The Three Phases Of Connecting
A New Zealand Study of the Treatment of Dissociative Identity Disorder

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Abstract

This grounded theory study generated a conceptual model of the processes by which clients with Dissociative Identity Disorder (DID) handle psychotherapy. Eight DID clients participated in this research. Out of the analysis emerged the fact that the main concern of DID clients is **Connecting,** with three distinct stages of 'Reaching out for therapy', 'Coming together', and 'Making human contact'. Core issues at each stage of the process have been identified and implications for clients and professionals have been discussed.

Introduction

Dissociative Identity Disorder can be defined as "the pathological separation of aspects of mental functioning, including perception, memory, identity, and consciousness, that would normally be processed together" (Spiegel, Butler, & Maldonado: 1998: 423). This separation manifests in the presence of two or more distinct personality states that alternate in exercising control over the behaviour of the person (American Psychiatric Association: 1994).

I have worked with numerous dissociative clients over the last eight years. I have borne witness to their struggle to survive day-to-day challenges, and deep black holes of despair, terror and pain. It was hard work for me, and more so for my clients. This prompted me to use the research component to look for ways in which both this severely traumatised client group and the treating clinician could be supported in the demanding therapy process. I felt equally moved to give clients an opportunity to speak about their experiences in their healing journey, as research into psychotherapy with DID clients so far has paid little attention to the experience of clients. Many "ills of modern

medicine" are rooted in ignoring the patient's view of their treatment (Spence: 1994). This study addresses this gap.

For a long time clinicians considered dissociative disorders a rare condition. However, international research indicates that DID is present in as much as 1% of the general population (Steinberg: 2000). One recent New Zealand study found that approximately 6% of the general New Zealand population suffer from high dissociative symptoms (Mulder, Beautrais, Joyce, & Fergusson: 1998). The impact of DID on a person's life and on society is enormous. A large percentage of persons with dissociative disorders depend on Social Welfare, are involved with child welfare services, have criminal records, and abuse drugs and alcohol (Loewenstein: 1994). Given the high prevalence of dissociative disorders and the high costs to the individual and society, improved understanding and service delivery for this client population are of paramount importance.

Methodology

I have chosen the method of grounded theory for my study, which offers the researcher a methodology and tools that identify core concerns of a group of people, and documents how they continuously resolve or handle these concerns (Glaser: 1998: 11). The 'coding families' of cause, context, conditions, strategies and consequences (Glaser: 1978) were chosen for data analysis to most accurately describe clients' experience. Clients' own expressions were used to stay close to the data. Forty-five therapists were asked to approach suitable clients for this research project. Eight female participants between the ages of 30 and 61 years were recruited. Two audio-taped unstructured interviews of 32 hours in total provided the data.

Results

The model of **Connecting** describes a process of persons—previously disconnected from themselves, others, and the world—gradually re-establishing those severed connections. Although presented here as a linear process in three consecutive stages, the experience of healing from DID is more a back and forth movement. All categories are present in all three stages, although they have varying degrees of significance in each stage.

Connecting

	Stage One Reaching Out For Therapy	Stage Two Coming Together	Stage Three Making Human Contact
Cause	Losing it	There must be more to life	Behind block walls
Context	No understanding	Being alone & in crisis	Don't know how to relate
Condition	Keeping going	Having faith	Repairing broken trust
Strategy	Grappling for control	Grouping together	Learning to relate
Consequence	Making a connection	Integration	Homecoming

Reaching out for therapy

In order to engage in effective therapy, DID clients had to find a suitable therapist whom they could trust. Yet it was particularly their ability to trust and their sense of safety that had been compromised by experiences of childhood abuse (Herman: 1994). Even though people were longing for human contact, their fears and their defences had built thick walls of protection around them, through which therapists had trouble reaching them.

> *Carol:* It's also very 'catch 22'. Because I needed the help of the therapist to feel stronger within myself, but in order to find that therapist, I had to reach out. So, it's a hard one. All that I knew was that I had to keep to myself. I had to protect myself with whatever means I could.

Losing it

'Losing It' is a state of total chaos— irrational thought patterns, dysfunctional behaviour, amnesia, and self-harming tendencies— and causes clients to reach out for therapy.

> Multiples seem to teeter continuously on the brink of total disaster. Every improvement is followed by a relapse. Hostile alters threaten suicide, internal or external homicide, and assorted other catastrophes (Putnam: 1989: 160).

> *Krista:* And I knew that if I stepped over that doorway I would totally lose it. I was trying to get my son into order, I was beating him. And I couldn't do that any more.
>
> *Carol:* [T]hey just said that I was very moody and they said that I had said things that I had no recollection of saying. It was like "I never said that...I didn't do that." And I felt like everyone was making up stories about me. It was like being against me. Everyone was out to get me.

'Losing it' described the eminently difficult task for DID people of coping with the symptoms of DID while also battling the debilitating symptoms of post-traumatic stress. Providing everything went right, clients seemed to be able to cope with everyday life. However, once things went wrong they quickly slid down to crisis point and got so far out of control that professional help was needed.

> *Sharon:* [W]hen he (son) attacked me, that was too much... Well for me basically it caused me to have a total breakdown... till then I managed to hold it together, still with ups and downs. It was not like depression where you slide into a pit. It was just sliding down into a strange world with all sorts of voices and all sorts of things happening.

No understanding

'No Understanding' was the context in which clients reached out for therapy. It emerged in this study as a significant obstacle to recovery. Indeed, it was the lack of the therapists' understanding that prolonged the clients' search for healing and compromised their safety. At the same time DID clients struggle with their own inability to understand both their symptoms and their needs, which makes finding a therapist a challenging task.

> *Ruby:* They (therapists, crisis team, respite worker) don't really know anything. I think there is a lot of misinformation around. I mean people, they know I've got DID, but they don't really know anything about DID so they don't really know how to deal with me. They either treat me like a psychotic person, or they treat me as someone who is totally incapable, or they treat me as someone who is really capable and who doesn't have a problem.

Participants felt that this lack of knowledge, understanding, and the sensationalist depiction of DID in the media, have been breeding places for being stigmatised and labelled crazy.

> *Ruby:* I tell some people about some of my parts and they freak out. They don't bother to get to know the rest of me. They just freak out on that.

Participants highlighted how important it was for them that their therapist was able to see the world through their eyes and share their reality, because it is "impossible to conceive of a self arising outside of social experience... social interactions make possible the development of self" (Charon: 1998).

> *Sharon:* You are asking that someone suspends what they think of as real, and what they think are the normal boundaries that they experience every day. . . .To be able to help the patient through you've got to be able to go to the place that that patient visits. And to not do that, I can't see how anyone could help. It's like a wall between you.

Society is held together by people communicating or sharing their knowledge, meanings, and attitudes (Charon: 1998). Shared reality is indispensable for the creation of truth as it is impossible to perceive something as true that is not recognised, understood, acknowledged, or accepted by at least one other person (Rahm, Otte, Bosse, & Ruhe-Hollenbach: 1993). Thus, being understood and having one's reality affirmed leads to immense relief and lessens the sense of isolation. 'No understanding', on the other hand, transports clients further into isolation and is ultimately disempowering and increases their sense of being out of control.

Keeping going

'Keeping Going' was regarded by DID clients as the condition under which they had wrestled while reaching out for therapy—particularly 'keeping going' in the face of shocking experiences with therapists and high numbers of transfers from one therapist to another. This made the therapy process for them extremely difficult and caused an overwhelming sense of being unwanted, abandoned and disappointed by therapists.

> *Carol:* I really don't know how the heck I kept going with therapists. I mean to this day I look at it and say, how many did I have? Eight (in 3 years)? Yeah! It really blows my mind.

The main challenge was to stay motivated for therapy in the face of frequent transfers. The eight participants in this research altogether had 32 therapists. These transfers were due to therapists' burnout, change of employment, or staff changes. Participants felt they ended up with a therapist selected by availability and not by suitability. This disrupted the already difficult task of

trusting and attaching to a therapist and were experienced by participants as counter-therapeutic and damaging.

> *Katherine:* As a client you have to put in so much trust, and that is a hard thing to do. . . . I know I left that therapist with the thought that I was a bad person. I finished with that, I was bad and stuffed up. As in, like 'mental'.

Participants reported other unsatisfying and shocking experiences such as breaching confidentiality or questionable professional practice.

> *Carol:* [S]he phoned him (abuser) up to come for a session between us. And I had no idea of it. She hadn't discussed it with me. It was shocking. So that was my first attempt. I had absolutely shocking experiences with counsellors.

The lack of progress was sometimes due to therapists' inability to cope with the material that clients brought up. DID clients are known for being highly attuned to their therapists and "will know if the therapist is unable to tolerate hearing what has happened to her, and the therapeutic progress will come to a standstill" (Putnam: 1989: 191). Therapists need to be aware of their avoidance of traumatic material and have the courage to admit and explore that together with the client (Dalenberg: 2000).

> *Treena:* They just didn't seem to be able to cope very well with what was coming out of my head. So I knew I had to go to someone else.
>
> *Krista:* And so I felt like I was pulling myself along. Doing it for myself still, because I was still, although I saw her and had a cup of tea now and then. At home I was still really working on my personalities and not using her. Trying to do it by myself.

If participants wanted to continue in their search for healing they needed to start anew with several therapists the difficult process of building trust and safety. This process of stopping and starting kept them for years trapped in the first stage of **Connecting**. The strain on the individual client and the economic costs of such inefficient treatment are colossal.

Grappling for control

'Grappling For Control' is the strategy DID clients use to solve the problems they encounter. Struggling to control their conflicting needs, terrifying experiences, confusing feelings, and fear-producing environment are common

experiences for traumatised persons in the beginning phase of therapy (Herman: 1994; Kluft: 1993; Putnam: 1989; Turner, McFarlane, & van der Kolk: 1996).

The sense of being out of control, feeling helpless and 'lost', evoked for participants a yearning for somebody, the benign other or good enough caretaker, to take control.

> *Carol:* Really, I guess, I look for somebody to take control when I am out of control. Or when I feel I am out of control. . . .I am then so lost, I don't even know what I need.

Clients' need for control often concerned making their environment predictable, especially when the inner world of the person was not predictable. Therapists who taught their client skills like journal writing, relaxation techniques, and ways to foster internal communication, helped them to control emotional states and to self-soothe.

> *Krista:* Teaching people routines is good. Teaching them to be consistent with what they do. Even though flipping through your personalities, still everyday life being consistently the same. So that you're not setting yourself up for situations where things happen.

Once women in this study had been diagnosed they involved themselves in researching DID, which increased their sense of control because they started to understand their actions and the historical origins of DID.

> *Ruby:* So then I started researching and went to the Mental Health Foundation. So I started getting information from my therapist, I started going to the library, I got medical things, and I got the DSM III. I started reading really seriously. . . .I did a lot of research on DID. So I know what I am talking about at least.

When therapy did not provide the client with good enough experiences, or when for example transferential issues were not satisfactorily resolved, some clients attempted to salvage control by terminating with their therapist.

> *Krista:* I needed someone to believe in all of us. . . . I felt that with my first therapist. I didn't feel that with my second. And that's when I knew I had to find another counsellor. It wasn't like I wanted to, but I had to.

A close analysis of the data revealed that clients only initiated four out of 32 transfers, and then only after a long period of struggle that left them feeling guilty and bad.

> *Mona:* I ran away and hid for a while.... I was pretty paranoid at that stage. And I actually felt that I was being abused... and she was the kind of therapist who tried and tried for me to come back. And just wanted one more session for closure. And I just needed to get away. I was terrified.

Making a connection

'Making A Connection' was necessary for clients to enter the second stage of connecting. For this to happen they have to connect with a therapist and DID has to be diagnosed. How long the client cycles through this stage for hinges to a large extent on therapists' diagnostic skills and their skill in communicating and relating to this traumatised client population.

> *Mona:* Therapists that I had gone to and it hadn't worked and I left after one session, there was nothing there. Like, we weren't like kindred spirits or not even that deep... it was simply something missing that was human .... it's like sort of transference, but it is deeper than that.

The ability to empathically feel with the client, to see the world through her eyes, and to acknowledge that this world might look different through her eyes rather than one's own (Rahm et al.: 1993) seems to have made the connection between therapist and client possible. Symbolic interactionism asserted that people's actions arise not only from their interactions with others and with the self, but also from their interpretation of those (inter) actions (Charon: 1998). Thus, DID clients' interpretation of the intersubjective moment determined whether or not they had found the right therapist.

> *Treena:* The fact that they could have the empathy with what I was saying, could have the understanding of what I was saying, and they could have insight which was helpful to me in what I was saying, created in me the healing opportunity.... It made me feel recognised. It helped me get insight. It really made me feel as if we were on the same war-path. Really, really good connection.

Diagnosis and the subsequent increased understanding surfaced as the crucial variable. Only when the client was able to trust that the therapist knew what she was doing, and that the treatment would help her to recover, was she able to overcome her fear of the traumatic material and start the next phase of the healing journey.

While diagnoses and the labelling of clients are controversial, participants in my study unanimously welcomed their diagnosis. They felt the healing journey

became clearer, they were able to make sense of their experiences, and the tasks ahead became more tangible.

> *Ruby:* I loved having that label. It was, I had an answer to my prayers. Like I knew who I was, I knew why I did what I did, and it's like it's all right to have lots of parts. It's OK. I am normal in a DID sense.

The importance of the diagnosis lay in the fact that it provided the intellectual and theoretical understanding for what the person was already experiencing on a physiological, psychological and emotional level. They could understand the concept of needing to connect what had been disconnected. The correct diagnosis was therefore the most crucial rite of passage for DID clients in this study.

Identity is a label a person gives herself (Charon: 1998), for example 'I am a woman' or even 'I am a multiple'. As such, identity is an important part of one's self-concept that undergoes changes or is affirmed in interactions. Participants in this research identified themselves as crazy or insane before they started therapy. The diagnosis of DID and their interactions with the therapist have given them the opportunity to identify with a different reference group such as abuse survivors.

Coming together

Two aspects emerged as most crucial to progress in this stage. Those were acceptance and understanding of the different personality parts, and the processing of traumatic material. Therapists' main tasks in this second stage were to provide safe containment, encouragement, acceptance of all personality parts, consistency and reliability, and thereby to assist the clients to develop a sense of object constancy. This gave clients the sense that the 'caring other' (object) can be relied on and trusted to be available when needed. Thus therapists provided self-object needs that clients could not provide for themselves just yet. Self-psychology (Baker & Baker: 1987) assumes that over time clients internalise these and will be able to provide these for themselves.

There must be more to life

'There must be more to life' is a realisation that motivates clients soon after finding a therapist to connect with and being diagnosed. Feeling accepted and understood by their therapists, participants started to become increasingly accepting and understanding of themselves and of all their personality parts,

setting in motion a process of integration, generating hope and desiring a better, different life.

> *Sharon:* And as I talked to my therapist I began to discover a yearning for more. I felt that there was more to life than getting yourself into a state where you can function from day to day and towards other people. It's got to be more than that.

Motivation also came from those experiences that participants in the study wanted to move away from, such as problems with relationships, parenting, work, suicidality, and self-harm urges.

> *Krista*: I don't want to be what my parents created. And that is the greatest fear for somebody like me. To treat my kids like shit and have them hate me at the end of the day.... And I really didn't like what I did. I really had to change.

The motivational direction of participants' goals changed once they had moved further along in their healing. It was at this stage of the process of 'coming together' that all participants identified future goals incorporating aspects of 'giving back to society'. They claimed that through being abused they had acquired skills and understanding that not every person would have had access to. By using them, and turning them around to help other people, they changed for themselves the meaning of the experienced abuse into something positive.

> *Sharon:* [I]t will enable me to say yes, I had these horrific experiences in my life. Experiences that no one should have to go through. But look how something positive comes out of it. I am not saying I needed to go through all this trauma. What I am saying is, I have gone through them and look, I am turning the tables on all those people who inflicted those various things. I am turning the tables on those. I am actually saying, I take that, and I use it. You gave me a gift. What you thought you were doing to me and what happens now is different. I am actually taking it and I am changing it into a gift that I can use in my life. And let it work for me rather than it running my life in a negative way.

Herman (1994:175) cites Freud, who stated that in dealing with trauma

> [the patient] must find the courage to direct his attention to the phenomena of his illness. His illness must no longer seem to him contemptible, but must become an enemy worthy of his mettle, a piece of his personality, which has

solid ground for its existence, and out of which things of value for his future life have to be derived.

Being alone and in crisis

'Being Alone And In Crisis' is an expression for the state of loneliness and the sense of isolation participants lived with. It has been a pervasive theme during interviews and became a significant aspect of all three stages of connecting. In this stage it referred to the feeling of being alone while in crisis, when people other than the therapist were perceived as toxic and dangerous.

> *Ruby:* I think (the hardest thing was) that I was alone and that I was doing it by myself. And I was scared of the darkness, I was scared of my... I was scared of everything. Oh my God, I think the worst moment was when I was alone and when I was shaking, all the little kids were out, and no one was there to help us. And we were all alone.

Trauma theory has identified isolation and the severing of human connections as a main impact of traumatic events that not only affected the psychological structures of the self but also shattered the "systems of attachment and meaning that link individual and community" (Herman: 1994: 51).

> *Carol:* I thought if I don't say anything, if I don't allow myself to interact with people and be with people, then I am not going to get hurt again.

Re-visiting, grieving and processing of the traumatic events are situated at the centre of recovery from trauma (Herman: 1994). Timing and pacing of the therapeutic work in order to avoid crises due to trauma processing are most important and should only take place once the client has sufficient self-resources and is stabilised in her environment (Briere: 1994). Models for working with DID (Braun: 1986; Kluft: 1993; Putnam: 1989; Ross & Gahan: 1988) identify a wide range of techniques and interventions to assist the DID client in the emergency state. It is suggested that the client be taught certain skills to help her deal with these problematic moments and to develop a sense of control and empowerment.

> *Mona:* When I was going through my memory stuff I had very little containment. And if I had been able to learn skills, to come into therapy, to do a memory, and switch it all off again, go home and get on with life and only remember in a safe place. And I mean I am dissociative, I knew those skills. I should have been... it would have been helpful if I had been helped to use those skills.

Transference issues were a significant contributing factor to participants' sense of isolation. The rewards were many when clients were helped to work through transference issues and able to identity how experiences in the past of being hurt, abandoned, rejected or misunderstood had clouded or influenced their interpretation of dynamics in the present between them and the therapist. Thus the therapist's recognition and skilful use of transference dynamics had a considerable influence on 'being alone and in crisis'.

> *Mona:* I was with that therapist for almost a year and in the end I begged and pleaded for another psychiatrist to come and review the relationship.... The psychiatrist said that I was having a psychotic negative reaction to her... and that none of that (examples of feeling abused) was true. That I had bad trust issues, that it was all in my head. And I don't know, that's probably true; all I know is that I spent eight months deteriorating. I had been doing really well before.

If transferential material was not worked through, clients were likely to control these overwhelming feelings by acting them out and, for example, withdraw or leave therapy. Traumatised people are prone to what is called traumatic transference, the expectation of being hurt by the therapist just as they had been in childhood, either through exploitation, abandonment, intrusion, betrayal, neglect or other forms of abuse (Tendler: 1995).

> *Ruby:* I was giving her a really hard time. Lots of us didn't trust her; lots of us like hated her. It was all that nasty countertransference stuff going on as well.... And I think gosh, she stuck around through all of that... it was a turning point in our relationship because I realised she really loved us.

When transference phenomena were dealt with well, not only did the therapeutic relationship end up being strengthened, but also clients were also able to deal with large portions of significant clinical material.

Coming together

'Coming together' occurred under the condition of 'Having Faith'. Participants not only developed a sense of faith in a higher power, but also faith in themselves, their own capabilities and capacities, and in the goodness of their internal personality parts. To be able to identify with the positive aspects of oneself, even though they might have been formed by trauma and abuse, allowed for an increased sense of power and compassion.

> *Katherine:* We learnt (from the therapist) that there was nothing wrong with us.

The development of faith was an ongoing process during the early stages of therapy and depended to a large extent on the therapist's ability to convey that healing was possible, that the process would produce healing, and that the client had the ability to manage the process. In turn, the women in this study were then able to develop faith in their own capability, not only to deal with the legacies of the abuse but also to create a different future for themselves.

> *Krista:* I think that [faith in me] coming from a counsellor is really important. Being told that, no matter what, what you do every day is just so great. Because in reality you are so defective. But you can do all these things in life and not be.... I needed someone to believe....

For the DID clients, 'having faith' in themselves entailed fostering a loving and trusting relationship with their different personality parts, for which an understanding of the originally positive intention and helping nature of the different parts of the client's personality was necessary.

> *Mona:* I had so much confidence in my people. I always accepted, even the ones who I thought might be cult active.... I had unconditional love all the time. And so we had a really good relationship and a lot of trust built up. And that was the best thing. It was like having a million dollars to the bank.

Two of the participants felt strengthened and encouraged by their therapists' acceptance and acknowledgement of their spiritual belief, which became a rich resource for self-soothing, skill development, and inner strength.

> *Sharon:* I think where the spiritual line helps, it gives you the strength to cope. In a really difficult situation, when your resources have gone, you've got no resources left; it's like an athlete running a marathon. It gets to the point when they get wobbly legs. And they've got nothing more to give and they are all confused, getting dehydrated, they've lost all their body salts and things like that. I got to that state where I'd got nothing else left. And tapping into my spiritual life gave me that strength to say, "I can do that, I can walk along, I can get on".

Grouping together

'Grouping Together' was the expression used for the interactions and strategies that helped people to come together as a person. The integrative aspect came

about when the person got to know and like the different personality parts and understood how traumatic events had shaped their tasks, beliefs, and behaviours.

> *Sue:* It gave me an understanding to who the child was. And helped me to connect with myself. I realised I was that child. At first she seemed like a stranger to me. And I felt bad about connecting her to me. And I find myself now being able to see myself not as a bad person.

Integration occurred when the traumatic memories had been disseminated amongst all parts of the person and the related affect re-associated. The validation and recognition of the different parts and their differing needs reduces fragmentation and crisis. Only when DID clients were able to communicate with their different personality parts were they able to negotiate the often conflicting needs of their whole system. This resulted in a reduction of acting-out behaviour and provided them with a less chaotic life.

> *Krista:* I feel now I've got someone with an arm around me. Who says, it's OK, it can't have been easy. All the sort of things I want to hear from somebody out there. If they are not there to tell me, I try telling myself more now. So as a unit we all stand together. Standing with the arms around us. And that is grouping. We all stand strong.

Integration

'Integration' was the outcome of the effort of 'coming together'. Participants were able to re-associate the previously fragmented and split-off parts of the personality into a coherent sense of self. Functions of memory and perception were no longer divided amongst personality parts.

> *Treena:* It is, it is very much becoming one. No voices any more, parts coming together, no voices any more.... It's a funny sensation. There is this weird sensation, you are all there together, but so united. There isn't voices talking to each other or talking at you.

While some participants stated they aimed for becoming one person, others were afraid of that concept and feared some of their parts would have to die. The latter was a source of enormous grief and fear.

> *Krista:* Unification. Yeah, because that was scary. When I met that lady who said how it was to become one, it freaked parts of me out. Because we thought, well, were would we go? And then I thought that's not me. We are not going to become one, we will become 15. And we will all work together.

Experts point out that integration cannot be expected to be a linear process but should be anticipated as oscillating between achieving a certain level of integration that could be followed by relapses (Putnam: 1989). Numerous events and stages over a person's lifespan—such as motherhood, old age, an accident, or a serious illness—might impact on a person's sense of identity and need to be integrated. It is of major importance to offer DID clients the opportunity to reconnect with the ongoing dynamic process of life, and help them to understand integrating as a living dynamic phenomenon in every person's life-journey.

Making human contact

All through the history of mankind, being part of a community has been indispensable for the survival of the species. The worst punishment, equalling the death sentence, has been to be expelled from one's community. Plato stated "...the individual apart from a community was an imperfect and fragmentary being, a mere collection of potentialities which were only realised in a society" (Field: 1961). It is for this reason that traumatic events have such a devastating impact on people, " because they breach the attachments to family, friendship, love, and community. They shatter the construction of the self that is formed and sustained in relation to others" (Herman: 1994: 51).

Thus DID clients live in isolation, because it is difficult for them to engage and connect with other people.

> *Krista:* But I've got a hunger, a hunger to be loved and to be treated like anybody else with respect and caring and all those things.

The data for this stage was less dense then for the other two due to the fact that all participants were still at the early stages of 'making human contact'.

Behind block walls

Living 'Behind Block Walls' became the reason people started 'making human contact'. Once participants had a sufficient sense of themselves as a person and internal chaos and conflict decreased, their need for human contact moved into the foreground.

> *Carol:* I don't know. I just felt very hurting. I don't know. I mean I wanted help. I wanted the support. There were just these block walls all around me. I was just pushing everyone and everything away from me.

Being 'behind block walls' became a major therapeutic focus, because the rising need for human contact met the fear of being re-abused, re-abandoned, and re-traumatised. This fear was not easily dismissed.

One of the most prominent symptoms of DID is the shifting between personality states, or 'switching' as DID clients call it. It not only keeps people safe but also prevents the establishment of meaningful relationships.

> *Sharon:* One of the things about DID that I found is, that permanence becomes a thing that exists for other people only.... Your whole world is completely changing all the time. It's shifting. It's like shifting sands.... The difficulty was that different alters trusted different people. So I speak to one person I will be quite friendly one day and another day I would be... keep away! That side of it got quite difficult.

Don't know how to relate

The context participants found themselves in is described as 'Don't Know How To Relate'. They soon realised they lacked basic relationship skills and felt unprepared to make contact with others.

> *Carol:* I never had a relationship until my boyfriend, and it's like wow, if I do get a relationship, what the hell am I going to do?

Herman (1994) compared these feelings of insecurity and awkwardness with behaviour usually encountered by adolescents. People learn relationship and communication skills by interactions with others and themselves. "Human nature is not something we are born with: instead, it arises in social interaction" (Charon: 1998: 156). DID clients, with their fragmented sense of self, would only marginally have benefited from such intricate interactional processes. They find themselves ill prepared for any social contact as a consequence.

> *Ruby:* I don't go out, it's too hard.

DID is intrinsically about disconnection, being separate, not being aware of others, and hiding from others. Concepts of linking, connecting, and relating were completely foreign to participants.

> *Mona:* It's almost that you have the ability, you know you are OK and that you want to be friends with people.... But you kind of have to learn the skills to do it. To get in the habit of doing it. The fundamental mechanics of it.... It's like kids have to when they are growing up. In a way it's like going back and doing all the stages of development again.

However, their work within therapy and therapeutic modalities such as group psychotherapy offer rich opportunities for learning about and experimenting with relatedness with others. It is at this point of the recovery process that group work can provide the DID client with the skills needed for 'making human contact'.

Repairing broken trust

'Repairing Broken Trust' became the crucial condition to enable human contact. Trust issues dealt with in the early stages again formed a pivotal part in this phase. Trusting and accepting oneself as well as others had to be revisited. Trusting now involved trusting one's own intuition, one's own judgement of other people, and one's own ability to be able to deal with letting down the walls.

> *Carol:* In order for connections to occur properly I had to have acceptance, acceptance of myself and acceptance of other people.

Herman confirms that by having established a safe haven through therapy "the person is gradually able to expand the level of contact with the wider community" (1994: 162). To do so participants had to change their view of other people and not automatically expect to be hurt by others.

> *Krista:* Because it is something that I have not experienced before, I am trying to open myself up to it. The fact that he touches me and rubs parts of my body that nobody ever has been allowed to touch before, is all put down to fighting what I feel and my past experiences and just letting it go and seeing what happens from it.

To let down the wall they had built in childhood for protection became easier as participants' self-system grew strong enough to self-soothe, self-acknowledge, and self-nurture, so that a disappointment from another person was not experienced as a 'fatal' injury anymore. One participant (Katherine) commented on how important it was for her to realise, that "it's OK to be disappointed".

Learning to relate

'Learning To Relate' included the strategies and interactions participants employed in order to make contact with other people: communication and relationships skills, testing themselves and other people, taking risks, and cautiously revealing themselves.

> *Katherine:* Each one has little terms to come out, and then bit-by-bit they gradually learn doing things together. It's like sticking their nose out, and testing, always testing. And then it's important to trust. Trusting the inside to be able to deal with the outside.

With living in isolation as the alternative, 'making human contact' and 'learning to relate' took on a desperate dimension. This is a time of enormous vulnerability because DID clients venture out into a situation for which they have no guidelines or roadmaps. However, the increasing sense of achievement and belonging helped them to continue making connections with other people.

> *Krista:* So I sort of try to open myself up a little bit more. But it's not that easy. That's what I am trying to do in that group. I'm afraid it's not going to happen and I am thinking, oh God, what am I going to do next? It's going to be somewhere for me.

Homecoming

'Homecoming' was the consequence of 'making human contact'. Participants have affirmed that to live without human contact means isolation, despair and hopelessness. The ability to establish and maintain relationships with other people that are fulfilling and nurturing, was seen as a central aspect of well-being.

> *Treena:* We are actually meant to have human friendships and closeness... If your life is basically in total isolation, and you don't have any quality relationships, that's what you can't cope with. And having that, to me is the quality of life, the happiness of life.

'Homecoming' also meant participants could give up striving to be who they were not; they could like themselves and be accepted. It meant coming to terms with their limitations and with the basic conditions of their lives. This provided participants with a sense of peace or even more with a sense of having found something very precious, something to be treasured and held very tight.

> *Carol:* The real me, that had been locked away. That part of me is now able to live a normal life. It's like being connected with the world, having your own thoughts, accepting who I am and accepting other people. Be the real me! I see myself as blossoming.

Conclusion

A main shortcoming of this study is the small number of participants and the fact that they had not completely finished the third stage. However, the three stages of **Connecting** corresponded with the widely understood trauma models of Herman (1994) and Briere (1994). Therefore the hypothesis is made that the model of **Connecting** reflected not only the experience of the participants in this study, but also of trauma survivors in general.

The importance of the therapist as the main facilitator and supporter of a person's process of connecting has been stressed by participants in all three stages of the recovery journey. The therapist's capacity and ability to enter the client's world with empathy emerged as one of the most crucial variables in 'reaching out for therapy'. It was imperative for the establishment of a 'human' relationship between client and therapist and for the establishment of safety and trust. The diagnosis and the subsequent increased understanding surfaced as the other crucial variable. Only when the client was able to trust that the therapist knew what she was doing, and that the treatment would help her to recover, was she able to overcome her fear of the traumatic material and start the healing journey.

The central feature of the second stage was participants' inner journey of 'Coming Together'. Therapists' main responsibility at this stage is to approach traumatic material gradually and carefully in order to prevent an escalation and intensification of post-traumatic symptoms and thereby a deterioration of clients' overall level of functioning (van der Kolk, McFarlane, & van der Hart: 1996). The ability of therapists to create a safe therapeutic environment and their stance of acceptance towards the different personality parts became the model for clients' restructuring and re-connecting of their self-system. Another finding of interest was that all participants planned or mentioned some sort of involvement in helping others or educating others about trauma. Herman (1994) considers finding a survivor mission a significant part of healing from trauma. To transform the abuse experience through interpretations that are growth-producing (Dalenberg: 2000) has been an important aspect for the participants. Therapeutic work that incorporates finding a survivor mission will enhance clients' healing processes.

The third stage, 'Making human contact', emphasised the crucial human need of making contact with others. The ability to connect with others and regain a sense of belonging emerged also in other literature as a basic human need and a core factor in experiencing quality of life (Laliberte-Rudman, Yu, Scott, &

Pajouhandeh: 2000; Taylor: 1994). Indeed, the ability to be in relationship with the environment and with people is a precondition for human survival and human development.

> In order to experience oneself as an autonomous 'I' we have to experience the 'Other'. Without the 'Other' there is no 'I'.... To be held and contained in the world is a basic experience (basic trust) that every human being needs (Rahm, et al.: 1993: 80).

This innate human need continuously fuelled the processes of participants. It cannot be treated as a by-product of therapy but has to be the most important goal of therapy and maybe even of one's life-journey itself.

Persons who have been diagnosed with Dissociative Identity Disorder have been badly wounded at the core of this basic human need and require respectful and understanding therapists who can help them to re-establish vital human connections. The rewards for working at such a deep level with another person lie in the privilege of bearing witness to the unfolding of a person out of the ashes of terror. It can touch our hearts and give rise to hope for a better world.

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