to do.

1. I would like you to listen to the two enclosed tapes, I have provided written transcripts to assist this, and rate the content against the five scales on the two questionnaires.
2. I would like you to rate the extent to which each criterion is present or absent on a 7-point scale. The scales are rated from 1 to 7.
3. Definitions of the terms used in the scales are defined in the following pages. I would like you to read these before rating the tapes.

It would be appreciated if you returned the tapes, transcripts, questionnaires, and any drawings or written material that was included in the pre-paid envelope by the end of September 1999. I would appreciate you letting me know if you are unable to meet this deadline.

If you have any concerns I shall be pleased to discuss them with you. My supervisor Dr Noel Howieson [Phone number provided] will also be pleased to discuss any issues that you may have regarding this study. When the study is completed I shall be pleased to discuss my findings with you.

Thank you for taking the time to participate, I appreciate your contribution.

Kind regards

Ian Brown

Appendix D

Summary of Greaves' indicators for integration

Integration Markers

Listed below is a summary of Greaves' (1989) integration markers, and negative indicators for integration.

Convergence phenomena

These phenomena are evidence for successful therapy. Convergence includes a broad variety of patient behaviours that indicate focusing of attention. This includes the keeping of regular appointments, attending on time and the production of new material that can be analysed. Such focusing requires the co-operation of several alters. The act of co-operation is in itself a convergence phenomenon.

Spontaneous appearances of alter personalities

The spontaneous presentation of alter personalities within the transference is a marker of trust.

Presentation of a wide range of vague physical illnesses of undefined medical origin

Subjects often present with a long and puzzling medical history, and with concurrent symptoms encompassing several physiological systems. Examination by physicians has frequently failed to establish a medical diagnosis. Symptoms are often somatic elements and somatic memories of the events that they represent. Once the original memories are fully acquired and abreacted, the somatic symptoms typically disappear.

Spontaneous appearances of a hostile alter

Hostile alters are characterized by intensely negative transference projections onto the therapist. These projections derive from traumatic past experiences with authority figures, particularly parents. A therapeutic alliance can be formed as the therapist explores, understands, and empathizes with the hostile alter. Therapist and patient share the goal of promoting integrity of the patient and personality integration.

The presenting or host personality hears voices for the first time

The patient's alters begin to converge and interact with the therapist. At this stage the patient implicitly acknowledges the dissociation as a coping mechanism. Hearing internal voices is the first major marker of integration.

Increased internal communication

The patient freely states that they know a lot more about what is going on inside them.

Increased co-consciousness

Co-consciousness between alters waxes and wanes, depending on the nature of the treatment focus. The personality conflicts dividing alters usually originates in a traumatic event, or series of traumatic events, which gave rise to the original split in consciousness, and which the patient has not been able to resolve. An increase of co-consciousness between alters occurs as the issues around the conflict are worked on. It is expressed in rapid switching between alters.

Copresence

In copresence, the patient indicates that other alters are present.

Major alter personalities cannot be distinguished by the therapist

As integration proceeds, the therapist may not be able to recognize which personality is active at any given time.

Personalities cannot distinguish themselves from one another

Personalities that are undergoing integrative processes may not be able to identify themselves at times and may experience identity diffusion in various forms.

Patient requests integration of two or more alters

The motives for this should be explored.

Spontaneous integration

Integrative therapy with DID patients aims to reduce dissociative defences so that spontaneous integration can proceed.

Ambiguous Markers

Greaves regards the following markers as ambiguous for integration:

Flooding of memories

In this, the patient is overwhelmed with new material faster than it can be processed.

Re-dissociation

May indicate a regressive form of stabilization or an indication of the excessive pressure of therapy.

Prolific reports of previously unknown personalities

This could reflect the discovery of new sub-systems, the creation of new personalities as defences against the demands of therapy, retreat into the internal world to thwart therapy, resistance to anticipated termination of treatment. The latter are “hold out” personalities. Greaves argued that these patients generally “hold out” unconsciously as treatment nears the final stages.

Negative markers

The commonest negative markers for integration are:

1. The patient ceases to produce material that can be analysed.
2. The patient frequently becomes psychotic following sessions.
3. The patient focus is consistently externalized.
4. The patient acts out against the therapist and the therapy process with behaviour that is potentially destructive to self and others.
5. Therapist experiences him or herself as becoming less and less effective

Appendix E

Judges' General Comments made in response to sessions that they had been asked to evaluate

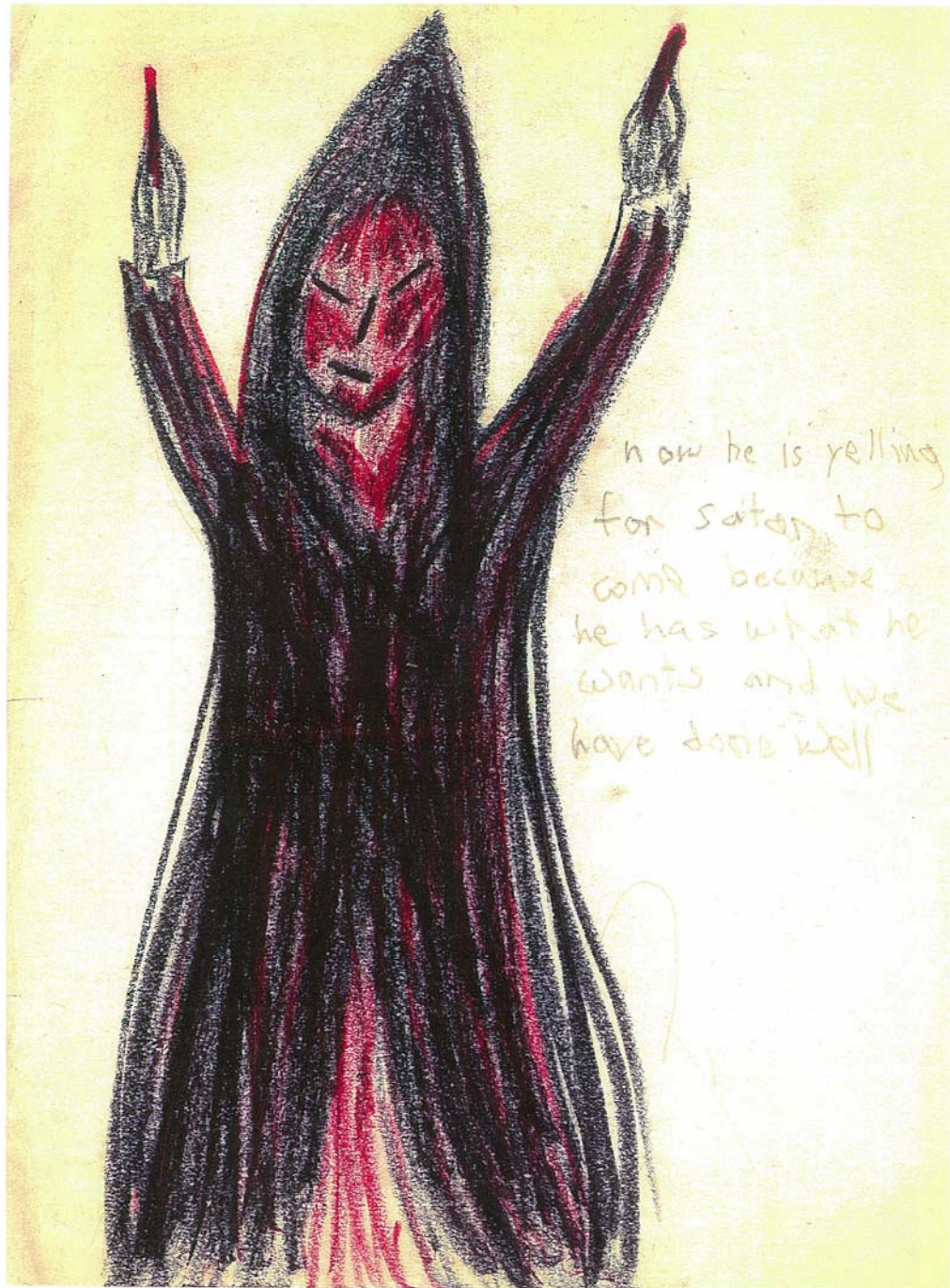
1. Direct questions are not in direction of encouraging exaggeration but of developing a more rational explanation.
2. The therapist stays alongside the client's regressed experience. There is no coercion in the sense that the therapist is using their superior understanding to coerce the client.
3. Therapist is genuinely allowing himself to be helpless and ignorance.
4. The presentation is not logical and rational in that the client is regressed and is being allowed to tell the story within the limitations of understanding of a child. There are the beginnings of ego, superego development i.e. an observing self, which can make rational sense of the experience.
5. Dissociation occurs as client shifts from one affect to another. The therapist is naming affect e.g., terror, sadness, comfort in order for sensations to have a name.
6. The client does not name affect but she shows sadness by crying, anger by tone of voice when she dissociates to Charlie. At times affect is confined and in turmoil e.g., in relation to sister as self-object.
7. With this client consistency might take some time as different fragments of the self might experience the same events in different ways.
8. One could follow the content even when the different personality's emerged.
9. The process of therapy means that one cannot be so neutral as to make no comment about what happened. Your responses indicate to me that you do accept her subjective experience as that – there is no pressure to adopt the therapist's point of view.
10. The account grows in consistency if you take dissociation into consideration.
11. She switches to deal with profound childhood abuse, and switches back to deal with the loss of her friend, Julie.

12. Changes position when changing ego states (alters) entirely appropriate.
13. It seems that the client's defence put in place (multiple personality) allows the client to think from many perspectives and therefore she does not contradict herself. Now, if we underline that they are all (Charlie, Les, Mary ...etc) one person, then yes, there are contradictions. But Les does not contradict herself, on the contrary, she corrects the therapist when he is confused about who is talking.
14. There are a number of examples of the client correcting and clarifying the therapist.

Appendix F

Selection of drawings and clay model produced by patient during therapy

1. Cult figures, (33 x 24cm) completed session 145.
2. Cult figures, (33 x 24cm) completed session 145.
3. Cult figures, (33 x 24cm) completed session 145.
4. Cat Disembowelled, (40 x 30cm) completed session 196.
5. Marcie's Wedding, (40 x 30cm) completed session 493.
6. Symbols, (30 x 21cm) completed session 385.
7. Darryl's Clay Model, Frontal (8cm) completed session 367.
8. Darryl's Clay Model, Profile (8cm) completed session 367
9. Chris/Carol, (40 x 30cm) completed session 210.
10. Marcie in Hell, (40 x 30cm) completed session 366.
11. Angels in Heaven (30 x 40cm) completed session 202.
12. U Gin, (40 x 30cm) completed session 1054.
13. No Pain to Pass!!! (42 x 30cm) completed session 1054.
14. Hands and head separate from the body, (30 x 40cm) completed session 445.
15. Knife, (40 x 30cm) completed session 169.
16. Marcie joined to the father's head, (51 x 75cm) completed session 982.
17. Marcie joined to the father's body, (60 x 41cm) completed session 907.
18. Marcie covered in the abuse, (51 x 75cm) completed session 605.
19. Marcie "spewing" the father's "badness", (20 x 30cm) completed session 791.
20. Marcie and Me in a container, (60 x 41cm) completed session 998.
21. Marcie and Me holding hands (41 x 30cm) completed session 1068.
22. Marcie enclosed in blackness, (42 x 60cm) completed session 980.



now he is yelling
for satan to
come because
he has what he
wants and we
have done well

This is a very very bad man
with a fire so he can hurt us.



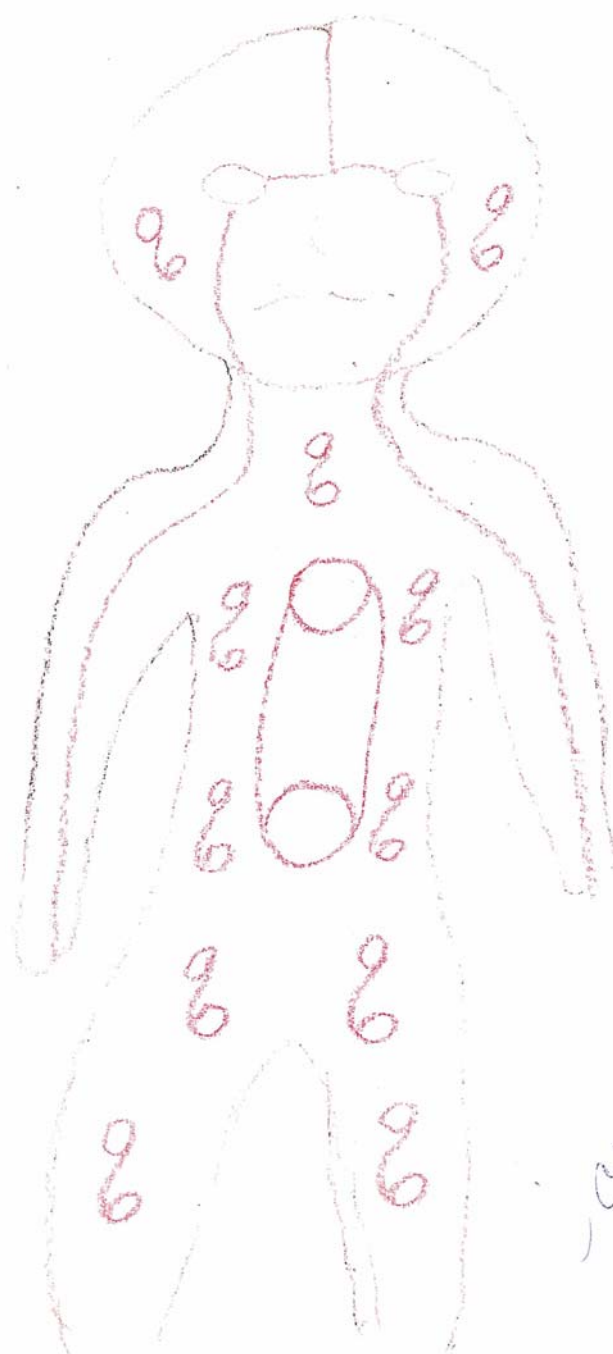






This is me getting
married Wanna Scream
Marcie

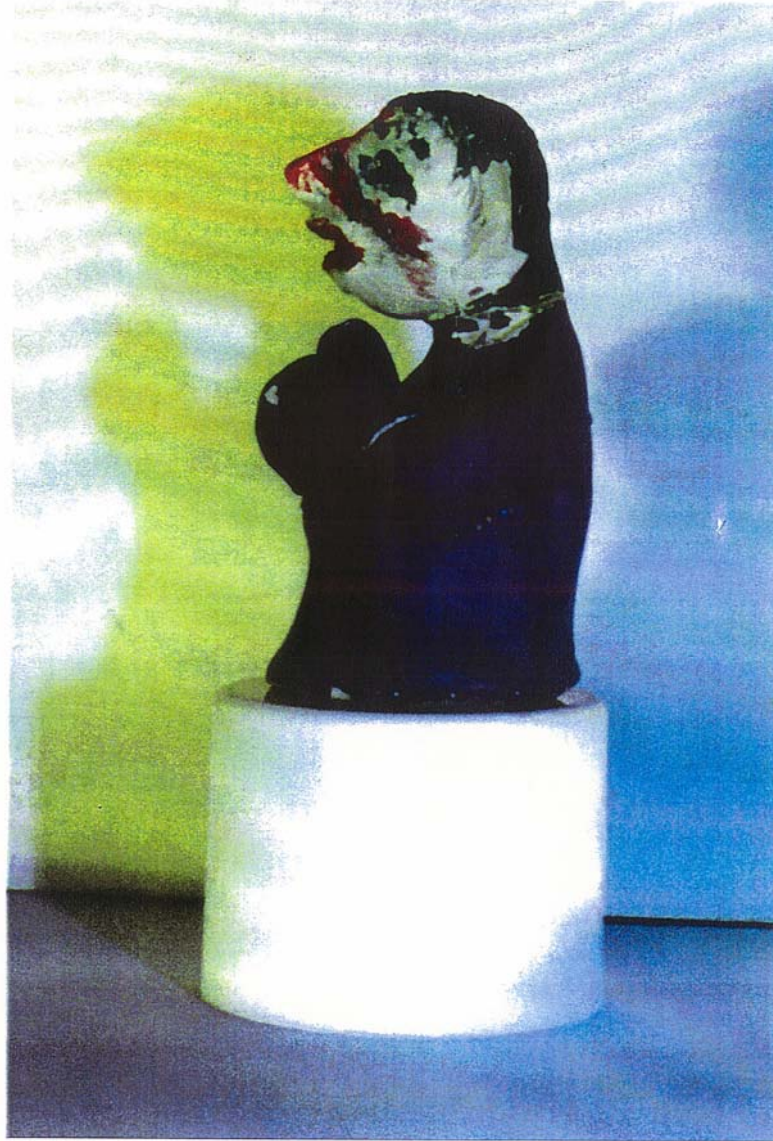
It dark with the
moon and leaves
people watching us



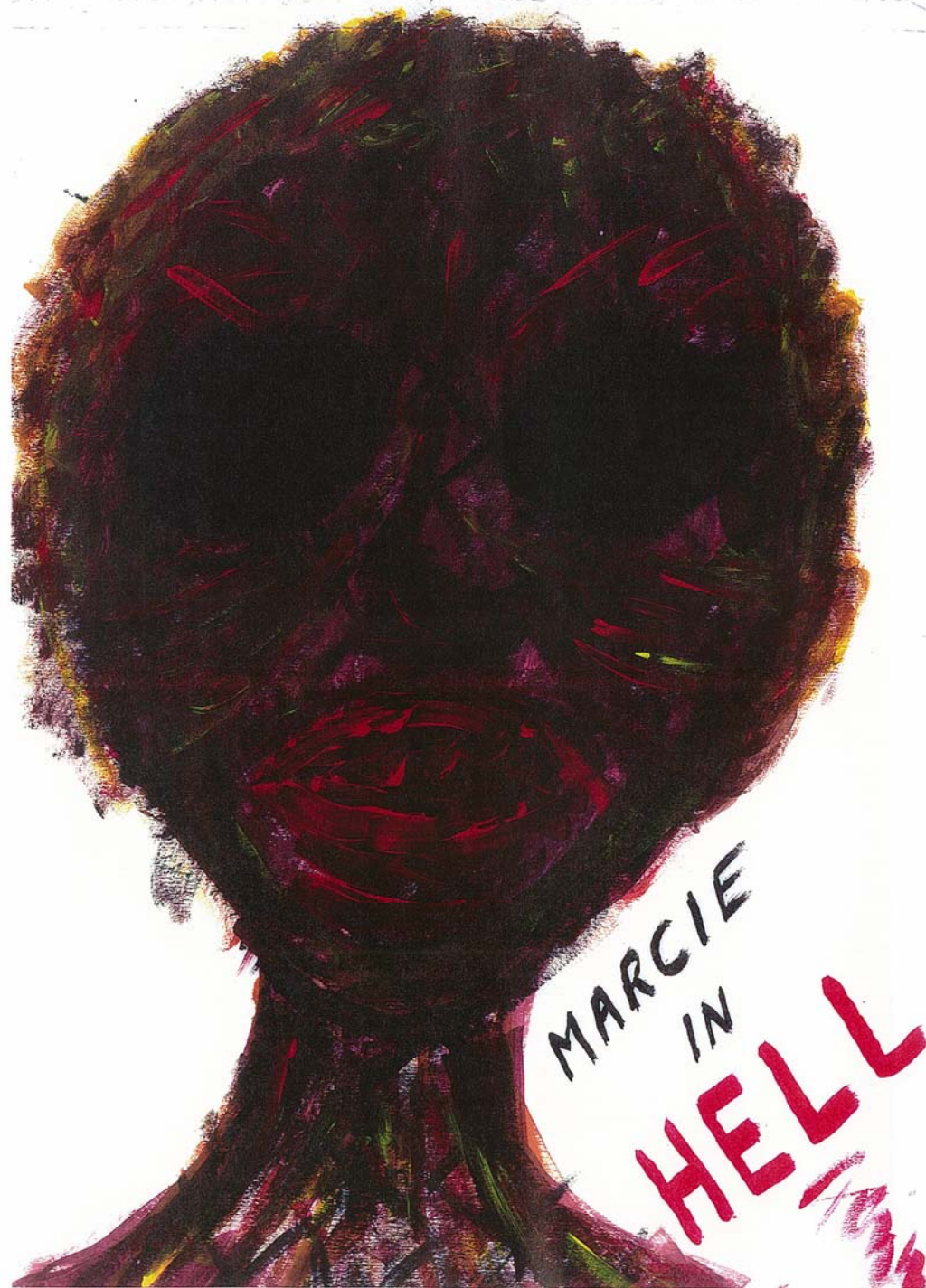
any

385















THE BODY HAS
NOTHING TO DO
WITH THE HEAD



THE HEAD
IS NOT
RESPONSIBLE
FOR THE
HANDS











