CASE 8 | Dissociative Identity Disorder

At the time of her first visit for outpatient treatment with a clinical psychologist, Wendy Howe was a 35-year-old, unemployed, divorced Caucasian woman with two children (a son age 20 and a daughter age 15). During the preceding year, Wendy had been hospitalized in a number of inpatient psychiatric units. During these hospitalizations, Wendy's symptoms had been given a variety of diagnoses—depression, substance abuse, schizophrenia, borderline personality disorder—and Wendy had undergone many different psychological and drug treatments. She had been treated with antidepressants, neuroleptics, anti-anxiety drugs, lithium, seizure medications, and beta-blockers; at the time of her first visit with the psychologist, Wendy was being prescribed all of the above. None of these interventions had proved helpful; instead, Wendy's symptoms had gotten worse. Her hospital treatment team had felt that they could not discharge Wendy because she displayed strong suicidal impulses and engaged in some very severe self-injurious behaviors. In fact, at the time of the initial outpatient consult with the clinical psychologist, Wendy had been on one-on-one observation in the hospital for the past 2 months, and the hospital had recommended transferring her to a long-term inpatient program.

The clinical psychologist received a call from a case manager for Wendy's insurance carrier who was trying to find an outpatient therapist familiar with the treatment of dissociative disorders. The insurance company considered Wendy to be a "large loss case," given her frequent psychiatric and medical hospital admissions (many of Wendy's medical admissions were for self-inflicted injuries) and her poor prognosis. The hospital treatment team had decided that Wendy would show a long downhill course, should be put on long-term disability, and should be treated with neuroleptics (a class of medications used to treat psychotic symptoms characteristic of schizophrenia) to keep her sedated enough to be less likely to hurt herself. The case manager informed the psychologist that the insurance company was willing to "try anything if it could get and keep Wendy out of the hospital."

Clinical History

Wendy's psychological difficulties were clearly linked to a very tumultuous childhood. As a child, Wendy lived with her violent and abusive mother in a small urban area; her father had left the household when Wendy's mother was pregnant with her. Throughout Wendy's childhood, the family was very poor and lived in tenements. Wendy's mother was unemployed for much of Wendy's childhood and made money to support her addictions to alcohol and heroin by selling Wendy for childhood prostitution. Wendy had been physically and sexually abused as far back as she could remember. In fact, there were hospital records of a severe physical abuse incident that occurred before Wendy was 2 years old. Wendy's mother was extremely sadistic and had tortured her regularly with extreme and violent means. For example, without any provocation, Wendy's mother would burn and cut her on various parts of her body, would give her enemas (sometimes with very hot or very cold water), would insert objects into Wendy's vagina and anus, and would watch while other people sexually or physically abused her. Her mother also abused Wendy's siblings (two brothers, two sisters), often making them watch as each was tortured. Sometimes her mother would force one sibling to physically or sexually hurt another. Wendy's grandfather sexually and physically abused her as well, as did many of her mother's boyfriends.

These abuse incidents were very frequent and very severe. Many of these incidents resulted in trips to the emergency room, and occasionally Wendy received inpatient treatment for internal injuries. When Wendy was 15, she suffered an exceptionally violent rape by one of her mother's boyfriends. The rape resulted in hospitalization due to the severity of her physical injuries, and plastic surgery was necessary to reconstruct her face. This rape also resulted in a pregnancy and the subsequent birth of her son. Legal records documented the assault and rape by her mother's boyfriend; in fact, this individual was later convicted and jailed for the rapes of five other women. School, hospital, and legal records documented virtually all of the other abuse incidents that Wendy described. Wendy's victimization history extended into early adulthood: There were records indicating that she had been raped three times, had been sexually exploited by a doctor, and even had her home taken over by some drug dealers looking for a place to stay.

Wendy stated that she had tried to block her childhood abuse from her consciousness in order to be able to parent her children. She said that she had spent all of her adult life struggling to "put it behind her." Yet, the effects of her abuse had dominated her life. For example, because of her mother's terrorizing about bathroom functions, Wendy could not remember the last time she was able to use a toilet. Because she feared toilets a great deal, she would delay bathroom functions as long as she could, and then she gave herself enemas to void more quickly. Consequently, Wendy felt that she was unable to travel far from home in the event she needed privacy to give herself an enema. Wendy's enema use had been so extensive that she had permanent intestinal damage.

Until the year of her recurrent psychiatric hospitalizations (i.e., the year preceding Wendy's first visit with the clinical psychologist), Wendy had been somewhat successful

at holding things together in a fragile fashion. Although she had dropped out of school during the 10th grade because of the birth of her son and her severe abuse at home, Wendy had obtained her high school equivalency diploma by taking a state exam. At age 17, she married in order to get out of her mother's house, a marriage that lasted 1 year. At the age of 20, Wendy had a second child (a daughter) from a brief relationship she was having with a married man. Although she had worked at many different jobs (e.g., waitressing, bartending, sales, secretarial work), until her hospitalizations Wendy had been working steadily for 5 years as a telephone operator.

However, two major events seemed to trigger Wendy's decompensation over the preceding year. First, Wendy learned that she would no longer be able to continue her job as a telephone operator because she had developed carpal tunnel syndrome in both arms from working with poorly designed work equipment. The telephone company wanted to place her on disability, provide corrective surgery, and then retrain her for another type of employment. Wendy had not complied with this plan, largely due to her fear that she would be molested by the doctor while she was under anesthesia (as had occurred to her several years before). Consequently, Wendy felt very afraid of her uncertain economic future and the possibility of two painful surgeries to correct her carpal tunnel syndrome.

Second, during this time Wendy's son entered an alcohol treatment program after getting in an alcohol-related automobile accident. The treatment program requested information on the family's substance abuse, psychiatric, and medical histories. In particular, the program was investigating the possibility that Wendy's son had bipolar disorder (see Case 10) and wanted to know about any family history of this disorder. Wendy had not had any contact with her son's father, who was in prison serving a 20-year sentence for the rapes of five women. However, in order to get the necessary medical history information for her son, Wendy went to the prison to interview him. Wendy was able to obtain the necessary information, but the visit evoked the memory of this man's violent rape of her at age 15. Wendy was overwhelmed by the flood of feelings and memories that she had previously tried so hard to block out of her mind.

Having this occur when she was already feeling vulnerable about her job status and possible surgery was too much for her. Seeing her son's father again had opened up the floodgates, and she could not stop the memories of her past abuses from pouring into her mind. Typical of the person with a severe posttraumatic stress disorder (PTSD) (see Case 4), she began to have distressing flashbacks of her childhood abuse almost continuously. During a flashback, Wendy would reexperience the traumatic events so vividly—through visual images, sounds, and bodily sensations—that she would feel as if the abuse were happening to her all over again. She had regular nightmares about her abuse experiences. Being an avid drawer and painter, Wendy began to focus all of her artwork on traumatic material (described in more detail later in this chapter). She had an exaggerated startle reflex (e.g., she became very upset from hearing a sudden noise such as a popping balloon), and she had great difficulty calming down after such a reaction. She showed significant problems with her memory and concentration. Also, Wendy had considerable sleep difficulties and could not sleep at all in a bed (much of her sexual abuse occurred in bed) or if other people (including her children) were nearby. Thus, Wendy usually slept on the floor or in a closet.

Wendy also experienced a major disruption in her spirituality, that is, she questioned the reality of God. This was probably because Wendy's mother had been overtly highly religious but had used her beliefs as a justification for much of her abuse of Wendy: "I need to give you this enema with cleaning fluid to clean you out because you are such a dirty and evil sinner." Moreover, when Wendy was 16, she had produced a "stillborn" child. Her mother told her that this child could never go to heaven because he had not been baptized. Since that experience, Wendy had struggled with her view of God and religion and had constantly felt guilty and anxious about the status of this baby.

Roughly a month after her visit to the prison, Wendy's symptoms had become so severe, and she had become so distressed over them, that she committed a very serious suicide attempt. Consequently, Wendy was admitted to a psychiatric hospital for the first time, an admission lasting 2 weeks.

As she had done in childhood, Wendy tried very hard to distance herself from these memories and to calm herself. One method Wendy used to cast the intrusive memories out of her mind was injuring herself with self-inflicted cuts and burns. She was covered with bruises from hitting herself with heavy objects, and she had many scars, cuts, and burn marks on her arms, legs, and chest. In addition, Wendy had an open wound on her foot that she had not allowed to heal for 15 years. During one of her hospitalizations, this wound had become infected (as it had been on many occasions in the past), and the hospital staff were frustrated in their attempts to treat it because Wendy kept removing the bandages and reopening the wound. Later, they learned that Wendy had received medical attention for the wound many times in the past (sometimes surgery and stitches), but Wendy had always taken out the stitches and kept the wound from healing. For years, Wendy was in constant pain and had trouble walking and getting around easily. Although the staff did not know it at the time, Wendy cut herself vaginally on a regular basis during her hospital stays and became anemic from the blood loss. The staff could not understand at the time why Wendy was so anemic.

In addition, Wendy had learned to rely on her hypnotic abilities to psychologically distance herself from her distressing memories and emotions. Specifically, Wendy learned to dissociate herself from the ongoing abuse she suffered throughout childhood. At first, this strategy helped Wendy to cope with the ongoing abuse by psychologically separating her from the trauma. However, her *dissociation* had become so extensive (in *DSM-IV-TR* [*Diagnostic and Statistical Manual*, 4th ed., Text Revision], the term *dissociation* refers to a disruption in a person's consciousness, memory, identity, or perception of the environment) that, since childhood, Wendy had developed more than 20 distinct personalities. Wendy often found herself in a trance, either reliving abusive experiences or so distanced from them that she felt unreal or inhuman (symptoms corresponding to the terms *derealization* and *depersonalization* in *DSM-IV-TR*). By distancing herself from traumatic cues, Wendy came to have major problems with amnesia: She would often "lose" large sections of time (occasionally hours at once) when she could not recall what she had done or where she had been. For example, even subtle cues or reminders of abuse incidents could trigger a dissociative episode in which Wendy would switch to a different personality; once she had returned to her usual state, Wendy could not recall what had occurred during the episode.

Each of Wendy's personalities had its own distinct pattern of behaviors (e.g., speech, posture, mannerisms), perceived ages, sex, and appearance. Each personality had a unique store of information, memories, and access to feelings. Amazingly, each of Wendy's personalities possessed different physical reactions or different physical abilities, such as different responses to medications and different types of allergies or allergic reactions, and even different eyesight abilities (i.e., different personalities required different eyeglass prescriptions). Based on his initial sessions with her, Wendy's clinical psychologist reasoned that when Wendy experienced major incidents of abuse, she had frequently coped by "walling" off the part of herself that was taking the abuse so that the rest of her did not know what was taking place. By dividing things up this way, Wendy was able to have parts of herself that could contain the feelings and knowledge about the tortures and abuse that were going on at home and still have other parts of herself that could handle going to school (and later, going to work). However, these various parts of her began to take on lives of their own as they were repeatedly called upon to handle other abusive situations. For instance, one personality would always be present when her grandfather would orally rape her. Thus, this personality had developed with no sense of taste and a minimal gag reflex. Another personality handled being burned by her mother and was able to be insensitive to and tolerant of physical pain. Yet another personality was experienced as having no mouth, stemming from experiences where Wendy's mother burned her every time she screamed.

As is typical for most persons with dissociative identity disorder, Wendy possessed many child personalities. These personalities tended to be the parts of Wendy that had been walled off during childhood abuse incidents and therefore had been stopped in time. These personalities saw themselves as the age at which the abuse had occurred and often believed that it was still that year and that they were still living in the same place, going to the same school, and so forth. The voices, postures, drawings, penmanship, and vocabularies of these personalities were all age appropriate. Each personality had its own purpose, and many of the characteristics of each personality contributed to these functions. Personalities that handled torture were anesthetic (as were the ones present during episodes of self-injurious behavior, such as removing stitches from the foot wound). Personalities that had been forced to submit to her mother's bidding had internalized these rules and presented as little tyrants. Personalities that were left with the pain from the torture and abuse seemed autistic (e.g., socially detached and nonresponsive), whereas the personalities that handled school or work were quite charming and able to relate. In fact, Wendy had typically been quite functional in highly structured and consistent environments (where the switching of personalities would be less likely) and had been able to do well at most of her jobs. However, even after a good work day, Wendy would often come home and hide in her closet until morning because of her perceptions that her traumatic experiences were happening to her all over again.

Most of these personalities were very isolated from the others. Many did not know about each other, and some did not know about the abuse. One personality (named "Susan") had been developed to handle sex with the men to whom Wendy's mother had sold her for prostitution. Susan quickly learned that if she initiated the sexual interaction and found a way to experience sexual feelings, it would be far less painful. Thus, Susan had come to believe that she loved sex, and she would

actively engage the men her mother brought around. This coping style was very helpful when Wendy was a child as a means of dealing with such a turbulent environment. However, after Wendy had left her mother's home for good, "Susan," by virtue of being cut off from the other personalities, did not know that anything had changed. For many years, Susan continued to seek out men for sexual encounters. (In her normal state, Wendy reported that she had abstained from sex for many years, with the exception of occasional prostitution to support herself and her children after she was placed on leave at the telephone company.) If the situation became violent or abusive, Susan would "leave," and another personality would handle that aspect of the encounter. Therefore, Susan did not know about the violence and would feel quite comfortable bringing home the same individual who had abused her a few weeks before.

Another childhood personality was perceived as being male. This personality had developed after Wendy had witnessed some men choose her and another girl for violent sex, leaving her brothers unharmed. Wendy felt that if only she could have been a boy, then she would have been safe. Consequently, a "boy" personality emerged so that Wendy could feel safe between episodes of abuse. When being that little boy, Wendy felt invulnerable and able to concentrate on other things.

Because Wendy's personalities were so distinct and separated from one another, their abrupt emergence often caused her considerable interpersonal difficulties. People always viewed Wendy as weird, inconsistent, and eccentric. Because they often witnessed Wendy change personalities without understanding what they were seeing, they would become confused as to why her preferences, memories, attitudes, and general demeanor would change in such dramatic and unpredictable ways. Wendy lost many relationships due to such behavior and, as noted earlier, was frequently taken advantage of by exploitive persons.

Initially, Wendy had tried hard to minimize and deny all of her dissociative symptoms, in part because acknowledging such problems would have meant becoming aware of aspects of her past that she was unwilling to tolerate. Because most of her dissociative symptoms had been present since childhood, to some degree Wendy felt quite accustomed to them and had come to believe that everyone lived the way she did; for example, later in treatment, Wendy was quite surprised to learn that not everyone lost large sections of time when they could not remember where they had been or what they had done. One of Wendy's personalities would often be activated in public, usually triggered by cues that reminded her of past abuse (e.g., watching a movie that contained scenes of rape with a group of people). The corresponding personality would emerge and be very confused about place and time (because the personality had been formed years ago in an abusive environment) and would act in ways that would confuse others around her (e.g., begin speaking in a childish manner, then run out of the house and hide under the porch). If this occurred when Wendy was alone, she would "forget" that she had just lost time. When this occurred in the presence of others, Wendy would be unaware of the episode and very confused about the reactions of those around her. If they forced her to face what had just happened, Wendy would usually try to "fake it" and pretend that she was fooling around, or else she would try to make excuses for her behavior. However, when people would not allow her to forget such behavior, Wendy would become quite upset and frightened.

Although Wendy's dissociative symptoms (e.g., trances), multiple personalities, and self-injurious behavior could be viewed as her way of effectively distancing herself from painful memories and feelings, Wendy experienced increasing feelings of self-hatred and blame for engaging in such protective maneuvers. Prior to treatment, Wendy had made no connection between her protective behaviors and her traumatic experiences, and thus she regarded these behaviors as a sign that she was crazy (an opinion frequently voiced by others who happened to witness such behavior). For example, if Wendy began to experience a distressing recollection of a past abuse incident, she occasionally cut or burned herself during a dissociative state to make the memory stop. Although she often felt better momentarily, Wendy would then berate herself for being so "perverse" as to cut or burn herself. She did not understand that she had needed to do so to avoid becoming totally overwhelmed by the distressing memory.

DSM-IV-TR DIAGNOSIS

On the basis of this information, Wendy was assigned the following *DSM-IV-TR* diagnosis:

Axis I	300.14 Dissociative identity disorder (principal diagnosis)
	309.81 Posttraumatic stress disorder, chronic
	296.33 Major depressive disorder, severe without psychotic features
Axis II	301.83 Borderline personality disorder (provisional diagnosis)
Axis III	Carpal tunnel syndrome, intestinal damage from laxative abuse
Axis IV	Unemployment, inadequate finances, severe family discord
Axis V	Global assessment of functioning = 25 (current)

Prior to beginning her outpatient treatment, Wendy exhibited all the symptoms of the *DSM-IV-TR* diagnosis, dissociative identity disorder (DID) (American Psychiatric Association, 2000). In *DSM-IV-TR*, DID is defined by the following features: (a) two or more distinct identities or personality states are present, (b) at least two of these identities or personality states recurrently take control of the person's behavior, (c) the person is unable to recall important personal information that is too extensive to be explained by ordinary forgetfulness, and (d) the disturbance is not due to the direct effects of a substance (e.g., blackouts during alcohol intoxication) or a general medical condition (e.g., complex partial seizures). In *DSM-IV-TR*, DID is included in a category referred to as the dissociative disorders, which are characterized by alterations in perceptions or a sense of detachment from one's own self, from one's world, or from memory processes. The most extreme form of dissociative disorder is DID, reflecting the fact that dissociation can be so extensive that whole new identities are formed. Other types of *DSM-IV-TR* dissociative disorders include *dissociative amnesia* (extensive inability to recall important personal information, usually traumatic or stressful in nature), *dissociative fugue* (sudden, unexpected travel away from home or work, accompanied by an inability to recall one's past and confusion about

personal identity or the assumption of a new identity), and *depersonalization disorder* (persistent or recurrent feeling of being detached from one's mental processes or body that is accompanied by intact reality testing, that is, the person is aware that it is only a feeling and that he or she is not really detached from the body or mental processes).

The nature and treatment of dissociative identity disorder (referred to as "multiple personality disorder" in the revised third edition of the *DSM*) are discussed in more detail in the next sections of the case. Posttraumatic stress disorder, major depression, and borderline personality disorder are discussed in Cases 4, 9, and 15, respectively. However, note that Wendy's borderline personality disorder was assigned with the qualifier "provisional diagnosis." This qualifier is used when the features of the disorder are present but there is uncertainty about whether the formal criteria for the disorder are met. In Wendy's case, the clinician wished to document the presence of symptoms characteristic of borderline personality disorder (e.g., self-mutilation, unstable self-image or sense of self) but was mindful that many of these features could possibly be subsumed under (or better accounted for by) her other diagnoses.

CASE FORMULATION USING THE INTEGRATIVE MODEL

Although the causes of DID are not well understood (cf., Barlow & Durand, 2009), the research in this area has revealed some striking similarities in the histories and characteristics of patients with this disorder. Although not part of the formal *DSM-IV-TR* definition of DID, research has shown that virtually every patient with this disorder has been exposed to extreme traumatic events, usually in the form of sexual or physical abuse (Gleaves, 1996; Ross, 1997). This was certainly true for Wendy, who suffered severe physical and sexual abuse throughout her childhood and adolescence. How common is trauma in the histories of patients with DID? In an investigation of 100 persons with DID, 97% had experienced significant trauma, usually sexual or physical abuse (Putnam, Guroff, Silberman, Barban, & Post, 1986). A history of incest was observed in 68% of this sample. In another study that reviewed 97 cases of DID, 95% of patients reported physical or sexual abuse (Ross et al., 1990). In many cases, this abuse was unspeakably severe and sadistic: Some patients reported that they had been buried alive; others reported being tortured with burns (e.g., from steam irons or matches) or with cuts (e.g., from razor blades or glass). In fact, researchers have discovered that the background for some patients with DID is a childhood filled with Satanism and ritual abuse that is part of satanic cults (Sakheim & Devine, 1992).

These observations have led researchers to believe that the origins of DID are a natural tendency to escape or "dissociate" from the persistent distress and suffering associated with severe abuse (Kluft, 1991). The tendency to try to psychologically "distance" oneself from painful or stressful events or memories is quite natural and is a feature present in everyone to some extent. For example, it is quite common for otherwise normal individuals who are undergoing unusual stress to attempt to escape or dissociate from the emotional or physical pain in some way (Spiegel & Cardeña, 1991). Noyes and Kletti (1977) surveyed more than 100 persons who had experienced various life-threatening situations (e.g., severe accidents) and found that most had experienced some type of dissociation such as feelings of unreality (referred to as *derealization*), blunting of emotional or physical pain, and even a feeling of being

detached from their bodies (referred to as *depersonalization*). However, other research has indicated that pathological dissociation is categorically distinct from these "normal" dissociative reactions (Waller & Ross, 1997).

These features were quite evident in Wendy, who coped by psychologically walling herself off from the part that was taking the severe abuse. As noted earlier, this allowed Wendy to have parts of herself that could contain the feelings and knowledge about the abuse, while other parts of herself could handle the more normal aspects of her life (e.g., going to school or work). However, these parts began to have lives of their own because they were repeatedly called on to handle abusive situations. Consequently, these personalities were very isolated from the others; many did not know about the others, and some were not even aware of the abuse.

Obviously, not everyone who has been exposed to extreme stress or abuse develops multiple personalities or other dissociative symptoms (e.g., amnesia). Thus, the question arises as to what are the characteristics of persons who are more likely to develop these symptoms following exposure to traumatic events. Although no strong research exists in support of this notion, many researchers believe that people who are more hypnotizable (or "suggestible") are able to use dissociation as a survival skill against extreme trauma (Putnam, 1991). Being in a hypnotic trance is very similar to "dissociating" (Carlson & Putnam, 1989). In a hypnotic trance, people tend to become totally absorbed or focused on one aspect of their world (and become very vulnerable to suggestions by the hypnotist). Moreover, in the phenomenon of self-hypnosis, persons might be able to dissociate from most of the world around them and "suggest" to themselves that, for example, they won't feel any pain in their hands. Accordingly, development of DID may be linked to a person's ability to use self-hypnosis to dissociate parts of himself or herself from severe abuse or trauma; hence, the person's identity separates into multiple dissociative identities. As mentioned earlier, Wendy's clinical psychologist believed that she was very hypnotizable and felt that she had learned to rely on this ability to psychologically distance herself from her distressing memories and emotions.

Treatment Goals and Planning

Therapy for DID necessitates that the patient gently move toward dismantling the walls that have developed between the personalities, which psychologists often refer to as *alters*, the root word for "others." This process involves (a) recognizing the existence and gradually getting to know the different alters, (b) understanding the purposes that each alter has served, (c) learning new coping strategies and obtaining increased supports so that more awareness of traumatic memories is tolerable, (d) confronting and reliving the early traumas to understand the original need for the walls and to process the intense negative feelings and thoughts associated with these memories, and (e) coming to understand the ways in which the traumas affected many ways of coping, and learning how the present differs from the past in ways that allow new and more adaptive (i.e., nondissociative) coping strategies to be used.

You might note that step (d) in the treatment of DID is similar to a therapeutic strategy used to treat PTSD (see Case 4). Specifically, the therapist must assist patients to gradually visualize and relive aspects of their traumatic experiences.

In the treatment of both DID and PTSD, a goal is to work through and reduce the negative emotions and thoughts that are linked to these distressing memories. However, unlike the treatment of PTSD, other goals in the treatment of DID are to uncover each of the patient's personalities formed as the result of these traumas and to understand the purposes that these alters served. Ultimately, after this information is uncovered and after new coping strategies are learned, the walls between these alters may become more permeable, allowing the patient to integrate these aspects of themselves into a single personality.

COURSE OF TREATMENT AND TREATMENT OUTCOME

A crucial initial phase of treatment is to develop a sufficiently safe and trusting therapeutic relationship for the patient. Clearly, such a relationship was necessary for Wendy to concede to exploring the terrifying memories of her childhood. Frequently, establishing a strong therapeutic relationship is quite difficult because of these patients' extreme distrust, based on their negative childhood experiences with family or caretakers. However, one incident during this phase of Wendy's treatment proved to her that the therapist really cared about her. Several months after this incident, Wendy reported that this was the turning point in her treatment that led her to become more engaged in the therapeutic process. As noted in the beginning of the case, when Wendy began outpatient treatment with the psychologist, she was out of work because of an on-the-job injury. Over the first several months of her treatment, Wendy's disability payments had not started to come in. Yet, her rent was due, and her landlord made it clear that she would be evicted if she did not pay. Wendy also had no money left for food for herself or for her children, and she had no family or friends who were willing and able to lend her money. Therefore, the therapist lent Wendy five hundred dollars so she would not be homeless and so she could buy groceries. Wendy was "blown away" by this kindness and trust on his part, as she had never before really experienced caring from someone else. This is particularly noteworthy because most mental health professionals would not recommend such a practice as lending a patient money because of the conflicts and confusion that it can create in the therapeutic relationship. However, in this instance, Wendy felt that the loan was the first time someone had trusted her and had wanted to help with no strings attached. Ultimately, the therapeutic relationship was the most important factor in Wendy's treatment: The therapist had to honestly care about her and communicate his belief in her ability to get well (as well as display a genuine respect for and appreciation of her amazing survival skills). Moreover, the therapist had to possess a willingness to hang in there through some very scary and frustrating times when Wendy was confronting and working through her memories and emotions.

Until the loan, an ongoing problem in Wendy's treatment was her potential for harming herself. She was chronically suicidal and on the verge of injuring herself for most of the first year of treatment. However, these symptoms gradually decreased as Wendy became more engaged in the treatment process and as she began to understand the causes of these symptoms. One focus of Wendy's therapy was understanding the connection between her symptoms and the early events for which these symptoms provided protection. In the first step, Wendy was guided to see

that the symptom or behavior in question served an important function and was thus not meaningless or crazy. Once she understood the function of this behavior, she was assisted in becoming aware of how current situations differed from those in the past when the behavior developed. Finally, the therapist helped Wendy to substitute more appropriate and adaptive methods of coping with the behavior.

For example, this process was used to address the open wound on Wendy's foot that she had not allowed to heal for 15 years. As a child, Wendy had incurred many injuries that resulted in stitches. However, once she got home from the hospital, her mother would use the stitched-up wound as a chance to be sadistic. The mother became enraged that someone had helped Wendy and told her not to trust such help from anyone. To teach Wendy that "help is only going to cause more pain," her mother would pull on the stitches while pouring alcohol on the wound. Consequently, the sight of stitches terrified Wendy, as she knew what lay ahead, and she developed a personality who would take out stitches in order to avoid her mother's reaction to them. Thus, in this instance, Wendy's understanding of the purpose of her symptom led to her seeing that no one was going to behave in the manner her mother had. Wendy realized that she was now an adult who could protect herself from such attacks and that it was, in fact, safe to leave in stitches.

For this progress to occur, the alter that pulled stitches had to become known to the rest of her. Wendy initially viewed him (the alter personality was male) as a terrible tormentor and a part of her she would like to eliminate. However, once his role was understood, Wendy began to view him more accurately as a protector rather than a villain, and she ultimately embraced him for his true purpose, protecting her from these sadistic attacks. Once the alter knew more about the present and the rest of her knew more about this aspect of the past, Wendy was able to have her foot stitched and finally allowed it to heal. Of course, this change also meant dealing with the vast array of feelings that were evoked by remembering the severity of her mother's cruelty.

In another example of this therapeutic process, it became apparent to the therapist that Wendy's regular practice of burning or cutting herself served to help her get into a trance (self-hypnotic) state. Wendy hurt herself when she was feeling the intrusion of painful memories, and, once in this state, she could use her own hypnotic abilities to push away these feelings and be in a calmer, more peaceful place. Once this process was understood, it was relatively easy to assist Wendy to develop and use an alternative way of coping. This coping strategy involved the therapeutic application of hypnosis. When painful feelings began to intrude, Wendy learned to use self-hypnosis by inducing a trance with guided imagery. This technique worked just as well as self-injury had worked to elicit an altered state but allowed Wendy to avoid harm to her body. In addition to the use of hypnosis to teach Wendy to soothe herself when these memories intruded, during the treatment sessions the therapist relied on hypnosis a great deal to facilitate communication among Wendy's alters. Again, this aspect of treatment was very important because it helped Wendy integrate these aspects of herself into a single personality.

During the course of treatment, Wendy became able to remember and integrate the terrible experiences of her childhood. Thus, she had less need for the rigid walls between her various personalities. The artwork that Wendy was doing during this phase of treatment illustrated this process. As noted earlier in this case, Wendy had

always been an avid painter and sketcher; in fact, she harbored a secret desire of becoming a commercial artist. The therapist's view was that Wendy's art and the therapeutic work centered around it became the most significant aspect of her treatment. Early in treatment, Wendy regularly drew pictures of babies who were crying (Figure 8.1). The pictures were two-dimensional but generally showed what Wendy referred to as the "mutant baby inside her." This was Wendy's sense of a personality that was walled off from her awareness but felt very "bad" and "evil"—part of her that she wanted to destroy. One day, after many discussions with her therapist, Wendy brought in a picture of this baby that no longer had the chaos inside the eyes but, rather, was a picture of a baby with the chaos *outside* her (Figure 8.2). The therapist felt that this was the turning point in her treatment. That night, Wendy went home and was flooded with memories of having been raped and beaten as a small child by her mother. That night Wendy also drew a very graphic picture of the abuse experience (Figure 8.3). This was an incredibly important event in her therapy because she changed her understanding of herself and her symptoms from being "I am crazy and have these awful parts of myself and weird symptoms" to "I am a normal person who was terribly abused and therefore understandably developed extreme kinds of coping mechanisms." At first, the "baby" part of her was finally able to sleep and be calm, but the rest of her was in turmoil from knowing about the traumas. However, as Wendy worked through her feelings about the abuse, she continued to draw pictures of the baby that showed a healthier development from that point forward (Figure 8.4). The baby was able to experience a variety of feelings and needs and then gradually begin to grow up and join the rest of Wendy's personality (Figure 8.5).

Another valuable aspect of treatment addressed Wendy's disrupted sense of spirituality. Recall that Wendy had continually struggled with her view of God and religion (and had experienced considerable guilt and anxiety) after being told at the age of 16 that her stillborn child would never go to heaven because he had not been baptized. At one point in therapy, a minister was invited to some of the sessions to discuss this issue. He ultimately offered to perform what he called a "baptism in spirit," in which he baptized her baby so the baby could move on to heaven. This ceremony created intense relief for Wendy and helped her to see that the church could be a loving and helpful institution.

At the time this case was written, Wendy was continuing to attend regular sessions with the clinical psychologist. Thus far, she has been in therapy for 4 years (more than 400 treatment sessions). Although Wendy had attended two sessions per week, she has recently decreased meetings to twice per month. Given the remarkable improvements she has achieved, Wendy is using these sessions in a more supportive capacity. Most notably, the walls between her personalities have gradually become more and more fluid, and Wendy now feels that all of the feelings, behaviors, and qualities are her. None of these personalities have gotten lost in the process (i.e., the abilities and memories of each personality remain intact); rather, out of the pieces a far more whole person has emerged who is able to utilize many lost strengths and abilities. She has dramatically decreased her use of dissociation as a protective maneuver and experiences lost time or other such symptoms only occasionally, when a new memory is emerging, and then it does not last long. Wendy still experiences flashbacks of new parts of various memories sometimes, but she is

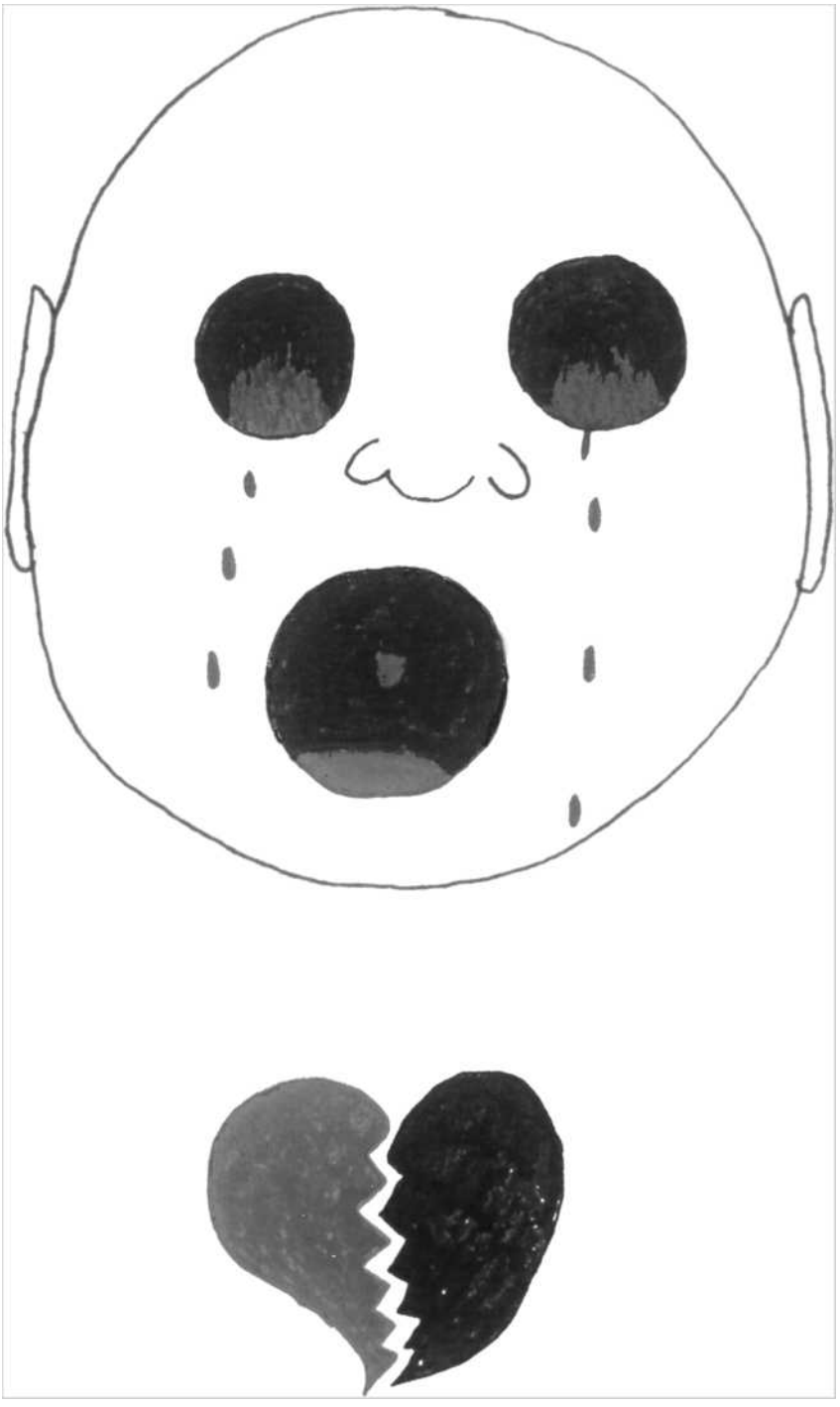

Figure 8.1

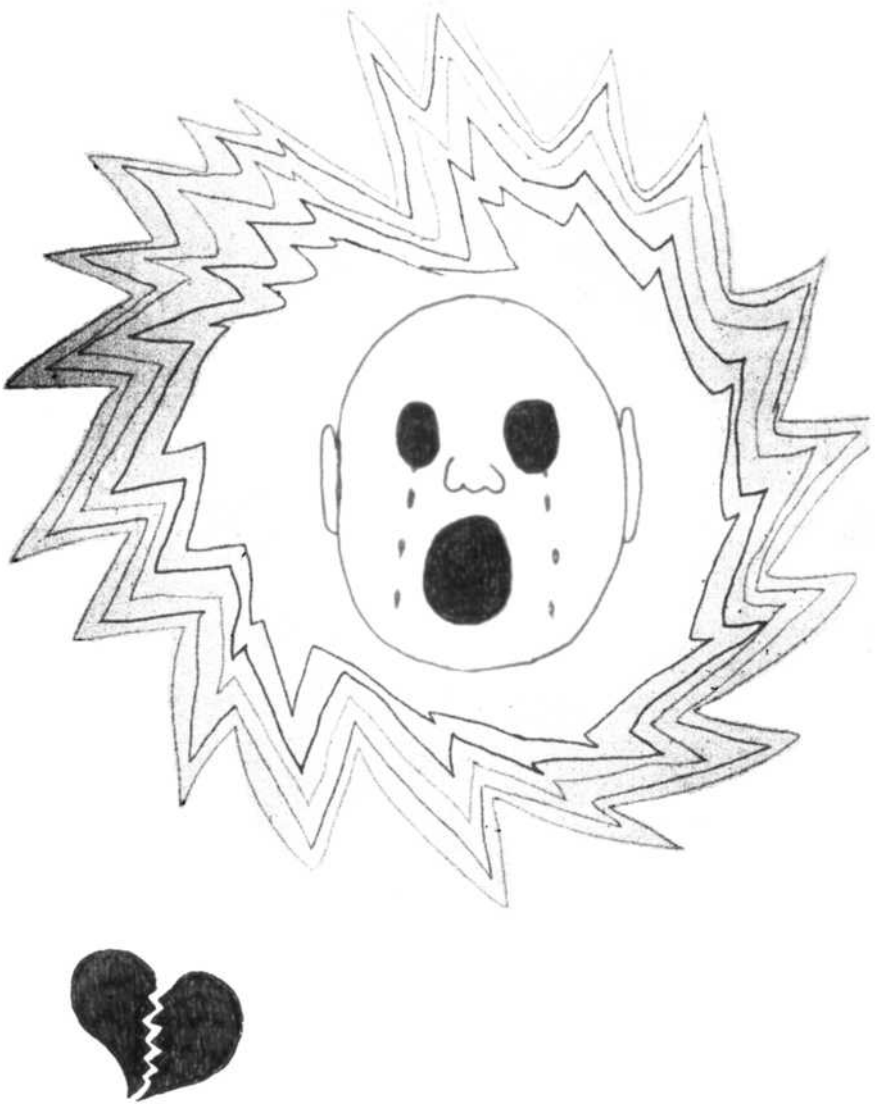

Figure 8.2

much more able to tolerate them and to deal with these experiences rapidly and effectively. In addition, she still exhibits an exaggerated startle response, which is characteristic of many trauma survivors who have completed treatment successfully. Nevertheless, Wendy's dissociative symptoms no longer interfere with her life, and her therapist considers her symptoms to no longer qualify for a *DSM-IV-TR* diagnosis. Remarkably, Wendy is off all psychotropic medications yet is no longer depressed or anxious, and she no longer experiences psychotic episodes. She has given up her self-injurious behaviors, which had included burning or cutting herself, inserting objects into herself, and giving herself enemas.

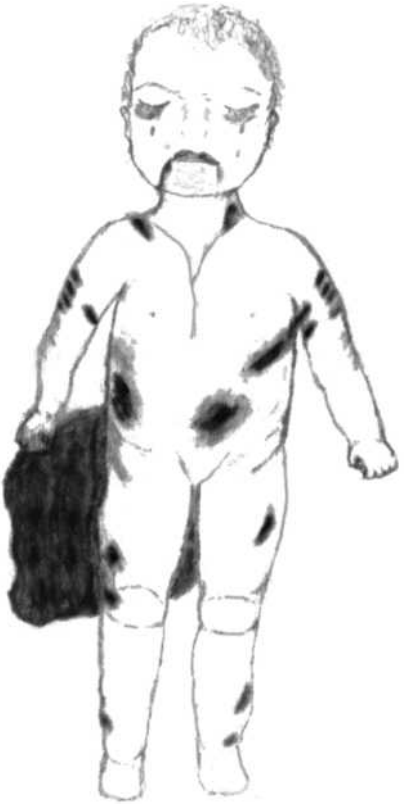

Figure 8.3

As the result of treatment, Wendy's interpersonal relationships have improved dramatically. She has been able to establish honest and supportive friendships and learned to deal in healthier ways with her children (e.g., to rely on them less for support and to set better boundaries with them). She removed herself from a number of abusive relationships and has become more assertive and direct in all of her social interactions. Wendy continues to have sexual problems, primarily a fear of being sexually involved, and has not yet explored this aspect of relating. However, she is just beginning to allow herself to get close to a man and is currently enjoying flirtation for the first time in her life.

One focus of treatment was to assist Wendy in attaining her degree in commercial art. Not only did Wendy obtain this credential but she also found work and started making a good income. Financial security was totally new to her and proved to be an important facet in her healing process. She was able to purchase her own condominium, a kind of security that she had never imagined possible.

Currently, Wendy is working on a book using her artwork to illustrate the healing process so that other child abuse survivors will have a helpful guide. She wants to reach out to other "hopeless cases" to show that the process of healing is very difficult but can be navigated successfully. Wendy is also helping others more directly, such as volunteering with people with physical disabilities. She says that

Figure 8.4

she has been fortunate in the ways that people have cared about and helped her, and she wants to be able to give help back to people who need it. Moreover, Wendy is helping to raise her granddaughter, an adorable little girl, of whom she is very proud and able to love. Although Wendy raised her own children, she was so removed from her feelings that she often experienced them as not really hers. Wendy's granddaughter is a very real person to her, and others note that their relationship is delightful to watch.

DISCUSSION

Recall that one of the criteria of the *DSM-IV-TR* diagnosis of DID (American Psychiatric Association, 2000) is the requirement that the disturbance is not due to the direct effects of a substance (e.g., blackouts during alcohol intoxication) or a general medical condition (e.g., complex partial seizures). This criterion is based in part on evidence that individuals with certain neurological disorders, particularly seizure disorders, may often experience dissociative symptoms (e.g., Bowman & Coons, 2000; Cardeña, Lewis-Fernandez, Bear, Pakianathan, & Spiegel, 1996). For example, Devinsky, Feldman, Burrowes, and Bromfield (1989) reported that roughly 6% of patients with temporal lobe epilepsy reported "out of body" experiences (referred to in

FIGURE 8.5

DSM-IV-TR as "depersonalization"). In another study of patients with temporal lobe epilepsy, approximately 50% showed some kind of dissociative symptom, including development of alternate identities (Schenk & Bear, 1981).

Such findings suggest that dissociative symptoms may result from abnormal electrical activity in the brain. While more research is required, our existing scientific knowledge highlights some strong differences between persons with dissociative symptoms that are associated with diagnosed seizure disorders and persons with DID. For instance, patients with seizure disorders usually report that their dissociative symptoms began in adulthood and were not associated with a traumatic event. As discussed previously, virtually all patients with DID report a past history of exposure to trauma (usually physical or sexual abuse) and recall that their dissociative symptoms emerged shortly after these experiences.

If you have read Case 4, on PTSD, it may have occurred to you that the origins of DID and PTSD are similar—specifically, that both conditions reflect strong emotional reactions to a severe trauma, although exposure to a traumatic event is not a diagnostic criterion for DID. Moreover, dissociative symptoms are frequently present in PTSD (e.g., dissociative flashbacks, inability to recall significant aspects of the traumatic event). Based on this overlap, many researchers have concluded that DID could be a very extreme subtype of PTSD, with a greater emphasis on the process of dissociation than on symptoms of anxiety (although dissociation and anxiety are present in both DID and PTSD). However, given the paucity of research on DID, this observation is merely a speculation that needs to be verified (or refuted) in future investigations.

The prevalence of DID is still not known, although researchers now think that it is more common than we previously estimated (Johnson, Cohen, Kasen, & Brook, 2006; Kluft, 1991; Ross, 1997). Studies that have examined patients diagnosed with DID have found the ratio of females to males as high as 9 to 1. The onset of DID is almost always in childhood. The condition tends not to remit in the absence of treatment (Putnam et al., 1986), although the frequency of "switching" (shifts in personality states) may decrease with age (Sakheim & Devine, 1992). As with Wendy, several case studies of patients with DID suggest that different personalities may emerge over the years in response to different life events. It very rarely occurs in the absence of other clinical diagnoses. Consistent with Wendy's case, depression, PTSD, and borderline personality disorder (among other diagnoses) are frequently assigned as additional diagnoses to individuals with DID (Johnson et al., 2006; Ross et al., 1990).

As with all other aspects of DID (e.g., prevalence, course, etiology), very little research has been conducted on the development and evaluation of treatments for this disorder. However, several case studies have reported success in reintegrating identities during long-term therapy (e.g., Brand, Classen, McNary, & Zaveri, in press; Brand et al., 2009; Putnam, 1989; Ross, 1996). Unfortunately, what little evidence does exist suggests that the prognosis for most patients is poor. For example, Coons (1986) found that only 5 of 20 patients were successful in treatment (defined as full integration of one's identities). Similarly, a more recent study found that 22% of patients had integrated their dissociated personalities by 2 years after discharge from a specialized inpatient treatment program (Ellason & Ross, 1997). There is no evidence to date to indicate that medications add significantly to a favorable outcome. Thus, in light of the unquestionably severe levels of distress and lifestyle interference associated with DID (documented in the case of Wendy), the development of effective treatments for this disorder is strongly needed.

Thinking Critically

1. There continues to be controversy over whether DID actually exists. Do you believe it is possible for some people to have several different personalities that may or may not be aware of each other? Why or why not?
2. DID has been used as a legal defense in murder trials (i.e., the person committed the murder under an "alter" personality and was arguably unaware of the