Blessed by God: Working with Seismic Shifts in the Structure of Self

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Abstract

This article identifies some of the essential ingredients required in working with a client with the most extreme form of dissociation, Complex Dissociative Identity Disorder (DID). The most important aspect of such work is the quality of the therapeutic alliance. I draw attention to the extent of parallel process for both therapist and client. I outline some of the causes of the shattering of self for my client and explain how our work together, for more than 13 years to date, has helped to build in her a stronger sense of self and in me, a larger capacity as a therapist.

Waitari

E tohu ana tēnei tuhinga i ētahi o ngā rawa whai tikanga inā mahi tahi me tētahi kiritaki tino mau te āhua noho wehe, te Tuakiri Rangirua Wehenga Matatini, arā te Complex Dissociative Identity Disorder (DID). Ko te tirohanga matua o te mahi pēnei, ko te kōunga o te whakakotahitanga rōpū haumanu. Ka whakaaturia atu e au te korahi o te hātepe whakarara mō te kaihaumanu rāua tahi ko te kiritaki. Ka tāutua atu ētahi o ngā take o te whatinga o te whaiaro o taku kiritaki ka whakamārama ai i pēhea tā māua mahitahitanga mō te nekenga atu o te tekau mā toru tau ki tēnei rā, i pai ai te whakapakari ake i tōna ake whaiaro te whakawhānui ake i tāku tirohanga i aku mahi haumanu.

Keywords: dissociation; Complex Dissociative Identity Disorder; alters

Blessed by God

Several years into our therapy, Maria went to a Christian Women's camp. Maria had a private prayer session and the next time I saw her, shared with me that she had prayers for me and our work together, asking for God's blessing on both of us. When Maria told me, I was moved to tears, knowing beyond any doubt, then and now, that in spite of all the obstacles and challenges, our work feels held by a power greater than ourselves. In this I believe we are blessed — and hence the title of this article.

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Initial Meeting

We met on 6 March 2001. A few days earlier I had been phoned by a GP asking if I would see a patient of hers who had an eating disorder. She let me know that it would be complex work. While I was not keen on working with issues around eating, I trusted the GP and her reasons to have me in mind for her client.

Maria was in her 30s, seriously overweight, with a shy, tentative and courteous manner. She talked with more confidence and clarity as the initial session went on and was clearly keen to get help for the problems she experienced with eating. She sometimes used food to stuff her feelings when they threatened to become overwhelming, especially to smother feelings of disgust at what she had had to put in her mouth in the past. She said that she panicked at the thought she may not have enough food available in case she needed it. At times she has lost phenomenal amounts of weight and regained some of it. She said that she ate well during the day, but that she used food for comfort when day turned to night and her fears increased.

As she disclosed more of her history, I began to realise just how complex the work might be. She let me know that she had been in therapy for six years previously with a clinical psychologist in the public mental health system, but that she had felt betrayed, lost trust and would never return. Their disjunction had come about over how to manage the eating problems, so I was immediately aware of how delicate a balance this would be to achieve and maintain. She wanted strategies as she had been told she would be dead in five years if she did not get control of her weight, which was now in the morbidly obese category.

In the first session I heard that she had grown up in a cult. She knew that she dissociated and wanted to know why. She had previously received the diagnosis of Dissociative Identity Disorder (DID) from a psychiatrist, after many years of emergency hospitalisations and misdiagnoses. She disclosed that she had been subjected to sexual abuse and that she used cutting as a coping strategy. While she had ended previous therapy with many issues unresolved, she had experienced a period of 18 months after it ended with little loss of time and she had believed that she was cured. Then, in 2000, she had gone home to her family for Christmas. As a result of a then undisclosed horrendous experience there, she had dissociated again and was struggling with the amount of lost time she was once again experiencing. This was especially distressing as she had just begun a degree course that was demanding on many counts. Her goals included: being able to tell her family to "get lost" and in particular to face her mother; to know who was responsible for the abuse; to have no more lost time; and to be able to think, feel and speak without dissociating; she wanted to experience a greater range of emotions (beyond good/bad); to feel a greater sense of self-worth, and to hold optimism for the future.

While I was experienced in working with the traumatic effects of sexual abuse and had been interested in dissociation, I had no direct experience of working with DID. I decided that I should recommend that she return to the public mental health system. I questioned whether this work was appropriate for a private practice like mine.

The second session began with more revelations about the family. She spoke of the extent of current dissociating and the "sabotage eating" that seemed to be happening.

Suddenly there was a noticeable shift in her body posture and facial features. The voice that continued the discussion was that of a child who wanted to argue with me about not being allowed to eat cheese scones. While I was taken aback, I did not panic. I did ask questions which this young presence told me was rude to do; she asked if I practised witchcraft and she gave me advice about my room, which I realised she had been scanning for clues about my safety. I asked how we could get back my client (the "adult") as time was up and she needed to drive home. I was told that of course she (the "girl") wouldn't drive; she was too young and it was against the law; but also that she goes when *she* decides. Then the adult was back in the room, looking confused. I did not explain what had happened; I hardly knew myself. We made another time and I never brought up the suggestion of her going back to the mental health system. Somehow I sensed that a therapeutic alliance had been formed with me, albeit tentatively, and not in a way I had been ready for.

I now feared that I would not be able to manage what was required but, already, I felt morally obliged to continue. By the fact she came out to talk with me, the young "girl" who spoke to me had presumably decided that I was trustworthy. She may have been testing me on behalf of others. So, despite my misgivings, I felt I was committed. This sense deepened quickly over the next few sessions. I let go of the fear of failing. I needed to muster resources as quickly and effectively as I could, in order to be ready for the task required. I consulted, gathered reading material and sourced workshops and available training. In order to for me to maintain my professional integrity and for Maria to explain directly to her previous psychologist why she wanted to change therapists, Maria and I had a session with her. I sensed that she was relieved.

Assessment Based on Criteria for DID:
According to the *Diagnostic Manual of Mental Disorders (4th edition)* (American Psychiatric Association, 2000), the diagnosis for DID is:

> Amnesia/Depersonalisation/Derealisation/Identity Confusion/Identity Alteration. This is the most chronic and severe manifestation of dissociation and is believed to follow severe and persistent sexual, physical and/or psychological child abuse. Distinct coherent identities exist within one individual and are able to assume control of the person's behaviour and thought. The person experiences amnesia for personal information including some of the identities and activities of alternate personalities. (p. 519)

While dissociation originally enabled the client's core self to survive intact, the rest was/is shattered into many parts, sometimes dozens. Healing requires the restoration of these parts to an acceptable whole. According to Blizard (2001) the goals of therapy for DID are: "integration of these dissociated ego states, synthesizing split perceptions of self and other, and development of affective skill for meeting the needs of both attachment and self-protection" (p. 50). Terminology is problematic when discussing DID as "they" feels more appropriate than "she" or "he", even though the goal of healing is for everything to come back to the one. Rather than the terms "host" and "alter" which

are commonly used in the literature, Maria has a preference for the terms "Number One" and "the others".

I am grateful to my client for allowing aspects of her story and of our work to be shared. I sought and obtained her consent, bearing in mind the considerations outlined in the article by Tudor and Grinter (2014) published elsewhere in this issue. Given the nature of the disorder, I also sought consent from the current significant alters; the younger ones particularly appreciated being asked. Maria herself is a highly principled and ethical person, one of whose values is seeking good for others, so she was particularly engaged in the discussion about consent for this article. She herself is someone who seeks to help the healing of others through the sharing of this case material. I have purposefully obscured any identifying details and information. I call her Maria which is not her real name and neither are the names of any of the others. Her full history, the multiplicity and effects of abuse and the therapy for this are beyond the scope of this article.

Beginning: Safety and Stabilisation

Maria (and/or at least one of the others) is meticulous in her attendance of sessions and she has rarely cancelled. I also endeavour to be as consistent, constant and reliable as I can. Her sessions are weekly for two hours at a time in order for her to have sufficient time to settle in, to enter into and complete significant amounts of work, and then to be in a suitable state to leave therapy and drive home. I try to ensure that whoever arrives to the session is the one who leaves, unless it is one of the others who arrives and then Maria presents. I came to know the first alter to emerge as Mary. Early in our therapy she asked me for a hug at the end of a session before she left. It is part of the ritual of goodbye for her. After a significant session, Maria asked if she could have a hug too, which is unusual for her. Even though touch is normally outside my frame with clients, the hug is always brief and, to me, feels a human response.

Maria was born one of identical twins. From birth she was placed in an institution for unwanted or damaged children, until the age of four, while her twin was brought up in the family. During her time in care, a male caregiver sexually, psychologically and physically abused her and some of the other children in the institution. That small group of children felt like her family and they bonded deeply with each other. She loved and was loved by them. At four she returned to her family and took the place of her twin who had died. She was given her twin's name, possessions and life. Her father died a few years later and her mother remarried. The family was very involved in both a traditional Christian church and a cult. Many of the same people were involved in both the "good family" and "the family from hell", as Maria described them. She believes some form of trance induction was used to facilitate switching between the two systems.

Initially, Maria told me that her father loved her and was a good parent. In believing this, she was caught in the contradiction of dissociation. She could deny love and acknowledge abuse *or* she could deny abuse and acknowledge love (see Blizard, 2001). Her mother, her father, her stepfather, brothers and others within and close to the family, sexually and psychologically abused Maria. Abuse by her mother included manipulation

to encourage sexual abuse by others, withholding and misusing food, use of catheters and forced urinary retention. Often when her mother was engaged in some form of torture of her, Maria's father would seemingly appear by chance to save her. The price for saving her was to sexually abuse her. Maria has been buried, burned, tortured, smothered, and locked in small spaces, as well as suffering many other indecencies. Many times she thought she would die. As a result she has had many phobias.

The need for DID originates in the experience of trauma along with a lack of attachment. Children are most vulnerable between 18 months to eight years, when there is a cloudy distinction between self and object. With the absence of a good enough caregiver, the child relies on dissociative defences to soothe and protect the self. Maria's abuse began at a very young age, by multiple abusers with many forms of trauma inflicted, and no reliable care-giver available to her. The extent of her dissociation therefore could be predicted to be chronic and severe. Her caregivers were dangerous and unpredictable. The attachment style of people with DID is insecure-disorganised-disoriented (Liotti, 2004). I wondered how this would influence the therapy.

From as long ago as she can remember, Maria experienced loss of time. She had incomplete recall and understanding of her life, as though there were bits of a jigsaw missing. There was so much that did not make sense in total: things that happened during cult activities were given completely different explanations by day, or simply not ever referred to. At the age of 15, she tried to draw attention to the situation for her at home but this ended with her being hospitalised in a mental institution, the first of many such events. As a result of abuse, in her early teens she became pregnant several times, and all the pregnancies were terminated. On two occasions she gave birth to babies who died in circumstances traumatic to Maria. One of her coping strategies was to cut herself, for which she was again hospitalised from time to time. She made many serious suicide attempts, some while she was in hospital.

Maria has high intelligence, and many fine qualities. She lives alone, having had no significant other and she has never had an intimate partnership. Maria is a very committed evangelical Christian, so the power of prayer is very important to her. While I do not identify as Christian, I have a concept of spirituality that can encompass hers and she trusts this. While Maria and Mary both identify as Christian, some of the others do not, which has caused internal ructions. Some were still strongly identified with the family traditions of the cult, which resulted in a great deal of fear about what they might do to put them all at risk.

Accessing Trauma Material

While the frame I use is that of psychodynamic psychotherapy, I use an eclectic range of modalities as seem appropriate. This includes exercises from Neuro Linguistic Programming, Gestalt, Psychodrama, Family Therapy, Cognitive Behaviourial Therapy, Dialectic Behavioural Therapy, Integrative Drawing Therapy, Transactional Analysis, Sand Tray Therapy, and dream work. I also use the technique described by Putnam (1989) as "talking through" (p. 150) to others. We mainly work in my room but have worked at a beach for large drawing in the sand, where this was the preferred method of disclosure.

Working with dreams according to the model developed by Faraday (1974) has been invaluable in helping to uncover previously dissociated material. There are memories of repetitive nightmares from early years. Maria and Mary often share the same dream and others may too. They have been receptive to processing dreams to find the message within them. Sometimes the dream seems more like one (or more) of the others has had a flashback which can be processed if they are willing, then the information shared. What seems like a dream could also be an alter trying to send a persecutory message.

Gathering aspects of Maria's history was sometimes almost overwhelming for me in its quantity and horror. Putnam (1989) has pointed out that it is vital for the therapist to be able to face the trauma. I was not able to tell anyone the full extent of what I had been told. This was in part due to considerations for Maria's privacy. I also feared my supervisors and colleagues in my supervision group would doubt the veracity of the facts of Maria's life story. Gradually I shared less and felt more alone. One of the major tasks of therapy with DID is to make available to the entire system the knowledge and secrets held by specific alters. Ironically, the more I learned of Maria's story, the more separated I felt from others and the more secretive I became. This sense of isolation was alleviated when, in 2004, I enrolled in online training through the International Society for the Study of Trauma and Dissociation (ISST-D), the Dissociative Disorders Psychotherapy Training Program. For the next three years I was part of an international group of colleagues receiving superb training by some of the most experienced clinicians in the world. We were sent readings, had online discussions and seminars and wrote case studies with expert feedback provided. Some of the connections I made then are still available for consultation.

Establishing a trusting therapeutic relationship and working within the transferences is essential. For Maria, most of the time I am a "good enough mother". With the food issue, I run of the risk of becoming the bad mother, withholding food. The most trustworthy object in her life for Maria was "wall". Leaning against a wall — any wall — was when she would feel safest. The transference with me did — and does — reflect the insecurity that she experienced with her own mother. Any negativity or anger towards me has been expressed by others and very little by Maria herself. Dalenberg (2000) has warned of the dangers of idealisation, explaining that trauma clients can be inclined to "respond with exaggerated deference and efforts to please" (p. 202).

In the early stages of therapy, my miniature poodle Francki provided a safe object and became much loved by many of them, less so by Maria who does not like dogs, and cats even less. Francki would meet the arrival with much enthusiasm and the young alters loved being so genuinely greeted. Each would compete for a chance to pat her and to vie with the others about who Francki liked best. Francki could detect in an instant when a switch had been made, by the slight change in touch; she provided authentic comfort when she sensed distress and upset.

Types, Examples and the Role of Alters

As in all DID systems, Maria's many child alters held vital but dissociated historical information, much of which she did not know at the beginning of our therapy. In encouraging them to disclose their secrets, it has been a delicate balance supporting and caring for them at the same time as educating them about what happened and why. They had the limited understanding of a child. The goal of therapy is to know what each has needed to process, in order to let go of their separate role within her. She has had to learn to have empathy and compassion rather than blame for the young ones. In order to acknowledge and take care of the needs of the young alters I have had to guard against falling into a common trap of being tempted to treat these highly appealing personalities as real children, to make up to them for the horrendous childhood they had. Putnam (1989) warned of this pitfall. Some alters seem to stay the same age as when they first emerged, while others age at the same rate as Maria. Mary is usually around four years, yet she carries huge responsibility for their overall functioning and is capable of profound wisdom.

There is some degree of co-consciousness between Maria and some others, especially Mary, but total amnesia with many others. In Maria's system, there appear to be three main groups of alters, then others besides who are outside these groups. Putnam (1989) has explained that this is not unusual. Each group has a young internal self-helper (ISH), sometimes called a central ego state. At any time, one of the ISHs is likely to know what is happening. Each is aware of their group and observes everything, having co-consciousness with nearly all the others in their group. The ISHs have co-consciousness with each other when they wish to, but also can block each other from information. I ask these young ones to tell me what I need to know, sometimes with a degree of persuasion. The right amount of therapeutic leverage is necessary for trauma resolution but I also need to acknowledge the conflict this can place on the young ISH.

When Mary appeared to talk about food, she had a very distinct voice, visual appearance and body language. Since then, many others have presented in sessions, and some have engaged in communication with me via e-mail. While most of the others are female, there are males in the system and some who are gender neutral. Some are not quite human and may be memory traces, some could be demons or spirits. The majority have come into existence as a result of the necessity to survive, so their age, role and characteristics relate directly to the need of the system at the time to survive the perceived threat. There are also others who were created from outside the system as a result of mind control, to do the bidding of the family. Gradually, as the need for the role has diminished, many seem to disappear or maybe just retreat deeper into the system. This is what had happened in the period prior to Maria coming into therapy with me. When the system was under severe threat during that Christmas in 2000, the coherence was once again shattered. With the emergence of new alters, I have had to judge, sometimes with advice, whether I need to engage with them or whether they are distraction from where we need to be working. I have also received quality supervision from within the system, at one stage advising me that I needed to be tougher in my therapy with Maria, as I was being too soft on her to be helpful.

Early on we had to establish what Mary had a right to talk about with me, as she would

let me know things that Maria was thinking and had not said out loud. Then Maria would feel as if she had no privacy. So we agreed that Mary — or any of the others — should alert me to matters of safety in the present, or to "secrets" relating to the abuse in the past, which Maria was not yet ready to deal with but about which she had been triggered. Often it has been the personality who had experienced the original trauma who initiated the therapy for the experience. My aim is always to let Maria know what I have been told so that she knows what I know, but this needs to be carefully paced. Only then is she ready to process it for herself, cognitively and emotionally. Some significant trauma involved many others, so it has been slow progress, and I often had to remind myself of the saying: "The slower you go, the faster you get there".

Mary and others may compete for food and expect that they have a right to eat too, including eating for comfort. Even when Maria is ready to limit her own food intake, there are others with whom I have not yet been able to engage, who seem barely human and who will literally eat anything if they have a suspicion that food is being rationed. Others buy and store "bad" food and sabotage Maria's best efforts.

For a long time there were many fights and disagreements by opposing forces. In order to encourage co-operation, I have used a range of methods including drawing, writing, psychodrama, and family therapy sessions. From time to time we held a meeting, with each alter who wanted to be involved adding items to the agenda. By using a whiteboard to record points being discussed, we got agreements through negotiation, which became binding. We emphasise the golden rule of: "Do unto others as you would be done by" which has reduced, though not stopped, all the sabotage and subterfuge. Strategies to outwit others are still necessary. For example Maria would like to save and have money in the bank. She has had to ask a friend to look after her credit card as there are some who want to spend everything she has. Even still money disappears. They can hide things from each other. Before shifting flats a while ago, she had to have a garage sale of items surplus to requirements, which she discovered when packing. This included crocheted and knitted baby blankets and wool to make more. Maria does not know who created these.

For Maria keeping a journal has been frustrating, as others attempted to negate what was written. Entries were scribbled over and pages torn out. Maria, who has very neat, precise habits, would give up. There was no privacy as each was intent on scanning for safety everything written, then acting unilaterally as censor. E-mails are better, so long as whoever writes something can send it to me before someone else deletes it.

When a role has become redundant, sometimes there has been a sense that the alter has chosen simply to "leave" quietly. Sometimes there has been spontaneous fusion between two or more. Only once have I become involved and reassigned a role to one (called Peaches). She felt sad at her impending redundancy and was not ready to leave for good. I asked her to consider becoming a special carer for the young ones, which she still does when required, such as times of hospitalisations. Another asked me to choose a new name for her to match her new role.

Each time that Maria has been unable or unwilling to function as Number One for any length of time, there has been another who has stepped in, albeit reluctantly. Those who are not used to being "out" find it very tiring. Once during a very stressful time, there

was only one other who was available to cover, along with her small self-helper (not Mary). Neither of these two knew how to eat and had no interest in it. I had to teach them how to swallow. Another who started out antagonistic to Maria stepped in to cover for her. She did it so well and for so long, that she came to feel more like Maria, who had the same sensation when she re-emerged. As a result, the amnesiac wall between them gradually thinned and there was a very organic fusion between the two, neither existing separately again, but taking Maria's name.

When Maria started work after qualifying in a profession, she found there was another with the same name as herself who kept trying to take control of the job. We discovered that she was part of a system all of her own, believing that she was one of a twin who had died and she existed with the spirit of the dead twin, but otherwise she believed she had complete autonomy, being bothered a bit from time to time by distant voices in her head. She was very efficient but with no heart. She truly believed the job was hers. It took serious discussion to explain how it all worked, as well as major negotiation to get her to agree to leave the job to Maria — or else they would "both" be sacked.

As a result of the abuse experienced during the years in the institution, three young boys emerged. They have distinct names and personalities and provide support and comfort for each other. I know when they arrive as they address me as "Hey lady". Apparently this is for my safety so that no one else hears my name. They are scathing of the girls and their girlie activities. Initially I spent time on the floor of my room playing marbles while we talked and got to know each other. They are terrified of hospitals and always concoct an escape plan.

At times of the greatest stress and distress when Maria has been suicidal and I have become concerned, I have been able to communicate with one who holds the position of a wise woman, who generally stays deep within the system. She has spoken truth to Maria directly at times when needed most. Because of the terrible experiences Maria has had in mental hospitals and with many psychiatrists, I know it would be a major betrayal of her if I were to involve mental health services, so this would always be a last resort. I am relieved to be able to consult within her own system. There is no privacy ever, as there are always others listening. Sometimes this is useful as in "talking through" to others who needed to know (Putnam, 1989). It is easy, however, to make mistakes and to get things wrong for some, while at the same time getting it right for others.

As more and more alters made their presence known, we made many attempts to map where they fit into the scheme of things. Most of these were known already by Mary and others, but some were new. It was a relief when I was introduced to a model developed by Steven Frankel and Todd O'Hearn (1996) in which the authors equate organisation within the ghettos of Eastern Europe as similar to the roles of alters and their purpose within a DID system. Reading this article, everything fell into place for me, as it framed every role in a positive light. It makes even clearer how there are no "goodies and baddies": every role was to ensure survival of the whole, by whatever means they believed to be best. It helped me to find and maintain a position of neutrality towards all others. This article clarified for me that, while the initial goal was to achieve integration, to have alters act in harmony with consciousness may be a good enough alternative.

An exciting development was when there was an introduction by e-mail of a group

called the Silent. No one had known of their existence prior to their first making contact in writing, as they were the deepest layer in the system. They are the archivists and had been waiting for a long time to tell the stories they knew. Finally, it seemed safe for them to begin. Taking turns to tell the one who could write, they dictated their realities. They identified themselves by name and/or the aspect of the story they wanted to tell. They are totally without needs, other than to tell the truth. The telling has not yet been completed. I hope it will be. Each story matches the experience of others, so is very validating.

Putnam (1989) has explained the concept of "layering", when groups of personalities are buried beneath others: "Frequently one overtly recognisable personality will have been masking several covertly active personalities. In many cases, the alters involved are all related in some fashion to specifically traumatic material or life issues" (p. 124). This is true of the Silent.

As in all circumstances where violence has prevailed amongst people within a system, a process is needed to provide an ethical framework, to establish the truth of what happened and to start a process of reconciliation. I found it helpful to call on the model of forgiveness used in South Africa within the Truth and Reconciliation Commission (see www.justice.gov.za/trc/). It is a compromise between a trial and an amnesty, embedded in a theological framework, essentially a Christian ethic, calling for repentance and reconciliation (Sparks & Tutu, 2011). It was a call for harmony, idealising the interdependence of the whole community, as injustice to one diminishes all. This concept was easily understood and accepted by Maria and important others, as it fitted well within her own value system. Survival in the circumstances of her childhood necessitated her doing things that later came to plague her conscience. It has been necessary to search for ways that could provide a sense of redemption. Within the system, some have held others responsible for what was done under pressure where they felt harmed. Empathy has often been in short supply. Being accountable for behaviour for which responsibility needs to be taken, is separated from what was done under duress on threat of torture or death. All behaviour which caused pain to others has needed to be confessed. This has been most difficult for those who started from a place of loyalty to the external "enemies". When they realized the extent they had been manipulated, their guilt and shame have been enormous. As Kluft (1994b) has pointed out, in the process of reversing the effects of dissociation, getting better and feeling better rarely occur simultaneously. It has been extremely moving for me to witness the process of restorative justice which has led to reconciliation and further unity. The alters understand and accept the slogan "Truth hurts, but silence kills" (Sparks & Tutu, 2011, p.191).

Setbacks

Maria had, and still has, a range of extremely serious health issues. She has had many serious surgeries and faces more. She is on a huge range of medications. Her health issues are mainly related to problems caused by weight, which, in turn, is the result of her eating habits that are the direct result of abuse. She is terrified of dying.

The eating disorder is not resolved. The residual internal disputes play out over food: who is in charge of it and who refuses to be controlled. Maria is mortified at still

being overweight and knows that she is judged for this. It is painful for her to have to accept that people, especially health professionals, assume she is fat because she is too weak to control her food intake. She could never feel safe enough to explain the real reasons.

I have agonised over mistakes I have made with her and hated it when I have inadvertently got it dreadfully wrong. For example, I had developed a good working relationship with Arima, a stand in for Maria for many months. In a session with her, I carelessly blurted out a word she had been at pains to avoid. She left immediately and to my knowledge she has never spoken to me again. I did learn early on that disjunctions provided opportunity for profound repair. The first time I apologised was the first time Maria remembered receiving one; the first time she was not blamed when the mistake was not hers.

It is sometimes hard to distinguish genuine voices from within versus psychosis. Until Maria's mother's death a few years ago, she was capable of triggering young alters even over the telephone, in order to gain information about Maria's present life. When her mother died, Maria went home for the funeral but did not see her mother in the coffin. For several weeks after her death Maria believed that her mother was still alive. She heard her mother talking on the phone, instructing her to harm herself. This was a very frightening time for the others as they could not talk Maria out of this belief. She disappeared for several weeks and once again they had to cover for her. Her reaction was not surprising, given the power of manipulation that her mother held over her life, and that deaths were never as they seemed in her childhood: there was always another story. Up to this point we had been making excellent progress and I was devastated at the serious setback. It took all of us co-operating to encourage Maria back and for her to believe that her mother was in fact dead and therefore no longer a threat to her. This seemed to be a psychosis that was eventually resolved.

Parallel Processes

As each new personality has come forward to get to know me, I had to re-establish the relationship all over again. This has felt exhausting, especially when a relationship has begun with a great deal of anger and mistrust, and I wanted to be able to rest on the trust I had built in others and with Maria herself. Many times in our work together Maria would also reach a limit of not wanting to know more about her life. She would despair when more information was about to be revealed. Letting her know what I knew required pacing and care. Similarly, at times I did not think I could cope with knowing more of the depravities and torture to which she had been subjected. I have experienced the distress which comes from empathic attunement to this degree of traumatisation: I have felt witness guilt. Parallel to this was the survivor guilt felt by Maria and some of the others in relation to what they had witnessed, and especially when they had been manipulated to act to ensure their own survival at the expense of another. Blizard (2001) stated: "The client's transference enactment may illuminate the dynamics of the active ego state, while the therapist's countertransference reactions may reveal the disowned ego state" (p. 53). I have often had to carry compassion as best I could. Maria could be blaming of the

others when traumatic material was emerging, and I had to be careful not to blame Maria for blocking. Kluft (1994b) discussed the pitfalls: It is not uncommon for a cycle of mutual projective identification to occur in which therapist and patient create ... and pass their distress, discouragement, disillusionment back and forth in a sharing that has unfortunate implications for the fate of the psychotherapeutic venture. We both know what this feels like.

Towards Resolution/Integration

When Maria first came to therapy she hoped for complete integration. Gradually she has accepted the possibility that she may never be able to take on all the tasks which have been shared by others. She could not cope yet without the particular help that Mary gives her, as, for instance, Maria is not able to do her own self-care; Mary takes responsibility for all toileting and bathing, and Maria has learned to be more grateful to her for that.

Putnam (1989, p. 115) has described the "delusion of separateness" when alters may not recognise that they share the same body, or are not interested in the health of that body. I have had to emphasise repeatedly that there is only one body. This is a difficult concept for many to grasp initially. Recently I had a planned surgery and, before I went to hospital, a little one handed me a little gold Guardian Angel which she had been given by her carer Peaches, for her safety when she has to go into hospital. Up until then, no one else except the two of them had known about it. When the boys learned of it, they asked Mary if that meant they were also kept safe by the Angel, as, if it worked for one, then surely it would work for all, as they share the same body. This was breakthrough understanding.

When Maria first came to therapy, her goals included wanting to know who was responsible for the abuse. She is clear about this now. She has less lost time and is more able to think, feel and speak without dissociating. She wanted to experience a greater range of emotions (beyond good/bad). She now experiences and acknowledges a wide range of emotions. She feels a greater sense of self-worth and holds optimism for the future, apart from when her physical health issues threaten to overwhelm her.

The reward of coming through such horrors is that there are blessings and gifts. Dissociation was Maria's first blessing, as, while she shattered into many parts, she survived with her core intact. Her source of spiritual strength has helped her to heal the shattered self to become more whole. Working with her feels a privilege and I have a greater understanding of myself and my own capacity as a result. We both remain committed to this therapeutic endeavour: we know that we are held by God.

In order to help my client achieve this greater sense of wholeness, I was required to go to greater depths in myself than I had previously known. My capacity as a psychotherapist and as a person was thereby expanded and for this I am most grateful.

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Susan Hawthorne grew up in the culturally rich environment of Tolaga Bay on the East Coast, before moving to Gisborne to complete secondary school. She graduated with a Bachelor of Commerce (Economics) and a teaching qualification in Wellington. While living there she became active in left-wing political causes, an interest which continues. She has worked to help to raise awareness in racism and sexism, and to confront perceived injustices. Her first paid career was in teaching at primary, secondary and tertiary levels. In 1977-1978 Susan and her husband, Burke Hunter, with their son Matthew, taught for two years in Western Samoa with the Voluntary Services Abroad. Their daughter Phoebe was born after their return to Aotearoa New Zealand. During the mid 1980s the family lived for two years in San Francisco and Susan worked in a Franciscan programme for the homeless. Returning to Whakatu Nelson, she worked for the next 13 years in the public health system in social work and counselling, while completing her Masters in Counselling from Massey University and then NZAP membership in 1995. Since 2000 Susan has worked in the Psychotherapy Partnership practice with Burke. She has served on NZAP Council, holding the portfolio of Public Issues and was the NZAP's representative on the Accident Corporation Commission's

Sensitive Claims Advisory Group. Susan maintains her mental health by gardening, walking with her poodle and other friends, snuggling with her Burmese cat and reading lots of good books. In 2001 she began working with her first client who had been diagnosed with DID, which stimulated a strong interest in and respect for dissociation. In early 2015 she will retire from her practice, although she will maintain her involvement with the NZAP. She plans a project from her work in dissociation. Contact details: susaburk@ihug.co.nz .